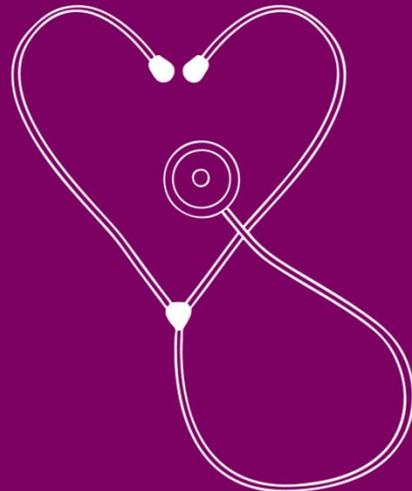


MASON
HAYES &
CURRAN

Reform of the Mental Health Act Seminar

Tuesday 8 November 2016

@mhclawyers

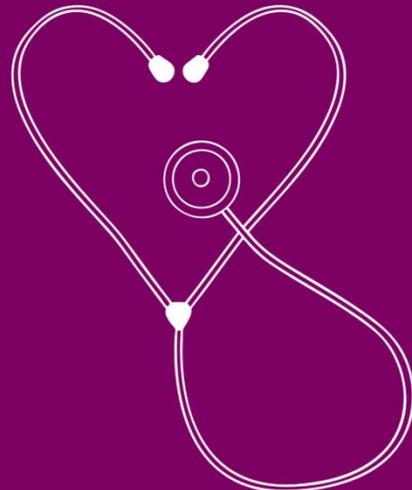


Welcome

Dr Kevin Power

Partner

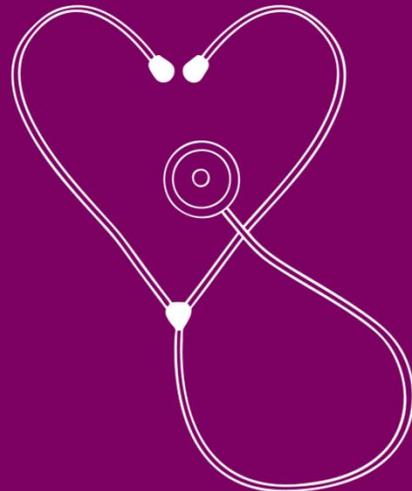
Mason Hayes & Curran



Reform of the Mental Health Act 2001

Patricia Gilheaney

Chief Executive, Mental Health Commission



Reform of the Mental Health Act
2001
Seminar
Mason Hayes & Curran

Expert Group Review of the Mental Health Act 2001

Patricia Gilheaney

Member of Expert Group (EG)

&

Chief Executive, Mental Health Commission

8 November 2016

Structure of Review

Phase 1: Initial Review - Scoping Phase

- June 2011 Steering Group appointed by Ms Kathleen Lynch T.D., Minister
of State at
the Department of Health

“to review the provisions of the Act having regard to:

- a) Its general operation since its commencement;*
- b) The extent to which the recommendations of ‘A Vision for Change’ could or should be underpinned by legislation;*
- c) The provisions of the UN Convention on the Rights of People with Disabilities, and*
- d) The current economic environment*

And to make a report to the Minister by June 2012 with recommendations, including recommendations for legislative amendments where appropriate.”

- **Membership** Department of Health Officials
(Mental Health Unit), HSE Mental
Health Specialist, MHC Chief Executive.
- **Meetings** 15 July 2011 - 23 April 2012 (n=8)
- **Process**
 - Review of documentation
 - Public Consultation
 - Leaflet drop to 4,000 members of a national service user organisation
 - 102 submissions received
 - Meetings with representative Groups x 15 (September 2011 – January 2012)
 - Dept. Justice and Equality (x2), NSUE, IHRC, Children’s Mental Health Coalition, Irish Mental Health Lawyers Association, ICGP, IAN, Mental Health Reform, Amnesty International, HSE, NSUE, MHC, College of Psychiatrists in Ireland, Dept. Children and Youth Affairs.
- **Publication of Report** 27 April 2012

Key Areas identified for Substantive Phase of the Review

Human Rights and Paternalism

A Vision for Change

Children

Voluntary, Involuntary Patients and Capacity

Consent to Treatment

Detention

Authorised Officers

Comments of the Steering Group were intended to point the way forward and be a guide for the substantive phase of the Review.

