Mental Health Reform
Promoting Improved Mental Health Services

Dear Senator,

We understand that correspondence from the President of the College of Psychiatrists of Ireland (CPI) has been shared with your office regarding our campaign, which includes several statements that do not accurately reflect our position. We would like to provide clarification as set out below. You can also read the full contents of this email in the attached PDF, and I've included a second document which provides a concise summary of our respective positions.

Our analysis is grounded in careful review of the Bill and informed by extensive consultations with our member organisations, people with lived experience, and a range of legal, clinical, and human rights experts. Our sole objective is to ensure that Ireland's mental health legislation upholds human rights standards and reflects the needs and priorities expressed by people with lived experience. While we recognise the valuable and vital work undertaken by all mental health professionals, given the inherent vulnerability of many mental health service users, it is essential that the legislation includes robust safeguards to protect individuals engaging with services across the full continuum of care.

The reformation of the Mental Health Act was a founding purpose of Mental Health Reform. Our advocacy is guided by principles of transparency, accountability, and respect for the dignity and autonomy of all individuals. We remain committed to constructive engagement with all stakeholders to ensure that this reform delivers a genuinely rights-based mental health system.

1. Capacity assessments before involuntary treatment begins and thereafter

President of CPI states:

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:

Before 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

After 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

Mental Health Reform responds:

The Bill **clearly** allows for involuntary treatment to commence before a capacity assessment is completed. For example, Section 48(1)(b) provides that:

> *"a capacity assessment or a second capacity assessment is being carried out under section 46,* ***but that assessment has not been completed, treatment may be administered to the person concerned*** *for a period not exceeding 21 days from the date of making of the involuntary admission order."*

If the directive set out in legislation does not correspond to the best practice outlined in the commentary above, it should be removed from the Bill. Mental Health Reform argues that the legislation must not be left open to interpretation; it should be clear and unambiguous. If involuntary treatment cannot commence prior to a rigorous capacity assessment, this requirement must be explicitly stated in the legislation.

The commentary included above suggests that capacity is reassessed at multiple points during detention. However, this requirement is not set out clearly in the legislation. The Bill must explicitly require capacity reassessment at appropriate intervals – particularly when detention and treatment may be extended beyond 21 days.

2. Extended Timeframes

President of CPI states:

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 responds:

The initial involuntary treatment period allowed for under the Bill is 21 days but, following recent amendments, this period can now be extended by a further 21 days (Section 48(3)). Moreover, recent amendments allow for an application for Decision Support to be made at any time within the 21-42 day window and for involuntary treatment to continue until a Circuit Court ruling on the matter (potentially allowing for involuntary treatment to continue well beyond 42 days (See Sections 48(6) and 50(1)). Mental Health Reform believes this significant

extension in the involuntary treatment window, compared to previous versions of the Bill, is concerning. We are particularly concerned that a person could be involuntarily treated for such a significant period without access to decision supports or an independent advocate.

Mental Health Reform does not dispute that the Bill requires a review by a second psychiatrist not involved in the care of the person if involuntary treatment is to extend beyond 21 days. However, the Bill does not mandate that a capacity assessment is completed before this extension and does not require that continuous capacity assessments are completed throughout the involuntary treatment period.

3. Expansion of Criteria for Involuntary Treatment

President of CPI states:

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 notbe 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 responds:

Mental Health Reform does not dispute the potential benefits of treatment for a person experiencing mental health difficulties. Mental Health Reform disputes the use of "likely to benefit" as a criterion to justify involuntary treatment. We believe involuntary treatment must be a last resort and there should be a higher bar for it than is currently provided for in the Bill. We believe involuntary treatment should only be initiated in urgent cases where the delay or absence of such measures could have a serious impact on the health or safety of the individual. It should be noted that a person may have very good reasons for not wanting specific medications (such as concerns about side effects or poor prior experiences with such medications) and their wishes deserve to be considered.

As noted in our previous correspondence, even the current Mental Health Act 2001 has a higher bar, requiring that involuntary admission/treatment be likely to benefit "**to a material extent**" (Section 3(1)(b)(ii)). The commentary provided above states that involuntary admission/treatment only happens in cases where a person

is refusing potentially life-saving treatment. Requiring that the treatment be "potentially life-saving" is a considerably higher bar than "likely to benefit" and if that is what is already happening in practice, this should be reflected in the legislation. Regarding the examples provided, Mental Health Reform have repeatedly stated in our correspondence that we believe 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. As such, a person could still be involuntarily treated in both examples provided for above.

4. No Legal Right to Independent Advocacy or Independent Complaints Mechanism

President of CPI states:

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 responds:

The examples provided above do not represent either an independent advocate or an independent complaints mechanism.

