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Tuarascáil ón bhFochoiste um Meabhairshláinte maidir leis an nGrinnscrúdú Réamhreachtach ar Dhréacht-Cheannteidil an Bhille chun an tAcht Meabhair-Shláinte, 2001 a Leasú

Deireadh Fómhair 2022

Sub-Committee on Mental Health

Report on Pre-Legislative Scrutiny of the Draft Heads of Bill to Amend the Mental Health Act 2001

October 2022

33/HO/04

Membership of the Sub-Committee on Mental Health

Membership

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Cathaoirleach's Foreword

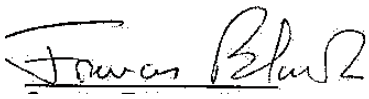
I welcome the publication of this pre-legislative scrutiny report on the draft Heads of Bill to amend the Mental Health Act. The Sub-Committee is encouraged by these draft Heads of Bill from the Department of Health, as they recognise the shift in how mental health is viewed as a society, and how treatment should be provided for people experiencing mental health difficulties.

The Sub-Committee on Mental Health agreed to undertake pre-legislative scrutiny of the General Scheme in 2021 and the Sub-Committee has endeavoured to scrutinise the proposed legislation and provide recommendations on areas where it believes changes or amendments are warranted. The Sub-Committee held eight meetings and also received submissions from a number of stakeholders.

On behalf of the Sub-Committee, I wish to thank all of the witnesses who joined us in public session, and who provided us with written submissions. The experiences of these witnesses provided us with a valuable insight into the issues with Mental Health Services in Ireland, from both the perspective of practitioners and those accessing services. Through these public sessions, it has become apparent that there is a need for a human-rights based approach to mental health services. Ensuring that the autonomy and dignity of those accessing mental health services is protected is of vital importance, and will improve the experience of those accessing these services.

The Sub-Committee has made 19 recommendations which are explored in this report. The Sub-Committee has made these recommendations in the hope that they will assist Minister Donnelly and Department officials in improving this important piece of legislation. I ask the Minister for Health to progress this urgently needed piece of legislation in early 2023 and to work towards implementation without delay.

I would also like to thank the Members of the Sub-Committee and the secretariat for their input into this report. I hope that this report will help to inform the legislative process and make a beneficial contribution to the forthcoming legislation.



Senator Frances Black

Cathaoirleach of the Sub-Committee on Mental Health

October 2022

Contents

Introduction

Background

The Mental Health Act 2001 sets out the criteria and process for involuntary detention in inpatient health facilities for those with mental health difficulties. The Act also established the Mental Health Commission as well as an Inspector of Mental Health Services. It also set out safeguards for persons receiving treatment in the Act. The 2001 Act represented a 'vast improvement' from its predecessor, the Mental Treatment Act 1945, in adopting a more human rights-based approach to protecting the rights of persons detained involuntarily in Irish mental health services.[1] It was seen to bring Irish provisions in line with the European Convention on Human Rights (ECHR).

In 2012, an Expert Group was established to comprehensively review the Act and recommend changes. The Expert Group included legal and clinical experts in the field, representatives from people with lived experience of mental health services, and representatives from the HSE, the Commission and from the Irish Human Rights Commission. The Expert Group's report on the Act was published in 2015. The report contained 165 recommendations, about 70% of which related to changes to legislation.[2] A government decision was taken on 14 July 2015 to draft a General Scheme of a bill to amend the Mental Health Act 2001 to incorporate the recommendations of the report of the Expert Group Review ('ERG').

The Irish Human Rights and Equality Commission notes that while the ERG report is a key resource in the reform of the Act, it did not substantially engage with human rights and equality standards in a meaningful way and its recommendations predate the ratification of the UNCPRD.[3] The Sub-Committee heard substantial evidence throughout its engagements with stakeholders of the need to ensure that the paradigm shift that is required as a result of Ireland's ratification of the UNCRPD is adequately reflected in the revised Act.

[1] Legal Expert Consultancy, Review of the Mental Health Act 2001 (2021) Dr. Charles O'Mahony & Dr. Fiona Morrissey
[2] Report of the Expert Group on the Review of the Mental Health Act 2001 December 2014
[3] Irish Human Rights and Equality Commission Submission to the Sub-Committee on Mental Health (2022) April 2022

Since the Expert Group Review was published, three Mental Health Amendment Acts have been enacted and are detailed below.

Legislative amendments

The first piece of amending legislation is the Mental Health (Amendment) Act 2015, which updated the provisions of the 2001 Act regarding treatment, namely the administration of medicine and the use of Electroconvulsive Therapy ('ECT'). Following implementation of the 2015 Act, ECT and medication (administered for over three months) can only be administered to an involuntary person accessing mental health services without consent where it has been determined that the person is unable to consent to the treatment. All references to the administration of treatment, where a person is 'unwilling' to consent, were removed from Sections 59 and 60 of the Mental Health Act 2001.

The second amending piece of legislation is the Mental Health (Amendment) Act 2018 which makes changes to the 2001 Act regarding the definition of 'voluntary patient' and introduces guiding principles for adults instead of the existing principle of best interests. The Act also introduces guiding principles for children and refers to capacity within the meaning of the Assisted Decision-Making (Capacity) Act 2015. The changes in the Mental Health Amendment Act 2015 and 2018 are based on recommendations of the Expert Group Review.

The third Act is the Mental Health (Renewal Orders) Act 2018, which amended Section 15 of the Mental Health Act 2001 following on from a Court of Appeal finding of unconstitutionality. The Act improves the rights of involuntarily detained people by shortening the maximum permissible period of detention without a review from twelve months to six months, with an additional right for a person accessing services to access a review after three months of this period of detention have passed. The shortening of the maximum permissible period of detention was one of the recommendations of the Expert Group.

The Mental Health (Amendment) Act 2015 and the Mental Health (Renewal Orders) Act 2018 have both been enacted and commenced, while the Mental Health (Amendment) Act 2018 cannot be commenced until relevant provisions in the Assisted Decision-Making (Capacity) Act 2015 are fully commenced.

The Department produced an initial draft General Scheme on the Bill to reform the Mental Health Act in July 2019 and consulted with relevant stakeholders. In March 2021, the Department launched a public consultation of the review of the Act. 100 submissions were received with over half of these coming from organisations, and the rest from people with lived experience of mental health services, family members and supporters, and professionals. Submissions are available here.

The draft Heads of Bill to amend the Mental Health Act was approved by Government on 13 July 2021. The draft Heads of Bill are primarily based on the 165 recommendations of the Expert Group Review of the Act, as well as the results of a 2021 public consultation, extensive consultation with key stakeholders such as the Mental Health Commission and HSE, and in light of domestic legislative changes in Ireland, including the Assisted Decision-Making (Capacity) Act 2015 and the Mental Health (Amendment) Act 2018, and Ireland's international obligations, including the UN Convention on the Rights of Persons with Disabilities ('UNCPRD'). The provisions of the Bill will have an impact upon the delivery of care for people accessing mental health services across both acute and community settings

Rationale for the new General Scheme

The Department informed the Sub-Committee that there has been a fundamental shift in how we view mental health as a society, and how we should provide treatment for those with mental health difficulties. This shift in thinking has inevitably meant that the original legislation needs to be reviewed and updated.

> *The purpose of the General Scheme is to move the Act towards empowering people accessing mental health services to make decisions about their own healthcare insofar as possible.* [4]

The Department has also noted that updating the act will bring a range of further benefits including:

- a more person-centric approach towards mental health care

[4] Sub-Committee on Mental health 02 November 2021

- the introduction of a more multi-disciplinary approach towards the care and treatment of people accessing mental health services
- enhanced regulation of mental health facilities and services
- compliance with the United Nations Convention on the Rights of Persons with Disabilities
- positive impact on the experience of people with mental health difficulties
- a specific part of the Bill related to the care and treatment of children
- compatibility with Assisted Decision-Making Capacity Act 2015

Pre-legislative scrutiny of the General Scheme

In accordance with Standing Order 146A, the draft Heads of bill to amend the Mental Health Act were referred to the Oireachtas Joint Committee on Health on 7th September 2021. The Committee agreed at its meeting on 2nd November 2021 to refer the draft heads to the Oireachtas Sub-Committee on Mental Health to undertake pre-legislative scrutiny.

The Sub-Committee conducted pre-legislative scrutiny during the course of 8 meetings and engaged with various stakeholders which are detailed below. Following the conclusion of these meetings, further submissions were invited from a select number of stakeholders which are available in Appendix A.

Engagement with stakeholders

The Committee commenced pre-legislative scrutiny in November 2021 and concluded scrutiny in April 2022. The following table provides detail of witnesses invited to present on key issues of interest to the Committee.

Date	Witness	Link to Official Record

02 November 2021	Department of Health • Mr. Seamus Hempenstall, Principal Officer, • Ms Lorraine Doyle, Higher Executive Officer, • Mr. James Kelly, Assistant Principal.	Transcript
16 November 2021	The Mental Health Commission (MHC) • Mr. John Farrelly, Chief Executive, • Dr. Susan Finnerty, Inspector of Mental Health Services, • Mr. Gary Kiernan, Director of Regulation, • Ms Áine Flynn, Director of the Decision Support Service, • Ms Orla Keane, General Counsel for the Commission.	Transcript
30 November 2021	The Health Service Executive (HSE) • Mr. Michael Ryan, Head of Mental Health Engagement and Recovery, National Mental Health. Mental Health Reform • Ms Fiona Coyle, CEO, • Ms Bernadette Grogan, Policy and Advocacy Co-ordinator.	Transcript
25 January 2022	The Office of the Ombudsman for Children	Transcript

	• Dr. Niall Muldoon, the Ombudsman for Children, • Dr. Karen McAuley, Head of Policy, • Mr. Diego Castillo Goncalves, Policy Officer.	
08 February 2022	The Irish Medical Organisation (IMO) • Dr. Aideen Brides, IMO GP Committee, • Professor Matthew Sadlier, IMO Consultant Committee, • Ms Susan Clyne, CEO, • Ms Vanessa Hetherington, Assistant Director, Policy and International Affairs. The Irish Hospital Consultants Organisation (IHCA) • Ms Alice McGarvey, Assistant Secretary, • Dr. Anne Doherty, Consultant Liaison Psychiatrist from the Mater Hospital, • Dr. Brendan Doody, Consultant Child and Adolescent Psychiatrist, Linn Dara CAMHS, • Dr. Donal O'Hanlon, Consultant Adult Psychiatrist, Naas General Hospital and Kildare-west Wicklow Mental Health Services, • Mr. Martin Varley, Secretary General.	Transcript
08 March 2022	• Dr. Fiona Morrissey, Disability Law Researcher, Adjunct Lecturer at the Centre for Disability Law and Policy in National University of Ireland, NUI, Galway, WHO Quality Rights Trainer, Mental Health	Transcript

	Tribunal Member and Member of Disabled Artists and Disabled Academics, • Ms Rosy Wilson, Poet, Retired Adult Education Lecturer, Mental Health Advocate and Member of Recovery Experts by Experience, • Dr. Liz Brosnan, Academic, Survivor Researcher, Mental Health Advocate and Member of Recovery Experts by Experience, • Dr. Charles O'Mahony, Senior Lecturer and Former Head of School in the School of law, NUI Galway, • Ms Fiona Anderson, Member of Recovery Experts by Experience, • Ms Jennifer Hough, Family Member, • Ms Deirdre Lillis, Mental Health Advocate; • Dr. Harry Gibjels, Retired Lecturer, UCC, Former Mental Health Nurse and Co-ordinator of the Critical Voices Network Ireland.	
22 March 2022	The Irish Association of Social Workers (IASW) • Mr. Vivian Geiran, Chair, Irish Association of Social Workers, • Mr. Eoin Barry, Irish Association of Social Workers Member and Chair of Social Workers in Child and Adolescent Mental Health Services, CAMHS, Special Interest Group.	Transcript

	College of Psychiatrists of Ireland (CPI) • Dr. Atiqa Rafiq, Consultant Specialist, Later Life Psychiatry, • Dr. Imelda Whyte, Consultant Specialist; Child and Adolescent Psychiatry, • Dr. Lorcan Martin, Vice President and Consultant Specialist, General Adult Psychiatry, • Dr. Norella Broderick, Senior Registrar, representing the college faculty of learning disability psychiatry.	
05 April 2022	Session 1: Shine • Ms Nicola Byrne, Chief Executive Officer, • Ms Estella Vidal, Advocacy Officer. Psychological Society of Ireland (PSI) • Dr. Anne Kehoe, President-elect, • Dr. Michael Drumm, Council Member. Session 2 Mental Health Reform, • Ms Fiona Coyle, Chief Executive Officer, • Ms Bernadette Grogan, Policy and Research Manager.	Transcript

	The Mental Health Commission • Mr. John Farrelly, Chief Executive, • Mr. Gary Kiernan, Director of Regulation, • Ms Orla Keane, General Counsel.	

List of Abbreviations

List of Abbreviations	
2001 Act	Mental Health Act 2001
ADM Act	Assisted Decision-Making (Capacity) Act 2015
AHDs	Advance Healthcare Directives
ECHR	European Convention on Human Rights
ECT	Electroconvulsive Therapy
ECHR	European Court of Human Rights
ERG	Expert Review Group
GAL	Guardian *ad litem*
HSE	Health Service Executive
IHREC	Irish Human Rights and Equality Commission
MHC	Mental Health Commission
MHT	Mental Health Tribunal
OCO	Ombudsman for Children's Office

PSI	The Psychological Society of Ireland
UNCRC	United Nations Convention on the Rights of the Child
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
WHO	World Health Organisation

Key Issues

1. Guiding principles: a human rights-based approach

There has been a shift over the past thirty years on an international level to incorporate a human rights approach to the treatment and care of those with mental health difficulties and in particular, in relation to involuntary admission and treatment. Most recently, there has been a recognition that as international human rights law has developed, mental health legislation in Ireland needs to adapt to embrace this fundamental shift in how we uphold and respect the human rights of people with mental health difficulties. Sharing the Vision, our National Mental Health policy, uses the language 'mental health difficulty' and the UNCRPD talks about 'psychosocial difficulties'. For the purposes of this report, when speaking about mental health difficulties the Sub-Committee is also including psychosocial disabilities and therefore the rights extended to people under the UN Convention on the Rights of Persons with Disabilities ('UNCRPD').

1.1 UN Convention on the Rights of Persons with Disabilities (UNCRPD)

Since the ERG report was published, the legislative landscape has changed with the introduction of the UNCRPD as an instrument to protect and reaffirm the rights of disabled people. It fundamentally alters the approach to mental health law by moving towards a more human rights-based approach. The UNCRPD is the first internationally binding document to explicitly apply to disabilities. It is regarded as the most significant development in human rights and disability law of the 21st century.[5] Ireland ratified the UNCRPD in 2018 however it has deferred ratification of the Optional Protocol ('OP') which establishes an individual complaints mechanism for the Convention as well as individual rights on economic, social, and cultural rights.

Article 12 of the UNCRPD requires equal recognition for those with disabilities before the law, including an obligation under Article 12(4) that states shall ensure all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. It states that such safeguards shall "ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent, and impartial authority or

[5] Charles O' Mahony and Fiona Morrissey, (2021) Legal Expert Consultancy, Review of the Mental Health Act 2001

judicial body." The safeguards in question shall be proportional to the degree to which such measures affect the person's rights and interests.

Article 14 of the UNCRPD provides for the right to liberty and security of persons to ensure that persons with disability 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. It provides that if people 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.

The Committee heard evidence that the UNCRPD Committee has interpreted Article 14 of the UNCRPD as a key non-discrimination provision that is particularly relevant for persons with psychosocial disability, who are at increased risk of deprivation of liberty.[6] The Committee also heard evidence that a number of provisions of the CPRD may have implications for mental health legislation here including Article 5 (non-discrimination), Article 12 (legal capacity), Article 14 (liberty), Article 17 (physical and mental integrity) and Article 15 (torture or cruel, inhuman, or degrading treatment).

Legal experts have noted however a slight dichotomy between the operation of Article 5 of the European Convention on Human Rights ('ECHR'), which allows for deprivation of liberty subject to certain exceptions for those with mental health difficulties and the operation of Article 14 of the UNCRPD which takes a stronger view on exceptions and exemptions on the grounds of mental illness.

At a European level, the European Court of Human Rights ('ECHR') has held that the deprivation of legal capacity constitutes an interference with the right to private life pursuant to Article 8(1) of the ECHR.[7] The Court has further held that any interference with the right to a private life pursuant to Article 8(1) would constitute a breach of that Article unless it "is in accordance with the law" and" is necessary in a democratic society" for one of the aims provided for under Article 8(2). Furthermore, any such interference must be proportionate to the legitimate aims being pursued.