Phase 2: Expert Group Review - Substantive Phase

August 2012: Expert Group Appointed by Minister Lynch

Terms of Reference (ToR)

- “1. To examine each of the recommendations of the Interim Review of the Mental Health Act 2001, and
 - a. Propose which recommendations can be agreed without further assessment or modification,
 - b. Establish which recommendations require further analysis before being finalised, and
 - c. Make decisions on those areas where the Steering Group had offered choices rather than specific recommendations.*
- 2. To consider Departmental proposals for amending the Mental Health Act which pre-dated the Steering Group Report and recommend a course of action in respect of them.*
- 3. To examine any further specific issues which may be referred to the Expert Group by the Minister.*
- 4. To ensure that the recommendations of the Expert Group take account of any Capacity Legislation published in the meantime and be consistent with such legislation and existing criminal law insanity legislation, which is also under review at this time.*
- 5. To conclude its deliberations and submit final report to the Minister by End March 2013.”*

Process

- Meetings 18 September 2012 to 16 September 2014 (n=13)
- Original timescale (2013) extended for 2 reasons:
 1. To provide time to consider the implications of the Assisted Decision-Making (Capacity) Bill 2013
 2. Balancing of individual human rights with public health and safety gave rise to a number of detailed discussions which required careful analysis of the suggested options.

Context

- Acknowledgement that despite some positive changes in society people with mental illness still suffer discrimination and stigmatisation (p.12).
- Belief that the often contested view of mental illness should be something both mental health professionals and the Courts services should have to take into account and that mental health expertise is deeply contested. (p.11)

Guiding Principles

- Aim of Guiding Principles – to set tone of the Act
 - ‘Best Interests’ as the ‘principal consideration’ plus generally ‘purposive interpretation’ of the Act has led to interpretation in a paternalistic manner.
 - A shift from paternalistic interpretation is required to comply with the ECHR and CRPD.

“the ‘best interests’ principle is not a safeguard which complies with article 12 in relation to adults. The “will and preferences” paradigm must replace the “best interests” paradigm to ensure that persons with disabilities enjoy the right to legal capacity on an equal basis with others” (General Comment No.1, Committee on the Rights of Persons with Disabilities, 2014).

- Best interests at odds with the person centred ethos of *Vision for Change* (Department of Health, 2006)
- Terms of Reference requirement to take cognisance of the Assisted Decision-Making (Capacity) Bill 2013.

Guiding Principles

1. In so far as practicable, a rights based approach should be adopted throughout any revised mental health legislation.
2. Following list Guiding Principles of equal importance should be specified in the new law:
 - a. The enjoyment of the highest attainable standard of mental health, with the person's own understanding of his or her mental health being given due respect
 - b. Autonomy and self-determination
 - c. Dignity (there should be a presumption that the patient is the person best placed to determine what promotes/compromises his or her own dignity) (will and preferences)
 - d. Bodily Integrity
 - e. Least restrictive care

Mental Disorder/Mental Illness

3. Mental Disorder should no longer be defined in mental health legislation but instead the revised Act should include a definition of mental illness
4. The definition of mental illness should be separated from the criteria for detention
5. Reference to 'significant intellectual disability' and 'severe dementia' in existing legislation should be removed to ensure compliance with the ECHR and CRPD.
6. Revise definition of mental illness to recognise that it is a complex and changeable condition.

