



Public consultation on draft legislation to update the Review of the Mental Health Act, 2001.

Response on behalf of the Irish Advocacy Network April 9th 2021

Dear sirs,

Above, please see below a response on behalf of the Irish Advocacy Network (IAN). By way of information and context, the Irish Advocacy Network is an island wide, peer led advocacy organisation delivering peer advocacy services to person's challenged with mental health problems across the island of Ireland. We also deliver training programmes to service users, carers/family members, partner organisations and service providers covering a range of areas such as advocacy, capacity building and peer support. Our priority of place where we deliver one-to-one peer advocacy is approved psychiatric centres and residential settings. Our submission is therefore guided and informed by our work with our primary client group, relevant to this consultation ie; psychiatric inpatients impacted by the Mental Health Act, 2001. The fact that on an annual basis we have consistently recorded close to or over 20,000 engagements and supports with people experiencing mental health problems lends credibility to our submission.

We unfortunately and regretfully note that we did not receive an invitation to submit a response to this review consultation, being informed of proceedings through a third party. It is also unfortunate to note that the timeframe allowed for a submission to this extremely important consultation was woefully inadequate (exacerbated by the fact we heard of the consultation later than most) inhibiting deep analysis and broad consultation among our staff and 'client group'. Consequentially, we believe this consultation has been devalued, and that public and stakeholder groups have been denied due process and due consideration to participate meaningfully to this review. Given the time constraints as outlined, we have had to restrict our response to a number of key issues and engage a principled approach in our response.

To begin, we are aware that in July 2019, the Department sent an initial draft of a general scheme to the Mental Health Commission for their expert opinion. The Commission provided a detailed submission to the Department in March 2020. Following a redrafting of the general scheme, the Department sought the advice of the HSE, as the main provider of mental health services in the State, in August 2020. The HSE returned its final submission in late February 2021. Our response considers the process just described and recommendations provided by the Expert Group.

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Principles and broad concerns. Effects and consequences of language.

Irish Advocacy Network (IAN) Recommendation 1

We recommend that the term ‘treatment’ in the Mental Health Act should be reconsidered, clarified or/and contextualised in accordance with therapeutic intent, outcomes and impact on those deemed mentally disordered. We argue and elaborate in Appendix 1 that mental health practices should work to relieve mental, emotional, psychological distress and discomfort. If an intervention does not achieve this then it must be clearly stated what it offers and consequences of same. The Mental Health Act should categorise interventions in order to distinguish and address practices that enhance/compliment or conflict with human rights. Distinctions between practices of ‘doing to’, including physical and coercive interventions, whose consequences and intents are to manage and control symptoms and behaviours (treatments) need to be made against interactions that are designed to deliver person-centred care, support and participatory practices (drawing up care plans, talking therapies, support from Occupational Therapy, Decision making supports recommended by the Expert Group, 4.12). Given the (relatively) new introduction of Safeguarding legislation and increasing attention paid on human rights, categorising interventions in this way would enable deep analysis, address failings and negative consequences towards the health of recipients of these interventions. Ultimately this will minimise conflicts with human rights such as threats to bodily integrity, dignity, freedom of thought and movement. In short, the Mental Health Act in making such distinctions would discourage non-participatory (including non-consensual, 4.11 in the Expert group report), intrusive practices and encourage participatory ones.

4.1 Definitions

The Expert Group recommended that “Mental Illness” replace the term “Mental Disorder” in the Act. There are two problems here. Firstly, both terms when applied can lead to resistance among those categorised as such. This, in our experience is common. Identity threat is experienced, endangering the dignity of the person – feeling judged as having a ‘flawed character’, ‘broken’, with inherent undesirable traits, behaviours and experiences (See appendix 2 for further elaboration). Secondly, we also observe (and question) consequences if the term Mental Disorder is replaced with Mental Illness. Will this exclude persons diagnosed with Personality Disorder or Borderline Personality Disorder? A cohort that requires specific attention, care and support yet often subject to exclusionary practices.

IAN Recommendation 2

We recommend that both of these terms (“Mental Illness” and “Mental Disorder”) need further reflection, their consequences on the dignity of the person taken seriously and addressed. This process should be conducted in the spirit of co-production with service users and carers/family members.

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4.1 Definition of voluntary patient

IAN Recommendation 3

We agree that a definition of Voluntary patient needs to be clearly stated in the Act as recommended by the Expert Group.

4.4 Authorised Officers

We note a recommendation that consideration be made to expand the role of the above.

IAN Recommendation 4

We strongly suggest, in the spirit of co-production that the process of expanding the role of Authorised Officers includes service users, carers/family eg; delivery and development of training programmes.

4.5 Interdisciplinary approach to care and treatment

The recommendation from the Expert Group that a consultant psychiatrist consult with a mental health professional from a different profession prior to the making of an admission order, at the point of a renewal order requires more detail inviting scrutiny.

