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17th October 2025

Re: Mental Health Reform's campaign on amendments to the Mental Health Bill 2024

Dear Senator,

Severe, acute mental illness can significantly infringe on a person's right to dignity, autonomy and bodily integrity by temporarily distorting judgement and insight. It can also lead to behaviours that cause embarrassment as well as a loss of ability to make informed decisions, thereby preventing access to care. This loss of judgement and insight is temporary but only if treated. The treatment becomes involuntary **only if** the unwell person refuses this potentially lifesaving care, refusal of which places themselves and others at risk. There **must** be strong legal protections in place to oversee this treatment.

The Mental Health Bill 2024 is highly specialised legislation intended to provide these robust legal protections and to protect the rights of this vulnerable cohort; but this legal framework should never prevent or delay treatment. The proposed amendments to the Mental Health Bill 2024, published on 10th June 2025, represent some positive movement towards more workable, person-centred legislation.

It has come to our attention that Mental Health Reform are running a campaign against some of these amendments. They have expressed concern about eight points. These criticisms are misguided and inaccurate and we hope the following provides clarification on these aspects of the 2024 Bill.

Mental Health Reform says: ***Involuntary treatment without timely capacity assessment***
The Bill allows for treatment without consent before a capacity assessment has been completed, increasing the risk of rights violations.

We say:

Comprehensive assessments of mental state and insight are conducted by multiple highly trained and rigorously regulated professionals as follows:

<u>Before</u> treatment begins

a) An authorised officer – a trained mental health professional; assessment takes 2 hours

b) A registered medical practitioner – usually a GP; assessment takes 2 hours

c) On arrival in hospital, the psychiatry doctor on call for a **minimum of 2 hours**

d) Observed at least every 15 minutes overnight by trained psychiatric nurses – 12 to 18 hours

e) Assessed by the consultant psychiatrist for a further 2 hours

f) Total initial assessment time: **MINIMUM 20 HOURS**

<u>After</u> treatment begins

g) **Continuously** by trained psychiatric nurses

h) Weekly by a full multidisciplinary team at the formal care plan review – mandated by the Mental Health Commission

i) An independent consultant psychiatrist who writes a report for the tribunal which scrutinises the involuntary admission

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Mental Health Reform says: ***Extended timeframes for involuntary treatment*** *The Bill proposes extending the initial treatment period from 21 to 42 days without a new capacity assessment, which may lead to unnecessary and prolonged detention*.

We say:

a) This is not accurate. The initial treatment period is for 21 days, during which time the person is continuously assessed.

b) If a further treatment period is required (the renewal period), an independent consultant psychiatrist must assess the person prior to the renewal period being granted.

c) A "prolonged detention" would only arise if treatment is delayed; nobody would expect someone to recover from a heart attack without treatment. Similarly, a person is **NOT** going to recover from an acute psychotic or severe depressive episode without treatment.

Mental Health Reform says: ***Expansion of criteria for involuntary treatment:*** *The inclusion of "likely to benefit" as a treatment criterion may result in excessive discretion to impose forced treatment, even when it may not be clearly necessary.*

We say:

a) Extensive research shows that treatments ***ARE*** "likely to benefit" the unwell person. People recover, are happy to continue treatment, and they return to their normal lives.

b) ***Only*** those suffering from serious mental illness with the most severe and acute symptoms are involuntarily admitted to acute psychiatric settings.

c) Of this very small group, ***an even smaller group*** will temporarily lose their insight and refuse treatment, because they are unable to recognise that they need this potentially lifesaving treatment.

d) An admission order ***will not*** be completed by a Consultant Psychiatrist ***unless*** the person is suffering from a serious mental illness with acute and severe symptoms, and, is refusing potentially lifesaving treatment.

e) To suggest that treatment '*may not be clearly necessary'* is an absolute affront to common sense; the person has already met the threshold for an involuntary admission.

f) But far more disturbing, suggesting treatment *'may not be clearly necessary'* is a gratuitous act of cruelty; it condemns the unwell person to suffer the most appalling fear and distress. Would anyone wish for their elderly mother to continue not eating or drinking because she is severely depressed and believes the food is poisoned? Or for their 25 year old son to continue mutilating his body because he believes he is possessed by the devil?

Mental Health Reform says: ***No legal right to advocacy or an independent complaints process:*** *People subject to involuntary treatment still have no statutory right to an independent advocate or to access an independent complaints mechanism*.

