Submission to the Department of Health on the Review of the Mental Health Act 2001

7 October 2011

Introduction:

The Children's Mental Health Coalition (the Coalition) [1] has 50 members representing groups from service providers, the education sector, human rights and children's rights organisations. The Coalition seeks improvements in children's mental health in relation to mental health services, the education system, the justice system and the care system. The Coalition welcomes the opportunity to make a submission on the review of the Mental Health Act 2001. **This submission is largely concerned with provisions relating to children under the Mental Health Act 2001.**

The provisions of the Act relating to children have been subject to some debate and criticism and are in many ways inadequate, incomplete and out of line with international human rights law. While the Mental Health Commission (MHC) has produced a detailed Code of Practice on the admission of children under the Act, the fact that only six out of 36 approved centres which admit children were found by the Inspector of Mental Health Services to be fully compliant with the code in 2009 illustrates the need for stronger provisions in our law in this area.

The Coalition recognises that additional costs will be required to provide age-appropriate child and adolescent services and advocacy supports for children. In this light the Coalition welcomes the Programme for Government commitment to 'ring fence €35m annually from within the health budget to develop community mental health teams and services as outlined in *A Vision for Change* to ensure early access to more appropriate services for adults and children'. In the long term the Government needs to support best practice and move towards the provision of

[1] Alcohol Action Ireland, Amnesty International Ireland, Association of Secondary Teachers Ireland (ASTI), Barnardos, Bodywhys - The Eating Disorders Association of Ireland, Border Counties Childcare Network, CARI Foundation, Children in Hospital Ireland, Children's Rights Alliance, College of Psychiatry in Ireland, Dáil na nÓg, Disability Federation Ireland, Educate Together, EPIC (formerly Irish Association of Young People in Care), Family Breakdown Support Services, Foróige, Headstrong- the National Centre for Youth Mental Health, Home-Start National Office, Irish Congress of Trade Unions (ICTU), Irish National Council for AD/HD Support Groups (INCADHD), Inclusion Ireland, Inspire Ireland, Integrating Ireland, Irish National Teachers Organisation (INTO), Irish Association of Social Workers, Irish Branch of the Association for Child and Adolescent Mental Health, Mental Health Reform, Irish Penal Reform Trust, Irish Primary Principals Network, Irish Refugee Council, Irish Second-Level Students' Union, ISPCC, Mater Child & Adolescent Mental Health Service, Miss Carr's Children's Services, Mothers Union, Mounttown Neighbourhood Youth and Family Project, National Association for Parents Support, National Association of Principals and Deputy Principals, National Parents Council, National Youth Council of Ireland, One in Four, Pavee Point, Psychiatric Nurses Association, Society of St. Vincent de Paul, Spunout, St. Patrick's University Hospital, The Psychological Society of Ireland, Youth Advocate Programmes Ireland, Youth Health Programme, and The Base (Youth Centre).

mental health services for children from early childhood up to early adulthood of up to 25 years old.

i) <u>The need for a separate section on children</u>

Currently the provisions of the Act relating to children are spread out among different parts of the Act. The Coalition agrees with the recommendation of the Law Reform Commission (LRC) in its recent Report: *Children and the Law: Medical Treatment,* that the Act be amended to include specific provisions for persons under the age of 18[2] This would make the Act more user-friendly and would also facilitate the setting out of a specific set of guiding principles and overarching provisions which should underpin those provisions of the Act relating to children.[3]

Recommendations:

1. *All provisions relating to children should be set out in a standalone part of the Act*
2. *The section of the Act relating to children should begin with a set of guiding principles and overarching provisions, which should reflect a number of important human rights principles as set out in international human rights law and standards.*[4] *These should include*:
    - *that children be given information about the proposed admission and treatments and their effects and outcomes in a manner that is accessible and appropriate;*
    - *that children be treated in the least restrictive environment appropriate (i.e. insofar as possible, in the community);*
    - *That children may only be admitted under the 2001 Act if such an admission is in their best interest, objectively assessed by reference to their rights;*[5]
    - *that treatment administered to children be the least intrusive and restrictive treatment appropriate and that such treatment be administered for the shortest possible period and in accordance with an individualised care plan agreed in consultation with the child;*
    - *that the evolving capacities of the child be respected and that (a) the child be given the opportunity to express his/her views (regardless of age) and (b) that such views be given due weight in accordance with the age and maturity of the child*[6]*; and*
    - *that 'best interests' be defined in a way that is informed by the views of the child, bearing in mind that those views should be given due weight in accordance with the age and maturity of the child.*[7]

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[2] LRC 103-2011, recommendation 4.13 .