The Sub-Committee notes the reservations by the State on Articles 12 and 14 of the UNCRPD and urges the immediate removal of such discriminatory declarations. When ratifying the UNCRPD in 2018, the State added a reservation allowing for substituted decision-making

[6] Charles O' Mahony and Fiona Morrissey, (2021) Legal Expert Consultancy, Review of the Mental Health Act 2001

[7] *Shtukaturov v. Russia,* 44009/05, Judgment of 27 March 2008, para. 83.

arrangements. The reasoning behind this reservation was the concern that preventing supported and substituted decision-making arrangements would ensure that there were no contradictions between the UNCRPD and the Assisted Decision Making (Capacity) Act of 2015. When considering Article 14, a reservation was added to allow compulsory care. This infringes upon the liberty of those with disabilities. The Sub-Committee strongly believe that those with disabilities should have the right to wholly engage with decisions regarding their own healthcare, and to consent or withdraw consent to treatments as required. The rights to legal capacity and liberty of people with disabilities should remain with the individual themselves.

A key issue that was raised during hearings on the proposed Heads of Bill was the application of the UNCRPD, and how this would impact upon provisions relating to some of the most complex and challenging elements of legislating for the treatment of those with mental health difficulties including involuntary admission and how we listen to, respect and uphold the views of people accessing mental health services and treatments.

There are specific provisions and principles in the 2001 Act which apply to people who are admitted involuntarily to mental health services in Ireland. The 2001 Act states that when making a decision relating to the care or treatment of a person, the best interests of the person will be the most important element to consider. Regard will also be paid to the interests of other people who may be at risk of serious harm if the decision is not made.

However, this approach will change under the proposed General Scheme. The Committee heard that the General Scheme replaces the existing "paternalistic" best-interests principle in Section 4 of the current legislation with a set of guiding principles for adults and children. This change has been welcomed by the Mental Health Commission ('MHC') and Mental Health Reform ('MHR'), which have advocated for a rights-based approach that is person-centred.

Under the General Scheme, every person will be presumed to have the capacity to make decisions affecting themselves in line with Assisted Decision Making (Capacity) Act 2015. For those who lack capacity, these guiding principles set out how decisions are made about their care and treatment. For children, best interests will continue to be the primary consideration in line with commitments under the UN Convention on the Rights of the Child ('UNCRC').

The MHC told the Sub-Committee that it very much welcomed the move away from the best interests test, stating that it had been interpreted by society and the courts in a paternalistic manner. It said that under the General Scheme, a person should be involved in decision-making around their care and treatment, and if they require assistance in comprehending any aspect, all relevant supports should be provided for.

The General Scheme states that the addition of the guiding principles is based on a more human rights-based approach, but that other perspectives, such as clinical perspectives, should still be considered. The Department told the Sub-Committee that more generally, the

approach to consent to treatment has been completely revised to take account of a person's capacity in line with the Assisted Decision Making (Capacity) Act, moving towards a model where each individual is involved as a co-decision maker in their care and treatment. The limited circumstances where treatment without consent can be given have been clearly defined in the General Scheme.

The Sub-Committee welcomes the shift towards how we as a society view mental health, noting that we have moved from a dark age where people with mental health difficulties were mistreated and were often involuntarily ostracised, 'locked away', stigmatised and excluded from society. The need for legislation to recognise that shift is clear. The Sub-Committee notes the remaining work to be done on reducing and tackling stigma around mental health difficulties and would like to thank those with lived experience who speak out and share their stories.

Dr. Fiona Morrissey told the Sub-Committee that the CRPD:

> "*Requires us to move away from coercion in our legislation, which deprives people of their liberty and the right to make decisions for themselves. We are required under the legislation to support people to make their own decisions and to respect their wishes in the mental health syste*m."

Whilst the majority of stakeholders agreed with the need for a human rights-based approach in this regard, it was acknowledged that there was a requirement for appropriate resourcing to be implemented as a first step. Resourcing of mental health services emerged as a common thread throughout the Committee's discussion of the proposed Heads of Bill and is discussed in more detail in Part 4 of this report.

Other stakeholders noted that a human-rights based approach should not be dependent upon funding and that there was a need for leadership and resourcing within the health services. It was noted that other supports, such as the reinstatement of the National Director of Mental Health post within the HSE and reporting directly to the CEO are urgently needed also. There is currently a Mental Health Operations lead within the Community Operations Division in place, as well as a Clinical Lead for Mental Health. This call has also been made on the floor of the Dáil by Minister of State for Older People and Mental Health, Mary Butler, on 26th January 2022. This proposal has cross-government and cross-party support but to date, there has been a hesitancy from the HSE to address this issue.

The Committee also heard that the WHO recently published a guidance document "Guidance on community mental health services: promoting person-centered and rights-based approaches" which provides examples and recommendations for scaling up

community health services that promote person centered recovery orientated and rights-based health services.[8]

On a similar issue related to resourcing matters, other concerns were raised by psychiatrists relating to the fact that whilst there is a human right to be involved in one's own healthcare, there is also a need to balance that right with the right to treatment in a timely manner.

In its final hearing on the Heads of Bill, the Sub-Committee heard that a reference in the General Scheme that states "the provision of mental health services is subject to the availability of resources" would be removed from Section 84(4) in the context of children and the proposed Section 4(9) in the context of adults.

The Irish Human Rights and Equality Commission told the Sub-Committee that reform of mental health legislation must be accompanied by State measures, including legislation, aimed at ensuring that less restrictive forms of treatment in the community are available and the ultimate eradication of coercion in the treatment of persons with psychosocial disabilities. This includes investment in community-based supports and services for people with psychosocial disabilities and through assisting persons to utilise the Assisted Decision Making (Capacity) Act 2015 to exercise their capacity. In the Mental Health Reform's submission on the Heads of Bill, they have called for the inclusion of provisions to capture data on when community-based supports and services are not made available to those who need them, when they need them. The Sub-Committee is greatly supportive of this call and notes that it would be a positive development.

1.2 Assisted Decision Making (Capacity) Bill

The Assisted Decision-Making Capacity Amendment Bill 2022 is at the time of writing this report in the Seanad and will be enacted in advance of the amended mental health legislation. The Sub-Committee discussed the overlap between these two pieces of legislation and the work undertaken by Government Departments to co-ordinate on these significant areas of legislation to ensure that both were aligned.

The Committee heard that whilst the Assisted Decision Making (Capacity) Act 2015 has yet to be commenced, the proposed 2022 legislation would amend the Act and allow for its commencement. This would bring an end to wardship in Ireland and also ensure a new approach to capacity by giving those with decision-making support needs access to their rights to make their own decisions and have their will and preferences upheld and respected. It will also allow for the Decision Support Service ('DSS') to be operational.

IHREC told the Committee that one of the key guiding principles which is cross-referenced in all three Acts is the inclusion of the presumption of capacity for all adults. It told the Committee that it welcomed the introduction of a coherent approach being taken in respect

[8] WHO (2021) 9789240025707-eng.pdf

of the guiding principles and in ensuring that they align with the principles of the UNCRPD, signifying that Ireland is indeed embracing the paradigm shift towards a more human rights-based approach.

The Pre-legislative Scrutiny Report of the Joint Committee on Children, Equality, Disability, Integration and Youth (DCEDIY) recommended that the interaction between the 2015 Act and people whose involuntary treatment is regulated under Part 4 of the Mental Health Act 2001 should be examined. Minister Anne Rabbited has told the Dáil that she will work with the Minister for Health to implement that recommendation.[9] In the Report and Final Stage Dáil debate of the Assisted Decision Making Act, on 29th June 2022, Minister Roderic O'Gorman stated that DCEDIY are engaging with the Department of Health on the omission of those involuntarily detained from the Act and they are working on devising a policy solution that they could bring forward at Seanad stage (link).

The Department informed the Sub-Committee that it was working with DCEDIY, and that it was also in discussions with the Office of the Attorney General to ensure both Bills were in alignment. The Sub-Committee heard that there are certain provisions, between the two Acts, that will have to be amended, depending on which Bill is enacted first.

Mental health advocates told the Sub-Committee that it was a positive step that the General Scheme aimed to align with the guiding principles of the Assisted Decision Making (Capacity) Act. The Sub-Committee heard evidence that there was a need for a similar model of decision making to that of the Assisted Decision-Making Capacity Bill, ensuring that people are supported and empowered to make their own decisions, and that it was imperative that decisions were not being made for them.

The MHC told the Sub-Committee that access to Decision Support Services pursuant to the Assisted Decision-Making (Capacity) Act should be a feature of care and available in every environment. It observed that the Assisted Decision-making (Capacity) (Amendment) Bill 2022 excludes people who are involuntarily detained under Part 4 of the Mental Health Act 2001 and those who are involuntarily detained under the Criminal Law (Insanity) Act 2006. The Commission noted that whilst it was intended to repeal this section, this needs to be urgently resolved in to ensure that any individual in an approved inpatient facility is aware of the ADMC Act 2015 and consequently has access to its full range of supports.

Similarly, during the discussion relating to the provisions of the General Scheme relating to children, it emerged that children aged 16 and 17 do not have access to Decision Support Services under the Assisted Decision Making (Capacity) Act 2015. This lacuna is discussed in more detail in section 4 below.

[9] Dáil Debate (2022) Assisted Decision-Making (Capacity) (Amendment) Bill 2022: Second Stage – Dáil Éireann (33rd Dáil) – Wednesday, 1 Jun 2022 – Houses of the Oireachtas

The College of Psychiatrists ('CPI') informed the Committee that it expected that the bill would work in conjunction with the Assisted Decision-Making Capacity Act and every support would be in place for individuals to be active participants and directioners in their own treatment and have all the necessary supports, advocates and necessary aids required to uphold their human rights. It was observed however that in relation to the issue of capacity, the proposed legislation is entirely dependent on a fully functioning capacity Bill, implemented with all the requisite supports for people accessing such services. The Sub-Committee heard evidence that it is imperative that the law addresses any gaps and ensures that protections are in place for people accessing mental health services.

In respect of research, learning disability psychiatrists noted that the Bill in its current format prohibits research with respect to any person accessing services who is unable to consent. It was suggested that approaching the area from the perspective of the Assisted Decision-Making Capacity Bill may be a more helpful way of ensuring that research could continue.

IHREC told the Sub-Committee that it was important that the reform of the mental health legislation must ensure that the use of substitute decision-making arrangements comply with human rights and equality standards and that there needs to be close alignment between the relevant mental health legislation in compliance with the standards of the UNCRPD.

Committee Members watched the progression of the Assisted Decision-Making (Capacity) (Amendment) Bill 2022 through Dáil stages and remain seriously concerned at the omission of people involuntarily detained from the provisions of the Bill. A member of the Sub-Committee is also a member of the CEDIY Committee and put forward amendments to address this discriminatory exclusion. At the time of writing no solution had been brought forward by the Government and the Sub-Committee urges an immediate resolution to be found. With the delay of the enactment and commencement of the ADM Bill, the Sub-Committee respectfully request that finalising this legislation be prioritised on the return of the Dáil and Seanad in the Autumn/Winter Legislative Session and that it be sent to the President prior to the start of Budget 2023 debates in mid-October.

1.3 Terminology and definitions

The Sub-Committee heard that whilst the use of language has improved in the Heads of Bill, there is still a need for similar language to the UNCPRD to be used in Irish mental health legislation. The Sub-Committee observed that the use of language was important in this context as it can be used to label or stigmatise certain groups and can have a long-lasting detrimental effect on a person's wellbeing.

Some Members and witnesses expressed concern that under the Heads of Bill, the definition of a “mental illness” would include intellectual disability as a means for questioning an individual’s capacity.

The Sub-Committee notes that while it supports the replacement of the term “mental disorder”, it does not believe the term “mental illness” should be used in its place. It is recommended that instead the phrase “psychosocial disabilities” should be used, which would align with the approach taken in the UNCRPD.

The Sub-Committee heard evidence that the reasoning behind this is that it is quite medicalised language, and it does not adequately reflect the full diversity of mental health difficulties and their causes and the combination of origins and contributory factors. The Sub-Committee also suggests the term “mental health difficulties” as an alternative term, as is used in our current national mental health policy, Sharing the Vision, given the fact that the term “psychosocial disabilities” is not yet used widely in Ireland and some people with mental health difficulties may choose not to identify as disabled.

The Sub-Committee also heard powerful testimony from individuals with lived experiences of accessing mental health services and who were of the opinion that the label of mental health disorder can be damaging and disempowering. The HSE informed the Sub-Committee that from in its consultation with service users on this issue, there was no consensus on the preferred term. Many people believed the word “illness” captured the enduring and severe end of the spectrum well and people are familiar with the word “illness” and further said it would not be happy with the continuation of the word “disorder” but on balance, the word “illness” would be more acceptable.

Professional bodies including the PSI told the Committee there was a need for parity of esteem between mental and physical health, and the use of ‘disorder’ in this context was offensive.

Recommendations

1. The Sub-Committee recommends that a stronger focus needs to be put on a human rights-based approach within the proposed legislation and the proposed heads need to fully adhere to the spirit and rationale of the UN Convention of the Rights of Persons with Disabilities

2. The Sub-Committee recommends that the General Scheme be amended to remove references to the term ‘mental disorder’ and replace it with ‘persons with psychosocial disabilities’ in line with the UNCRPD and the social model of disability

3. The Sub-Committee recommends that the State should ratify the Optional Protocol of the UNCRPD at the earliest possible opportunity.

4. The Sub-Committee recommends that the reform of mental health legislation must be accompanied by State measures, including legislation, aimed at ensuring less restrictive forms of treatment in the community are available and the ultimate eradication of coercion in the treatment of persons with psychosocial disabilities. This includes investment in community-based support and services for persons with psychosocial disabilities and through assisting persons to utilise the Assisted Decision Making (Capacity) Act 2015 to exercise their capacity. The provisions in the Assisted Decision Making (Capacity) Act 2015 will need to be extended to all citizens, including those involuntarily detained, in order for this to be possible.

5. The Sub-Committee recommends that there is close alignment between the relevant mental health legislation in compliance with the standards of the CRPD.

2. Admission of Involuntary and Intermediate Persons to Approved Inpatient Facilities

2.1 Involuntary detention

Most admissions to approved mental health centres occur on a voluntary basis, but situations still arise where a person can be admitted to an approved centre involuntarily. Head 9/ Section 8 outlines the criteria for involuntary admission to an approved inpatient facility.

According to the CPI, addressing the Sub-Committee on the 22nd of March 2022, in 2020, just over 15,000 people were admitted to psychiatric units or hospitals. Just under 2,500 of these were involuntary admissions, of which just under 950 were admitted for the first time. Evidence provided to the Sub-Committee indicated that the majority of those who were involuntarily admitted had diagnosis of schizophrenia, schizo-affective and delusional disorders.

The Sub-Committee heard that the process of involuntary detention has been updated in the General Scheme in line with Sharing the Vision and Ireland's commitments under the UNCRPD where involuntary detention should only be used as a last resort.

Proposed Head 9 – Section 8

A person may be involuntarily admitted to an approved centre inpatient facility pursuant to an application under section 9 or 12 and detained there on the grounds that he or she is suffering from a mental disorder fulfils the following criteria:

(a) the person has a mental disorder of a nature and degree of severity which makes it necessary for him or her to be involuntarily detained in an approved inpatient facility to receive treatment which cannot be given other than in an approved inpatient facility, and

(b) where such treatment is immediately necessary to protect the life of the person, or to protect the health of the person from the threat of serious harm, or for the protection of other persons, and

(c) the reception, detention and treatment of the person concerned in an approved inpatient facility would be likely to ameliorate the condition of that person to a material extent.

The Department informed the Sub-Committee that whilst under the existing Act, detention can take place on the basis of risk or treatment, the Bill will ensure that treatment is part of the basis for all cases of involuntary detention. Furthermore, the Bill will provide for all applications for involuntary detention to be made by an authorised officer. Proposed changes

to Section 8 would amend the criteria for involuntary detention so that treatment will now form part of the basis for all instances of involuntary detention.

The Department informed the Sub-Committee that the General Scheme is in line with the ERG recommendations and has limited the group of people who can make an application to authorised officers, which are already a prescribed grade within the HSE. The rationale for this is that the authorised officer will have a more holistic view of the person, such as where they live and what supports are available to that person in the community. There is a more detailed discussion on proposals in relation to authorised officers in section 2.2 below.