Treatment

7. Treatment should include ancillary tests required for the purposes of safeguarding life, ameliorating the condition, restoring health or relieving suffering (HSE v MX, 2012)
8. The definition of treatment should be expanded to include treatment to all patients in an approved centre.
9. Treatment should be clearly defined and clinical guidelines further developed for the administration of various forms of treatment.
10. Treatment should be interpreted in the wider sense and not viewed simply as the administration of medication.
11. The provision of safety and/or a safe environment alone does not constitute treatment

Criteria for Detention

- Right to Liberty protection– Article 40.4 Bunreacht na hÉireann; Article 5 ECHR.
- *Wintwerp v the Netherlands* [1979] ECHR 4 - lawful detention of a person of unsound mind must meet the following criteria:
 - Except in emergency cases, no one can be deprived of liberty unless s/he can be reliably shown to be of unsound mind on the basis of objective medical expertise;
 - Mental disorder must be of a degree warranting compulsory detention;
 - Validity of continued confinement depends on the persistence of the disorder
- *Shtukurov v Russia* [2008] ECHR 4409/05
 - Importance of appropriate and accessible review of detention.
- *Stanev v Bulgaria* [2012] ECHR 46 – further criteria
 - Consider alternatives to admission
 - Demonstrate that the admission is ‘necessary in the circumstances’.

WG view –limits can be placed on a person’s liberty where the limits are deemed to be necessary, proportionate and carried out in accordance with a procedure set out in law.

13. Criteria for detention

- a) the individual is suffering from a mental illness of a nature or degree of severity which makes it necessary for him/her to receive treatment in an approved centre which cannot be given in the community;
- b) It is immediately necessary for the protection of the life of the person, for the protection from a serious and imminent threat to the health of the person, or for the protection of other persons that he or she should receive such treatment and it cannot be provided unless he or she is detained in an approved centre under the Act; and
- c) The reception, detention and treatment of the person concerned in an approved centre would be likely to benefit the condition of that person to a material extent.

14. Detention should only be for as long as absolutely necessary and the person continues to satisfy all the stated criteria.

15. Immediately a person no longer satisfies any of the criteria the admission or renewal order must be revoked.

Exclusion criteria for detention:

Retention of the current criteria – person cannot be detained **solely** because s/he is suffering from a personality disorder, is socially deviant, or is addicted to drugs or intoxicants

(plus a new addition)

Or,

Capacity

- Definition of capacity should be consistent with the AD-MC Bill 2013 (now ADM(C)A 2015).
- Presumption of capacity and a functional approach
- MHC should develop and publish guidelines in relation to the assessment of capacity.
- A person who lacks capacity and has a mental illness but does not fulfil the criteria for detention may in specified circumstances be admitted as an 'intermediate' patient.

Voluntary Patients

- Definition – WG considerations
 - EH v St Vincent Hospital and Others (Supreme & High Courts).
 - International human rights standards.
- A voluntary patient should be defined as a person who has the capacity (with support if required) to make a decision regarding admission to an approved centre and who, where the person retains capacity, formally gives his/her informed consent to such admission, and subsequent continuation of voluntary inpatient status and treatment on an ongoing basis as required.
- Functional approach to capacity regarding subsequent care and treatment. It is important not to automatically presume that each person continues to lack capacity when decisions are required.
- Should be fully informed of his/her rights (consent /refusal to treatment, right to leave)

New category of Patient

- Group acknowledged the importance of having the then proposed Assisted Decision-Making (Capacity) Bill 2013 enacted.
- Person with a decision-making assistant or a co-decision-maker can be admitted as a voluntary patient.
- If the mental health professional forms the review that the person may lack decision-making capacity they must be referred for formal capacity assessment.
- Person with a decision-making representative appointed under the AD-MCB cannot be admitted as a voluntary patient.
- If criteria for detention cannot be fulfilled the person concerned cannot be admitted as an involuntary patient.
- New category of patient 'intermediate' who will have the review mechanisms and protections of a detained patient. Detailed guidance to be provided (MHC & OPG)

Authorised Officers

- Expansion of role
- AO to sign all applications for involuntary admission and change of status from voluntary to involuntary.
- Application shall remain in force for 7 days
- Does not matter who sees patient first (RMP or AO) but application must be completed first followed by a recommendation
- Family/carer can request a second AO opinion and that fact must be disclosed

Mental Health Tribunals

- Title & Power
 - Mental Health Review Board (MHRB)
 - Authority to establish whether an ICP is in place/
compliant with the law/views of patient & MDT sought.
- Timing
 - Review by MHRB no later than 14 days
- Composition
 - No change proposed at this stage
 - 'other person' to be known as 'community member'
 - Other person exclusions: persons who are or were a medical practitioner, nurse, mental health professional, barrister, solicitor in Ireland or elsewhere.

