Mental Health Reform Update

Mental Health Bill 2024: A Plain English Guide to Key Concerns and Recommendations

October 2025

Mental Health Reform

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Glossary of Terms

Advance Healthcare Directive (AHD): a written legal document through which a person sets out their preferences for future healthcare and treatment. This document should be followed if they lose capacity to make decisions[1]. A valid AHD must be signed and witnessed correctly and contain directives (directions) that apply to the specific treatment or care being suggested.

Autonomy: a person's capacity to make their own choices about their life, what they do and about their care.

Authorised Officers: a qualified health worker who has been trained to be allowed to fill in the necessary forms to recommend that someone be involuntarily admitted, so that Gardaí and/or family members don't have to make these applications.

Capacity: Capacity is a person's ability to understand when a decision is being made and the nature and consequences of the decision in the context of the available choices. Under the Assisted Decision-Making (Capacity) Act 2015 (ADMCA), people should always be presumed to have capacity and cannot be considered to lack capacity simply because they:

- Need information to be explained in an appropriate way considering their circumstances
- Can only retain the relevant information for a short period of time
- Lacked capacity for a particular decision at one time but may no longer lack capacity to make that decision, or
- Lack capacity for some decisions but have capacity to make decisions on other matters[2]

Capacity Assessment: is a structured process used to check whether a person has the ability to understand, retain, use, and weigh information relevant to a specific decision, and can communicate their decision by any means[3].

Chemical Restraint: the use of medication (generally sedatives) mainly to control or change a person's behaviour, or to restrict their freedom of movement, rather than to directly treat their condition[4] [5].

Coerced Consent: is when a person feels they have no real choice but to agree to treatment because they feel pressured or threatened, not because they freely chose it. This can happen if they face threats such as:

- involuntary detention,
- the use of restrictive practices,
- removal of supports (such as financial or social supports), or
- legal proceedings.

[1] https://www.irishstatutebook.ie/eli/2015/act/64/enacted/en/html
[2] https://www.citizensinformation.ie/en/health/legal-matters-and-health/assisted-decision-making-act/#6e1b65
[3] https://www.irishstatutebook.ie/eli/2015/act/64/section/3/enacted/en/html#sec3
[4] https://www.mhcirl.ie/sites/default/files/2024-12/Restrictive%20Practices%20Report%202023%20FINAL.pdf
[5] https://www.hiqa.ie/sites/default/files/2020-03/Restrictive-Practices_Literature-Review.pdf

In this circumstance, a person's apparent consent may not meet the ethical or legal standards of being free and informed[6].

Decision-Making Representative: a person legally appointed under the ADMCA to make certain decisions on behalf of a person who is deemed to lack capacity[7].

Decision-Making Supports: help provided to a person to make informed choices about their mental healthcare. These supports are regulated by the ADMCA[8].

Independent Advocate: An independent advocate is someone who is trained to help a person understand their rights, express their views, and make informed decisions about their care.

Independent Complaints Process: a mandated, fair and easily accessible process for a person to make a complaint about their care or treatment. This process should be independent of service providers (not run by people who are part of the service providing the care).

This process needs to have:

- clear timelines for when the complaint will be investigated and dealt with,
- the power to properly investigate, and
- safeguards protecting people from any potential negative consequences from making a complaint.

Involuntary Admission: being admitted to hospital against your will[9].

Involuntary Treatment: refers to any form of medical or psychological intervention that is administered without the consent of the person receiving it[10].

Mental Health Act 2001: laws currently governing the care and treatment of people with mental health difficulties in Ireland. If a person is in hospital or inpatient centre for treatment for mental health difficulties, there are laws that these places have to follow right now. Until the Mental Health Bill is signed into law by the President and becomes an Act, there will be no changes in a person's rights. Even after this, it can take some time for a new law to be commenced, which means started or put into operation. Sometimes parts of a law are commenced before others. It will likely be a few years before the Mental Health Bill is fully commenced.