[3] The Law Reform Commission was also in favour of setting out a set of guiding principles in this way. See LRC 103 –2011 , recommendation 4.13.

[4] See in particular the Convention on the Rights of the Child (CRC), Council of Europe Recommendation 2004(10) (in particular Article 29) and the Convention on the Rights of Persons with Disabilities (CRPD).

[5] As recommended by the Law Reform Commission LRC 103-2011, para. 3.80-3.81

[6] This is in line with both Article 12 CRC and Article 3(h) CRPD, which reiterates as a general principle the need to respect the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

[7] The UN Committee on the Rights of the Child has stressed that there is no tension between the best interests of the child and the right of the child to be heard and that the two general

ii) Admission of children to adult facilities

The Act does not currently require that children be admitted to age-appropriate mental health facilities. However, the UN Committee on the Rights of the Child expressed its concern at this practice in its most recent Concluding Observations on Ireland's compliance with the CRC in 2006.[8] During 2008, there were 263[9] admissions of children to adult wards, an increase of 14 per cent on the previous year. There were 205 admissions of children to adult services during 2009[10], and there were 155 admissions in 2010. The Inspector of Mental Health Services has aptly described this practice as "inexcusable, counter-therapeutic and almost purely custodial in that clinical supervision is provided by teams unqualified in child and adolescent psychiatry".[11]

In an effort to address this issue, the MHC introduced an Addendum to its Code of Practice relating to the Admission of Children under the Mental Health Act 2001 on 1 July 2009, which provides that no child under 16 is to be admitted to an adult unit after 1 July 2009; no child under 17 from 1 December 2010; no child under 18 from 1 December 2011 and in the exceptional cases where a child is admitted to an adult unit, the Approved Centre must submit a detailed report to the MHC setting out why the admission took place.[12] For the first six months after the addendum came into force in relation to children under 16[13], only one child under 16 was admitted to an adult ward. However, in the next six-month period, 11 children under the age of 16 were admitted to adult wards. Arising from this, the MHC commissioned an independent investigation into the admission of children to adult mental health wards in Ireland.[14] The report of this investigation was published in December 2010 and made various recommendations to address the inappropriate admission of children (including one child as young as 13 years of age) to adult mental health units and paediatric units.[15] The report recommended that the operational criteria for "exceptional circumstances", where the admission of patients under 18 to adult centres is justified, be defined.[16]

Human rights guidance

Article 37(c) of the CRC provides "…In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child's best interests not to do so…". The Coalition recommends that a provision be included to place this requirement on a statutory footing. Thus the Act should provide that no child or young person shall be admitted to an adult inpatient unit (voluntarily or involuntarily) save

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principles are complementary. See UN Committee on the Rights of the Child *General Comment No 12, UN Doc* CRC/C/GC/12 (20 July 2009) para 74.

[8] UN Committee on the Rights of the Child *Consideration of Reports Submitted by States Parties under Article 44 of the Convention, Concluding Observations: Ireland* UN doc CRC/C/IRL/CO/2 (29 September 2006) para 46.

[9] *National Psychiatric Inpatient Reporting System (NPIRS) Preliminary National Bulletin Ireland 2008* (Health Research Board 2009) at 2; the Mental Health Commission reported in its annual report that there were 247 admissions of children to adult units during 2008 because data had not been returned from all Approved Centres when the Annual Report went to print.

[10] MHC Annual Report 2010 p. 45.

[11] MHC Annual Report 2008 p. 29.

[12] http://www.mhcirl.ie/Mental_Health_Act_2001/Mental_Health_Commission_Codes_of_Practice/

[13] 1 July 2009 to 31 December 2009.

[14] *The Irish Times* 'Inquiry into children sent to HSE adult units' 8 November 2010.

[15] Dr Sally E Bonnar *Report for the Mental Health Commission on Admission of Young People to Adult Mental Health Wards in the Republic of Ireland* (MHC Dublin 2010).

