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Mental Health Bill 2024 Issues, Concerns and Solutions

As described and discussed in meeting of the College and Department of Health, Mental Health Unit

Monday, 18th November 2024

Key Areas of Concern Identified:

1. **Consent to treatment**
2. **Definition of mental disorder**
3. **Psychosocial assessment (PSA)**
4. **Regulations concerning care plans**
5. **Powers of the review board**
6. **Inspection of all community mental health services, including CAMHS**

1. Part 3, Chapter 3: Consent to treatment

Summary

- Required to obtain consent prior to commencing treatment
- If treating consultant suspects the person is lacking capacity, they need to carry out a capacity assessment and arrange a second opinion. If the person is found to lack capacity and no DMR or AHD is in place, then the treating consultant is required to make an application to the circuit court for treatment.
- If second opinion differs, person is concluded to have capacity; opinion of treating consultant is automatically overruled
- **Section 47** allows for treatment while awaiting capacity assessment or court order, but only where it is *"immediately necessary for the protection of life of the person or that of another person or necessary for protection from an immediate and serious threat to the health of the person or that of other persons"*.

  This is not treatment; it is management of acutely disturbed behaviour.
- **Section 49 - Administration of treatment:** As in Section 47, this refers to treatment where capacity is lacking. It applies the same criteria as Section 47: "*immediately necessary for the protection of life of the person or that of another person or necessary for protection from an immediate and serious threat to the health of the person or that of other persons*". It adds a time limit of 21 days for treatment.

  Section 49 does not make sense, and it is not clear what scenario it is intended for. It repeats Section 47, but adds a time limit of 21 days.

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Consequences of current wording for consent to treatment

- Prevents treatment of an involuntarily admitted person (who does not consent) without court intervention

  Only those with severe symptoms of mental illness are involuntarily admitted to hospital. An extremely common (almost universal) manifestation of severe symptoms of mental illness is a loss of insight and usual judgement. This judgement and insight will often return with treatment, but cannot possibly return without. If the person lacks the rationality to consent to admission, and there is a mechanism to allow admission in these circumstances, then common sense would dictate that the same mechanism should allow for treatment.

- A patient is deprived of their liberty (due to severe symptoms of mental illness), but doctors are prevented from administering both symptom-alleviating and potentially lifesaving treatments

  It should be remembered that the person is frequently very distressed and terrified as a result of the symptoms they are experiencing. Imagine being convinced that the Devil is talking to you and threatening to kill you and your loved ones or believing that there is a conspiracy to harm you and rob you of all your money and that your family and friends are part of this. Delaying treatment that alleviates this distress is not humane; in fact, it is an act of cruelty that none of us would wish for ourselves or our loved ones. It is akin to admitting a person in severe pain to a medical or surgical ward and withholding pain relief.

- Extends the distress of the patient and their family
- Neurotoxic effects of untreated mental illness (leading to brain damage)
- Extends the length of hospital stay required for the patient; lengthens recovery time; impacts coping and life skills; puts further pressure on bed availability numbers, both for those requiring treatment in an acute unit (with their consent) and those requiring involuntarily hospitalisation
- Consultant specialist psychiatrists spending time in court arguing for vital treatment for inpatients

  Community patients will suffer as their psychiatrists' available time for their scheduled clinical appointments will be eroded; waiting lists for first referrals to see a psychiatrist will increase.

- Cost and resource implications for the court system

  There are approximately 2,000 involuntary admissions a year nationally. The majority of those will refuse treatment and so require court intervention if this bill is enacted in its current wording. The courts do not have the resources to meet this demand.

Solution

Reword the criteria for involuntary admission to include involuntary admission and treatment as follows:

The criteria for involuntary admission to and treatment in a registered acute mental health centre.

- Remove Section 12 (1) a. –

  This can be removed as treatment of mental illness is covered in Section 12 (1) b. If a person requires involuntary admission, the attendant risks are inherent and understood and therefore do not need explicit wording within the bill.

- Reword Section 12 (1) b. to the following:

  The person has a mental disorder, the nature and degree of which is such that

  - *They require care and treatment*
  - *The care and treatment required to be given to the person cannot be given to the person other than in a registered acute mental health centre*
  - *The reception, detention and care and treatment of the person concerned in a registered acute mental health centre would be likely to benefit the condition of that person*
  - *The person lacks capacity to consent to admission and*
  - *The person lacks capacity to consent to treatment*

Rationale for above:

This becomes an admission **and treatment** order, rather than simply an admission order.