The Department acknowledged that this is a key provision within the Act, given the gravity of the potential impact that any deprivation of liberty can have on an individual. It further stated that there was a need to ensure there are appropriate structures in place and that the person making the decision as to whether someone should or should not be involuntarily detained has the adequate information about the person themselves, about what services are available to that person in the community and that the decision is reviewed. Under the proposed Heads of Bill, admission orders for involuntary detention only last two weeks now rather than three weeks. The Sub-Committee notes the absence of any Deprivation of Liberty Safeguard legislation, which is reportedly at a very early stage of the legislative process. The Sub-Committee is concerned about what protections will apply in instances where any lacuna may arise in the legislation.

The Sub-Committee was further informed that additional checks and balances will be built into the system through the operation of mental health review boards, which are referred to in the 2001 Act as mental health tribunals. There is a more detailed discussion of the operation of mental health review boards in section 2.7 below.

In contrast, the human rights organisations and legal experts who appeared as witnesses informed the Sub-Committee that Section 8 in its current form was problematic for a number of reasons. IHREC noted that Section 8 implements recommendations made by the ERG in respect of involuntary admission, which predated the ratification of the UNCRPD and did not sufficiently consider the implications of Ireland's obligations under the Convention. It noted that a mental disorder appears to be a necessary element for the criteria for detention where it is of such a 'nature and degree of severity' which makes it necessary for a person to be involuntarily detained and was problematic. The Sub-Committee notes that this is indeed problematic, as it is imperative that the Act wholly reflect Ireland's obligations under the UNCRPD.

IHREC further observed that a person may be detained on the basis that treatment is immediately necessary to protect the life of the person, or to protect the health of the person from the threat of serious harm, or for the protection of other persons, however the wording here was vague and needed to be defined as it appears to represent a low threshold for admission.

Similarly, the General Scheme appears to permit the involuntary detention of a person with a psychosocial disability who has capacity to refuse treatment where there is a serious risk to the health of the person. Accordingly, the Sub-Committee notes that the General Scheme should set out the rationale for permitting a person to be detained in such circumstances.

IHREC also observed that there appeared to be a lack of parity of esteem between the treatment for mental health and physical health. By allowing detention on the basis that it would protect the 'health of the person from the threat of serious harm' the proposed legislation treats people with psychosocial disabilities differently from those with a physical disability, which could potentially be construed as being in direct contravention of the UNCRPD.

The justification for the use of coercion is often based on 'medical necessity' and 'dangerousness' and IHREC is of the view that these justifications are subjective and that there is a lack of research to support their application, which can often result in grave violations of human rights, such as the denial of legal capacity or the deprivation of liberty. The Sub-Committee notes that this needs to be viewed through the lens of the person-centred approach in ensuring that human rights are upheld and that any elements of subjectivity in relation to the justifications for the use of coercion should be removed. The Sub-Committee further notes Professor Dainius Puras's submission whereby it is stated that the use of 'dangerousness' and 'medical necessity' as justifications are not based on sound research, and that the discipline of psychiatry must not act as a tool for social control.

A range of other stakeholders noted that there needs to be a greater emphasis placed on community mental health service provision, and to note that whenever possible, treatment should be carried out at a local community level. The Sub-Committee also heard evidence from family members and supporters that crises do not start at 3 a.m. and that there is a lead up to them. As such, the Sub-Committee notes there such, there should be a provision to allow for situations in which where there is a clear "escalating" risk.

Evidence from psychiatrists highlighted the complexities and possible challenges of implementing such an approach in practice and these were explored further by the Sub-Committee.

The Sub-Committee heard however that while there is a clear and urgent need for a human-rights human rights- based approach from those with lived experience and human rights experts, evidence from psychiatrists in particular highlighted the possible complexities and possible challenges of implementing such an approach in practice relating to the medicalised model of treatment for mental health difficulties.

The College of Psychiatrists of Ireland (CPI) observed that any delay in treatment for those who may need to be involuntarily admitted may have longer-term functional impact on the effects of their treatment. The Sub-Committee were also told that a majority of psychiatrists

believe that the proposed restrictions as outlined in the Bill may impact on their ability to treat people accessing services, and also have secondary impacts such as increased workload, burnout and could cause issues for staff recruitment as well as increasing risk to staff in units. The Sub-Committee acknowledges that while the vast majority of practitioners aim to provide treatment in an ethical manner, measures to protect the human rights of those accessing treatment should be applied in all cases.

The CPI have also noted that there was a real risk that people accessing services could not be detained unless there was a 'serious risk' however it noted that for some people accessing services, families and health professionals can detect early signs of relapse which is sometimes accompanied by a lack of insight into the person who is accessing services. They said that under the proposed revisions to the Act serious mental health difficulties will need to be advanced to the point where there is a risk to life or health before treatment can commence, adding that there is no other illness where doctors have to wait for a person to deteriorate to a life-threatening state before treatment can be initiated. The Sub-Committee heard that those representing the CPI felt the changes might "disproportionately impact" upon those who are homeless or in direct provision and could marginalise those with severe mental difficulties. It underlined the need for a balance to be struck and for the proposed section to be amended. However, the Sub-Committee notes the growing evidence-base and research available on moving away from an overly medicalised model of treatment for mental health difficulties and the need to listen to, and include, the person in their care and treatment options. The Sub-Committee also acknowledges that while persons accessing treatment may not be considered to have the capacity to make medical decisions for themselves upon admission to a service, as a person receives treatment, their capacity for medical consent increases, and this should be taken into account when revieing the treatment options available to the person. The Sub-Committee also notes the importance of multi-disciplinary teams and input from other healthcare professionals who have experience working with/and or supporting the person in their recovery. These points were supported by all other witnesses before the Sub-Committee and all other submissions to the Sub-Committee. It is worth noting that while some psychiatrists have concerns about some of the proposed changes, Professor Dainius Pūras, former Special Rapporteur for Health in the UN, is also a practicing psychiatrist and supports this area of reform, as is discussed below.

Psychiatrists from a number of practice areas provided the Sub-Committee with observations on how the proposed section may work in practice. Psychiatrists dealing with later life psychiatry highlighted that the current section was contingent upon the fully operational ADM Bill being implemented with all the supports. It was further observed that family members may feel excluded from the process under the current proposals for the Bill as there may not be a method by which they can ask an authorised officer for an assessment or initiate some kind of mechanism whereby such an assessment can take place. This also has to be

balanced with the fact that family relationships can be negatively impacted if the family is felt to be responsible for the person's involuntary detention, as discussed below in section 2.2.

Similarly, in the case of young people accessing the CAMHS service it was noted that in the case of young people with eating disorders that they may not be at imminent risk, but they are at a risk of suffering chronic malnutrition and without intervention and treatment in an inpatient facility, their prognosis would be significantly worse. With the higher threshold, those types of cases could, in the opinion of the psychiatrists, potentially miss out on getting the care and treatment they need. The Sub-Committee notes that these concerns were not expressed by any of the other witnesses, those advocating for the human rights of the person, for international best practice, those working in social work or recovery. Such concerns have only been voiced by the College of Psychiatrists. The Sub-Committee also note that there has been some discourse in the public about the upcoming reform of the Mental Health Act and that there are some differing opinions amongst psychiatrists. Dainius Puras, the former Special Rapporteur of the UN, is a leading global psychiatrist and sent in a separate written submission to the Sub-Committee. The Sub-Committee welcomes the inclusion of differing views across the psychiatry professions and is grateful to have received varying opinions on the Heads of Bill.

In the PLS session on 5th April 2022, psychiatrists also expressed concerns about a sub-group of people who may not appear to be an 'immediate risk' but may no longer have capacity or represent a serious risk of harm to themselves or others. They told the Sub-Committee that they may be engaging in perceived 'reckless behaviour' which may cause later depression or social embarrassment, and it was stated that often this type of behaviour was a sign of illness. The Sub-Committee notes these comments were put forward by the College of Psychiatrists and do not reflect the appearances of other witnesses including experts by experience. The Sub-Committee note the importance of reducing the use of stigmatising language and narrative when discussing people's mental health difficulties, experiences and treatments.

The Psychological Society of Ireland (PSI) told the Sub-Committee that the bulk of people accessing services coming in may lack insight and capacity but would not necessarily be at an immediate serious risk. As they are treated, their capacity improves. The further stated that the believe that best practice would be that when somebody reaches that threshold, the whole issue of whether they should be involuntarily detained anymore comes into play. That is why they have the option of regrading somebody from an involuntary to a voluntary patient.

It was observed by Mental Health Reform that the value attached to coercive practices such as seclusion and restraint and the need for involuntary treatment in general is influenced by beliefs and habits rather than empirical evidence. The Sub-Committee heard evidence that the most important point in relation to the use of coercive practices is that research shows

that such practices can be extremely harmful for individuals accessing services and may indeed be deeply retraumatising for many individuals. Mental Health Reform further indicated the need to move towards a more trauma-informed recovery-oriented model of care that respects the individual's dignity and human rights.

The PSI told the Sub-Committee it was supportive of the recommendation of the expert review group that a mental health professional from a different discipline would consult with a consultant psychiatrist and would also complete an assessment prior to making an admission order, as well as at the point of a renewal order. Additionally, it is recommended that a psychosocial report should be carried out by a member of the multidisciplinary team and provided to the tribunal (soon to be renamed 'Review Board') to assist in its decision-making

The IASW told the Sub-Committee that every person who is involuntarily detained should have a right to a psychosocial assessment conducted by a CORU registered mental health social worker.

Representatives from NGOs and advocacy groups informed the Sub-Committee that it was extremely important that mechanisms be established to provide support to families before and after the admission of a person accessing mental health services by way of an allocated key worker who would then communicate with the multidisciplinary team where appropriate, and particularly where concerns regarding risk to the individual or others are raised.

The MHC told the Sub-Committee that it had noted the issues raised by various other parties, to include the medical practitioners, and it would support and/or advise the Department, where required, in regard to discussions with these parties to ensure clarity and understanding and to ascertain if there is a way forward that works for the person at the centre of the process.

Observations and Recommendations

The Sub-Committee is extremely cognisant of the urgent need to move away from a paternalistic approach towards a more person-centred one, where there is no parity between the treatment of people with severe mental health difficulties and those with physical health issues. The Sub-Committee notes that the deprivation of liberty is one of the most severe restrictions on human rights, and thus it must always be viewed through a human rights lens, one that is very much in line with obligations that arise from international law.

During the course of the hearings on the proposed General Scheme, it became clear that there is a divergence in opinions of the CPI and other stakeholders on the use of involuntary detention. Medical professionals and psychiatrists provided evidence to the Sub-Committee of the potential unintended consequences of placing a higher threshold on the requirements for involuntary detention.

The Sub-Committee is particularly mindful of the fact however that the comments put forward by the medical professionals and psychiatrists do not reflect the opinions of other witnesses who appeared before the Committee, including advocacy groups and service users with lived experiences. The Committee also noted that there is a need to consider human-rights based approaches to the mental health system, rather than relying solely on an over-medicalised system.

The Sub-Committee notes that the MHC has offered to support the Department in discussions with parties to ensure a way forward that works for the person by placing the individual at the centre of the process and it has welcomed that offer, given its expertise as an independent regulator. It is vital that the General Scheme has a person-centred approach and further dialogue with professionals to provide practical solutions to issues raised in hearings may be a way forward in addressing some of their concerns.

The Sub-Committee is strongly of the view that the General Scheme must progress with a person-centred focus and a higher threshold for involuntary admission, based on the need for treatment, as outlined in the General Scheme currently. The Sub-Committee notes that community-based supports and timely interventions when needed must be provided and that a focus should be placed on early intervention and prevention.

Recommendations

6. The Sub-Committee recommends that the General Scheme be amended to provide that a person fulfils the criteria for involuntary admission 'where such treatment is immediately

necessary to protect the life of the person, or to protect the health of the person from the threat of serious harm, or for the protection of other persons from such harm'.

7. Section 8 of the Heads of Bill should be amended to 'require that detention is to last only for as long as absolutely necessary in emergency circumstances.'

2.2 The role of authorised officers

As outlined in Section 9 of the Bill, authorised officers will have an expanded role in the process of involuntary detention in deciding whether an application to involuntarily detain someone should be made. An authorised officer means an officer of the HSE who is of a prescribed rank or grade and who is authorised by HSE to exercise these powers.

The Sub-Committee heard that if the officer believes that the person needs more acute care, he or she could make the application for involuntary detention. At each stage before the person is brought to the approved centre, consideration will be given to what other supports are available to them, including any family support. The Sub-Committee notes that involuntary detention should only happen as a last resort. When a person is resident in an approved centre, they should be there for as short a time as possible. When that person's condition starts to improve to the extent that they can be discharged then they there should be discharge planning around where the person is going, whether they are going back to their family and the outpatient and/or community supports that will be immediately available to the person and their family upon discharge. The Sub-Committee notes that not everyone will have a supportive family environment and urges the prioritisation of wrap-around supports for the most marginalised, including access to independent advocacy services.

As the successful operation of the Act will depend upon the resourcing and availability of authorised officers, it is clear there will be a need for sufficient resources to be put aside to ensure there are enough authorised officers to be available across the country on a 24/7 basis.

The Department told the Sub-Committee that a preliminary discussion has taken place with the HSE on the potential costs involved and resources required in relation to this. As it currently stands, only specific grades can become authorised officers however it has been noted that this may need to be increased in order to expand the pool of people available. The Department stated that limiting the authorised officers as being the only group who can make an application for involuntary detention is a positive development, noting that it allows that person to act as an impartial third party in such situations.

The Sub-Committee expressed concern that there may be a delay in bringing this section into effect until the full service is in place, and that this section may need to be commenced at a later date than in relation to the rest of the Act. It heard that in 2019, there were 159 authorised officers in the State. In 2021, there were 126. It was also observed that there was a noted decline in numbers in certain community health organisations, for example in CHO7 the number of authorised officers decrease from 25 to 11 which raises concerns about the capacity of the HSE to enforce a primary lever within the Act.

The Mental Health Commission told the Sub-Committee that it has written to the HSE in relation to the number of authorised officers and that a committee has been established to examine this issue and to work on new requirements in relation to authorised officers. The MHC stated that whilst it did not have the figures as to the shortfall in the number of current authorised officers which will be required under the current legislation, an indication for the number and capacity required may be reflected in the fact that under the current legislation, An Garda Síochána have used section 12 almost 10,000 times during the period of Covid-19. It said that there were known issues and it would be expected the HSE would be preparing for this demand.

As regards to the implementation of the Act, and in particular the resourcing of authorised officer, the MHC informed the Sub-Committee that there were a number of issues, including the capability of the HSE to ramp up, implement the Act and ensure adequate resources.

Representatives from medical organisations informed the Sub-Committee that authorised officers have a valuable role to play in making an application for involuntary detention however it was noted that there were concerns that the requirement that the authorised officer be the only person allowed to make an application to a medical practitioner for involuntary detention will introduce an additional layer of bureaucracy to the process and potentially lead to delays in treatment for people accessing services. It noted the need for increased levels of authorised officers across all healthcare settings and to ensure 24/7 availability at one hours' notice.

Potential delays in accessing care, as well as the fact that family members will no longer be in a position to make an application were noted as other potential issues relating to this provision. Additionally, medical groups stated that it was unclear where clinical responsibility would ultimately lie if an authorised officer decided not to complete an application and a person came to any harm as a result of not being admitted.

However, the Sub-Committee notes that other professional groups including the IASW and PSI welcomed the introduction of this provision stating that it ensures that individuals are more likely to attend an approved centre with a clear plan of action for their care and treatment.

Representatives from mental health advocacy groups have also welcomed the provision as it may assist people in accessing mental health care and treatment as many people with lived experience had difficulties in getting admitted.

The Sub-Committee heard that if the teams are rolled out properly, it has significant potential to make a big difference in how people experience care "whereby they do not have blue lights at their door, and they are able to be admitted in a planned way". Often authorised officers work to agree a plan with the individuals so they may not need to be admitted or signed in through an order but may actually go in voluntarily. The Authorised Officers should be trained in recovery oriented, trauma informed care, in human rights and any other de-escalation trainings. Authorised Officers should also be a point of support for family, friends, supporters and carers through the admissions process, in appropriate circumstances and with the person's consent. While some family members have requested the right to still apply for involuntary admission, it has been found to damage some familial relationships. Therefore, having a state agency provide this service should also aid recovery and reintegration.

Observations

It is clear that the success of the proposed General Scheme, will largely depend on adequate provision, resourcing, and training of authorised officers, who will be responsible for implementing some of the scheme's most challenging and complex provisions. Authorised officers will be liaising directly with people accessing services and their families at times of crisis, and it is of utmost importance they are properly trained and resourced.