[16] ibid, para. 5.1.

where it is in his or her best interests to do so. The Act should also provide that where a child is admitted to an adult unit, he or she shall be accommodated in an area separate from adults and in an age-appropriate environment, with appropriate education, recreation and other age-appropriate facilities.[17]

Other jurisdictions

Section 131A of the Mental Health Act 1983 (England and Wales) provides that where a child is admitted to or detained in hospital for treatment for mental health problems, the hospital management must ensure that "the patient's environment in the hospital is suitable having regard to his age (subject to his needs)". The Code of Practice to the Mental Health Act 1983 for England (2008) lists a number of factors to be considered in determining whether the ward environment is suitable for the child or young person in question. These include: a) appropriate physical facilities, b) staff with the right training, skills and knowledge to understand and address their specific needs as children; c) a hospital routine that will allow their personal, social and educational development to continue as normally as possible; and d) equal access to educational opportunities as their peers, insofar as they are able to make use of them.[18]

Recommendations:

3. *The Coalition recommends that the Act be amended to specifically provide that no child or young person shall be admitted to an adult inpatient unit (voluntarily or involuntarily) save in exceptional circumstances where it is in his or her best interests to do so. The Code of Practice should elaborate on the types of situations which would amount to "exceptional circumstances".*

4. *The Act should also provide that where a child is admitted to an adult unit, he or she shall be accommodated in an area separate from adults and in an age-appropriate environment, with appropriate education, recreation and other age-appropriate facilities.*

iii) Specialist independent advocacy for children

The Act does not currently make any provision for independent advocacy services, whether for adults or children. The LRC has recommended that all children and adolescents admitted and treated under the Mental Health Act 2001 should have access to independent specialised advocacy services.[19] In addition, the author of the recent MHC Report on the admission of children to adult mental health wards commented that she found it difficult to ascertain how the wishes and opinions of children are heard.[20] The Coalition strongly endorses this recommendation. There is a particular need for specialist advocacy services for children. The non-statutory advocacy services currently provided by the Irish Advocacy Network (IAN) do not cover children. Specialised independent advocacy is necessary to ensure that

[17] This reflects the policy position of the MHC, whose recent guidance provides for a gradual phasing out of admissions to adult units between July 2009 and December 2011. See also MHC Report 2010 (ibid) paras 4.6 and 5.3 where Dr Bonnar discusses inappropriate settings for care of acutely ill adolescents and the need to meet the educational, recreational and developmental needs of young people in an age-appropriate manner.

[18] Young Minds *Briefing on the Responsibilities of NHS Boards under Section 131A of the Mental Health Act 1983, which was due to come into force on 1 April 2010* available at: www.youngminds.org.uk.

[19] LRC 103-2001 recommendation 4.13.

[20] MHC 2010 para 3.9. She also contrasted the situation in Ireland, where there is no statutory provision on advocacy, with the situation in Scotland, where the Mental Health (Scotland) Act 2003 enshrines independent advocacy and thereby allows for the voice of young people to be heard apart from their parents. ibid, para 3.3

children can be aware of and exercise their rights under the Act. The MHC published a resource pack to assist using mental health inpatient services in speaking up for themselves, asserting their rights and getting involved in decisions in relation to their care and treatment (*Headspace Toolkit*),[21] which AI very much welcomes but recognises does not replace the need for specialist independent advocacy services, providing specialist advocates trained to work with children.

***Recommendation**:*

5. *The Act should be amended to provide that specialised child/adolescent-focused independent advocacy services are made available for all children and adolescents in inpatient mental health services.*

iv) Whether a third category of informal admission for children and young people who are admitted should be created

The current position is that children (i.e. up to the age of 18 years) are regarded as "voluntary" patients where their parent(s) or guardian(s) consent to their admission and treatment.[22] The Act does not recognise the right of the child or young person to express his or her views freely and have those views given due weight in accordance with the child's age and maturity as is required by Article 12 CRC. Thus it is likely that a substantial number of the children recorded as "voluntary" patients of mental health services are, in fact, involuntary, without any of the protections that should flow from involuntary status.