IAN Recommendation 5

A statement from the person from a different profession would be required, (why they agree or disagree with the admission order; any concerns etc), if they are working on the same unit/on the same MDT, is there a pattern whereby the same professional person is consistently asked to consult in these decisions and if agreement is always the outcome?

4.6 Changing timeframes

The Expert Group recommends reducing the length of renewal orders, shortening tribunal hearings from 21 days to 14 days.

IAN Recommendation 6

We agree, but feel that we must point out that on occasions the patient's solicitor does not engage with the patient until the day of the tribunal. This is unacceptable, as some patients do not feel they have built a relationship, have not been attended to, listened to or been suitably and accurately heard and taken seriously under such circumstances.

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4.9 Change of status from voluntary to involuntary

The Expert Group recommends that the existing powers to allow for a change of status from voluntary to involuntary patient remain in the Act. The Group further recommended that an individual should not have to request to leave an approved centre.

IAN Recommendation 7

It remains the case that voluntary patients are sometimes refused to leave (eg; go to the shop) and told that if they leave the unit that there will be a change to involuntary status. This also applies to patients who refuse medication. Such incidents seem to go unrecorded. The Act needs to invite or develop a mechanism whereby such acts of coercion are recorded and addressed.

Further to this topic, Section 26 – Absence with Leave

Looking at the criteria for Involuntary admission (Section 3). It does not make sense that an involuntary patient can be absent with leave. If a person is fit to have leave, they should no longer need to be involuntary. Clarity and consistency is required (recommended) here.

4.12 Information and individual care/recovery planning

The Expert Group recommended that individuals be fully informed of their rights as a patient, their care and treatment, and in the case of voluntary patients and involuntary patients with necessary capacity, of their rights regarding consent or refusal of treatment and their right to leave the approved centre at any time.

IAN Recommendation 8

Access, promotion and investment in independent advocacy needs emphasised, improved and expanded. Our preference, with the current drive and acknowledgement of the value of peer support in HSE mental health services, being peer advocacy.

4.15 Provisions related to the Mental Health Commission

The Group recommended that responsibility for setting standards in mental health facilities by the Commission should be set out on a statutory basis.

IAN Recommendation 9

We agree with the Expert Group Recommendation that standards as developed by the Commission have statutory footing. We also recommend that similarly, Guidelines produced by the Mental Health Commission need to have a Statutory basis. We would recommend there be a guarantee that these guidelines and standards be co-produced with service users, carers/family members.

Additional to the above, and in order to emphasise and highlight the lived experience of the ‘psychiatric patient’, we have included a third appendix with a list of common issues raised by clients through our advocacy work.

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Finally, we trust our observations, statements and recommendations are taken seriously, met with openness and reasonable consideration. We would like to be given the opportunity to elaborate and expand on the content herein and look forward to acknowledgement of our submission.

If any clarification or further engagement is sought, we are only too happy to oblige.

Yours sincerely,

On behalf of the Irish Advocacy Network

A handwritten signature in black ink, which appears to read "Jim Walsh". The signature is written in a cursive style and is positioned above a horizontal line.

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Appendix 1

The problem with the non-contention of the term ‘treatment’ in the Mental Health Act

We work with service users who inform us that psychiatric medications helps(ed) them. As a contrast, we also work with service users who experience physical threats, emotional and psychological discomfort due to psychiatric medications. It is this self-reporting we refer to below which should not be ignored or dismissed. Further, the causative relationship between psychiatric medications and the onset of physical health problems is long established, evidenced in numerous research papers, written by academics, practitioners, scholars (we reference just a few). Increased risk to physical health problems includes significant weight gain, likelihood of developing diabetes and increased risk of heart disease. There is also an exceptional (consistently growing) amount of evidence pointing to negative impacts of psychiatric medications on the mental health of recipients, inverse to therapeutic assertions including increased likelihood of suicidal ideation, suicide attempts and completed suicide; agitation and lethargy to name a few. Given the depth, breadth and credibility of evidence on the effects of psychiatric medications, the therapeutic value it offers is questionable, certainly problematic. Evidence also points to the fact that one of the major effects of psychiatric medications, which some might judge therapeutic, is heavy sedation. The sedative effects of psychiatric medications are often at a level that inhibits the potential for therapeutic interactions with psychiatric staff with any appreciation toward caring environments threatened, if not lost. The above side effects bound with substantial sedation, points to therapeutic failure in accordance with desirable outcomes as laid out here - to relieve mental, emotional, psychological distress and discomfort. Further, Section 3) (1) (b) (ii) of the Act states: “the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent”. If it takes more than 3 months to benefit or alleviate the condition of the person, one would need to question the effectiveness or continuation of the treatment?