- Attendance
 - Patient may defer hearing for 2 periods of 14 days if such deferral is sought through the patient's legal representative.
 - 'Must' attendees : LR & RCP
 - 'May' attendees : Patient; Advocate (at invitation of patient); ICP (upon MHRB request); Author of psychosocial report or other member of MDT (upon MHRB request).
- Reports
 - ICP : Prepare assessment report for MHRB with input from another mental health professional of another discipline (to be specified) within 5-7 days of hearing.
 - Psychosocial report (concentrating on non-medical aspects) within same timeframe
- Oversight
 - By MHC in line with Best Practice

Renewal Orders

- Certified by RCP following consultation with at least one other MH professional of a different discipline
- Renewal order for periods up to 3 months, 6 months
- Clarify s 15(2) – renewal order comes into effect after the expiration of the previous order (MDv SBH, MHC,MHT[2007]; AMC v St Lukes Hospital[2007])

Section 26

Time limit: maximum 14 days

MHC guidance

Grounds for Appeal

- Burden of proof
 - approved centre rather than the patient
- S.I.11/2007 Circuit Court Rules (Mental Health)
 - Amend to reflect approved centre should be respondent.
 - MHC potential involvement as a notice party.

ECT

- Amend S. 59 to remove 'unwilling'.
- Decision-making representative (D-MR) - consents: proceed
- D-MR refuses consent: certain conditions met (life – saving)
 - Refer to MHRB within 3 days.

Medication

- Amend S.60 to remove 'unwilling'.
- Reduce 3 month period to 21 days
- MDT review (CP + Another MH professional) & further reviews 3/12
- Authorised by 2nd CP from outside of Approved

Inspections

- Proportionate approach
 - Inspect at least once in every 3 years & more often according to risk
 - Register all community mental health teams & inspect an increasing proportion of the community services
 - Register all community facilities and introduce inspections on a phased basis
- Revise S.33(1) so that MHC makes standards in respect of all mental health services & inspects against them. Standards should be made by way of regulations and underpinned by primary legislation.

Information /Complaints

- On admission every patient has a right to information
- Obligation to ensure patient is aware of the complaints process
- Mandatory for the Inspector to meet a patient who has made a complaint when s/he is subsequently inspecting the approved centre.

Children

- Standalone Part of the Act and provisions of CCA 1991 expressly included
- Definition to be brought in line with the Children Act 2001
- Guiding principles to be expressly stated
- 16/17 yrs presumed to have capacity to consent/refuse admission and treatment
- 16/17 yrs must consent to voluntary admission (or not object)
- District Family Law Court – where 16/17 yrs old objects
- Provision of advocacy services to child and family

Advanced Healthcare Directives

- AHD's should apply to mental health on an equal basis to physical health.
- AHD's due to be introduced at Committee Stage of the AD-MCB 2013
 - Await outcome
 - Either amend AD-MCA or introduce provisions in revised MHA to comprehensively address the matter.
- AHD should be clear & unambiguous and recorded in the patient's care plan
- If AHD is overridden, the IMHS must be notified within 3 days & included in the Inspector's report on the approved centre
- Guidance – MHC, HIAA plus professional

Summary

- Review Report reflects the majority views, is progressive and addresses the Terms of Reference
- **A step too far for some and not far enough for others**

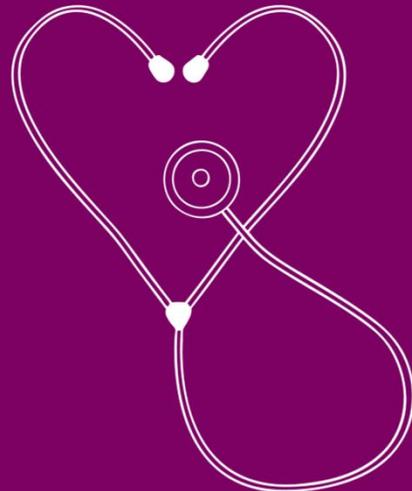
“The balance between autonomy and need for protective measures complex and not easily agreed and not always resolved to the full satisfaction of all sides” (Chair, p.3)