Mental Health Bill 2024: The Mental Health Bill 2024 is proposed legislation in Ireland aimed at replacing the Mental Health Act 2001. It is currently before the Seanad for review. Its goal is to update mental health law to align more closely with human rights standards.

[6] https://www.tandfonline.com/doi/full/10.1080/09638230802052203
[7] https://www.irishstatutebook.ie/eli/2015/act/64/enacted/en/html
[8] https://www.irishstatutebook.ie/eli/2015/act/64/enacted/en/html
[9] https://www2.hse.ie/mental-health/services-support/involuntary-admission/
[10] https://www.mdpi.com/2227-9032/12/4/445

Mental Health Review Board: updated term in the Bill for what was previously known as Mental Health Tribunals. This independent panel will review whether a person's involuntary detention is in line with the legal criteria for involuntary admission outlined in the Bill.

Statutory Right to Advocacy: a legal right to independent support that empowers people to express their views, make informed decisions, understand their rights, and access the services and supports they are entitled to.

Will and Preferences: refer to a person's values, beliefs, choices, and expressed wishes, which must be respected in accordance with the ADMCA[11].

UNCRPD (United Nations Convention on the Rights of Persons with Disabilities): an international treaty that protects the human rights and freedoms of all persons with disabilities, including those with mental health difficulties[12]. Ireland ratified (agreed to follow) the UNCRPD in March 2018.

[11] https://www.irishstatutebook.ie/eli/2015/act/64/enacted/en/html
[12] https://social.desa.un.org/issues/disability/crpd/convention-on-the-rights-of-persons-with-disabilities-crpd

Mental Health Reform Update

Overview

The Mental Health Bill represents a landmark effort to update Ireland's mental health legislation in line with human rights principles and international best practice. Throughout the legislative process, Mental Health Reform (MHR) has continued to play a central role in advocating for stronger protections for people experiencing mental health difficulties. This advocacy has spanned several years and has included key milestones, such as appearing before the Oireachtas Joint Committee on Health to present concerns and recommendations directly to policymakers.

Timeline of the legislative process (2011 to date)

2011 – Government agrees to review the Mental Health Act 2001:

The legislative process for the Mental Health Bill began in 2011, when the Government committed to a comprehensive review of the existing Mental Health Act 2001.

2011-2022 – Public consultation:

From 2011, the Bill progressed through several key stages. This includes public consultations (getting feedback from the public) and 'pre-legislative scrutiny' (analysis of the draft legislation).

2024 – Mental Health Bill Published

Mental Health Bill 2024 was published in July 2024.

February 2025

Minister Butler restored the Bill to Second Stage in the Dáil as one of her first acts as Chief Whip.

May 2025 – Cabinet approves amendments:

The Cabinet (Government Ministers) approved 241 amendments.

June 2025 – Amendments brought to Committee Stage:

These were introduced during Committee Stage in June 2025. Unlike the usual procedure, where Committee Stage is held within an Oireachtas Committee, this phase of the Bill was carried out in the Dáil chamber. While this made the legislative process faster and allowed for Minister-led debate, it also limited opportunities for detailed analysis, stakeholder engagement, and input from experts (such as people with lived experience of mental health difficulties, health professionals, and community organisations).

July – Bill passed by Dáil:

In July, the Bill progressed through Report and Final Stages in the Dáil and was passed by 86 votes to 69.

September 2025:

On 24th September, the Bill progressed to Second Stage debate in the Seanad.

Mental Health Reform acknowledges several key positive developments in the Bill

MHR acknowledges the Government's commitment to prioritising this important piece of legislation and welcomes several positive developments in the current draft of the Bill. These include:

- stronger guiding principles (greater emphasis on respecting a person's will, preferences, and autonomy, and a requirement that any care be the least restrictive option necessary to meet the person's needs),
- the use of more person-centred language,
- expanded role of authorised officers in the involuntary admission process so Gardaí don't have to be involved in these applications,
- a section focused on children's mental health needs,
- 16 and 17-year-olds will be able to consent to or refuse mental health treatment in line with their physical health treatment rights, and
- the Mental Health Commission's regulatory powers will be expanded to include oversight of community mental health services and Child and Adolescent Mental Health Services (CAMHS).