The Sub-Committee understands that the HSE will need to guarantee that there are trained authorised officers in all areas on a 24/7 basis. This will require considerable investment, at a time that mental health services are subject to huge resourcing and recruitment issues.

Recommendations

8. The Sub-Committee recommends that the Minister liaise with the HSE on the potential implications of resourcing authorised officers for implementation of the section and that an implementation plan be published detailing timelines and method by which the HSE plans to provide for recruitment and retention of authorised officers. A timed and costed action plan for recruitment should be produced by the end of Quarter 3, 2022 with recruitment starting before the end of 2022. The HSE should examine the possibility of peer supporters qualifying to become Authorised Officers.

2.3 The role of An Garda Síochána and detention periods

The Sub-Committee heard that under the latest General Scheme members of An Garda Síochána cannot complete the necessary paperwork to involuntarily detain people, and that this must be done by an authorised officer as outlined in the above section.

The MHC noted that the time-period for which an individual can be held in custody in the Act is twelve hours, however the MHC believes that a shorter time period should be considered, noting that for cases of drink driving, people can be detained for short periods of six and twelve hours. The Sub-Committee recognises that a Garda station can be an extremely challenging environment for individuals who are experiencing mental health difficulties.

The MHC told the Sub-Committee that if proper supports are established in terms of access to GP care, there should always be out-of-hours services that can be called upon when required. They provided further evidence that to date, it appears getting a GP has never been an issue or at least it is not an issue that they have ever come across.

The Sub-Committee also heard evidence that the new scheme provides for the MHC to establish codes of practice for An Garda Síochána. Stakeholders indicated that there was a need for An Garda Síochána to have human rights training and training around the United Nations Convention on the Rights of Persons with Disabilities and de-escalation techniques.

2.4 Admission orders and renewal orders

The IHCA told the Sub-Committee that the proposal to shorten the period of review for admission and renewal orders from 21 days to 14 days, as per Section 18(3) may cause increased distress for people accessing services and provide inadequate time to evaluate those people who may demonstrate complex presentations. In addition, the inevitable associated increase in costs has not been quantified. Shortening the period would also result in a reduction in the time available to consultant psychiatrists for the direct provision of people accessing services, adding to the existing overstretched mental health service situation. The Sub-Committee notes that it is imperative that legislation not be considered on a basis of scarcity of resources and that there must be robust legislative provisions in place to provide the highest standard of care.

2.5 Intermediate admission and renewal orders

Head 18 of the General Scheme introduces a new section providing for intermediate admission, whereby a consultant psychiatrist is of the reasonable opinion that the person concerned may lack capacity to consent to their admission, but that he or she does not meet the criteria for detention in Section 8, the consultant psychiatrist shall carry out, or shall arrange for another mental healthcare professional to carry out a capacity assessment.

Under Section 14A (4) the intermediate admission order will detail that the person has been found to lack the necessary capacity to consent to their admission to an approved inpatient

facility, and requires treatment in the approved inpatient facility, but that the person does not meet the criteria for involuntary detention.

The Sub-Committee heard that people who are subject to an intermediate order are not detained, but their admission and treatment are still subject to a review, similar to an involuntarily detained person. An intermediate person is admitted when the person is deemed to lack the capacity necessary to consent to admission as a voluntary person, but still requires treatment on an inpatient basis. The Department told the Sub-Committee that the ERG recognised the need for an intermediate category to safeguard the rights of persons who cannot consent to admission, but that further work would be needed by way of code of practice to clearly set out the implementation of such provisions.

The MHC told the Sub-Committee that it objects to the insertion of the intermediate admission and renewal order provisions in the General Scheme. In its view, the provisions in the General Scheme would undermine the 2001 and 2015 Acts and fundamentally change what is being proposed. It said that under the General Scheme there will be a new category of people who are not detained but are going to receive the same oversight. Effectively, the MHC will then be reviewing people as to their capacity.

Furthermore, it also noted that the MHC is the owner or operator of both the Mental Health Act and the Assisted Decision Making (Capacity) Act. As a result, the General Scheme is in effect setting up a parallel process of reviewing capacity under the Mental Health Act when all those issues should be dealt with under the 2015 Act. The MHC also expressed the view that legally this approach may not be sound. The Commission also expressed concern that under the General Scheme intermediate admission orders could be extended for three months, or six months and in effect this risks undermining the aims of the Assisted Decision-Making Capacity Act. The Commission said:

> *Our basic concern is that the Bill is allowing somebody to be detained because of a capacity issue and not because of the basic criteria for detention, mental disorder, or mental illness. That is a concern for us because capacity is being dealt with under a separate Bill*

The MHC told the Sub-Committee that these provisions were initially suggested by the Expert Review Group to address the lacuna that existed prior to the 2015 ADMC Act however the 2015 Act has since addressed the issue of capacity and will deal with this issue separately. It explained that under the ADMC Act 2015, there would be a process whereby there is essentially a question mark over somebody's capacity and where under that Act, and all the guiding principles it contains, everything has been done to support the person to make their own decisions, including decisions around healthcare and treatment. There is then a route to the Circuit Court to make a declaration about a person's capacity in respect of discrete items, which in this case would presumably be consent to treatments for a mental health difficulty.

If the court in that case were to find that capacity was lacking, it could then make an order to appoint a decision-making representative who would then, ideally, be somebody in a pre-existing relationship of trust or failing that, a person appointed from a panel to be maintained by the Decision Support Service who would act within the strict terms of a time-limited decision-making representation order to act as an agent, having regard at all times to the person's will and preferences and who would be in a position to supply the necessary consents if that were to be required. All of that is kept very strictly under review and monitored by the Decision Support Service. There is a well worked out and protected process in place, which this intermediate category designation bypasses.

Mental Health Reform outlined that the intermediate category was introduced because of the "grey area between voluntary and involuntary" noting that for example, if someone were a voluntary person and seclusion, restraint or restrictive practices were used, there may be a question as to whether that person is voluntary or involuntary. It noted that it if someone does not want to be secluded or there is use of quiet time, it comes back to the main general thrust of the legislation of it being person-centred and that the person is involved in the decisions being made and that restrictive practices are only used as a last resort and for the shortest time possible.

Other stakeholders who appeared before the Sub-Committee said they broadly welcomed the introduction of this category as an additional support in a time of crisis, but that clarity was required in terms of its implementation. Dr Charles O' Mahony told the Sub-Committee that the creation of the new intermediate category has the potential to provide a level of protection for people who are voluntary patients but de facto detained, with no oversight of their detention. He expressed concern that there is a potential risk that the introduction of this new intermediate category could widen the net of coercion. As an alternative Dr O Mahony suggested that voluntary persons who are considered to lack capacity under the Mental Health Act could be supported by the provisions in the 2015 Act to make decisions.

The Committee notes that the Ombudsman for Children has welcomed the provision for intermediate admission orders, noting that it may be a useful provision in relation to the detention of children who do not consent, whilst parental consent is present. This provision is dealt with in more detail in Part 4 below.

Observations and recommendations

The Sub-Committee notes the Mental Health Commission's concerns in relation to this intermediate category. Given the uncertainty around the ADM Act and mental health, the Sub-Committee recommends the continued inclusion of the intermediate category. Provisions, however, should be strengthened to ensure that the category is used to extend protections and rights rather than to curtail them.

The Sub-Committee also notes that concerns regarding the capacity of an individual should not be treated in a different manner than in other areas of treatment. The person accessing treatment should receive the supports provided by the DSS under the Assisted Decision Making (Capacity) Act, as the person is voluntarily seeking treatment.

2.6 Clinical leadership and multidisciplinary teams

During the course of the meetings with stakeholders, there was much discussion regarding the new definition of community mental health service teams and changes within the framework of the current legislation in relation to the role of the clinical director.

The current policy 'Sharing the vision' observes that models of leadership for community mental health teams should be reviewed in line with best international practice:

> *Clinical leadership, as described in AVFC 2006–16, was vested in the consultant psychiatrist role, in keeping with the requirements of legislation. Consideration should be given to amending legislation to facilitate the delivery of a shared governance model.*[10]

The IMO told the Sub-Committee it had concerns about the interdisciplinary approach whereby the consultant must consult with at least one other mental health professional before certifying an admission order, renewal order or before recommending or administering treatment or medicine to a detained person who lacks capacity. It said this provision does not have sufficient evidence to support its effectiveness and does not refer to existing clinical and legal governance, under which the consultant must operate. Members of the Sub-Committee noted however that consulting with an additional member

[10] Sharing the Vision (2020), p45 gov.ie - Sharing the Vision: A Mental Health Policy for Everyone (www.gov.ie)

of staff would seek to provide an additional layer of oversight to the process which would be a positive development.

The Sub-Committee also heard while the IMO recognises the value of multidisciplinary care, to suggest that the skills of each team member are interchangeable represents a misunderstanding of the education, training, and roles of healthcare professionals. It noted that under their current contracts, consultants are clinically independent and retain responsibility for the care of the person accessing the service. It said that to introduce a legal requirement on consultants to confer with other members of staff poses a risk to the person's safety, undermines the contractual responsibility of the consultant, and blurs the lines of accountability and clinical responsibility.

Additionally, the IMO further noted that there could be a potential clash with contracts as they currently stand. The legislation uses the word 'must' however there may be circumstances where this is not possible. The use of the word 'must' may create a conflict in the sense that up to the present time, the consultant psychiatrist has been the person who held clinical responsibility for the treatment of the person accessing services. It further indicated that it was their belief that having one named person who holds clinical responsibility is of benefit to both the person accessing care and the service itself.

The IASW said there was a need for clear governance and management on multidisciplinary teams, and that it is essential that there are clear lines of responsibility and a clear lead, co-ordinator or manager and that within that team the different disciplines need their own respective lines of accountability and governance. It said there was need for structures to be resourced with increased supervision.

The Sub-Committee observed that the Bill seemed to be moving in the direction of a shared governance model, however there appeared to be a certain amount of objection to that by clinical professionals (namely, psychiatrists). The Sub-Committee heard that on multidisciplinary teams in mental health services, different disciplines would generally report to their own line managers within their own specific discipline, but the consultant would retain the role of clinical lead for the team. Furthermore, if there were any clinical issues pertaining to particular individuals, it would be the consultant that is clinically responsible. If there is an issue or an adverse outcome, the consultant is the one would be ultimately responsible.

The RPI told the Sub-Committee that psychiatrists are trained doctors with a specific skill set which allows them to manage a person's illnesses, and other diagnosis and medications which may interact with psychiatric medications. It said that working as a multidisciplinary team as currently defined, if well resourced, well supported and well structured, is an effective way of working.

The IASW told the Sub-Committee that clarity will be needed in relation to what the individual roles are, including the role of the clinical lead on the team. Moreover, the clinical governance of the team is not just about the clinical element but rather it includes the need for appropriate supervision and line management of the various professionals. It said that any registered discipline can lead a team, in certain respects, such as operationally or in co-ordinating the work, and there have been examples in some areas or fields of practice where that has been the case.

The PSI told the Committee

> *Recent focus on the provision of child and adolescent mental health services, CAMHS, has highlighted the need for change in regard to clinical leadership. The model of leadership by a single profession, a consultant psychiatrist, is considered now to be limited in that it does not give full access to the skills of the range of multidisciplinary team members. In the UK, CAMHS teams are led by a range of appropriately qualified, capable, and competent mental health professionals. Good clinical governance allows for a model of clinical responsibility which recognises that each individual clinician carries clinical autonomy and responsibility with regard to their own specific treatment and intervention.*

The PSI said that the role of the clinical lead and the clinical director in all community mental health services should be expanded to include qualified, experienced mental health professionals in line with international best practice.

The Sub-Committee notes that the move towards a multidisciplinary model in the Bill is very much in line with a shared governance model and is aligned with the person-centred approach towards mental health in Ireland. It represents a move towards a human-rights based approach and is a welcome addition to the legislative framework.

Observations

The Sub-Committee believes that the move to a multi-disciplinary model in the Bill is in line with the move towards a shared governance model and more parity between professions working on multi-disciplinary teams. This approach gives a greater voice to the people accessing services and rebalances the perceived control of the medical model over the care of the individual.

The Sub-Committee understands that a clear governance model is vital, and it is important that roles are clinically defined. On the basis of evidence received the role of clinical lead and clinical director in all community mental health services should be expanded to include qualified, experienced mental health professionals in line with international best practice.

2.7 Mental Health Review Boards

Head 21 of the General Scheme provides for the renaming of mental health tribunals to mental health review boards and the extension of membership of review board and independent consultant psychiatrist panels to five years (from three currently.) The power of review boards is outlined in Head 22/Section 16B and it provides for an obligation that the consultant psychiatrist responsible for a person's care attends the review board. It also sets out that the person should be supported in as much as possible to attend their review boards, although noting that they are not obliged to attend. The Sub-Committee notes the importance of access to independent advocacy as potential support in going through the review board process.

The Department told the Sub-Committee that a mental health tribunal is made up of a psychiatrist, a legal professional and a member of the community or layperson. When one is involuntarily detained, an admission order is made and the tribunal will review the order after 21 days, but it is proposed to reduce the time to 14 days. A person who is involuntarily detained will be assessed by an independent consultant psychiatrist. On this basis, there will be another examination of the person and a report will be furnished to the tribunal. The tribunal will then meet the person and the person's treating psychiatrist. After the tribunal reviews all of the documentation and evidence provided it will either affirm the order or the order will be refused. The Sub-Committee notes that the purpose of this provision is to ensure that the person's detention is regularly reviewed.

Stakeholders informed the Sub-Committee that the review boards are an essential procedural safeguard for those detained under the Act. Dr Charles O Mahony further informed the Sub-Committee that a review of international literature in respect of mental health boards has

identified issues with tribunals in other jurisdictions indicating the tribunals are not adequate in protecting human rights but, in fact, can deny human rights, legitimise coercion, and restrict access to justice and that there can be a sense of a lack of meaningful participation by detained individuals.

The Sub-Committee heard evidence that cultural change is required to ensure that tribunals comply with international human rights law and the legislation could be strengthened in this respect. Advocates also recommended that it is important that the person is actively listened to and heard, and similarly, it is important that hearings should be fully explained to the detainee.

The CPI told the Sub-Committee that pursuant to the General Scheme, mental health review boards must take place within 14 days of the commencement of detention. It noted this will lead to more consultant time being taken up with the administrative work associated with the frequent and more numerous sittings of boards. Time spent in review boards is time not spent in outpatient clinics, on ward rounds or supervising junior staff in training.

Observations and recommendations

The Sub-Committee agrees with the proposed reduction of time awaiting a review board.

Recommendation:

9. The Sub-Committee recommends that independent, accessible advocacy services be offered to persons involuntarily detained at the earliest possible juncture. Cognisance must be given to the needs of the person at various times throughout their admission. Approved centre staff should ensure that a person receives the necessary information in a manner appropriate to them in sufficient time before a review board hearing.

2.8 Human rights training

The Sub-Committee heard that a specific human rights and ethics committee within CPI reviews new legislation and areas relating to human rights and ethics in general. Not only are there modules for those in training but there are also continuing professional development events that deal with issues relating to ethics, law and so on. It is a case of lifelong learning that starts in the period of training and works through to the continuing professional development period.

Recommendation

10. The Sub-Committee recommends that all professionals working on multi-disciplinary teams working in the area of mental health services have human rights training and this should be extended to trainee grades as well.

The Sub-Committee also recommends that human rights training is a mandatory module in the College of Psychiatrists and that there is also greater training emphasis on co-production, supporting the will and preferences of the person and a move towards the biopsychosocial model of treatment.

3. The Commission and Enhanced Regulation of services

Part 3 of the General Scheme makes provision for regulation of the sector by the Mental Health Commission.

3.1 Role of the Mental Health Commission

The Sub-Committee heard that the Mental Health Commission's regulatory remit will be extended beyond approved centres to encompass all residential mental health facilities and mental health services. In future, all mental health facilities and services will, therefore, be registered, regulated, and inspected by the Commission. Currently the MHC inspects 60 approved centres however the scope for regulation will be much greater under the proposed changes and will eventually cover all services including counselling services and any mental health service that is provided on behalf of the State.

The Sub-Committee noted that while provision of funding may fall outside the scope of legislation it is vital to ensure that resources are provided to ensure the full and proper implementation of the legislation. It discussed resourcing of the Sub-Commission and the MHC informed the Committee that an independent review of the structure of the MHC in terms of regulation of mental health services was in progress. It further informed the Sub-Committee that it had a provisional budget for urgent situations.

