**Public Consultation on Draft Legislation to Update the**

**Mental Health Act, 2001**

**Submission on behalf of Bodywhys: The Eating Disorders Association of Ireland**

## Introduction

Bodywhys – the Eating Disorders Association of Ireland, is the national voluntary organisation supporting people affected by eating disorders, which includes families and friends.

Bodywhys welcomes the opportunity to contribute to the public consultation on the review of the Mental Health Act 2001. As with any submission that forms part of this consultation, we are contributing from a particular perspective to the reform of the Mental Health Act, 2001.

This submission will respond to the main themes of the Act that the Department of Health are seeking clarity on as per the department's guidance document for public consultation on review of the Mental Health Act 2001 (March, 2021).

## Mental Health Act, 2001

The Mental Health Act 2001 describes how people who need inpatient mental health care should be cared for and treated. The Act also describes the circumstances of how, when and why involuntary detention can happen. The Act created different protections for people accessing these services and a rights-based approach must underpin any changes to the Act. Changes are urgently required to the Act in order to progress the recommendations of *Sharing the Vision*, Ireland's mental health policy, and to comply with several key human rights instruments, including the European Convention on Human Rights and the United Nations Convention on the Rights of Persons with Disabilities. Currently, the Mental Health Act, 2001 is clearly not compliant with either Convention.

As a starting point to amending the 2001 Act, the Department of Health (DoH) must accept the fundamental principles of **parity between mental health and general health.** A significant investment in mental health is required to ensure the delivery of the recommendations of *Sharing the Vision* and to realise parity between mental health and general health services.

## Focus of this submission:

Through this submission, with reference to the 165 recommendations of the Report of the Expert Group on the Review of the Mental Health Act 2012-2015, together with relevant mental health policy and legislation i.e.

- A Vision for Change (2006)
- Sharing the Vision – A Mental Health Policy for Everyone (2020)
- Assisted Decision Making (Capacity) Act 2015
- Mental Health (Amendment) Act 2018

- Mental Health Parity Act 2017 – James Brown Bill (lapsed due to dissolution of Dail).

## Review of the Mental Health Act 2001

### 4.1 *Changes to Definitions*

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

Bodywhys **supports** the Expert Group's recommendations to change definitions in the Act as follows:

- replace the term **'mental disorder'** with **'mental illness'.**
- Remove **'significant intellectual disability' and 'severe dementia'** from the Act so that a person cannot be detained under the Act for only having dementia or an intellectual disability.
- update the **definition of treatment** to remove reference to 'medical' and amend to 'clinical' which encompasses care other than that provided by a registered medical practitioner. Treatment applies to all people in approved centres be they an inpatient facility, community residence or community mental health service. Bodywhys recommends that treatment be available; appropriate to the person's needs; and fit for purpose.
- Support the provision of a **new category of patient** to be included in the Act for people who need mental health treatment in an approved centre who do not have the capacity to consent to treatment but do not need to be involuntarily detained.
- An **adult is** a person over 18 years of age.
- A **child** is a person under 18 years of age
  A clear definition of children aged **16 and 17** years is needed as related to consent to treatment.

Bodywhys **does not** support the Expert Group's recommendation of the term **'recovery plan'** and suggests that an **'individual care plan'** is broader than a 'recovery plan' but encapsulates the latter. An 'individual care plan' should include the treatment and care required by the person, the necessary resources to deliver such care, appropriate goals for the person and reviewed regularly between the person and their community mental health team. A discharge plan should form part of a person's 'individual care plan' with planning commencing on admission.

### 4.2 *Guiding Principles*

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

Bodywhys welcomes the recommendation of the Expert Group to include a new set of **guiding principles** in the Act to replace the principle of 'best interests'. Replacing 'best interests' with the guiding principles of the Assisted Decision-Making (Capacity) Act 2015, empowering the person to be the decision-makers over their own care.

The guiding principles as recommended, i.e.