- Need to dovetail a revised Mental Health Act and Assisted Decision-making capacity legislation
- Further consideration of technical challenges at drafting stage
- Revised legislation should be reviewed 5 to 10

Reform of the Mental Health Act 2001

Tom Maher

Director of Services, St. Patrick's Mental Health Services





St Patrick's
Mental Health Services
Empowering recovery

Reform of the Mental Health Act Seminar Nov 2016

Tom Maher
Director of Services, St Patrick's Mental Health
Services

Recommendation 9



“Treatment should be clearly defined in revised mental health legislation and clinical guidelines should be further developed for the administration of various forms of treatment”

- NCEC
- National, Collaborative
- MHC Involvement



“The Group recommends that every time section 23 is used to initially detain a patient (even if section 24 is not subsequently used to detain the person) the Mental Health Commission should be notified.”

- ? Authorised Officers
- S23(1) detentions per service user
- DAMA's

INVOLUNTARY ADMISSIONS 01/01/2015 to 31/12/2015



NUMBER OF S15 and S24 ADMISSIONS:	87	Re-admit : New-admit = 2 : 1		
NUMBER OF TRIBUNALS:	63			
NUMBER OF INVOLUNTARY ADMISSIONS REVOKED:	82	Prior to 1 st Tribunal 33	Post / Prior to 2 nd Tribunal 45	At Tribunal 4
NUMBER SECTION 60 Medication Review 2014	10	Refused Consent (Form 17) 5	Consented 5	
ECT SECTION 59 (FORM 16)	20	(unable) 20	(unwilling) 0	
NUMBER OF SECTION 21 (FORM 10 TRANSFER)	19	Transfer in 12	Transfer out 7	
NUMBER S 23(1)	92	% of S 23(1) that were subject to Section 24 41 (44%)	% of S 23(1) that stayed on voluntary basis 50 (98%)	% of S 23(1) that did not stay on voluntary basis 1 (2%)
NUMBER S 14 (2)	39	% of S 14(2) that were subject to Section 15 34 (87%)	% of S 14(2) that stayed on voluntary basis 5 (100%)	% of S 14(2) that did not stay on voluntary basis 0
Total number of S 23 (1) and S 14 (2) who became involuntary	75			

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INVOLUNTARY ADMISSIONS 01/01/2015 to 31/12/2015



230 people asked to leave

Total DAMA's	138
S23(1)	92

INVOLUNTARY ADMISSIONS 01/01/2015 to 31/12/2015



230 people asked to leave

Total DAMA's 138 (60%)

S23(1) 92

INVOLUNTARY ADMISSIONS 01/01/2015 to 31/12/2015



230 people asked to leave

Total DAMA's 138

S23(1) 92 (40%)

Repeat uses of 23(1) during 2015

Total 92 x 23(1)

3 SU's x 4

1 SU's x 3,

10 SU's x 2

57 SU's x 1

Recommendations 90 - 97



S59 and S60: (consent to treatment with medication and ECT)

- Differentiation between S59 and S60?
- Criteria for this differentiation
- Hierarchy of treatments?

Recommendation 121



“Advocacy services to children and to the families of children in the mental health service should be available.”

- Advocacy service for CAMHS in SPMHS
- ? Independence



*“However, while the importance of having our mental health legislation and our national mental health policy aligned is appreciated, it is also recognised by Group members that it would not be practicable or desirable to legislate for how specific services should be delivered **or indeed to provide a right for individuals to services**”*



“The Group now recommends that the principle of reciprocity should apply in all scenarios where a person is being detained under the Act and that if all treatment is refused by a person with capacity (see also the section on Advance Healthcare Directives in this regard) then the person should be discharged”



*“an officer of a **health board** who is of a prescribed rank or grade and who is authorised by the chief executive officer to exercise the powers conferred on authorised officers by this section.”*

- **Mental Health Services not under the governance of the HSE?**



“Throughout this period when the patient is at the emergency department, hospital or clinic, responsibility for the mental health treatment of the person should remain with the Clinical Director of the approved centre to which the patient is being admitted.”