The above reforms are welcome and reflect long-standing calls for greater accountability and person-centred care.

However, MHR remains concerned about the late-stage introduction and limited analysis of several recent amendments

We are concerned about the late-stage introduction and limited analysis of several substantial amendments passed at Committee and Report Stage in the Dáil.

Many of these changes have significant implications for human rights and for people receiving mental health services.

As the Bill moves through the Seanad, it is vital that these concerns are addressed, and the legislation is more closely aligned with the UNCRPD.

MHR's concerns and recommendations for improvement

We outline our concerns about the Mental Health Bill 2024 in two sections:

A. Our concerns about amendments to the Bill that were recently approved (during the summer of 2025). Read Concerns 1–8.
B. Our general concerns about the Bill. Read Concerns 9–12.

For each concern we list recommendations to address these issues. We ask you to carefully consider our issues and recommendations.

A. Concerns about recently approved amendments

Below, we will list eight concerns about amendments to the Mental Health Bill 2024 made during the summer of 2025. We suggest practical recommendations to address these concerns.

Concern 1: Involuntary treatment can begin before a capacity assessment is completed[13] [14].

Section 48(1)

Under the Assisted Decision-Making Capacity Act (2015) (ADMCA), an adult is presumed to have capacity, meaning that every adult is presumed to have the ability to make decisions unless proven otherwise. Those with recognised decision-making capacity have the right to refuse medical treatment and to have that decision respected. One of the key aims of the Mental Health Bill 2024 was to better align mental health legislation with the principles of the ADMCA.

Earlier versions of the Bill clearly outlined an expectation that involuntary treatment should generally only occur after a capacity assessment had been completed. However, recent amendments allow for involuntary treatment to begin ***without*** a capacity assessment having been completed.

We are further concerned that there is no clear timeline for when a capacity assessment must occur once involuntary treatment has begun. There is also no requirement for ongoing or repeated capacity assessments throughout the involuntary detention period. As capacity is dynamic and can change over time, it is important that people's will and preferences are actively and repeatedly sought and respected throughout the course of their care.

Recommendations:

Require capacity assessments be generally completed before a decision is made to involuntarily treat a person

1.1 We recommend that, in general, capacity assessments should be required to be completed before any involuntary treatment is given.

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[13] Dáil Éireann debate - Wednesday, 11 Jun 2025 Vol. 1068 No. 5
"A new Section 47 which allows for treatment to be administered to an involuntarily admitted person who has been assessed as lacking capacity, or who is undergoing capacity assessments, for a period of 21 days or 42 days following admission. A person must meet criteria for treatment set out in this section."

[14] Mental Health Bill 2024, As Passed

In the very limited circumstances where capacity assessments cannot be completed before involuntary treatment has been started, we recommend that there must be a comprehensive capacity assessment within a short, clearly defined timeframe (for example, 3 days) from the start of involuntary treatment. If this cannot be done, the capacity assessment should be completed at the earliest possible opportunity.

The reasons for not completing the assessment before involuntary treatment was started, as well as for any further delays, should be clearly documented by the responsible consultant psychiatrist.

Require repeated and regular capacity assessments

1.2 We recommend the introduction of mandatory regular reassessments of capacity throughout the involuntary treatment period. All assessments should be clearly documented and reviewed by the multidisciplinary team.

Require written record of assessments

1.3 We recommend that each capacity assessment should include a written record of how a person's will and preferences were identified and respected, or why they could not be followed.

Independent audit and review of involuntary treatment

1.4 We recommend that the Mental Health Commission sets up procedures for independent audit and review of involuntary treatment decisions, particularly cases where involuntary treatment begins before a capacity assessment is completed.