The LRC has recommended the introduction of a third category of 'intermediate' admission for children and adolescents who are admitted under the Act by parental consent.[23] The Coalition welcomes this recommendation, which makes an important distinction between children who are genuinely voluntary patients, i.e. who give free and informed consent to their admission, and those children who do not have capacity to consent to admission and whose parents consent to their admission in accordance with law. It is of the utmost importance that children who are admitted as "informal" patients are granted the same protections and safeguards as "involuntary" patients. Accordingly, the Coalition endorses the LRC's recommendation at parpgraph 3.9.3 of their Report, which is reflected below:

Recommendation:

6. *A third category of 'intermediate' admission informal patients should be introduced for children who are admitted under the Act by parental consent. The Act should require that the admission and treatment of 'intermediate patients' would be subject to regular review, in the same manner as involuntary patients.*

v) Capacity to consent and children between 14 and 18 years of age

The Act does not recognise the capacity of a young person under the age of 18 years to consent to admission or treatment for mental health problems. Rather, parental consent is determinative of a young person's status (voluntary or involuntary) regardless of their age or maturity. The Coalition understands that this raises a particular issue in the case of children who are in state care because, according to HSE policy, any such children who require inpatient care must be involuntarily detained under the provisions of the Act. Social workers cannot consent in *loco parentis* to psychiatric treatment for children in the care of the HSE. The

[21] See http://www.headspaceireland.ie/index.html (launched 22 February 2010).
[22] There is a gap in the law in that social workers cannot consent *in loco parentis* to psychiatric treatment for children in the care of the HSE.
[23] LRC 103-2001, para. 3.94

amendments proposed below, whereby children of a sufficient age and maturity could legally consent to admission and or treatment would address this issue.

Children aged 16 to 18 years

The consent of a young person aged 16 years or over is effective for any surgical, medical or dental treatment (i.e. the ensuing treatment will not be an offence against the person) under section 23 of the Non-Fatal Offences Against the Person Act 1997 (the 1997 Act). However, there is an inconsistency between this provision and the Mental Health Act (which defines a child as anyone under the age of 18 other than a person who is or has been married) and the MHC in its guidance has stated that parental consent is determinative of the status of a child (i.e. voluntary or involuntary) under the Mental Health Act.[24] This inconsistency has the potential to cause confusion in practice, for example in a scenario where a young person who has self harmed is admitted to an A&E unit and requires psychiatric treatment, as well as treatment for his or her physical injuries.

Section 23 of the 1997 Act does not give a right to consent to treatment as such; rather it is a defence to any subsequent charge of assault. Therefore it needs to be clarified and expressly stated that children between the age of 16 and 18 years have the right to consent to treatment. The corollary of the right to consent to treatment is the right to refuse treatment; the former is arguably rendered meaningless without the latter.[25] Accordingly, when setting out the age of consent to treatment, the Act needs to expressly state that this includes the corollary right to refuse treatment.

The Law Reform Commission makes recommendations to reduce the age of consent to medical treatment below 18 years[26]. The Report sets out a Draft Health (Children and Consent to Health Care Treatment) Bill 2011 and an Outline Scheme of Mental Health (Amendment) Bill. The LRC has recommended that a person of 16 years of age or older should be presumed in law to have capacity to consent to health care and medical treatment. This proposal would mark a welcome development in addressing the inconsistency between section 23 of the 1997 Act and the Mental Health Act as regards the age at which a young person may legally consent to or refuse medical treatment. The Coalition welcomes the fact that the LRC sees no reason to differentiate between issues of capacity and consent in relation to physical and mental health (paragraph1.45 of the Report and paragraph 6.123 of the Consultation Paper). This recommendation is also in line with the CRC principle that the evolving capacities of the child/young person be respected and that such views be given due weight in accordance with the age and maturity of the child/young person (Article 12 CRC).

As is the case with adults, in order to consent to admission and/or treatment a young person must have the necessary functional capacity to do so. Where the capacity of a young person between the age of 16 and 18 years is in question, it would seem that the provisions of the proposed new capacity legislation would apply.

Also, as is set out in the Scheme of the Mental Capacity Bill 2008,[27] a young person should not be treated as unable to make a decision unless all practicable steps to help him or her to do so have been taken without success. This is in line with Article 12 of the CRPD, which places an obligation on States Parties to "take appropriate

[24] Mental Health Commission Code of Practice Relating to the Admission of Children under the Mental Health Act 2001 (1 November 2006), para 2.7.
[25] See, for example, Report of the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover UN Doc. A/64/150 (10 August 2009) para 28.
[26] LRC 103 – 2011.
[27] Available at:http://www.inis.gov.ie/en/JELR/Pages/Scheme_of_Mental_Capacity_Bill_2008.

measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity". Specialist child and adolescent advocates could have an important role to play in this regard.