We say:

a) This is demonstrably untrue.

b) All persons involuntarily admitted are automatically assessed by an independent consultant psychiatrist who does not work in the service where the person is admitted. This is a free, expert second opinion.

c) All persons involuntarily admitted are automatically appointed a free legal representative; a trained, working solicitor. The legal representative forensically scrutinises the involuntary admission procedure and paperwork and strongly advocates for the person at the tribunal (renamed to Review Board in the bill).

d) The review board is mandated to happen **no later** than 21 days after involuntary admission. It is a legal proceeding where a 'panel' comprised of the chair (a solicitor or barrister), an independent consultant psychiatrist and a lay person hears evidence from the treating consultant psychiatrist, the legal rep and the person themselves. They also read a report submitted by the separate independent consultant psychiatrist.

e) The HSE has an independent complaints procedure called "Your Service, Your Say". The involuntarily admitted person has the same access as every other patient to this service. Leaflets with details of this are on all acute psychiatric units around the country and anyone wishing to make a complaint is made aware of this service.

Mental Health Reform says: ***Involuntary treatment of individuals who have capacity:***
The Bill permits involuntary treatment for up to 72 hours even when a person has decision-making capacity, a decision-making representative, or a valid Advance Healthcare Directive.

We say:

a) This is not accurate; there is no 72 hour treatment window for a person with capacity.

b) There is a provision for an application for treatment to the High Court for someone who has the capacity to refuse treatment (section 51, paragraph 1, subsection a). This is a violation of civil liberties and runs directly counter to the spirit of this act and indeed the Assisted Decision Making Capacity Act. No court should have the power to compel a person with capacity to accept treatment that they have refused.

Mental Health Reform says: ***Failure to regulate the use of chemical restraint:*** *The Bill does not provide statutory safeguards to govern the use of chemical restraint, despite its significant impact on bodily autonomy*.

We say:

a) There is no reference anywhere in the bill to such a term as "chemical restraint" because it does not exist.

b) Any restrictive practices carried out are reported to the Mental Health Commission and are forensically inspected as part of the yearly unannounced inspections by the Commission.

c) These restrictive practices are subject to rigorous codes of practice laid down by the regulator, the Mental Health Commission.

d) Restrictive practices, such as physical restraint are used **as a last resort** and **only** when the risk to the person, other patients and staff is serious and imminent. Staff are regularly trained in an array of compassionate, supportive and de-escalation techniques to avoid, where possible, restrictive practice. Prescribed, emergency relaxing medication e.g. Valium, might be offered to the person voluntarily, but only when other techniques like a quiet environment, reassurance and support have failed. The person has the right to refuse medication in this scenario. Unfortunately, there are rare situations where the person's distress is extreme because of their acute and severe symptoms. In these instances, a person may not be able to respond to reassurance and support and will temporarily pose a serious risk to themselves or others. Only in these situations, are medications given against a person's will. This is done to alleviate their distress and maintain their safety and the safety of others.

Mental Health Reform says*: **Admission of children to adult units:** The continued practice of admitting children to adult mental health units is incompatible with children's rights and best interests*.

We say:

The wording of this suggests this is a regular occurrence. It is not. It is rare. More often, the child will be admitted to a medical paediatric ward until such time as a bed becomes available in a CAMHS unit.

Mental Health Reform say*: **Use of stigmatising language:** The term "mental disorder" is outdated and stigmatising. More respectful, person-centred language is needed, in line with Sharing the Vision*.

We say:

a) The World Healthcare Organisation, WHO, refer to cardiovascular disease as a "group of disorders", and some respiratory illnesses as "disorders". Use of the word disorder is not uncommon in healthcare and is not, of itself, stigmatising or disrespectful.

b) *Sharing the Vision* outlines aspirations and plans to reduce stigma for those with mental illness; it does not raise a specific objection to the use of the term mental disorder.

c) Use of euphemistic language such as "mental health difficulties" does **NOT** convey the severity of illness a person requiring involuntary treatment is suffering from. It trivialises their experience and **this** is what leads to them feeling marginalised, stigmatised, not represented and voiceless.

As per previous correspondence, we welcome the opportunity to discuss this crucial legislation with the Seanad. As highly trained and regulated specialist doctors who work with the current Act daily in delivering psychiatric care to rigorous standards, we remain available to any member of the Dáil and Seanad to discuss the 2024 Bill and its implications for the delivery of this vital care to some of the most vulnerable in our society.

Yours sincerely,

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Dr Lorcan Martin
President