Concern 2: The timeframe for involuntary treatment can be doubled from 21 to 42 days and, in some cases, even longer[15] [16].

Section 48(3)

This change increases the risk of prolonged, involuntary treatment. MHR is concerned about this because:

- the original Bill had a strict 21-day window for involuntary treatment. This window has now been ***doubled***. Further, based on amendments made to Section 50 (see Concern 5), involuntary treatment may potentially even continue beyond the 42-day window in cases where a person is awaiting decision making supports; and
- this change was introduced at a late stage in the Bill's progress without adequate discussion or consensus. The additional 21-day extension for involuntary treatment

[15] Dáil Éireann debate - Wednesday, 11 Jun 2025 Vol. 1068 No. 5
"Amendments to section 47 provide for treatment of involuntarily admitted people lacking capacity following their admission. Such people may be treated for a period of up to 42 days, increasing from 21 days in the Bill as initiated. An initial 21-day treatment window is provided for in the amendments, which can be extended by one further period of 21 days where it is approved by a second consultant psychiatrist."

[16] Mental Health Bill 2024, As Passed

appears to go ahead without the need for a new capacity assessment. The only requirement in this case is that the multidisciplinary team continue to determine that the person meets the conditions for involuntary detention. This is concerning given that a person's capacity can change over time and could have changed considerably after 21 days.

Recommendations:

Keep the involuntary treatment window at 21 days – no more.

2.1 We recommend reverting to the involuntary treatment window of 21 days.

Require regular capacity assessments

2.2 As a minimum, we recommend there be a statutory requirement for regular capacity assessments throughout a person's care (i.e. assessments should be repeated when a person's consent is needed or if their psychological state has changed in a way that could affect their capacity to consent).

Concern 3: There is a risk that people being involuntarily treated are left waiting too long to get access to decision-making supports[17].

Section 48(6)

The original draft of the 2024 Bill required that an application to the Circuit Court to put decision-making supports in place - for someone who is believed to lack capacity, or who is waiting for a capacity assessment - be made ***before*** involuntary treatment could begin. This was intended to ensure that a person got access to these supports in as timely a manner as possible. These supports could include help accessing and understanding information, making personal welfare decisions, and letting other people know what decision was made.

However, under recent amendments, this application can now be made ***at any time within the involuntary treatment window*** (21 to 42 days). This wide range increases the risk of delays for a person to access essential supports to protect their rights and preferences.

Based on amendments to Section 50 (see Concern 5 below), involuntary treatment can continue while waiting for the Court's decision, even beyond the 42-day window. As such, an application could be made on the 42nd day and a person could then be subject to

[17] Dáil Éireann debate - Wednesday, 11 Jun 2025 Vol. 1068 No. 5
"A new section 48 which provides for an application to be made to the Circuit Court to seek the appointment of a decision-making representative or the making of a decision-making order where a person lacks capacity and does not have a valid substitute decision- making arrangement. The application to the Circuit Court must be made at any point within the 21 or 42 days following admission, and treatment may be administered before the application is made to the Court."

potentially months more of involuntary treatment without these supports while they wait for the Court's decision.

Recommendations:

Applications to Circuit Court to be made as soon as possible after involuntary admission

3.1 To ensure people get decision-making supports in a timely way, we recommend that the application for these supports be made to the Circuit Court within a short and clearly specified time period (for example, as early as possible and no more than 3 days (72 hours) from the start of involuntary detention).

Provide access to independent advocate

3.2 We recommend people accessing mental health services are given access to an independent advocate. This could help make sure decision-making supports are provided in a timely manner (see Concern 9 below).

Concern 4: The criteria for involuntary treatment have been significantly widened[18].

Section 48(2)

Recent amendments to Section 48 of the Bill significantly broaden the criteria for involuntary treatment to now include circumstances where a psychiatrist believes treatment is immediately required, and the suggested treatment would be "likely to benefit" the person's condition. This marks a significant shift from the original 2024 Bill, which permitted involuntary treatment only when it was deemed immediately necessary to protect the health or safety of the individual or others.