Furthermore, if the age of consent is reduced to 16, consideration will need to be given to extending the category of persons who would be able to apply for involuntary admission of persons over 16 years, as this currently rests with the HSE alone.

Recommendations:

7. *The Act should be amended to provide that young persons between the age of 16 and 18 years shall be presumed to have capacity to make decisions regarding admission and treatment unless proven otherwise.*

8. *The Government should consider whether the category of persons who may apply for involuntary admission of persons over 16 years needs to be extended in line with the provisions relating to applications for involuntary admission of adults.*

Under 16 year olds

The position in relation to children below the age of 16 years is less clear-cut. Competence is a matter of fact, which differs from child to child depending on the individual child's maturity, and an age of consent would not appear to be appropriate for this age group.

The Coalition would support the introduction of a 'sliding scale test' in determining whether a minor under 16 has maturity and capacity to consent, including decisions in respect of admission and treatment, as put forward by the LRC. The LRC has stated that its recommendations regarding healthcare decision-making by persons under 16 should also be applied in the context of mental health. Their recommendations state that there should not be a presumption of capacity for those under 16, but that a person under 16 may consent to, and refuse treatment where it is established that he or she has the maturity and understanding to appreciate the nature and consequences of the specific treatment. The Commission also recommend that the usual situation should be that the parents or guardians are involved in the decision-making process and that the child should be encouraged to involve his or her parents and that it is therefore only in exceptional circumstances, and having regard to an objective assessment of both the rights and the best interests of the child, that treatment would be provided to those under 16 without the knowledge or consent of parents or guardians.

> It is of the utmost importance that the concept of the best interests of the child or young person be interpreted and applied in light of the need to respect the evolving capacities of the child. The UN Committee on the Rights of the Child has stressed that there is no tension between the Article 3 [best interests] and Article 12[right to be heard] [28].

Recommendations:

9. *Echoing the recommendations of the Law Reform Commission, the Act should be amended to provide that:*

- *A person under 16 may consent to, and refuse treatment or admission where it is established that he or she has the maturity and understanding to appreciate the nature and consequences of the specific treatment. Specific*

[28] See UN Committee on the Rights of the Child *General Comment No 12* (the right of the child to be heard*) UN Doc* CRC/C/GC/12 (20 July 2009) para 74.

factors to be taken into account in determining such capacity should be outlined, as recommended by the LRC. It is only in exceptional circumstances that treatment would be provided to those under 16 without the knowledge or consent of their parents or guardians. [29]; and

- *it shall be lawful for a healthcare professional to provide healthcare and medical treatment to a person who is 12 years of age but less than 14 years of age, provided that the healthcare professional has complied with certain requirements.[30]*

It must be stressed, however that *all* children who are capable of forming their own views (a threshold which should be far lower than that of functional capacity) must be allowed to express their views freely and it is only when deciding what weight is to be assigned to those views that functional capacity comes into play. It should be noted that there have been criticisms of the mature minor rule in the sense that it places young patients entirely in the hands of the medical professional who determines whether or not the young person is capable. Accordingly, thought needs to be given as to who should be tasked with determining whether the child is in fact capable and whether a multi-disciplinary team might be more suitable to perform this assessment.

vi) The appropriate forum for reviews of admissions and detention of children under the Act and appropriate procedures

The LRC has recommended that a mental heath tribunal (with an age appropriate focus) rather than the District Court should review the admission and treatment of children as involuntary patients for the purposes of the Act.[31] The Coalition agrees with this recommendation. Moreover, the Act should provide similar procedures for the involuntary admission of children as apply in the case of adults, including, for example, obtaining a report by an independent psychiatrist. The role of parents/guardians in the process should also be clarified. The Act should also provide that both the treating consultant psychiatrist who makes the involuntary admission or detention order and the independent psychiatrist should have specialist training in child and adolescent psychiatry. It is imperative that the proceedings be appropriate for children in accordance with Article 12 CRC.[32]

Appropriate and mandatory procedural rules need to be put in place for tribunal hearings involving the involuntary admission and detention of children under the Act (which are set out in the Child Care Act 1991 (the 1991 Act)) in accordance with the requirements of the CRC.[33] The MHC recommended in its 2008 Report on the Act that increased emphasis be given to the rights of children by making it mandatory that children detained under the 2001 Act be appointed a legal representative and be offered the services of an advocate.[34] There is also need for clarification as to how a