The Inspector for Mental Health Services told the Sub-Committee that there are approximately 114 24-hour supervised residences, each with up to eight or nine people, meaning that there are approximately 1,200 people in 24-hour residential facilities. Whilst the Inspector has been examining them, she expressed concern over some of the residential centres, their facilities, care planning, therapeutic activities, and programmes and she welcomed the fact that these centres will be regulated and will be subject to enforcement measures. She also welcomed the fact that community mental health services, community mental health teams and specialist teams, such as eating disorder teams or child and adolescent mental health services teams, will also be regulated.

The Inspector told the Sub-Committee that most of the community residences are owned and run by the HSE, whilst a number of public providers provide services in the form of 24-hour residences; however, these are provided for on behalf of the HSE.

The Sub-Committee queried the enforcement powers laid out in the Act, and, whether these would in practice mean a higher standard of accommodation in approved centres. The MHC informed the Sub-Committee that the enforcement powers within the registration section of the General Scheme require that it assesses whether the premises will be satisfactory before a centre of approved inpatient facility can be registered. It informed the Sub-Committee that it was important that the 2006 Regulations are revised in parallel with the Act so that they include detail on the appropriate premises' standards. The Commission will then be able to make an assessment as to whether a premises will comply with those regulations when

determining whether a facility should be registered. The legislation is certainly strengthened in that regard.

The Sub-Committee also queried the role of the regulator in regard to the closure of centres under the new Heads of Bill. The MHC told the Sub-Committee that measures are set out in the statutory instrument setting out the 2006 Regulations which require that a care plan be in place, that there be consultation, that notice be given to the Commission three months in advance and that appropriate arrangements are made for onward transfer in consultation with the resident. The revised Scheme transfers this into the Act as the primary legislation. All of those provisions are now in the General Scheme of the Bill to amend the 2001 Act. That will strengthen these provisions further, to monitor them more closely and to take more direct action should the Commission have concerns. It observed that there is a potential for prosecution in the case of non-compliance with the Act.

The MHC told the Sub-Committee

> *The revised scheme does make the provisions around closure stronger in the sense that it brings them into the primary legislation in terms of the provisions for consultation with the residents, listening to their wishes and acting on them in so far as possible. It requires that the existing provider follows up for a period of three months afterwards on their ongoing care. It also provides that they make the appropriate assessments to ensure that their ongoing placement is appropriate for them and is in keeping with their needs. Those provisions come into the revised scheme and that hopefully will strengthen the Bill.*[11]

Whilst regulation may be improved under the General Scheme, the Sub-Committee queried the enforcement powers of the regulator, noting for example that it has produced reports on structural issues in specific approved mental health centres, however these reports often appear to be ignored for many years by service providers, and little is done to address the underlying structural issues within the relevant buildings.

The MHC informed the Sub-Committee that a capacity review is currently ongoing in the Department and the HSE in order to ensure that mental health units provide dignity for people and that many premises have improved a lot over the last few years. It noted that it had identified premises to the HSE both at a regional and national level. It was noted that certain regions are more effective at keeping their stock up to date than other regions, which is unfortunate for people accessing services in those regions. The Sub-Committee hopes that the reform of the HSE will lead to greater accountability and stronger, more robust governance mechanisms in order to ensure that all buildings are of a satisfactory standard.

The IMO informed the Sub-Committee that there was a need for the MHC to engage an independent body to carry out an in-depth analysis of the role of community multidisciplinary

[11] Sub-Committee on Mental Health (2021) main.pdf (oireachtas.ie) 16 November 2021

teams and to assess whether the current model of community based mental health teams is the best model of provision.

It also noted that the MHC should assess the budget allocation received by a service, when inspecting mental health services, to ensure it has the correct staffing levels and is capable of meeting the needs of the people accessing services within their catchment area. A range of other stakeholders noted that the MHC remit is extended to community mental health services for all groups, and this would be extended to all HSE hostels.

The IMO informed the Sub-Committee that in its view that there are postcode lotteries when it comes to mental health and that the MHC must ensure that staffing levels are appropriate, and that the funding which is allocated to a service must be sufficient to meet the requirements of that catchment area.

It also recommended that the agencies providing mental health care should receive accreditation to national standards. Further, it added that the remit of the MHC should be expanded to allow for the inspection of all agencies irrespective of whether they are public, voluntary or private. The Sub-Committee noted that the MHC needs to have the remit to oversee the mental health services in all sectors.

Additionally, the Sub-Committee heard evidence that the difficulty with many talk-therapies was the lack of regulation as some providers may not have the necessary qualifications. Doctors in primary care have no access to talking therapies and as a result, they have to rely on recommendations or previous experiences, however some of the therapists may not meet any professional regulation or standards. The Sub-Committee expressed concern that there is no central register in respect of talk therapies provided by private and voluntary organisations.

Observations

The Sub-Committee welcomes the extension of the powers and remit of the Mental Health Commission to regulate all residential mental health facilities and mental health services.

Recommendation:

11. The Sub-Committee recommends a quality assurance register of regulated professionals.

3.2 Regulation of restrictive practices

Part 5 of the General Scheme provides for the regulation of mental health services and this section contains provision relating to the regulation of restrictive practices.

The Sub-Committee heard evidence that restrictive interventions or practices are still in use in various approved centres regulated by the MHC and a code of practice is currently in use to regulate these practices[12]. The MHC recognises that any intervention employed that may compromise a person's liberty should in all instances be the safest and least restrictive option of last resort necessary to manage the immediate situation. Such intervention ought to be proportionate to the assessed risk and employed for the shortest possible duration.

Four main areas of seclusion and restraint are currently in use in approved centres:

- seclusion
- physical restraint
- involuntary medication
- mechanical restraint

According to Sharing the Vision, "*while a zero restraint and seclusion service may not always be achievable due to safety requirements of service users and staff, there are examples where major reductions in the use of restraint are working effectively. Therefore, a high-level aim of this policy is to reduce the use of restraint and seclusion*."

Use of Restrictive Practices

There were **5,369** episodes of restrictive practices reported to the MHC.

Physical restraint was the most frequently used restrictive intervention, with 3,460 episodes of physical restraint involving 1,169 people in 2021. It was used in most centres and accounted for 68% of all interventions in 2020, compared to 75% in 2019. In 2020, 48 centres (73%) reported episodes of physical restraint, while 58 centres reported episodes in 2019.

Seclusion There were 1,884 episodes of seclusion involving 654 people in 2021, an increase from 1,840 episodes in 2020.

Mechanical Restraint The use of mechanical restraint was lower in 2021 than in 2020, as this practice continues to be relatively uncommon. One centre reported the use of mechanical restraint.

Source: Mental Health Commission (2022) Restrictive Practices Activity Report 2021.pdf (mhcirl.ie)

[12] Code of Practice on the Use of Physical Restraint in Approved Centres Issued Pursuant to Section 33(3)(e) of the Mental Health Act 2001. Code of Practice Mental Health Commission (2009)

Part 6 of the General Scheme contains provisions in relation to restrictive practices. Part 6 now covers Section 69 "Seclusion", Section 69A "Mechanical Restraint", Section 69B "Physical Restraint" and Section 69C "Chemical Restraint".

In relation to seclusion, Section 69 notes that seclusion is to be used only in exceptional circumstances, where there is no safe alternative and for as limited a time as possible. In addition, each approved inpatient facility will need to keep a register for the use of seclusion, and each use of seclusion shall be recorded in the register, and on the person's clinical file, in addition to any other information required by the Commission.

Section 69A mechanical restraint provides for the insertion of a new Section for mechanical restraint whereby a person shall not apply mechanical means of bodily restraint to a person. A mechanical device restricting a person's freedom of movement or access to their own body shall not be used, "unless such restraint is determined, in accordance with the rules made under subsection (2), for the purposes of treatment or to prevent the person from injuring themselves or others and unless the mechanical restraint complies with such rules." The Section notes that the use of mechanical restraint shall be regulated by the MHC and that it should only be used in exceptional circumstances, where there is no safe alternative and for as limited a time as possible.

Similarly, Section 69B provides for physical restraints in cases where it is necessary for the purposes of treatment or to prevent the person from injuring themselves or others.

Section 69C provides for chemical restraints in the form 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 condition, or the intended effect of the drug is to sedate the person for convenience or disciplinary purposes. Chemical restraints should be used only in exceptional circumstances, where there is no safe alternative and for as limited a time as possible. Each approved inpatient facility will keep a register of the use of chemical restraint, and each use of chemical restraint shall be recorded in the register, and on the person's clinical file, in addition to any other information required by the Commission, as set out in MHC rules.

Stakeholders from the medical profession informed the Sub-Committee that they objected to the use of chemical restraint to include rapid titration of medication, saying this could be misleading, stigmatising and frightening to families, and that titration is required when severely unwell people are admitted in order to minimise the need for seclusion and reduce the length of their hospital stay.

The Department informed the Sub-Committee that the Sections on restrictive practices have included additional safeguards and there is an understanding that the use of such practices are minimised to a point where they are no longer needed.

> *It is a stepping down process, however, and additional resources, training and so forth must be put into place in approved centres to ensure that all staff and residents feel safe. Over the lifetime of Sharing the Vision, we will move towards a "zero restraint, zero seclusion" policy but, for the interim, it is important to include safeguards* [13]

The MHC told the Sub-Committee that restrictive practices must not be confused with being an element of any form of therapeutic treatment for mental health and must be considered as an absolutely last resort. It welcomes the fact that such arrangements are now dealt with in a separate part of the General Scheme. The Commission is currently undergoing a process to revise the rules on seclusion and physical restraint. That is being done through an expert group and a process of public consultation that will look at the best available evidence internationally.

The Commission informed the Sub-Committee that it will be introducing robust rules with regards to seclusion and restrictive practices and that people must work within them and if there are breaches to the rules, there will be prosecutions. It noted that the first prosecution under the Act which occurred a number of years ago related to seclusion. It emphasised that use of restrictive practices should be viewed as a very last resort and only when all other appropriate alternatives have been considered.

Other stakeholders indicated that there was a need for a move towards zero seclusion and zero restraint. The HSE informed the Sub-Committee that it was working with approved centres on an initiative to examine methods of reducing restraint. This ties in with the question of care planning and the recovery approach.

The IHCA told the Sub-Committee that people accessing mental health services have a right to be safe in hospital whilst staff have the right to work in a safe place. It noted that the purpose of seclusion on psychiatric wards is to prevent serious violence to other people accessing services as well as to staff members. Seclusion should only ever be used for the minimum time possible and to prevent serious violence.

Section 69 states that the rules on seclusion and restrictive practice shall be made by the Mental Health Commission, without further input from the Oireachtas. The IHCA said this was a clear "democratic deficit". Stakeholders from the medical profession noted in particular that failures to comply with the rules or breaches of these rules are punishable with summary convictions and fines, meaning that consultant psychiatrists can receive criminal convictions for matters that may include errors on seclusion forms and paperwork. The IHCA said criminal sanctions are not appropriate, stating it may impact upon recruitment.

[13] Sub-Committee on Mental Health main.pdf (oireachtas.ie) 02 November 2021

The Sub-Committee heard further evidence that an alternative solution would be to introduce the concept of malicious intent, to ensure that people will not be prosecuted in the courts for an administrative or technical failure. Stakeholders from the medical profession said that without that wording and with the Mental Health Commission devising rules and guidance that could potentially lead to a criminal prosecution, those rules and guidance would need democratic oversight by the Oireachtas rather than allowing an agency to define what is a crime. They noted that it may not be workable to place an absolute ban on techniques such as restraints for the majority of people who come into adult centres voluntarily. The possibility of injuries to staff and other people accessing services needed to be considered.

The IASW told the Committee that the new Act should be informed by the guiding principles of trauma informed care relating to manual or other forms of seclusion and restraint and it recommends that the legislation explicitly prohibit the use of mechanical restraint on children.

The College of Psychiatrists told the Committee that any offence relating to the abuse of this power should be clearly set out in the primary legislation and should include a requirement to show malicious intent or intention to misuse seclusion or restraint. The Sub-Committee heard that no country in the world which has successfully eliminated seclusion and restraint. There are always extreme situations where somebody is experiencing extreme cases of mental health difficulties, as has been described. For their own safety and that of others, some kind of intervention will be required. The Sub-Committee did hear however, that jurisdictions in Australia and New Zealand were in the process of trialling restraint-free environments and it told the Sub-Committee it intended publishing a review of the international evidence on restraints.

Shine told the Sub-Committee that it understood that the Act was not designed to abolish these practices but, in the transition to eliminate them, it recommended that a change in the language used in order to reflect, first, that these practices should be a very last resort, second, that they are only used in rare and exceptional circumstances and, third, that they are only used for the amount of time strictly necessary. It recommended that definitions of "rare and exceptional" and "strictly necessary" be included in the Bill
Personal testimony from someone with lived experience made the following point about the use of restrictive practices:

> *They don't listen. They don't understand a person's situation. They think medication is the solution. But they don't understand the effects on a person. Weight gain, loss of drive for life and thoughts of suicide. I have been dragged from my home, put in a padded cell, and not allowed use the toilet. I have been forcibly pinned down and injected against my will. They terrified me.*

The MHC told the Sub-Committee that it noted that there was a cultural shift, and some professionals may be afraid that they would be liable for a change or that something could happen, as we traverse. It needs to be completed, with the aims of improving the experience of people accessing services, as well as keeping their safety, and the safety of health workers

in mind. It said it welcomed the amendments in the General Scheme which emphasise that these restrictive practices are not therapeutic and do not have a therapeutic effect and that a lot of the international evidence is that they can be harmful so they should be treated with extreme caution and used in the most exceptional circumstances. The MHC told the Sub-Committee that had already conducted a body of research to support this process and strengthen the rules on seclusion and mechanical, physical, chemical, or pharmacological restraint. It welcomed the amendments that create a provision for all categories of restrictive practice.

Mental Health Reform said the value attached to coercive practices such as seclusion and restraint and the need for involuntary treatment in general is influenced by beliefs and habits rather than empirical evidence. The significance of this is that the evidence shows that it can be harmful. It observed there was a need to move towards trauma-informed recovery-oriented care that respects the person's dignity and human rights. MHR also supports the move to work towards a zero restraint, zero seclusion model of restrictive practices.

The IASW told the Sub-Committee it should consider prohibiting the use of mechanical restraints on children. It said that while this was a very rare occurrence, it should be removed as an option and other options would be preferable.

Observations

The Sub-Committee notes that there is a move away from the use of restraints and some countries including Australia and New Zealand are currently piloting restraint free environments. The MHC is due to publish a review of evidence in this area shortly.

The Sub-Committee heard evidence from advocacy groups and those with lived experience of the traumatic impact restraints can have on people. Evidence provided to the Sub-Committee also revealed the complexity of the situation with medical stakeholders and others observing that such restraints were always seen as a last resort.

Recommendations12. The Sub-Committee recommends that all restrictive practices should be abolished for young people under 18.

13.The Sub-Committee supports a move away from restrictive practices and believes that developments and regulation in this area should be guided by an evidence informed approach based on international best practice.

14.Training in trauma informed care and human rights should be introduced across all services providing mental health care.

3.3 Regulation of ECT

The General Scheme makes provision for regulation of electro-convulsive therapy for adults and for children. Part 4 makes provision for adults under Head 66/Section 59, while Head 126/Section 106 makes provision for use of ECT for children.

In relation to ECT for children, the General Scheme provides that ECT shall not be administered to a child under 16 unless the child gives their consent in writing to the administration of the programme of therapy. Where a child aged 16 years or older has been deemed to lack capacity or where a child is aged under 16 years of age, or a child in respect of whom an order under section 89 is in force, a programme of electro-convulsive therapy shall not be administered in any circumstances to the child without the explicit approval of the court. It also provides that the MHC shall make rules providing for the use of ECT under this Act and a programme of electro-convulsive therapy shall not be administered to a person except in accordance with such rules.

The Department informed the Sub-Committee that the use of ECT is not the ECT we know from popular culture as in the film “One Flew Over the Cuckoo’s Nest”. It has developed hugely in the intervening 50 years and is now regarded as quite an effective treatment for certain types of mental health difficulties. Provisions relating to use of ECT will be retained as

it does have some clinical value, according to the Department. The Sub-Committee notes the value of exploring this statement further, given some of the first-hand experiences that have been communicated to the Members and thus, the Sub-Committee would urge the Department to reconsider its stance on this issue.