We are concerned that this change introduces a ***much lower threshold for forced treatment***, granting psychiatrists too much discretion to impose forced treatment based on presumed benefit, a standard that almost any recommended treatment could meet. Section 32(3) of the Bill allows for involuntary admission based on the same very low "likely to benefit" threshold.

By comparison, the Mental Health Act 2001, requires that involuntary detention and involuntary treatment be believed to be "likely to benefit or alleviate the condition of that person ***to a material extent***," which sets a higher bar[19]. Therefore, the proposed criteria in the Bill weakens existing safeguards around involuntary detention and involuntary treatment decisions.

[18] Mental Health Bill 2024, as passed.
https://data.oireachtas.ie/ie/oireachtas/bill/2024/66/eng/ver_b/b66b24d.pdf
[19] https://www.irishstatutebook.ie/eli/2001/act/25/enacted/en/pdf

In addition, while we welcome the requirement under the Bill to record the absence of consent, and details of treatment in medical records, it's important to note that there is no system in place for independent audit or review of involuntary treatment decisions. Mental Health Review Boards (or Tribunals as they are known under the current Mental Health Act) only review involuntary admission decisions. This makes the need for a guaranteed right to access an independent complaint process and independent advocates all the more important (see Concern 9).

Recommendations:

Remove the term "likely to benefit" from involuntary detention and treatment

4.1 We recommend removing the term "likely to benefit" as a basis for involuntary detention and involuntary treatment. Involuntary treatment should only be permitted in urgent cases where the delay or absence of such measures could have a serious impact on the health or safety of the individual.

Make it a requirement to regularly review capacity

4.2 We recommend that the Bill introduces a requirement for a continual review of capacity when a person is being involuntarily treated.

Access to an independent complaints process required

4.3 We recommend that people have access to an independent complaints process (see Concern 9 below). This would allow people to challenge treatment decisions, address any concerns about their care and help safeguard their rights.

Procedures needed for independent audit and review of involuntary treatment

4.4 We recommend that the Mental Health Commission establish procedures for independent audit and review of treatment decisions made while a person is forcibly treated against their will.

Concern 5: Widening of allowance for treatment without consent pending Circuit Court determination with limited safeguards[20]

Section 50(1)(2)(4)(5)

As previously noted, amendments to Section 48 of the Bill have doubled the timeframe for involuntary treatment and significantly extended the period within which an application for decision-making supports must be made to the Circuit Court.

Section 50 now allows involuntary treatment to continue while the Court is making its determination. Furthermore, unlike the original 2024 Bill - which required the application to be made before treatment could begin – Section 48 of the Bill permits the application to be

[20] Mental Health Bill 2024, As Passed

made as late as the 42nd day. ***This means a person could be forcibly treated against their will for more than 42 days without any decision-making supports while awaiting a potentially lengthy Court process.*** The absence of a requirement to apply for these supports within a reasonable timeframe is concerning.

Section 50 also appears to weaken safeguards further by creating an exception to the already extended timeline. Section 50(1) ***allows treatment beyond the 42-day limit*** if a capacity assessment is still underway and no Circuit Court application has yet been made for decision making supports. It is unclear why the capacity assessment and the Circuit Court application could not have been made within a 42-day period. This risks prolonging treatment without proper safeguards.

Section 50(4) is particularly concerning. It appears to permit prolonged involuntary treatment, well beyond 42 days, with only three-month reviews by an independent psychiatrist. This contrasts with the original 2024 Bill, which set a clear 21-day limit for involuntary treatment. The rationale for this provision is unclear, and the lack of additional safeguards is very concerning. It also undermines the relevance of the already extended 42-day timeframe.

Recommendations:

Capacity assessments and applications for decision-supports must be completed quickly to protect rights

5.1 We recommend that applications to the Circuit Court for decision-supports should be made as quickly as possible (such as within 3 days (72 hours) of involuntary admission).