- Self-determination
- Autonomy
- Dignity
- Bodily Integrity
- Least restrictive care
- Best attainable mental health (suggest changing **'best' to 'highest' attainable standard**)

Bodywhys recommends the addition of the principles of **inclusivity and diversity** in the Act and to remove 'insofar as practicable'. Parity between mental health and general health in all aspects of provision, is a fundamental requirement to realise these guiding principles.

### 4.3 *Criteria for Detention*

**Question: should the reasons for involuntary detention be changed?**

The new legislation must include a clear definition and understanding of the admission criteria of 'risk to health'. In relation to people affected by eating disorders, the 'risk to health' for involuntary detention must be determined for the purpose of treatment and not only for managing 'risk'.

### 4.4 *Authorised Officers*

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

Bodywhys supports the Expert Group's recommendation that Authorised Officers (AOs), as defined by the Act, be the only people allowed to make an application for involuntary detention. The professional requirements of AOs should be clearly defined and the appropriate assessment process which will be applied to determine involuntary detention be transparent and available at subsequent review meetings for clear accountability. AO access should be of 24 hour availability. Detailed information of the process should be made available to the family of the person who is the subject of the application for involuntary detention.

### 4.5 *Interdisciplinary approach to care and treatment*

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

Bodywhys endorses the Expert Group's recommendation for a more interdisciplinary approach to be taken to the care and treatment of persons under the Act.

Bodywhys supports the recommendation that a Consultant Psychiatrist **must** consult with a mental health professional from a different discipline (and for the mental health professional to complete an assessment) prior to the making of an admission order and at the point of a renewal order.

A psychosocial report should be carried out by a member of the multidisciplinary care team and provided to the tribunal for review.

### 4.6 *Changing timeframes*

**Question: should the length of time that a person is involuntarily detained before being reviewed, be reduced?**

Bodywhys recommends that clarity be provided in relation to changing timeframes in the context of considering whether the person is medically compromised and physically able to attend a review of their detention. Provision must be made to accommodate the person's needs in consideration of their physical and mental capacity and emotional wellbeing.

The Consultant Psychiatrist responsible for the care and treatment of an involuntary detained person should be required to attend the tribunal.

### 4.7 *Enhancing safeguards for individuals*

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

Life saving treatment should be on parity with general health.

Voluntary patients should not be given treatment without their consent.

Bodily restraint and seclusion section of the Act be revised to deal with all restrictive practices – seclusion; physical restraint (not addressed in the 2001 Act); chemical restraint (not addressed in the 2001 Act);.

The Mental Health Commission develop regulations or codes relating to each restrictive practice.

### 4.8 *Mental health tribunals*

**Question: what changes should be made to mental health tribunals?**

Bodywhys supports the Expert Group's recommendation that mental health tribunals be renamed but suggests changing the proposed text from 'mental health review boards' to **'review boards'.**

Bodywhys **does not support** the membership of the review board being extended to five years and should remain, as is currently, at three years.

### 4.9 *Change of status from voluntary to involuntary*

**Question: what changes should be made to change of status from voluntary to involuntary?**

The Act introduces a definition of a 'voluntary patient' to include only people who have capacity to make their own decisions (with support if required) and who do give their consent to admission to an approved centre. Currently, people who do not have the capacity to consent to admission and who do not object to admission are being considered voluntary patients, even though they are not able to consent to admission. They do not receive an external review of their detention, nor the oversight protections provided to 'involuntary patients'.

Voluntary patients should not be given treatment without their consent.

The below criteria is recommended for involuntary admission to an inpatient facility:

(a) The person is suffering from a mental illness of a nature or 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 in the community; and,
(b) The detention and treatment of the person concerned in an approved inpatient facility would be likely to ameliorate the condition of the person to a material extent with a view to contributing to the person's discharge.

### 4.10 & 4.11 *Capacity and consent to treatment*

**Question: how should capacity be introduced to the Mental Health Act?**

There must be a presumption of capacity in the amended 2001 Act and the 2015 Act. Presumed that every person has capacity to make decisions affecting himself or herself unless the contrary is shown in accordance with the provision of the 2015 Act.

Capacity should not form part of the criteria for involuntary admission to an inpatient facility and a capacity assessment should not take place prior to the making of an admission order (part 4 of the 2001 Act – 'Consent to Treatment').