- The current portion of the bill, Part 3, Chapter 3, consent to treatment is unworkable; rewording the criteria for involuntary admission to the suggested format above facilitates the removal of Part 3, Chapter 3
- Multiple checks and balances in place:
  - Trained Authorised Officer, GP and Consultant Psychiatrist PRIOR to an order being completed
  - Free legal representation once involuntarily hospitalised (detained)
  - Independent specialist consultant psychiatrist offers second opinion – will consider consent to treatment as part of the review of the involuntary admission
  - All five criteria now reviewed by the Review Board

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2. Definition of mental disorder

> "'*mental disorder' means, in relation to a person, any mental disorder, illness or disability, whether of a continuous or intermittent nature, which affects the person's thinking, perception, emotion, mood or judgment and impairs the mental function of the person;*"

As written in the 2024 Bill, the definition of mental disorder is too broad and open to misinterpretation. It needs to be clearer and more definitive.

Consequences of the definition of mental disorder

- Too broad and vague – any "mental disorder, illness or disability" could refer to anything!
- The role of any secondary service is to treat illness that cannot be treated in primary care; that means the person needs specialist intervention. Psychiatry doctors are specialists in our field; the definition of what we treat needs to reflect this. It needs to be clear.
- The lack of adequate primary care services means that people present to psychiatric services in the absence of an appropriate alternative or due to a lack of understanding about what we do. This comes at the expense of those with serious mental illness
- We are underfunded and under-resourced already, with only 5.7% of the overall Health Budget when Sláintecare states it needs to be 10%.

Solution

The following, more accurate wording is a solution to amend the definition of mental disorder:

> *Mental disorder means, in relation to a person, any mental illness which seriously affects the person's thinking, perception, emotion, mood and judgement leading to significant impairment in the person's ability to function in their usual way.*

3. Psychosocial Assessment (PSA)

In the 2024 Bill it is a legal part of the involuntary admission and of the change of status process (from voluntary to involuntary) for patients.

The following are the relevant two paragraphs; they directly contradict each other:

Section 22: Legal requirement of the involuntary admission procedure

"*(b) prior to, at the same time as or following an examination under paragraph (a), a mental healthcare professional (other than a consultant psychiatrist) on the staff of the registered acute mental health centre who is or will be involved in the care and treatment of the person the subject of the recommendation to carry out a psychosocial assessment of the person concerned*".

Section 37: Legal requirement of the changes of admission status procedure

"*(2) The responsible consultant psychiatrist shall carry out an examination of the person concerned under section 22(1)(a) and arrange for another mental healthcare professional (other than a consultant psychiatrist) on the staff of the registered acute mental health centre who is not involved in the care and treatment of the person the subject of the opinion to carry out a psychosocial assessment of the person concerned in accordance with section 22(1)(b)*".

Consequences of current wording and placement of the Psychosocial Assessment

- The value of PSAs and reports is not in dispute - TIMING is the issue
- No evidence exists that the PSA will benefit the patient who is in the acute phase of illness at this stage of the involuntary admission assessment
- In fact, carrying out a PSA at these times could cause harm and distress for someone with severe acute symptoms, who is already undergoing comprehensive assessment (i.e. multiple interviews)
- Allied Health Professionals do not work out of hours; therefore, it would be impossible to have these reports done at weekends or overnight, the most common times for emergency involuntary admissions
- **Section 37**, *Power to detain voluntarily admitted person who fulfils criteria for involuntary admission*, specifies someone *"who is not involved in the care or treatment of the person"*.

  If this happens out of hours, it will fall to a member of nursing staff of the unit. It could be argued that they **are** involved in the care of the person.

  In addition, the 24-hour time limit is prohibitive. It is currently very difficult to complete the existing process within 24 hours; adding the PSA will make it impossible

- This is a fundamental competency of specialist psychiatry doctors. It is inherent in their practice, i.e. it is already being done. Psychiatry trainees are expected to demonstrate skill in the bio-psycho-social model; it is a core competency without which they cannot succeed/pass.

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4. Section 181 (a): Regulations concerning care plans

This section needs to be removed as it is misplaced, unnecessary and is an outrageous example of political overreach:

"***181.*** *Without prejudice to the generality of section 3, the Minister may make regulations concerning care plans which may provide for any or all of the following matters:*

(a) the content of a care plan, including the setting of goals relevant to an adult or child, the subject of the care plan, as appropriate;"

Consequences of current wording for regulations concerning care plans

- No individual should have the power to direct a plan of care for a patient without significant and relevant medical training
- It is unsafe, poor medical governance and represents political overreach
- It also stigmatises the mentally ill patient, suggesting they are so ill they need input from a minister
- No other branch of medicine would have the content of a plan of care dictated by a politician

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5. Section 28 (3) (a), (d): Powers of review board

This contains problematic wording requiring amendment. As written, it compels and legally summons a specialist consultant psychiatrist to attend a review board without conferring with that specialist.