5.2 We recommend that no person should ever be involuntarily treated without a completed capacity assessment where at all possible. In the very limited cases where this is not possible, the assessment should happen as quickly as possible. In addition, we recommend an application for decision-making supports be completed within 3 days (72 hours) of a person being involuntarily detained.

Involuntary treatment should not continue beyond 21 days without access to decision-supports

5.3 We recommend that Section 50(4) be deleted, and substantially greater safeguards are put in place for a person being involuntarily treated while awaiting decision-supports.

Concern 6: Involuntary treatment of a person with recognised capacity may begin, even before a High Court Ruling on the matter[21]

Section 51(1)(2)(5)

Section 51(1) of the Bill allows for an application to be made to the High Court to authorise involuntary treatment of a person refusing treatment in cases where the person:

a) has capacity,
b) has a valid Advance Healthcare Directive (AHD), and/or
c) has an appointed Decision-Making Representative

Under recent amendments to Section (51)(5), involuntary treatment can be given in these circumstances for up to a full **3 days** (72 hours) once the application to the High Court has been made, or until the High Court hearing (whichever is sooner). Allowing for ***involuntary treatment of a person with recognised capacity or a valid AHD*** is not in line with human rights standards and is a significant step backwards from earlier versions of the Bill, which at least did not allow for involuntary treatment of a person in such circumstances before a High Court ruling. It also represents a marked move away from the standards applied to physical health treatment decisions. In addition, the decision made by a person with recognised capacity can be overridden based on the very low threshold that a psychiatrist determines they are "likely to benefit" from the proposed treatment.

In addition, giving medication during the 72-hour period that a person is waiting for their Court case ***may damage the person's ability to effectively communicate*** their will and preferences to the Court, placing them at a clear disadvantage. The Bill also does not specify how individuals will be supported in managing the effects of treatment or in understanding and exercising their legal rights during this critical window.

Section 51(2) states that an application to the High Court for involuntary treatment will be withdrawn if the person changes their mind and consents to treatment. While this provision may appear to respect the person's autonomy, in practice, ***it risks legislating for coerced consent*** (where consent is not freely given or fully informed). This raises ethical concerns, as a person may feel pressured to agree to treatment to avoid:

- court proceedings,
- having to stay longer in hospital against their will, or
- other negative consequences (such as fear of retaliation or having medication increased).

If there is no independent review, such consent may not be freely given or fully informed. Removing judicial oversight once consent is given undermines the safeguards designed to protect the rights of a person with recognised capacity to refuse treatment that they do not want.

[21] Mental Health Bill 2024, As Passed

Recommendations:

No person with recognised capacity should ever be involuntarily treated

6.1 In line with existing provisions for physical health care, we recommend that no person with recognised capacity should ever be involuntarily treated, particularly before a High Court ruling is made.

At a minimum, involuntary treatment should only be given in these cases to protect life

6.2 At an absolute minimum, we recommend that treatment provided involuntarily in such cases should only be given when strictly necessary to protect life. If such a provision remains, all cases where a person withdraws their refusal and consents to treatment after an application to the High Court has been made should continue to the High Court for review and there should be mandatory independent review procedures to assess whether consent was given freely, without coercion, and with the support of legal representation and an independent advocate.

Concern 7: Minimum timeframe for review of involuntary admission by Mental Health Review Board has been extended[22]

Section 32(3)

Recent changes to the Mental Health Bill mean that Mental Health Review Boards for reviewing involuntary admission orders cannot be held within 14 days of the admission order but must take place within 21 days.

This wording ***removes the possibility of a Review Board hearing taking place before 14 days,*** a notable shift from the original 2024 Bill, which allowed for earlier reviews[23]. It also contrasts with the Mental Health Act 2001, which permits hearings within a shorter timeframe[24]. Furthermore, it diverges from the recommendations of the 2015 Expert Review Group, which proposed reducing the ***maximum*** timeframe for these hearings from 21 to 14 days[25].