In our consultations with lived experience representatives, people repeatedly raised how intimidating it is to face a multi-disciplinary team as an individual, particularly an individual already in acute distress. 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. We are particularly perturbed by the idea that a second consultant psychiatrist's review would in any way take the place of the role of an independent advocate.

While we acknowledge the work done by legal representatives at Review Boards, these representatives are not supporting individuals throughout the involuntary detention/treatment period. Their role is to represent them at the Review Board alone. Moreover, the Review Board (or Tribunal as it's currently known) only reviews the appropriateness of the involuntary admission. Therefore, any legal representative for the Review Board would

not be supporting a person to understand their rights and ensure their voices are heard around involuntary treatment decisions or any other concerns they may have.

We also acknowledge the existence of the HSE "Your Service, Your Say". However, this is not an independent service and asking vulnerable people, particularly those involuntarily detained, to complain to a service provider directly about the service they are receiving is inappropriate and inadequate.

5. Involuntary Treatment of a Person with Capacity

President of CPI states:

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 responds:

We refer you to Section 51(5) of the Bill, which explicitly allows for up to 72-hour treatment of a person with capacity while awaiting a High Court decision:

> *"Where an application to the High Court has been made under subsection (1) or (4), treatment may be administered to the involuntarily admitted* ***person prior to the hearing of the application, for a period of 72 hours after its initiation or until the hearing*** *of the application by the High Court, whichever is sooner..."*

That said, we fully agree that involuntary treatment should not be forced upon a person with capacity, even with a High Court Ruling. We believe that all allowances for the involuntary treatment of a person with capacity should be removed from the Bill.

6. Failure to include safeguards around chemical restraint

President of CPI states:

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 responds:

Chemical/pharmacological restraint (the misuse or overuse of medications (particularly sedatives) with the primary aim of controlling a person's behaviour rather than to treat their condition) is unquestionably occurring in mental health settings in Ireland. It has been repeatedly flagged in our consultations with stakeholders, including multiple lived experience testimonials and in our conversations with staff working in mental health settings. In fact, the example provided in the final paragraph provided above suggests that chemical restraint does indeed exist.

In the 2024 Report to the Irish Government on the visit to Ireland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT), the following concern was noted:

> *"the administration of medication to calm or sedate a patient to reduce risk of harm, agitation or aggression did not qualify under the Irish legal framework as a form of restraint ("chemical restraint"), and therefore was not subject to the same legal and medical safeguards as other forms of restraint. The CPT recommends that use of chemical restraint be regulated by clear rules and subjected to the same safeguards applying in Ireland to other means of restraint, including medical approval, review and oversight, recording in a centralised register, and reporting to an outside monitoring body."*

We note the Mental Health Commission has stated that they consider chemical restraint to be a restrictive practice and have also called for regulation of this practice to be added to the Bill, as noted in their recently published report on restrictive practices:

> *"The MHC considers the use of 'pharmacological restraint', (the use of medication, which is prescribed and administered for the specific and exclusive purpose of controlling or subduing acute or episodic aggressive, disturbed, or violent behaviour) to be a restrictive practice. The much-anticipated new Mental Health Act will, it is hoped, include rules to govern the use of 'pharmacological restraint' in inpatient mental health services. The MHC looks forward to consulting on ways to address this area in the not-too-distant future."*

7. The Bill Continues to Allow for Children to be Admitted to Adult Units

President of CPI states:

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 Responds:

We disagree that Mental Health Reform's wording suggests this is a regular practice. Mental Health Reform has consistently noted and commended the work that has been done to significantly reduce these figures in recent years. However, Mental Health Reform has repeatedly raised concerns that without this protection in the legislation, there is nothing to stop these figures from rising again in the future.

8. Continued Use of the Term Mental Disorder

President of CPI states:

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.

Mental Health Reform responds:

In our consultations with members and lived experience groups, concerns have repeatedly been raised that the term "disorder" is deeply stigmatising and outdated and should be removed from the Bill. We have suggested the use of a number of potential alternatives, including "mental health difficulties" (in line with terminology used in Sharing the Vision), "psychosocial disability" (in line with the UNCRPD terminology) or, at a minimum, mental illness (in line with the recommendation of the Expert Review Group).

We appreciate your attention to the points outlined above. While they directly address the issues raised by the President of CPI, they do not reflect the full scope of our concerns. A more comprehensive overview can be found here.

As per previous correspondence, we welcome the opportunity to discuss this crucial legislation with the Seanad. Representing our coalition of over 80 member organisation and lived experience voices, we remain available to any member of the Dáil and Seanad to discuss the 2024 Bill and its implications for protecting the human rights and dignity of some of the most vulnerable members of our society.

Yours Sincerely,

Wendy Mitchell	Dr Louise Rooney
Head of Operations	Policy & Research Manager