It is important to note that one 'programme' of ECT may involve up to twelve individual treatments, as per the MHC's 2021 Annual Report. In 2020, there were 442 treatments (59 programmes) of ECT administered without consent in Ireland. In 2021, there were 299 treatments (48 programmes) of ECT administered without consent. The Mental Health Commission informed the Sub-Committee that it had strong rules about the use of ECT and that it issued a report every year on ECT to ensure transparency.

The Inspector of Mental Health services told the Sub-Committee that ECT was subject to strict rules and a code of practice and told the Sub-Committee it can be an important and lifesaving treatment for a small number of people who have severe depression with suicidal ideation and intent and for people who, because of severe depression, cannot eat or drink. The Inspector told the Sub-Committee that for involuntary patients, often people who are experiencing such mental health difficulties do not have the capacity to consent and in that case, the decision is made by the consultant psychiatrist with responsibility for the person, who will do an assessment of capacity and, if they are of the opinion that the person needs ECT as an emergency, contact another consultant psychiatrist to see whether the person is lacking in capacity and whether the person needs ECT.

The Sub-Committee notes the importance of the provisions of the Assisted Decision-Making Capacity Act 2015 and Amendment Bill 2022 in relation to treatments such as ECT. People who make Advance Healthcare Directives for mental health treatment should have parity of rights with someone making an AHD for physical health treatments. The Sub-Committee notes that more consideration needs to be given to other research relating to ECT as the statements during PLS have not presented a full picture of the use of ECT.

3.4 Care Plans

The issue of care plans was raised by the Sub-Committee, who were concerned that some providers do not adequately provide care plans for people accessing their services. The Department informed the Sub-Committee that the Act "refers to care plans front and centre". It said that there is an understanding that care plans are very important to the person accessing mental health services. Access to a care plan, regular reviews and having an input are very empowering for the individuals concerned and important for their path to recovery.

The Sub-Committee queries whether there will be any gaps in services, particularly for those experiencing a mental health issue and addiction as often there is a lack of coherence between care-plans in a case of dual diagnosis. The Department informed the Sub-Committee that in terms of the specifics of people with addiction difficulties or dual diagnosis, these would be looked after in the person's individualised care plan. The Department noted that it is important from an individual care planning perspective that comorbidities and other issues are considered.

The HSE informed the Sub-Committee that in its consultation with service users there was an express desire for care plans to be referred to as 'Care and Recovery Plans'. It noted that there was a need for a recovery and care plan approach that supports the recovery of someone but also supports teams in their work with individuals.

Advocates from the voluntary sector stated there was a need for care plans to be placed on a statutory footing and it was hoped that this would increase compliance with individual care plans. It was noted that Articles 12 and 14 of the CRPD require that mental health laws are replaced by consensual practices and services based on a social and human rights-based model rather than a medical model. This comes back to the person-centred approach, working with the person on their care plan and ensuring that they are empowered to make their own decisions. The Sub-Committee heard that there was a need for three professionals to be involved in capacity assessments, in order to ensure that there Is a broader view from mental health professionals not necessarily from the same cohort.

Stakeholders from the voluntary sector informed the Sub-Committee that the voice of the person accessing the service should be at the very the core of care planning and advocates should participate in the development of the care plan and that all plans should be developed in a format and language that the person can understand.

3.5 Regulation of Infrastructure

The Sub-Committee heard evidence that many facilities do not have private space for families to meet within inpatient facilities. It heard that this was a cause of distress for families, as in many situations they need somewhere private to meet loved ones to discuss their treatment and care.

Stakeholders noted that the Mental Health Commission should examine the provision of spaces for family meetings as part of its assessments of facilities to ensure that service providers make the necessary provisions for family visits and meetings to discuss treatment and care.

4. Care and treatment of children

Part 8 of the Heads of Bill provides for a specific section in relation to the process of admission and consent to treatment for children, introducing capacity and consent for young people and mirroring safeguards for adults under the Act for children, such as the right to information.

The Sub-Committee heard that the UN Committee on the Rights of the Child ('UNCRC') recommended in 2016 that Ireland "enact legislation that explicitly and comprehensively provides for children's consent to and refusal of medical treatment and ensure that the legislation is in line with the objectives of the Convention and encompass clear recognition of the evolving capacities of children".

The MHC informed the Sub-Committee that it welcomed the inclusion of specific provisions within the General Scheme relating to children whilst the Ombudsman for Children ('OCO') told the Sub-Committee that it welcomed the proposal to include a dedicated section focused on provisions for children under 18.

The OCO stated that a number of the current proposals under Part 8 do not have sufficient regard to children's rights and evolving capacities, and do not adequately provide for a child-centred, rights-based approach regarding children's admission to, and treatment in, approved inpatient facilities.

4.1 Guiding principles for children

The Ombudsman informed the Sub-Committee that whilst the proposed guiding principles have the potential to promote a more child-centred approach to decisions affecting children under 18 years, it was of the view that the current provisions, including those concerning the views of the child, need to be strengthened. The OCO welcomes the provision made under the guiding principles for the best interests of the child to be treated as the primary consideration (Head 104, Section 84(1)(a)).

The Ombudsman informed the Sub-Committee that consideration should be given to making appropriate provision for the factors that need to inform an assessment and determination of what is in the best interests of the child, taking into account relevant international human rights standards (Article 3 of the CRC and Article 7(3) of the UNCRPD). Further attention needs to be given to how relevant rights-based guidance from the UN Committee in respect of Article 3 (best interests of the child), Article 12 (respect for the views of the child) and Article 24 (children's right to the highest attainable standard of health) of the UNCRC. It also suggests that further attention be given to Head 104, Section 84 (1) (C) in respect of the views of the children, and it recommended that the reference to 'where practicable' be deleted.

The OCO told the Sub-Committee that it welcomed the provisions under the General Scheme for children admitted as voluntary, intermediate or involuntary persons to be entitled to engage an advocate, either by themselves or with their parent or parents or person or persons

acting in loco parentis. Appropriate advocacy services need to be made available to all children who wish to avail of them, irrespective of means, and children should be supported to access such services.

The CPI informed the Sub-Committee that it believed that the provisions for children under the Act were robust, with the introduction of provision for the appointment of a guardian ad litem (GAL) and legal representation for parents where there is disagreement. In cases where a young person is willing to be admitted but parents are not in agreement, healthcare professionals will work with the family to see if they can support them in their decision making.

It was noted that there should be increased provision of advocacy services for children in direct provision and in care. The IASW stated that certain children may not have the support of their families and it was important they have adequate access to advocacy services.

The Committee heard evidence that it was important that statutorily required information be given to children who are 16 and 17, which is not in the Act, and that the provisions for mental health be separated from the childcare legislation. In all section 25 applications for involuntary detention, children should have the right to access to legal representation.

4.2 Presumption of capacity for those aged 16 and 17 years

The Bill will provide for the presumption of capacity for all young people aged 16 and 17 years to consent to mental health treatment. This will bring parity between mental health and physical health on consent, as the Non-Fatal Offences against the Person Act provides for people aged 16 and 17 years to consent to medical treatment.

The Sub-Committee heard evidence that the changes for 16- and 17-year-olds will mean they will have more autonomy over their mental health treatment, in common with the rights they have in relation to physical treatment. It is intended that this addition will remedy the disparity between physical and mental treatment.

The Department informed the Sub-Committee that it has given the Mental Health Commission the responsibility to craft the guidelines in relation to how to assess capacity for those aged 16 and 17, how such capacity assessments are to be carried out and who should carry them out. It noted that should there be changes to reduce the age specificised in the Assisted Decision Making (Capacity) Act to 16 from 18, the Department would reconsider the provisions included.

The Committee heard evidence that the Assisted Decision-Making (Capacity) Act 2015 relates only to those over 18, so a relevant person within the meaning of that Act is not a 16 or 17-year- old. The MHC told the Committee that under the current ADM Act, it will only apply to over-18's.

Mental Health Reform told the Committee that Part 8 of the Mental Health (amendment) Bill is set to provide for 16- and 17-year-olds to give or withdraw consent to treatment in mental health services if they are deemed to have capacity. The Heads of Bill state that the Assisted Decision-Making (Capacity) Act 2015 would apply for the purposes of conducting the necessary capacity assessments. However, the Act does not provide for decision supports for under 18s.

The OCO informed the Sub-Committee that there was a gap between the two pieces of legislation. Whilst it welcomed the extension of the category of intermediary persons to children who are aged 16 and over, it noted that the Assisted Decision-Making (Capacity) Act 2015, does not apply to persons under 18 and therefore it does not seem that it will apply to capacity assessments that will be conducted in respect of children under this General Scheme. It informed the Committee that the MHC will prepare and publish a code on capacity assessments for children, but it was not clear what form these assessments will take and whether and to what extent they will actually draw on the Assisted Decision-Making (Capacity) Act. It observed:

> *One of our concerns is that if this fragmented system of capacity assessments is not clarified, or if there is not clarity between these two Departments or they do not take a joint approach ensuring provisions that impact on children reflect best practice, as provided for under the 2015 Act, the best interest of the child might not be upheld or there will be concerns about whether the evolving capacities of children will actually be taken into account.*

Recommendation

15. The Committee recommends that the required legislative changes be made to ensure that the Assisted Decision-Making Capacity Act decision supports apply to those who are 16 and 17 years old and that any conflict between the provisions of the Mental Health and Assisted Decision-Making Capacity Act be rectified as a priority.

4.3 Consent of children- Intermediate Category

The OCO informed the Sub-Committee that it had concerns in relation to the proposed scope of voluntary admissions in respect of children under 16 where the admission of a child was deemed voluntary on the basis of the consent of a parent or persons acting in loco parentis. It stated that this fails to give appropriate recognition to the child's status as a subject of rights. Instead, it suggested that consideration should be given to applying the category of intermediate person to children under 16 years who are admitted on the basis of parental consent. It noted the category of intermediate person would also provide better data on who has consented.

The Sub-Committee heard that a number of stakeholders, such as the former special rapporteur on child protection, have previously recommended provision for a category of intermediate person for children admitted on the basis of parental consent.

The Ombudsman for Children told the Sub-Committee:

> *One can see that even in the adult world where one has voluntary and involuntary. If an intermediary is provided, it means the person has been asked, has probably refused and somebody has forced the issue to bring the person into an inpatient unit. In turn, that allows one to create a different environment and work on that. At the moment, we assume that every child gives voluntary consent to be placed in an inpatient unit, but that is not the case. It just gives us a little more guidance in that regard and more respect to the child's voice.*[14]

The Sub-Committee observed the complexity of the issue, particularly in the cases of children who have eating disorders and may refuse treatment and may be involuntarily detained. The OCO noted that in those circumstances it is important that weight is given to the voice of the child, especially when they are aged between 16 and 17 years. It observed that, if it is a life-or-death scenario, the child's best interests may override other considerations, and it may be a situation in which the service providers need to take charge legally and medically. By asking children however, it gives them hope and a sense of being heard and recognised as an individual. There may be other situations where children don't want to leave inpatient units, and in that case, it may be a matter of working with the child to find the best way to support them to return to their community.

In relation to the issue of consent among under 18s, the OCO informed the Sub-Committee that the use of a purely age-based approach in respect of children under 16 does not have regard to the evolving capacities of children, and it argued there was a need for a more nuanced approach. A suggested provision that could be enabling children under 16 years could give or refuse consent to their admission, care or treatment in circumstances where it has been established the child has the maturity and understanding to appreciate the nature and consequences of the specific decision in regard to their admission or treatment. This would be in line with provisions of the UN Convention on the Rights of the Child and the Convention on the Rights of Persons with Disabilities.

The OCO observed that the Bill was silent on what measures will be taken to ensure due weight will be given the child's views including in regard to their proposed admission. Another concern highlighted was that a subsection of the general principles relating to whether a child under the age of 16 is capable of forming their own views includes a provision for the child to be consulted where practicable. It was the view of the OCO that this should be removed as

[14] Sub-Committee on Mental Health 25 January 2022

children should always be consulted. It added that further attention needs to be given to this as well as to another provision under the guiding principles in regard to giving due weigh to the views of the child and that how they interact with the views that are given by the parents or by the guardian

The IASW suggested that the legislation needed to be clearer on what would happen if a young person consents to treatment, but their guardian opposes it. It also suggested that family or guardians of a young person should be specifically included in the care of young people in inpatient facilities. This would ensure the best possible outcome when they return home.

4.4 Admission of children to adult inpatient units

The Sub-Committee observed that the General Scheme still allows for admission of under-18's to adult facilities under Head 128, section 128. The Sub-Committee believes that it is a draconian practice which needs to be phased out as a matter of urgency.

Admission of children to adult units

In its 2021 annual report, the Mental Health Commission reported that there were **32 admissions** of children to 10 adult units.

Source: Mental Health Commission Annual Report 2021

The Sub-Committee heard evidence that under the reporting mechanisms of the UN Convention on the Rights of the Child, Ireland was instructed to end the practice of admitting under 18's to adult facilities. Article 37(c) states that every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so.

The OCO told the Sub-Committee that it welcomed that the proposed guiding principles make it standard that children should be cared for and treated in an age-appropriate environment. However, that this provision is accompanied by the clause "in so far as practicable", and that the General Scheme permits the admission of children to adult inpatient facilities, is a symptom of a systemic failure on the part of the State.

> *That failure has been maintained over many years and means that, 15 years after Vision for Change, we still do not have sufficient appropriate child and adolescent mental health services and supports available.* [15]

The Department informed the Sub-Committee that the rationale for this provision was for cases where a child is in a CHO where there is no appropriate inpatient CAMHS unit, the child may be admitted to an adult ward for one night to provide for the transfer in order that he or

[15] Sub-Committee on Mental health 25 January 2022

she is in a safe environment. It noted that this happened on occasion and there was a need to include it in the General Scheme "to make sure that we are aware of how often it happens, when it happens and the reasons for it happening with a view to reducing it and hopefully not having to use that section in the future." The Department emphasised that this was to be seen as an absolute last resort and that the HSE was improving its service in terms of addressing such issues.

The Inspector of Mental Health Services informed the Sub-Committee that there are children, usually of the age of 16 or 17, who are admitted to adult units. There are four CAMHS units plus two private units in the country. At any given time, the number of beds varies in those four units. It is dependent on a number of factors, such as the resourcing of the teams in the unit or that there are enough beds to admit the person. A further difficulty is that on occasion, given the design of some of the units and if a child is critically troubled or experiencing extreme mental health difficulties, the unit may not be able to take somebody else into that particular part of the unit, which reduces the bed capacity.

The Inspector stated that it was not "ideal" that those under 18 are admitted to adult unit, noting there is a code of practice on the admission of children. The Sub-Committee heard evidence that there is no adult unit in the country that would meet the standards in the code of practice because the code of practice outlines very clearly that certain therapeutic activities and programmes appropriate to that age group should be provided, and obviously they are not, and also that the layout and facilities are conducive to treating somebody under the age of 18, and they are not.

With regard to length of treatment, the Inspector stated that admissions are short in general, usually a day or two, and on occasion slightly longer.

> *There is really no emergency provision of beds for young people. There is one bed in Galway and Linn Dara at Cherry Orchard in Dublin provides an emergency service but not necessarily a bed. Therefore, there is sometimes literally nowhere for the child to go, so they need for their own safety to be admitted to an adult unit.*[16]

The Inspector informed the Sub-Committee that there a number of areas in the CAMHs services which need to be strengthened, and she informed the Sub-Committee there was a need for the provision of more beds, as well as emergency beds and emergency provision of services for young people who need somewhere safe to go.

Mental Health Reform informed the Sub-Committee that there was a need for an express provision in the Act that no child or young person shall be admitted to an adult inpatient unit. It said that there was a need for a move away from the placement of children in adult units. It would be an ambitious goal to put this on a statutory footing to ensure this doesn't happen.

[1616] Sub-Committee on Mental Health, 16 November 2021

The HSE updated the Sub-Committee on the fact that there was a need to ensure young people are treated in the most appropriate setting. It stated that certain feedback received in its user consultation indicated that on some occasions young people might request that they are treated nearer to their homes and the only option to do this might be in an adult unit.

The OCO told the Sub-Committee that progress on phasing out the practice had slowed:

> *However, what is happening now is we have become lazy about it and we have let the idea that we do not have the resources in place rule the fact that the best interest of the child is being overrun. We need to move forward from that.*[17]

The OCO noted that in a recent research paper, *Take my Hand*, children had recounted the trauma they went through during their treatment in adolescent inpatient units. It added that it was a practice that we can no longer support and should not be legislated for, and it was important that children needed to be facilitated with appropriate supports, treatment and therapies. Adding this provision to the legislation, in practice will establish a legal basis for placing children in adult psychiatric units. It noted that it could have potential unintended consequences of legislating for the admission of children to adult units.