"*(3) A review board may, for the purposes referred to in subsection (1)—*

1. ***direct in writing any person whose evidence is required by the review board to attend before the review board <u>on a date and at a time and place specified in the direction</u> to give evidence and to produce any document or thing in his or her possession or power specified in the direction,***

...

(d) give any other directions for the purpose of the review board hearing concerned that appear to the review board to be reasonable and just in relation to the functions of the review board including to require that the evidence to be given by any person should be given on oath or affirmation and to administer an oath or affirmation for that purpose.

...

shall be guilty of an offence and shall be liable on summary conviction to a class A fine or to imprisonment for a term not exceeding 6 months, or to both".

Consequences of the current wording for powers of review board

- The wording suggests that the date and time of the review board could be directed without consideration of the treating specialist consultant's schedule or case load; essentially, it is a legal summons
- The majority of psychiatric patients are treated in the community; if a scheduled outpatient clinic is cancelled due to a review board direction, as many as thirty patients for that one consultant would be impacted in a single day
- Expanding those numbers nationally and over a month or a year, then the inevitable result is wide ranging disruption to the provision of community based psychiatric care

6. Inspection of all community mental health services, including CAMHS

Inspections are welcome. They are and have been permittable/possible under the current Mental Health Act.

However, we have concerns as follows:

- If recognised gaps in service provision are not funded and adequately resourced, these inspections will lead to reports that misleadingly appear to demonstrate declining standards of care
- Additional funding to carry out inspections alone will not lead to service improvements

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Other concerns with the 2024 Bill

- **Section 51 (1)** - allows for the High Court to compel a patient with capacity to accept treatment

- **Section 50 (4)** - "*Where no treatment can be administered to a person due to refusal of each and every specific treatment proposed… detain the person for a period of 72 hours in order to build a therapeutic relationship*".

  What then? Should the patient be discharged? The patient who was deemed sufficiently unwell to warrant an involuntary admission in the first place?

- **Definition of consultant psychiatrist** - excludes colleagues working in consultant positions who are not on the specialist register

- **List of mental healthcare professionals** - Psychologists are not included on this list

CAMHS-specific concerns

- **Section 10 (1) (f)** – *"that the welfare and dignity, including the child's right to privacy… shall be respected"*.

  A query was raised regarding the need to stipulate balancing this with treatment needs, for example 1:1 observations

- **Section 65 (3)** Application for admission in the absence of assessment

  On what grounds does 'the Executive' then apply for an involuntary admission? And who represents 'the Executive' in this instance?

- **Section 65 (5) (a)** Disqualification of consultant psychiatrist from examining where involved in treatment

  Does this include psychiatrists on OOH rota who would at times be responsible? Also, does this exclude the inpatient consultant from applying for a renewal order?

- **Section 71 (6)** - "*released into the care of the Executive*"

  Query regarding the exact meaning. This could be interpreted as a person brought to an Emergency Department (ED) and given into care of the ED staff.

Conclusion

Psychiatry relies on expert clinical examination and observation to diagnose and guide treatment. It is critical that sufficient time be allowed for this; there are no short cuts or methods of bypassing this process. Legislation should always avoid disruption of clinical time in order to avoid lower standards of care. If Consultant Psychiatrists are obliged to allocate increased time to legal processes, it inevitably leads to a reduced level of care.

Patients frequently report concerns that they have done something wrong or illegal when, during an involuntary admission, they are informed of the appointment of their legal representative. It is clearly necessary to have procedures safeguarding human rights; however, it is important to legislate only where it is absolutely necessary. Extreme caution needs to be exercised to ensure that the existence of legislation does not add to the stigma already suffered by those affected by psychiatric illness.

Summary – Potential Solutions

1. **Reword the criteria for involuntary admission to include involuntary admission and treatment as follows:**

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   - Multiple checks and balances in place:
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     - All five criteria now reviewed by the Review Board

2. **Change the definition of a mental disorder to:**

   Mental disorder means, in relation to a person, any mental illness which seriously affects the person's thinking, perception, emotion, mood and judgement leading to significant impairment in the person's ability to function in their usual way.

3. **Keep the Psychosocial Assessment but remove it as part of the admission or change of status procedures**

4. **Remove the piece on the Minister for Health/Mental Health regulating care plans**

5. **Change the wording in the Powers of the Review Board to incorporate the treating consultant's clinical case load to protect community services**

6. **Two streams of funding required for meaningful inspections of all community mental health services. In addition to funding for inspections themselves, requisite funding and resourcing is required to address services gaps and improvements to avoid misleading reports of declining standards of care.**