By setting a minimum threshold of 14 days, the current provision risks delaying access to independent oversight for individuals subject to involuntary detention.

Recommendations:

Reviews of involuntary detention should be happening as early as possible.

[22] Mental Health Bill 2024, As Passed
[23] https://data.oireachtas.ie/ie/oireachtas/bill/2024/66/eng/initiated/b6624d.pdf
[24] https://www.irishstatutebook.ie/eli/2001/act/25/enacted/en/pdf
[25] https://assets.gov.ie/static/documents/report-of-the-expert-group-review-of-the-mental-health-act-2001.pdf

7.1 In line with the recommendations of the Expert Review Group, we recommend that Review Board hearings happen within a 14-day window. At a minimum, the provision preventing these hearings from taking place as early as possible should be removed.

Concern 8: Unclear rules around consent rights of 16- and 17-year-olds[26]

Section 10

The age of consent to be admitted, cared for and treated in a mental health hospital has been lowered to 16 years in line with the laws around physical healthcare decisions.

However, recent amendments to Section 10 of the Bill state that the views, will, and preferences of the parents or guardian of a child aged 16 years or older must be given ***"due weight"*** in deciding consent around admission, care and treatment.

Our concern is that these guiding principles for 16 and 17-year-olds are ***unclear***. There is no guidance on what happens where the views, will and preferences of these young people conflict with those of their parent or guardian. It remains unclear whose decision would ultimately be respected in relation to:

- admitting the child into a mental health hospital
- decisions about their care and treatment

Recommendation:

Provide clarity around children's rights when conflict

8.1 We recommend the term "due weight" be removed from this section. At a minimum, clear guidance is needed to make sure that the rights and autonomy of the child are appropriately respected where there is a conflict between their will and preferences and their parents' or guardians' will and preference in relation to involuntary treatment cases.

[26] Mental Health Bill 2024, As Passed

B: General concerns relating to the Bill

Below, we will list four general concerns about the Mental Health Bill 2024. Again, we suggest practical recommendations to address these concerns.

Concern 9: There is no commitment for an independent complaints process or a statutory right to independent advocates for people accessing mental health services.

We have long advocated for both measures. They are ***essential to uphold the rights and dignity of people placed in such vulnerable and coercive circumstances***, particularly where they are being detained or given treatment without their consent.

The importance of an independent complaints process and a right to independent advocates is amplified by the Bill's recent amendments (see concerns 1-8 above), which have significantly broadened the potential scope and duration of involuntary treatment.

Without an independent complaints process and the right to independent advocates, people remain at risk of being subject to prolonged, coercive (forced) treatments ***without***:

- an independent advocate to amplify their voice,
- a way to meaningfully challenge decisions made about their care, and
- a clear way to seek redress (compensation) for inappropriate care.

Recommendations:

Make it a legal right to have an independent advocate when accessing mental health services

9.1 We recommend that the Mental Health Bill introduce a statutory right to independent advocacy[27] for all people accessing mental health services.

As a first step, all people subject to involuntary detention should have this right from the moment of their involuntary admission. This right should include the option to refuse advocacy support (opt-out), as well as the ability to engage with advocacy services (opt-in) at any stage during their detention.

Introduce a right to access and use a clear independent complaints process

[27] We note that the absence of a statutory right to independent advocacy for people being involuntarily detained puts Ireland significantly out of step with international best practice, including best practice in England, Scotland and Wales. We also note a clause that has recently been introduced to the UK Mental Health Bill requiring that, in order to learn from those with lived experience, a person detained must be offered a consultation with an independent mental health advocate. This would involve a review of their experiences of hospital treatment within 30 days of their discharge.

9.2 We recommend that the Mental Health Bill introduces a right of access to an independent complaints process to review complaints by people accessing mental health services.

This system must be legally separate from service providers.

It must also have:

- defined timeframes for investigating complaints,
- clear investigatory powers,
- protections for people making the complaint against retaliation
- a clear way of working, including clear and accessible instructions in different formats.