The IMO informed the Sub-Committee that paediatric emergency departments are only accessible to children under 16, and as a result children aged 16 and 17 years old have to present at adult paediatric units, which do not have child psychiatry cover. It said that there needed to be a clear unambiguous definition of what constitutes a child that is consistent across all healthcare services so that those aged 16 and 17 can receive appropriate care.

Stakeholders noted that the vast majority of children, who are under 18, are admitted to child and adolescent mental health facilities. In certain situations, in the best interests of the child, it may be prudent and necessary for the child to be admitted to an adult unit. In the last two years, the numbers admitted accounted for less than 7% of all admissions.

The MHC told the Sub-Committee that there had been a decrease in the practice over the past few years however admission of children to adult units has occurred at weekends when resources and children's emergency admission units are not available. It was noted by the Mental Health Commission that there could be unintended consequences for placing a prohibition on the placement of children in adult units, whereby young adults would suffer by not having any facility at all. It noted that there also was an argument that if we enshrine it, it may force the state to place the facilities in place. This was a complex issue which needed careful consideration by the Sub-Committee.

16.The Sub-Committee recommends that a prohibition be placed on the placement of children in adult units and that the practice be phased out as a matter of urgency. This

[17] Sub-Committee on Mental Health 25 January 2022

should be acknowledged in the proposed legislation and a timeline for the implementation of this recommendation needs to be outlined by the HSE.

4.5 Appointment of guardian ad litem

The Heads of Bill currently state that GAL would be appointed unless it is not in the child's best interests. Stakeholders told the Sub-Committee that this was an unusual form of wording noting that one of the core roles of a GAL is to recommend to the court what is in the best interest of the child.

The General Scheme of the Child Care (amendment) Bill 2021 was published last autumn and it aims to set out in law the role and functions of a guardian *ad litem*, etc. Any provision relating to the appointment of guardian's *ad litem* under the General Scheme of the mental health (amendment) Bill should include the provision in that Bill.

Stakeholders welcome the introduction of a provision for appointment of a guardian ad litem as a young person then has someone who will engage with them and represent their views to the court while also forming an independent opinion or view, which they can then bring back to the court.

Recommendation

17. The Sub-Committee recommends that there should be greater alignment between the Child Care (amendment) Bill 2021 and the General Scheme of the Mental Health (Amendment) Bill.

4.6 Transition from CAMHS to adult care

The Sub-Committee heard that further consideration needs to be given to the transition of children from CAMHS to adult mental health services. It explored whether this needed to be legislated for in the Bill.

The Sub-Committee heard evidence that there is a policy for the transition on the CAMHS side which is not replicated on the adult side and that there is a need for policies between both services to align. The Sub-Committee heard that whilst 18 is legally a very important age consent-wise, in the life of young people it is actually quite an arbitrary line. A young person could be in the middle of their leaving certificate year and could have been going to CAMHS for years and in some places, they might go straight into adult services.

The Sub-Committee heard that whilst legislation may not be needed on this point, there was a need for clear protocols between the different services, and that this should be clearly explained to the individual in advance of the transition between services, to reduce any potential worry and anxiety an individual may have.

The IASW told the Sub-Committee

> *As I said, the age of 18 years legally has major change. The age of 16 years has a change, but it is where they attend services. That arbitrary line, depending on how strictly it is enforced, and it is enforced in different places in different ways, can have a big impact on them.*

The Sub-Committee heard that the current model of community mental health teams works really well if adequately resourced with the right people. One of the big difficulties with the transition from CAMHS to adult is very often it is quite abrupt. It was observed this was an issue which could be resolved through greater co-ordination between adult and children's mental health services and may not need legislative proposals.

4.7 Other issues relating to care of children

The MHC told the Sub-Committee that there are number of issues which the Commission believes are important to include in the General Scheme, including provisions that each child should be appointed a legal representative from the beginning of an involuntary detention process all the way up to its conclusion. The Commission is of the view that this is the best way to ensure that the voice of the child is heard. Furthermore, the Commission could extend its legal aid scheme to deal with the appointment of such legal representatives.

It also said there needs to be separate provisions relating to children under 16 years and those who are 16 to 17 years old adding that there should be a statutory provision for the furnishing of information to the children and their parents/guardians. The provisions in the 2001 Act need to stand alone from those in the childcare legislation and there is need for greater involvement of children in the process in terms of attending court remotely and having a say in proceedings.

The Sub-Committee also heard that time periods in the Act which are relevant to children are quite long. The MHC told the Sub-Committee that a child who is voluntarily in an approved centre can be made involuntary but that it takes 72 hours to do so whereas for an adult, it takes 24 hours. The Sub-Committee notes that three days is an incredibly lengthy amount of time for a child. In addition, the court can make orders for 21 days and three months. It had recommended that this time period be reduced for 14 days, and that the period of three months also be reduced.

The MHC also raised the issue of technology and said that children, particularly 16 and 17-year-olds, should be able to attend hearings relating to them remotely. This would provide an enhanced role for children in the process.

The Sub-Committee observed that there is a clear need to ensure that supports and services are available to both adults and children at the earliest possible intervention and that these services are available and adequately resourced. Whilst not directly linked with this Bill, long delays in providing psychology appointments to children and CAMHs appointments could have detrimental long-term impacts on children, with some children currently waiting up to two years for appointments. The Bill needs to be properly resourced in order to be effective and whilst its focus may be on the acute end of mental health, consideration must be given to the long-term impacts of the lack of resourcing on mental health outcomes and recovery for people of all ages.

5. Advocacy and Complaints mechanisms

5.1 Independent complaints mechanism

The Sub-Committee heard evidence from a number of stakeholders that there was a need for a direct complaints' mechanism in relation to mental health treatment, one that is entirely independent from the current internal HSE complaints mechanism.

Mental Health Reform told the Sub-Committee that people with psychosocial disabilities and experiencing mental health difficulties should have a safe and independent avenue for complaints. This need has been highlighted in consultations with people using services and their families, friends, carers and supporters. It recommends that an independent complaints mechanism for mental health services be established, that would be separate to the HSE Your Service, Your Say complaints mechanism. It also said that the Inspector of Mental Health Services should be conferred with a statutory obligation to receive, investigate, and determine individual complaints relating to mental health services.

The Department informed the Sub-Committee that any person who wishes to make a complaint or have a complaint against a service provider such as the HSE investigated can do so regardless of whether it is for a disability service, mental health service or physical health service. It noted that that Office of the Ombudsman has a role in investigating complaints in the HSE and the Department said that the Ombudsman is open to anyone who accesses services through the HSE.

The Department informed the Sub-Committee that the Mental Health Commission and in particular, the Inspector of Mental Health Services has a role in terms of its functions and whilst it is not an independent complaints mechanism, when taken together, the Inspector and the Office of the Ombudsman already perform a function similar to that which an independent complaints mechanism might perform.

The Department further informed the Sub-Committee that an independent complaints mechanism did not come up in the recommendations of the expert group in 2015 but it did arise in the public consultation in 2021. It noted that the document was a living one and that it would consider any suggestions emerging from the pre-legislative scrutiny process.

The MHC informed the Sub-Committee that any citizen who uses the health service has the right to make a complaint to a body and that such a body should have a complaints process in place which includes independent elements. Following this, if a complainant is not satisfied with the HSE, he or she can go to the Ombudsman. This is the same process for complaints regarding general health and there is no distinction between mental health services and other health services.

The Commission emphasised that the culture around complaints should be that those dealing with the complaint should learn from it, to set up an independent body would cause a "rupture in quality improvement and in addressing the complaints of a person". The Commission also added that the General Scheme also introduces a patient advocacy service and the ability to make applications to it, which will strengthen the Act.

> *There should be a culture of complaining being a good thing, because that is how you improve the system. The advocates would help people to complain when they need to. It is the same as any other part of the health system.*[18]

The Sub-Committee also discussed the issue of retrospective complaints, and options for those who may not have the capacity to complain and who might not realise there was a problem until months or years later. The MHC agreed that there needs to be a facility for people to complain after the fact and it observed that there may be a need for a discussion with the HSE as to whether it is conveying how much effort it puts into its complaint process. It also stated that mental health institutions tend to be closed institutions and there has to be a general move away from the culture of being afraid to do things, to being open and transparent.

The Sub-Committee heard that there is an optional protocol under the UNCRPD which establishes a way for individuals to make complaints and hold the State accountable. The optional protocol has not been ratified in Ireland.

The Sub-Committee also heard that other jurisdictions have varying models of complaints mechanisms. In Wales, there are concerns teams to which people can complain. In New Zealand, there is an independent advocate called the health and disability commissioner who is the ombudsperson for mental health. In 2018, the World Health Organisation's European region published a piece about the rights and standards of care for institutional care. Some 28 countries in that report have different independent complaints mechanisms. Whilst the Heads of the Bill state that people should be informed of the facility's complaints mechanisms, stakeholders said this did not go far enough.

Certain stakeholders proposed alternative solutions including the establishment of a mental health ombudsman or the provision of a specific mandate to the Inspector of Mental Health Services. The Sub-Committee heard it was important there is further accountability and oversight and that the complaints mechanism should be able to examine clinical decision making.

[18] Sub-Committee on Mental Health 16 November 2021

Observations and Recommendations

18. The Sub-Committee recommends the ratification of the Optional Protocol of the UNCRPD as a matter of urgency – there are no barriers to the Government progressing with immediate ratification of the OP.

19. The Sub-Committee recommends the establishment of an independent, fully funded and resourced independent complaints mechanism for mental health services because there is no other cohort of person accessing health treatment that may be denied their liberty.

5.2 Patient Advocacy Services

The Sub-Committee heard that the MHC has put patient advocacy services in place at the time of the Covid-19 pandemic and it has made a difference. It noted that supporting the advocacy services and the extension of patient advocacy services into mental health is planned and would be welcome.

The Sub-Committee heard that National Advocacy Service for adults with disabilities, the Patient Advocacy Service and the Decision Support Service are all only for those aged 18 years and over. A youth advocacy programme is piloted in two centres presently however for children outside of these units there is no advocacy service.

The OCO observed that a well-resourced and well-trained advocacy service would be invaluable for children and their families, observing that it may service between 300- 400 children a year.

Some stakeholders with lived experience told the Sub-Committee there was a need for a statutory right of access to independent advocacy as well as the right to legal representation. This should be available to all persons, and not just to those who are involuntarily detained. Stakeholders noted there was a need for breadth of capacity in respect of the independent advocacy resource in order that it will not restrict itself in regard to whom it might serve, including children and young people aged 16 to 18, who may also be in need of an independent advocate. The Sub-Committee heard that the National Advocacy Service for People with Disabilities is growing, strong and independent of the HSE but it is not necessarily a peer-led service. Advocacy should be available for the start and first encounters a service, and not just in times of severe distress.

The Sub-Committee heard that in Scotland under the Scottish Mental Health (Care and Treatment) (Scotland) Act 2003, people may have access to independent advocacy support.

They can avail of this support before they go into hospital so there is someone to support them and to speak for them in respect of what their advanced healthcare directive says regarding what does and does not help them.

The Sub-Committee heard that while the Bill recognises patient advocacy, there is provision made for it in the General Scheme. It heard that it was vital that advocates have human rights training and it should be peer-led.

Shine told the Sub-Committee that the allocation of advocacy services that support family members and supporters was a welcome step in the right direction. The role of the authorised officer is essential in enabling families to stay in their role and to continue beyond admission to have a positive relationship with their loved one. This needs significant investment and stakeholder buy-in in order to be effective. It recommended that such resources be available to family and supporters, as in some cases persons with disabilities or illness may not have a family member to support them but may have a close friend or supporter.

The Sub-Committee heard:

> *Often, we are prescriptive in the way services are delivered but it is more important to have a person-centred approach. In care planning and recovery planning, it is really about individuals stating who works for them, who they trust and their supporters.*

It was acknowledged that this may be difficult to write into the legislation but could perhaps form a part of the guiding principles. Representatives from mental health organisations told the Sub-Committee that it was extremely important the role of the authorised officer, be complemented by the independent role of the advocate under the legislation. The Sub-Committee also heard that people need supports to navigate the often-complex mental health services and systems. It was observed that another option was to prescribe a right to advocacy but that the regulator could provide greater guidance on the operation of that right.

Observations and Recommendations

The Sub-Committee recommends increased funding and resources for the National Advocacy Service to expand its remit across both community and inpatient mental health services.

The Sub-Committee recommends increased funding and resources for organisations in the Sub-Community and Voluntary Sector providing advocacy services to people accessing mental health services and supports in the community, in approved centres, in outpatients settings. This is in line with Sharing the Vision Recommendation 65.[19]

The Sub-Committee recommends increased recruitment of peer support advocacy workers, peer advocacy support networks and peer support workers across all CHOs in line with the HSE's Mental Health Engagement and Recovery Office (MHER).

The Sub-Committee recommends the expansion of the Youth Advocacy Programme (YAP) of inpatient advocacy for under 18s across all CHOS and that youth advocacy be available to all under 18s in the community from when they first come into contact with needing to access mental health services.

[19] HSE Sharing the Vision Recommendations, Link

6. Reform of Mental Health Services

6.1 Resourcing of mental health services

Whilst the proposed legislation may not set out levels of funding, persistent issues relating to the resourcing of mental health services were a consistent theme during the Sub-Committee's consultation with stakeholders.

The Sub-Committee heard evidence from the IMO that funding for mental health now stands at just 5.5% of healthcare funding compared with 10% in the UK and Canada, 13.5% in Norway and 15% in France. It also heard that there were large numbers of key posts unfilled across mental health services including consultant psychiatry positions, psychiatric nurses, counsellors, psychotherapists, occupational therapists, social workers, with staffing levels up to 40% below recommended levels.

As of May 2022, 4,294 children are currently waiting for a consultant appointment with CAMHs whilst the Sub-Committee heard that Ireland has only 33.5 inpatient psychiatric beds per 100,000 population, which is less than half the EU average of 68 inpatient psychiatric beds (As provided by the HSE (link). In addition, acute adult psychiatric units operate at almost 90% occupancy, well above the 85% safe occupancy levels. The Sub-Committee also heard that there is no dedicated resource within general practice to deal with mental health difficulties.

While the Sub-Committee commends the spirit of the Bill, implementation of the Bill will certainly entail a need for further funding in order to effectively resource the Mental Health Commission's expanded remit and advocacy services. Without a commitment for appropriate funding, it is unlikely that this Bill will succeed in its aims.

Medical organisations pointed to the need to review the community-led model of mental health provision as there were issues with staffing and recruitment, and many teams could not function when a staff member went on leave or took another position. There needs to be a further examination of this model and review to see if improvements can be made. They pointed to the possibility of using chronic disease programmes at primary care level as a way by which to strengthen mental health provision.

The Sub-Committee also heard evidence that there is no one model in other jurisdictions which could be adopted in Ireland, however there are some examples of areas of best practice for example Norway, which has drug-free mental health units and Italy which has community-based healthcare. Advocates stated that in all instances, policy should always be aligned with the WHO guidance.

The Sub-Committee notes that the right to community mental health services should be outlined in the Act. Mental health services have not been given the priority that they require. The time for change is now and the Members hope that a recommendation can be made that significant investment is required at all levels of mental health services to ensure a fundamental change in how these services operate and benefit those who receive care and treatment.

6.2 Treatment and therapies

The Sub-Committee observed that there needs to be a move away from the "medical model" towards a space where citizens can have access to medical intervention as well as other forms of therapy.

The Sub-Committee heard that for many GPs, there are long waiting lists for primary care psychology in certain parts of the country. The Sub-Committee heard from doctors that there was more prescribing in general practice than what ideally happens if services such as talk therapies were properly resourced.

The Sub-Committee heard that it was important that mental health at a primary care level be examined and resources such as the multidisciplinary team, MDT, psychology, Occupational Therapy, Speech and Language Therapy, Talk Therapies, Art Therapies and other supports be implemented as a matter of urgency. This will filter onto secondary care and more time will be available for people who have specialist or severe and enduring mental health difficulties to access timely care.

Stakeholders informed the Sub-Committee that there was a need for a holistic approach, rather than just looking at the importance of resourcing and having those skills and specialist mental health teams. It was also noted that there needed to be additional resources at primary care level to allow timely support and access.

The benefits of social prescribing were also mentioned, and the Sub-Committee heard evidence that other mental health services offer free gym membership, physical exercise, physical fitness, or weight control programmes - various elements that can be implemented that quite often are very cost-effective because they are done in a group manner and can be just as beneficial as one-to-one counselling or the use of medications.