If a person who is detained under the 2001 Act is considered to lack capacity, the person's capacity must be assessed in the same manner as persons who are not detained under the 2001 Act. The provisions in the 2015 Act for the assessment of capacity, namely an application to court with the provision of supports, should apply to all persons, including those detained under the 2001 Act.

In relation to capacity, it is suggested that the DoH structure this section of the Act as follows:

- those that have capacity and consent;
- those that have capacity and do not consent;

- those that do not have capacity but have provisions in place (Advance Healthcare Directives) in order that decisions may be made with and/or from them;
- those that do not have capacity and have no provisions in place (Advance Healthcare Directives) for decisions to be made with and/or for them.
- Life-saving treatment should be treated on parity with general health. 2015 Act should be amended to ensure that AHDs be extended to include persons detained under the Mental Health Act 2001.

Advanced Healthcare Directives (AHDs) as referenced in the 2015 Act, must be applicable in the same way to patients receiving treatment for physical and mental health conditions and the 2015 Act should be amended to ensure that AHDs be extended to include persons detained under the Mental Health Act 2001.

The fundamental criteria for detention of a person under the 2001 Act should be for treatment. Treatment should be the only purpose of all involuntary detentions.

The provisions in the 2015 Act for the assessment of capacity, namely an application to court with the provision of supports, should apply to all persons, including those detained under the 2001 Act.

### 4.12 *Information and individual care/recovery planning*

**Question: what needs to be included on care plans and access to information for people receiving treatment in approved centres?**

Bodywhys recommends that all individuals in inpatient approved centres are provided with information (on admission) on the reason why they are in hospital, the treatment that they will receive, how long they can expect to be in hospital and who they can contact for advocacy support. Information on discharge should include the 'individual care plan' and details of support organisations.

The Act should be updated to include a right to advocacy for all individuals (voluntary or involuntary) accessing mental health services.

### 4.13 *Inspection, regulation and registration of mental health services*

**Question: what needs to be included on registering and inspecting community and residential mental health services?**

The role of the Mental Health Commission is to promote, encourage and foster high standards and good practices in the delivery of mental health services in Ireland through regulation and inspection of all facilities on a regular basis. As well as assessing structural and processes, a fully integrated & holistic approach to treatment and patient outcomes should be included in the registration and inspection.

**4.14** ***Provisions related to children***

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

Currently 16 and 17 year olds can consent or refuse physical healthcare decisions, but not to mental healthcare decisions. Parity between physical healthcare and mental healthcare needs to be addressed.

A dedicated national advocacy service for people under the age of 18 who are accessing mental health services needs to be established.

**4.15** ***Provisions related to the Mental Health Commission***

**Question: what changes should be made to the governance of the Mental Health Commission?**

Bodywhys supports the recommendation of the Expert Group to expand the brief of the MHC to set standards for mental health services beyond procedures to include patient outcomes. Members of the MHC should be independent having no vested interests.

**Bodily Restraint & Seclusion:**

The Expert Group did not recommend that the use of restraint should give rise to an assessment of the person's status as a voluntary patient. Constraints on the interpretation of the MHA in managing patients with Anorexia Nervosa in regards to NG feeding appears to be 'at odds' with the Mental Health Commission's Restraint Guidelines and needs clarity.

Bodywhys calls for the MHC to ensure its Code of Practice reflects the urgency of life saving/emergency situations.

ENDS.

Bodywhys acknowledges with sincere thanks the following:

Mental Health Reform with reference to *Briefing Note on the Mental Health (Amendment) Bill 2018* (March, 2021).

Mental Health Reform with reference to *Briefing Note Reform of the Mental Health Act, 2001* (February, 2021).

The Psychological Society of Ireland (PSI) with reference to *Submission to the Public Consultation on the Review of the Mental Health Act 2001* (March, 2021)

Bodywhys PO Box 105 Blackrock Co. Dublin 01-2834963

ceo@bodywhys.ie www.bodywhys.ie

Think Bodywhys CLG

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