[29] LRC 103-2011Recommendation 2.174.
[30] LRC CP59-2009 Recommendation 7.21.
[31] LRC 103-2011, Recommendation 4.19
[32] This requires that the child or young person in respect of whom any judicial or administrative hearing takes place must be provided with the opportunity to be heard directly and/or through a representative and in a manner consistent with the procedural rules of national law (Article 12(2)). Furthermore the child or young person's views must be given due weight in accordance with his or her age or maturity (Article 12(1)).
[33] This was recommended in section 6.89 but was not included in the final list of recommendations in Chapter 7 of the LRC's Consultation Paper (LRC CP59-2009).
[34] MHC (2008) Recommendation 26 p.89. In addition, the UN Committee on the Rights of the Child has recommended that states "introduce legislative measures requiring decision makers…to explain the extent of the consideration given to the views of the child and the consequences for the child." Moreover the child or young person should have the right to have their advocate present at such proceedings (in addition to their legal representative)

child or young person can appeal a decision to have him or her detained. Adult patients have a right of appeal to the Circuit Court under section 19 of the Act (albeit limited). It should be clarified whether this right of appeal would also apply in respect of children whose detention is subject to review by tribunals.

Recommendations:

10. *The mental health tribunal rather than the District Court should be the forum for decisions around involuntary admissions and reviews of detention orders for children and the Act must stipulate that the proceedings be appropriate for children and comply with the requirements of the CRC.*[35]

11. *The Act should provide similar age-appropriate procedures for the involuntary admission of children as apply in the case of adults, including, for example, obtaining a report by an independent psychiatrist. Such procedures should also address the role of parents/guardians, for example by providing that parents/guardians have a right to attend tribunal hearings unless it is not in the best interests of the child or young person.*

12. *The Act (or at a minimum the Code of Practice) should provide that both the treating consultant psychiatrist who makes the involuntary admission or detention order and the independent psychiatrist should have specialist training in child and adolescent psychiatry.*

vii) Time limits in relation to the review of children and adolescents admitted as involuntary or informal patients under the Mental Health Act 2001

The Coalition is concerned that the existing time periods in relation to the review of children and adolescents admitted as involuntary (or, in the future, informal) patients might not comply with the requirements of the CRC. The detention periods of 21 days (for initial admission orders), up to three months (for first renewal) and up to six months (for second and subsequent renewals) appear excessive and out of step with the average length of stay in inpatient units.[36] Article 37(b) of the CRC provides that "no child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time."[37]

As regards the review of detention, Article 37(d) of the CRC provides that every child deprived of his or her liberty shall have the right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of his or her liberty before a court or other competent, independent and impartial authority and to a prompt decision of any such action. Routine or automatic reviews of detention, while constituting important safeguards, do not, in themselves, satisfy

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should they so wish. UN Committee on the Rights of the Child General Comment No 12 (the right of the child to be heard) UN Doc CRC/C/GC/12 (20 July 2009) para 33.

[35] There is a need for tribunal members to be given specific training to deal with children in line with human rights principles as set out in the CRC.

[36] According to the most recent report of the HSE on Child and Adolescent Mental Health Services the average length of stay (for those admitted and discharged in 2009) was 34.4 days (median length of stay 17 days), increasing from 24.5 days in 2008. The average length of stay was significantly longer in the child and adolescent units, at 61.9 days (median 58 days), than in adult units, at 14.6 days (median 6 days). Thirty-six per cent of children and adolescents admitted in 2009 were discharged within one week of admission. HSE *Second Annual Child and Adolescent Mental Health Service Report 2009-2010* p. 40.

[37] Emphasis added.

the requirements of Article 5(4) ECHR.[38] Instead there should also be a mechanism whereby a child or young person who is involuntarily or informally detained may make an application to have their continued detention reviewed during the interim periods between automatic reviews of detention.[39] It may also be necessary to provide for a situation whereby an advocate or other representative could initiate such a review on behalf of the child or young person, in certain circumstances.