Make it a requirement to inform about the right to an independent advocate

9.3 We recommend that there is a requirement that people are informed of their right to an independent advocate. Doing so helps advocates to represent a person's expressed wishes and concerns.

Concern 10: The term "Mental Disorder" still needs to be replaced.

Section 2

Despite many improvements in the Bill's overall language, it continues to use the term "mental disorder," a term that individuals with lived experience have consistently described as ***stigmatising and outdated***. There is a strong view that this term should be updated to better reflect dignity, respect, and modern understandings of mental health.

Recommendation:

Remove and replace the term "mental disorder"

10.1 We continue to advocate for the term "mental disorder" in the legislation to be replaced by "mental health difficulties" in line with Sharing the Vision, the national mental health policy in Ireland, or "psychosocial disability" in line with the UNCRPD.

At a minimum, we recommend that "mental disorder" be replaced with the term "mental illness". While this is still considered a problematic term by some people, it is generally agreed to be less stigmatising than "mental disorder" and is in line with the recommendation of the Expert Review Group [28].

[28] https://assets.gov.ie/static/documents/report-of-the-expert-group-review-of-the-mental-health-act- 2001.pdf

Concern 11: The Bill continues to allow for children to be admitted to adult units.

Sections 62-65

The Bill continues to allow children to be placed in adult units without any limit on the amount of time they can be kept in age-inappropriate care. While, we welcome the decrease in the number of children being admitted to adult units in recent years, we are concerned ***these numbers could rise again in future years given the lack of safeguards in the Bill protecting against this practice.***

The Committee of the UN Convention on the Rights of a Child is also seriously concerned about Ireland's practice of admitting children to adult units.

Recommendations:

No children in adult units

11.1 We recommend that the Bill prohibit the admission of children to adult units.

Where no other option, a child should only be admitted to an adult unit for a short time

11.2 At a minimum, we recommend that where a child is admitted to an adult unit in an emergency because there is no alternative available, the Bill includes a clearly defined maximum timeframe for how long a child may remain in this unsuitable environment. We suggest a limit of 3 days (72 hours), within which the child must be transferred to a unit capable of providing age-appropriate care.

Concern 12: The use of chemical restraint needs safeguards.

Section 53–58, 84-91

The Bill provides no specific safeguards regulating the use of chemical restraint against people accessing mental health services.

Earlier drafts included a section on chemical restraint. However, there are now no references to***, nor protections against the use of chemical restraint***. The absence of these safeguards is particularly concerning, as this practice is not covered under existing regulations or Codes of Practice. This practice is also not currently reviewed or monitored by the Mental Health Commission.

Recommendations:

Add section regulating chemical restraint

12.1 We recommend a section under Chapter 4 (Restrictive Practices) of the Bill be added to clearly outline how the use of chemical restraint is regulated, which should outline clear rules and oversight.

Conclusion

The Mental Health Bill presents a vital opportunity to uphold the rights and dignity of some of the most vulnerable people in our society – those experiencing serious mental health difficulties.

The Bill also represents the chance to bring Irish legislation more in line with the progressive aims of the UN Convention on the Rights of Persons with Disabilities.

There is still an opportunity to introduce key changes that would significantly strengthen the Bill. By addressing our concerns above using our recommendations, the Bill can more fully reflect a rights-based approach to mental health that respects the rights, dignity, and voices of those with lived experience.

MHR continues to carefully review the changes in the Mental Health Bill. We reserve the right to alter our comments and observations in the light of new information and further changes to the Bill. We welcome feedback from our members or the public.

Please remember that this document is not legal advice. This is an overview of some of Mental Health Reform's views on the current draft of the Mental Health Bill 2024. Any errors are the authors.

To support public understanding of the Mental Health Bill and its implications, Mental Health Reform have produced supporting materials, including reports and webinars. You can find these on our webpage Reform the Mental Health Act.

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