As noted in section 3 above, the Sub-Committee also heard evidence that there was a need for further regulation of talk therapists and representations had been made by the Irish Association for Counselling and Psychotherapy to establish such a system.

Stakeholders with lived experiences informed the Sub-Committee that the over-emphasis on the medical model needed to change and noted a report by the WHO which highlighted the failure of biomedical health systems, where mental health systems over diagnosed human distress and over-relied on psychotropic drugs to the detriment of psychosocial interventions. It was noted that mental health services should seek to get to the root of people's trauma.

The Sub-Committee also heard that in other areas such as addiction services, there is a right to taper and to reduce the levels of medication within the system. It was suggested that statutory reviews of medication could be added to the legislation.

The PSI informed the Sub-Committee that the vast majority of people who attend mental health services attend as outpatients. Many of the people will not be on medication. It said that we need to change the notion that the medication is the best and only method of treatment. Management of mental health in the modern context is a biopsychosocial model. It is delivered by a trained multidisciplinary team and, as we discussed earlier, with everybody bringing their own particular skill set and training. The power imbalance of psychiatry needs to be addressed and expanded.

On the question of mental health and effective intervention, the Psychological Society of Ireland believes that social and psychological interventions must be provided first. It is what the World Health Organization and the NICE guidelines for excellence recommend. This must be done as a first line of action. There must be parity across the elements for the process to work.

The Sub-Committee observed that while there has been a culture shift, stigmatisation of mental health difficulties still exists, and mental health services often take a siloed approach which does not have a person-centred focus.

6.3 Mental health services in the criminal justice system

The Sub-Committee heard that there is no over-arching policy to address issues of those mental health issues entering the criminal justice system. The Committee heard that this Bill could be amended to facilitate this issue.

The Sub-Committee heard that a recent report by the Inspector of Mental Health Services Access to Mental Health Services for People in the Criminal Justice System, contains some law reform proposals that could be implemented through amendments to the 2001 Act.[20]

The report observed that gaps in mental health services can lead to people with mental health difficulties ending up in prison, while in some prisons, teams are under-resourced and struggle to provide a comprehensive service.

A high-level taskforce has been established to consider the Mental Health and Addiction Challenges of Persons Interacting with the Criminal Justice System to examine proposals in this regard.[21] Dr Charles O' Mahony informed the Sub-Committee that it was regrettable that the proposals in this regard do not feature in the current Heads of Bill. The Sub-Committee also expresses its disappointment that this has not been given further consideration in the Bill.

[20] Access to mental health services for people in the criminal justice system FINAL.pdf (mhcirl.ie)
[21] Department of Justice Establishment of a High Level Taskforce to consider the mental health and addiction challenges of persons interacting with the criminal justice system - The Department of Justice April 2021

6.4 Proposed right to Community Mental Health Services

Stakeholders from the voluntary sector have called for the need to establish a statutory right for the right to community mental health services stating this will contribute to a reduction in the number of cases that evolve into more complex mental health difficulties.
This would provide alternatives to inpatient facilities.

Summary of Recommendations

1. The Sub-Committee recommends that a stronger focus needs to be put on a human rights-based approach within the proposed legislation and the proposed heads need to fully adhere to the spirit and rationale of the UN Convention of the Rights of Persons with Disabilities.

2. The Sub-Committee recommends that the General Scheme be amended to remove references to the term 'mental disorder' and replace it with 'persons with psychosocial disabilities' in line with the UNCRPD and the social model of disability.

3. The Sub-Committee recommends that the State should ratify the Optional Protocol of the CRPD at the earliest possible opportunity.

4. The Sub-Committee recommends that the reform of mental health legislation must be accompanied by State measures, including legislation, aimed at ensuring less restrictive forms of treatment in the community are available and the ultimate eradication of coercion in the treatment of persons with psychosocial disabilities. This includes investment in community-based support and services for persons with psychosocial disabilities and through assisting persons to utilise the Assisted Decision Making (Capacity) Act 2015 to exercise their capacity. The provisions in the Assisted Decision Making (Capacity) Act 2015 will need to be extended to all citizens, including those involuntarily detained, in order for this to be possible.

5. The Sub-Committee recommends that there is close alignment between the relevant mental health legislation in compliance with the standards of the CRPD.

6. The Sub-Committee recommends that the General Scheme be amended to provide that a person fulfils the criteria for involuntary admission 'where such treatment is immediately necessary to protect the life of the person, or to protect the health of the person from the threat of serious harm, or for the protection of other persons from such harm'.

7. The Sub-Committee recommends that Section 8 of the Heads of Bill should be amended to require that detention is to last only for as long as absolutely necessary in emergency circumstances.

8. The Sub-Committee recommends that the Minister liaise with the HSE on the potential implications of resourcing authorised officers for implementation of the Act and that an implementation plan be published detailing timelines and method by which the HSE plans to provide for recruitment and retention of authorised officers.

9. The Sub-Committee recommends that independent, accessible advocacy services be offered to persons involuntarily detained at the earliest possible juncture. Cognisance must be given to the needs of the person at various times throughout their admission. Approved centre staff should ensure that a person receives the necessary information in a manner appropriate to them in sufficient time before a review board hearing.

10.The Sub-Committee recommends that all professionals working on multi-disciplinary teams working in the area of mental health services have human rights training and this should be extended to trainee grades as well.

11. The Sub-Committee recommends a quality assurance register of regulated professionals.

12. The Sub-Committee recommends that all restrictive practices should be abolished for young people under 18.

13. The Sub-Committee supports a move away from restrictive practices and believes that developments and regulation in this area should be guided by evidence informed approach based on international best practice.

14. The Sub-Committee recommends that training in trauma informed care and human rights should be introduced across all services providing mental health care.

15. The Sub-Committee recommends that the required legislative changes be made to ensure that the Assisted Decision-Making (Capacity) Act decision supports apply to those who are 16 and 17 years old and that any conflict between the provisions of the Mental Health and Assisted Decision-Making Capacity Act be rectified as a priority.

16. The Sub-Committee recommends that a phased prohibition be placed on the placement of children in adult units and that the practice be phased out as a matter of urgency. In order to facilitate this, this should be acknowledged in the proposed legislation and a timeline for the implementation of this recommendation needs to be outlined by the HSE. The Sub-Committee notes that no child should be left without a service and urges the Department and the HSE to consider how this can be achieved whilst ensuring that there is a complete prohibition on the placement of children in adult units.

17. The Sub-Committee recommends that there should be greater alignment between the Child Care (amendment) Bill 2021 and the General Scheme of the Mental Health (Amendment) Bill.

18. The Sub-Committee recommends the ratification of the Optional Protocol of the UNCRPD as a matter of urgency – there are no barriers to the Government progressing with immediate ratification of the OP.

19. The Sub-Committee recommends the establishment of an independent, fully funded and resourced independent complaints mechanism for mental health services because there is no other cohort of person accessing health treatment that may be denied their liberty.

Appendix A: Submissions

Organisation	Link to submission
Irish Penal Reform Trust	Link
Bodywhys	Link
Psychiatric Nurses Association of Ireland	Link
Law Society of Ireland mental health and capacity committee	Link
IHREC	Link
Dainius Puras	Link
Dr Ren Minghui WHO	Link

Appendix B: Orders of reference

1. That a sub-committee be established to examine mental health issues as outlined in paragraph 3 below, which will:

a. consist of the members of the Committee or substitutes as appropriate with at least one Member from the Dáil and one member from the Seanad and a quorum shall be three
b. elect one of its members to be the chairperson
c. meet initially on a fortnightly basis.

2. The sub-committee will have powers of the Committee devolved to it for the purposes of conducting its business, including the taking of evidence from witnesses.

3. The sub-committee will examine

a) access and continuity of treatment for those in need of mental health services, with specific reference to the impact of Covid-19 on demand and delivery of services.

b) the implementation plan for Sharing the Vision, to include funding, facilities and communications.

The sub-committee will make an interim report to the Joint Committee by 28 February 2021.Appendix 2: Orders of Reference

Standing Orders 94, 95 and 96 – scope of activity and powers of Select Committees and functions of Departmental Select Committees.

Scope and context of activities of Select Committees

94.(1) The Dáil may appoint a Select Committee to consider and, if so permitted, to take evidence upon any Bill, Estimate or matter, and to report its opinion for the information and assistance of the Dáil. Such motion shall specifically state the orders of reference of the Committee, define the powers devolved upon it, fix the number of members to serve on it, state the quorum, and may appoint a date upon which the Committee shall report back to the Dáil.

(2) It shall be an instruction to each Select Committee that—

(a)it may only consider such matters, engage in such activities, exercise such powers and discharge such functions as are specifically authorised under its orders of reference and under Standing Orders;

(b) such matters, activities, powers and functions shall be relevant to, and shall arise only in the context of, the preparation of a report to the Dáil;

(c) it shall not consider any matter which is being considered, or of which notice has been given of a proposal to consider, by the Joint Committee on Public Petitions in the exercise of its functions under Standing Order 125(1); and

(d) it shall refrain from inquiring into in public session or publishing confidential information regarding any matter if so requested, for stated reasons given in writing, by—
(i) a member of the Government or a Minister of State, or

(ii) the principal office-holder of a State body within the responsibility of a Government Department or

(iii) the principal office-holder of a non-State body which is partly funded by the State,

Provided that the Committee may appeal any such request made to the Ceann Comhairle, whose decision shall be final.

(3) It shall be an instruction to all Select Committees to which Bills are referred that they shall ensure that not more than two Select Committees shall meet to consider a Bill on any given day, unless the Dáil, after due notice to the Business Committee by a Cathaoirleach of one of the Select Committees concerned, waives this instruction.

Functions of Departmental Select Committees

95. (1) The Dáil may appoint a Departmental Select Committee to consider and, unless otherwise provided for in these Standing Orders or by order, to report to the Dáil on any matter relating to—

(a) legislation, policy, governance, expenditure and administration of—

(i) a Government Department, and

(ii) State bodies within the responsibility of such Department, and

(b) the performance of a non-State body in relation to an agreement for the provision of services that it has entered into with any such Government Department or State body.

(2) A Select Committee appointed pursuant to this Standing Order shall also consider such other matters which—

(a) stand referred to the Committee by virtue of these Standing Orders or statute law, or

(b) shall be referred to the Committee by order of the Dáil.

(3) The principal purpose of Committee consideration of matters of policy, governance, expenditure and administration under paragraph (1) shall be—

(a) for the accountability of the relevant Minister or Minister of State, and

(b) to assess the performance of the relevant Government Department or of a State body within the responsibility of the relevant Department, in delivering public services while achieving intended outcomes, including value for money.

(4) A Select Committee appointed pursuant to this Standing Order shall not consider any matter relating to accounts audited by, or reports of, the Comptroller and Auditor General unless the Committee of Public Accounts—

(a) consents to such consideration, or

(b) has reported on such accounts or reports.

(5) A Select Committee appointed pursuant to this Standing Order may be joined with a Select Committee appointed by Seanad Éireann to be and act as a Joint Committee for the purposes of paragraph (1) and such other purposes as may be specified in these Standing Orders or by order of the Dáil: provided that the Joint Committee shall not consider—

(a) the Committee Stage of a Bill,

(b) Estimates for Public Services, or

(c) a proposal contained in a motion for the approval of an international agreement involving a charge upon public funds referred to the Committee by order of the Dáil.

(6) Any report that the Joint Committee proposes to make shall, on adoption by the Joint Committee, be made to both Houses of the Oireachtas.

(7) The Cathaoirleach of the Select Committee appointed pursuant to this Standing Order shall also be Cathaoirleach of the Joint Committee.

(8) Where a Select Committee proposes to consider—

(a) EU draft legislative acts standing referred to the Select Committee under Standing Order 133, including the compliance of such acts with the principle of subsidiarity,

(b) other proposals for EU legislation and related policy issues, including programmes and guidelines prepared by the European Commission as a basis of possible legislative action,

(c) non-legislative documents published by any EU institution in relation to EU policy matters, or

(d) matters listed for consideration on the agenda for meetings of the relevant Council (of Ministers) of the European Union and the outcome of such meetings, the following may be notified accordingly and shall have the right to attend and take part in such consideration without having a right to move motions or amendments or the right to vote:

(i) members of the European Parliament elected from constituencies in Ireland,

(ii) members of the Irish delegation to the Parliamentary Assembly of the Council of Europe, and

(iii) at the invitation of the Committee, other members of the European Parliament.

(9) A Select Committee appointed pursuant to this Standing Order may, in respect of any Ombudsman charged with oversight of public services within the policy remit of the relevant Department consider—

(a) such motions relating to the appointment of an Ombudsman as may be referred to the Committee, and

(c) such Ombudsman reports laid before either or both Houses of the Oireachtas as the Committee may select: Provided that the provisions of Standing Order 130 apply where the Select Committee has not considered the Ombudsman report, or a portion or portions thereof, within two months (excluding Christmas, Easter or summer recess periods) of the report being laid before either or both Houses of the Oireachtas.

Powers of Select Committees

96. Unless the Dáil shall otherwise order, a Committee appointed pursuant to these Standing Orders shall have the following powers:

(1) power to invite and receive oral and written evidence and to print and publish from time to time—

(a) minutes of such evidence as was heard in public, and

(b) such evidence in writing as the Committee thinks fit;

(2) power to appoint sub-Committees and to refer to such sub-Committees any matter comprehended by its orders of reference and to delegate any of its powers to such sub-Committees, including power to report directly to the Dáil;

(3) power to draft recommendations for legislative change and for new legislation;

(4) in relation to any statutory instrument, including those laid or laid in draft before either or both Houses of the Oireachtas, power to—

(a) require any Government Department or other instrument-making authority concerned to—

(i) submit a memorandum to the Select Committee explaining the statutory Instrument, or

(ii) attend a meeting of the Select Committee to explain any such statutory instrument: Provided that the authority concerned may decline to attend for reasons given in writing to the Select Committee, which may report thereon to the Dáil,
and

(b) recommend, where it considers that such action is warranted, that the instrument should be annulled or amended;

(5) power to require that a member of the Government or Minister of State shall attend before the Select Committee to discuss—

(a) policy, or

(b) proposed primary or secondary legislation (prior to such legislation being published),

for which he or she is officially responsible: Provided that a member of the Government or Minister of State may decline to attend for stated reasons given in writing to the Select Committee, which may report thereon to the Dáil: and provided further that a member of the Government or Minister of State may request to attend a meeting of the Select Committee to enable him or her to discuss such policy or proposed legislation;

(6) power to require that a member of the Government or Minister of State shall attend before the Select Committee and provide, in private session if so requested by the attendee, oral briefings in advance of meetings of the relevant EC Council (of Ministers) of the European Union to enable the Select Committee to make known its views: Provided that the Committee may also require such attendance following such meetings;

(7) power to require that the Chairperson designate of a body or agency under the aegis of a Department shall, prior to his or her appointment, attend before the Select Committee to discuss his or her strategic priorities for the role;

(8) power to require that a member of the Government or Minister of State who is officially

responsible for the implementation of an Act shall attend before a Select Committee in relation to the consideration of a report under Standing Order 197;

(9) subject to any constraints otherwise prescribed by law, power to require that principal office-holders of a—

(a) State body within the responsibility of a Government Department or

(b) non-State body which is partly funded by the State,

shall attend meetings of the Select Committee, as appropriate, to discuss issues for which they are officially responsible: Provided that such an office-holder may decline to attend for stated reasons given in writing to the Select Committee, which may report thereon to the Dáil;

and

(10) power to—

(a) engage the services of persons with specialist or technical knowledge, to assist it or any of its sub-Committees in considering particular matters; and

(b) undertake travel;

Provided that the powers under this paragraph are subject to such recommendations as may be made by the Working Group of Committee Cathaoirligh under Standing Order 120(4)(a).'

Standing Orders 107 and 109 – Committees meeting in Private

That Standing Order 107 be amended by the addition of the following paragraph after paragraph (2):

'(3) Where a Standing, Select or Special Committee, by Order, meets in private, such meeting may be held on such specified videoconferencing platform as may be approved and provided by the Houses of the Oireachtas Commission: Provided that minutes of Private Meetings will be proposed and decided at the next (public) Meeting of the Committee.'

That Standing Order 109 (‘Quorum of Select Committees’) be amended by the inclusion in paragraph (4) of ‘or, for the purpose of Standing Order 107(3) taking part in proceedings on such specified videoconferencing platform as may be approved and provided by the Houses of the Oireachtas Commission,’ after ‘present’, and by the addition of the following proviso: ‘Provided further that references in Standing Orders to being present, taking part in proceedings, attending and participating shall be construed accordingly.’.

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