Recommendations:

13. *The maximum periods of detention of children under the Act should be reviewed and reduced to more appropriate time periods.*

14. *A new provision should be inserted into the Act whereby a child or young person who is subject to a detention order (or a person acting on their behalf) would have the right to apply to the tribunal for a review of his/her detention during such period on the grounds that he/she no longer fulfils the criteria for involuntary detention under the Act.*

viii) Treatment provisions

There is a growing acknowledgment in Ireland that it is not acceptable to administer treatment to a person with mental health problems against their competent refusal.[40]

The Act needs to make clear that, regardless of whether a young person is a voluntary, involuntary or informal patient, if he or she has capacity to make a treatment decision, then his or her right to refuse treatment should be respected. If a situation arises where the treatment in question is life sustaining, an application may be made to the High Court for direction as is recommended by the LRC in relation to treatment for physical illness. Where a child or young person does not have capacity to make a treatment decision, safeguards must be put in place so that such treatment is subject to an effective independent review at regular intervals. While it would seem that the intention behind the provisions of section 61 of the Act was to provide safeguards to children being administered medication over prolonged periods of time, they are not sufficient in this regard, as was discussed in detail in the LRC's Report[41]. As regards oversight over the administration of medication to children, the same safeguards should apply as are recommended in relation to adults.

Recommendations:

15. *The Act should expressly recognise the right of a young person, if s/he has capacity to make a treatment decision, to consent to or refuse treatment (regardless of whether s/he is a voluntary, involuntary or informal patient). If a situation arises where the treatment in question is life-sustaining, an*

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[38] Bartlett, Lewis and Thorold (2007) p.68. In the case of *Rakevich v Russia* the European Court of Human Rights made clear that control over when to challenge detention under Article 5(4) must rest with the person detained Application No 58973/00, judgment 28 October 2003, para 44.

[39] ibid. It is doubtful that *habeas corpus* or judicial review proceedings would be sufficient in this regard See, for example, *HL v United Kingdom* Application no. 45508/99, judgment of 5 October 2004, para 140, where the European Court of Human Rights found that the requirements of Article 5(4) were not satisfied, as suggested by the UK Government, by judicial review and *habeas corpus* proceedings.

[40] The Department of Health and Children's *Review of the Operation of the Mental Health Act 2001* stated that the then Minister of State with Special Responsibility for Mental Health, Tim O'Malley, accepted in principle the suggestion that "unwilling" be deleted from sections 59 and 60 of the Act so that "[w]here capacity exists any refusal to accept treatment should be respected and this right protected in law." 2007 Review of the Act pp 27-28.

[41] LRC 103-2011, para. 3.112 – 3.115, recommendation 3.115

application may be made to the High Court for direction as is recommended by the Law Reform Commission in relation to treatment for physical illness.

16. *Medication should only be administered with the free and informed consent of the child or young person or, where they lack the capacity to consent,*[42] *when the following safeguards have been fulfilled (which should be expressly set out in the Act):*

- *The treatment must be necessary and constitute the least intrusive treatment or therapy appropriate to the child or young person's health needs; and*

Both of these criteria should be certified by the treating consultant psychiatrist and confirmed by a second independent consultant psychiatrist.

ix) Psycho-surgery and electro-convulsive therapy

The use of psycho-surgery should be expressly prohibited in the case of children below the age of 18 years (regardless of their status as voluntary, involuntary or informal patients) and section 25(11) of the Act should be amended accordingly. The World Health Organisation (WHO) has stated that there are no indications for the use of ECT on minors, and hence this should also be prohibited by legislation.[43]

Recommendations:

17. *Section 25(11) should be amended to expressly prohibit psycho-surgery on children and young persons to reflect current practice in Ireland.*

18. *Section 25(13) should be amended to expressly prohibit the administration of ECT to children and young persons as recommended by the WHO.*

x) Other provisions of the Act applicable to children

The criteria for the involuntary admission or detention of adults (i.e. the definition of "mental disorder") also apply to children under the Act. Similarly, the provisions relating to seclusion and restraint (section 69 of the Act) apply to children. The Government should review these provisions and make any such amendments as may be necessary to ensure that they are sufficiently child-focused.

Recommendation:

19. *The criteria for involuntary admission and detention of children and the provisions on seclusion and restraint should be reviewed and amended as may be necessary to ensure that they are sufficiently child-focused.*

xi) Consultations on the review of the Act

In reiterating the key human rights principle of participation, Article 4(3) CRPD requires that children with disabilities are closely consulted in the development and implementation of legislation and policies.[44] Government must ensure that meaningful consultation with children informs its review of the Act.