Given the effects of psychiatric medications on the individual, human rights come to the fore. By design, they err toward managing and controlling symptoms and behaviours falling short, if not failing to meet the criteria of relieving mental, psychological, emotional distress. Risk management and safety concerns appear to be the major impetus to prescribe psychiatric medication, not therapeutic outcome. In essence, as an intervention, the prescribing of psychiatric medications is a blunt instrument. In the event medications are being considered; in the spirit of co-production and person-centred care, we also recommend the promotion of ‘Democratic psychiatry’ whereby in accordance with patient self-reporting the practitioner becomes willing and

able to meaningfully engage in negotiation and adjustment of medications. This should become part of the Decision making supports recommended by the Expert Group (4.12). We recommend that the Mental Health Act make a distinction between treatments with dubious intent from care and supports that have obvious therapeutic outcomes or intent.

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Further to this point, therapeutic intent and benefits thereof need to be clearly stated in the Mental Health Act when it comes to explicit forced interventions and acts of coercion such as seclusion and forced injections. Such distinctions illuminate practices that are contrary to human rights and need to be categorised as such to enable scrutiny and deep analysis of same. We acknowledge some of the work of the Mental Health Commission in this area along with the role of Mental Health Inspectorate. However, the infringement on rights from such practices need to be distinguished in law, from care and supports that have obvious therapeutic outcomes or intent. We argue that the Act can minimise conflicts with human rights such as threats to bodily integrity, dignity, freedom of thought and movement if such a distinction is made and protections more clearly stated. This will ultimately improve practices, quality of care and facilitate necessary mediation between ‘patient’ and services that can resolve and improve care and support to people experiencing mental, emotional, psychological distress and discomfort.

Appendix 2

Personal identity threat is experienced by some psychiatric patients as a reaction to receiving diagnoses or/and prescribed psychiatric medications (indeed the issue of personal identity threat expands into general health care where people do not feel they have been listened to, treated as commodities moved through a conveyor belt like system; see for example Colye, 1999). This must be understood as a perception of personal failure and should be addressed as such. For instance, being diagnosed with a mental disorder and being prescribed psychiatric medications is perceived by some as a judgement – that their character is flawed, that they are somehow defective or inadequate, inherently different. These deficiencies, as some patients perceive it, can only be corrected through chemical interventions confirming their analysis of why they are being treated. Traditionally these individuals have been judged non-compliant or resistant, their sense

of things ignored, dismissed or even worse subjected to acts of force and coercion. This will not resolve this issue. The only way to address service user experience of identity threat and associated threat to personal dignity is to firstly acknowledge their perception of things, validate their world view and enter into transparent and honest conversation to find resolution. As with the practices of democratic psychiatry, we recommend that a programme encouraging dialogue be established in order to acknowledge and address this perception. The ongoing challenges presented by this group should no longer be ignored, otherwise, given the promise of increased patient involvement, choice, autonomy, and self-determination (as appears in a growing number of health policy documents), distance between these world views will continue to widen.

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Appendix 3

Review of Mental Health Act 2021 – Issues raised by clients

Section 13 (4) – Powers of Garda Siochana

Gardai can and do forcefully enter an innocent person’s home and forcefully remove him / her to the approved centre. The person is often not given the opportunity to pack a bag and is left very concerned about the security of their residence, pets etc. – Not very therapeutic

Section 16 (2) – Notice of an Admission / Renewal Order

Clients often report not getting this notice. Where it is given, it should be in a language and format that the client understands and should be legible.

Section 17

The Legal Representative is a Legal representative for the patient not for the Consultant. Clients often believe that the legal representative is supporting the Consultant rather than them. It is not acceptable that the first and often the only interaction between the legal representative and the patient would take place on the day of the tribunal.

The second opinion Consultant needs to make him /herself known to the patient and the purpose of the engagement. More often than not, clients report that they have not met with a second opinion consultant.

The word “Tribunal” should be changed. This word has negative connotations for people. Clients ask why should they have a tribunal when they have done nothing wrong.

Section 18 – Remit of Tribunal Panel

The remit of the Tribunal Panel needs to be extended. They should also review the effectiveness of treatment in line with the definition of Mental Disorder and the criteria for Involuntary admission (Section 3) (1) (b) (ii) “the reception, detention and treatment of the person concerned

in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent” If it takes more than 3 months to benefit or alleviate the condition of the person, one would have to question the effectiveness of the treatment.

Section 23 – Prevent Voluntary Patient from leaving

How voluntary can a person really be if he / she cannot leave when they want?

Section 24 – Detention of Voluntary Patient

Second opinion psychiatrist - One colleague will not go against another colleague. Many clients question the independence of the second opinion consultant.

Section 26 – Absence with Leave

Looking at the criteria for Involuntary admission (Section 3) it doesn't make sense that an involuntary patient can be absent with leave. If a person is fit to have leave, they should no longer need to be involuntary.

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Part 4. Section 56 – Consent to Treatment

Clients very often report that threats are used if they refuse to give consent to taking a certain medication. Involuntary patients are threatened with seclusion, are held down by a number of staff and forcefully medicated. This also happens with voluntary patients with the added threat of being made involuntary. Nowhere in the Act, is refusing to take a medication cited as criteria for making a patient involuntary.

References

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