Recommendation:

20. *Government's review of the Act must be informed by meaningful consultation with children who have used or are using mental health services in Ireland.*

[42] As regards the assessment of capacity, an independent assessment should take place with the involvement of the multi-disciplinary care team, where possible.
[43] WHO Resource Book (2005) p. 64.
[44] Emphasis added.

xii) Complaints and Investigations under the Act

The availability of effective complaints mechanisms is an essential factor in ensuring that services are accountable for respecting the rights of mental health service users.

Recommendation:

21. *The Act should provide for an independent complaints mechanism for mental health services (separate from the HSE Your Service, Your Say complaints mechanism). The MHC and/or the Inspector of Mental Health Services should be given a direct role in receiving, investigating and resolving complaints relating to mental health services.*

xiii) The implications of the Convention on the Rights of Persons with Disabilities

International human rights law evolved to specifically deal with the issue of the rights of persons with disabilities, including mental health problems.

Recommendation:

22. *A further formal review of the Act should take place as soon as the UN Committee on the Rights of Persons with Disabilities issues guidance on the implications of the CRPD for mental health laws or in any event no later than five years from the date of the Government's next review of the Act.*

xiv) The general scope of the Act and the question of expanding its provisions

To date, Ireland's approach to legislation in the area of mental health has been limited and our legislation continues to focus on involuntary admission and treatment and inpatient services with little or no reference to community-based services in our laws. *A Vision for Change* also demands a radical cultural shift within services that would see the service user at the heart of the service with a clear focus on recovery. This can only truly happen when the full range of supports and services that promote recovery are available.

The Coalition believes that the Government needs to use legislation to effectively promote and drive the provision of comprehensive community-based mental health care and support services and improve accountability for how money is spent in the area of mental health.

Recommendation:

23. Government should place a statutory obligation on the HSE (by way of the introduction of additional provisions to the Health Act 2004):

- *to prepare and publish a detailed, multi-annual (three year) implementation plan for the closure of unsuitable facilities and the development and ongoing provision of comprehensive and community-based mental health services in line with A Vision for Change and to the maximum of available resources;*
- *to provide comprehensive and community-based mental health services including the specialist services identified in A Vision for Change in line with the detailed plan;*

- *to report annually by catchment area and service area to the Oireachtas on progress towards the implementation of its plan and expenditure of allocated funding and to publish this report;*

(Accompanying statutory regulations should stipulate the level of detail required to be included in the implementation plan and annual report to avoid adoption of an inadequate plan and inadequate reporting. The statutory regulations should therefore set out in detail the requirements of a good implementation plan including targets, annual milestones, outcomes, ongoing performance indicators, transformation indicators and costings.)

- *to provide for consistency between the mental health reform programme and the HSE annual service plan (by way of an amendment to section 31(3) of the Health Act 2004);*
- *to provide for a breakdown of the estimate of income and expenditure within the annual service plan by care programme (including mental health) (by way of an amendment to section 31(12) of the Health Act 2004); and*
- *to enshrine principles in statutory regulations to guide the planning and delivery of mental health services. These include:*
    - *the principle of non-discrimination;*
    - *the principle that services and supports should be designed in such a way as to enable people to enjoy their right to live in the community and participate in community life and to prevent social exclusion and isolation;*
    - *the need to provide access to a holistic range of services and supports in keeping with the principle of least restrictive and intrusive treatment and in order to facilitate the exercise of personal autonomy;*
    - *the need to provide mental health services and supports in the least restrictive environment appropriate and in the community, where appropriate;*
    - *the need to design mental health services in a way that promotes and underpins the recovery ethos; and*
    - *the need for service user participation to be a core element of mental health service planning and delivery.*[45]

Amendments to the Mental Health Act 2001 should reflect the policy objective of moving to a community-care model of mental health services by extending the inspection process and the registration process to cover community-based mental health services. They should include:

a. *extending the scope of Part 5 of the Mental Health Act 2001 so that the system of registration and approval of mental health services by the Mental Health Commission also applies to community-based services*
b. *requiring the periodic inspection of community-based mental health services (in addition to in-patient services) by amending section 51 of the 2001 Act (functions of the Inspector).*

[45] This is covered to some extent in Part 4 of the Health Act 2004. Moreover, the establishment of the National Service User Executive (NSUE) is a welcome step in ensuring the involvement of service users in service planning and delivery.

For further information please contact info@childrensmentalhealth.ie.
Ends//