- How does an Approved Centre fulfil these responsibilities?



“The patient’s detention must be subject to an assessment report by an independent Psychiatrist with input (to be officially recorded) from another Mental Health Professional of a different discipline to be carried out within 5-7 days of the Review Board hearing.”

- Additional professional participation is welcome
- ?Input
- The psychosocial report author – independence?

Recommendations 71 – 72:
Grounds for appeal



“Grounds for appeal to the Circuit Court should be amended such that the onus of proof as to the existence or otherwise of a mental illness that meets all the criteria for detention falls on the approved centre rather than the patient as is currently the case”

- There is no definitive test that determines the existence of a mental disorder / mental illness.
- Currently the agreement of 2 psychiatrists as to the existence of such an illness
- Will this ‘level’ of proof change?

...and finally....



Recommendations 124: Frequency of Inspections

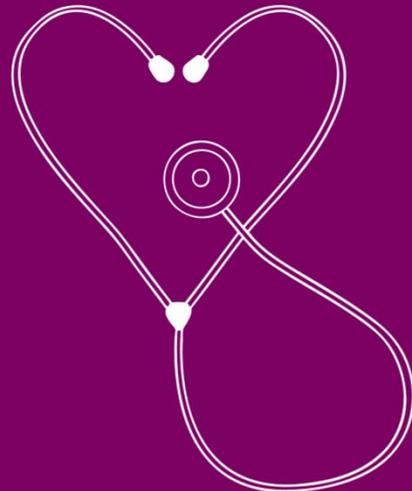
*“...inspect at least once in every three years
and more often according to targeted risk.”*

Potential Legal Implications

Dr Kevin Power

Partner

Mason Hayes & Curran



Legal Implications

- How might the proposals impact on MHPs/institutions?
 - Do they increase your legal liability?
- Do the proposals create uncertainty?
 - Uncertainty means inevitable court action
 - Putting them '*through their paces*' now reduces that risk
- Will they add value?
 - If not, why insert into legislation?

Topics

- Criteria for Detention (section 2.4/2.18)
- Capacity Assessments (section 2.6)
- Authorised Officers (section 2.9)

Criteria for Detention (section 2.4/2.18)

EXISTING: (a) because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, or ("the risk ground")

(b) (i) because of the severity of the illness, disability or dementia, the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission, and

(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. ("the therapeutic ground")

PROPOSAL: (a) the individual is suffering from mental illness of a nature or degree of severity which makes it necessary for him or her to receive treatment in an approved centre which cannot be given in the community; and

(b) it is immediately necessary for the protection of life of the person, for protection from a serious and imminent threat to the health of the person, or for the protection of other persons that he or she should receive such treatment and it cannot be provided unless he or she is detained in an approved centre under the Act; and

(c) the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit the condition of that person to a material extent.

Criteria for Detention (section 2.4)

- What about the service user *with capacity who* refuses every treatment option offered?
- No longer detainable on any ground

“The new criteria for detention recommended by the Group proposes that detention must cease if no treatment is or can be administered even if it is considered necessary for the protection of the person or the protection of others.”

- **Legal Implications**

- How does this affect duty of care to service user/others?
 - Is MHP obliged to discharge the service user with no further action?
 - Will the MHP be obliged to inform An Garda Síochána, and what role can AGS legitimately have in such circumstances?
 - Will the MHP be obliged to inform family members or those who may be at risk from such a service user?
- Will legislation exclude the MHPs legal liability (to the patient or others) in such circumstances?

Criteria for Detention (section 2.4)

- *What is left of the old ‘therapeutic ground’?*
 - 2001 Act: Detention if a failure to admit is *‘likely to lead to a serious deterioration in their condition’*.
 - New Proposal: Detention only if *‘serious and imminent threat to the health of the person’*
- **Legal Implications**
 - Change of emphasis from proactive and preventative to reactive practice.
 - May lead to brinkmanship
 - Where does liability lie if adverse outcome?

Capacity Assessments (section 2.6)

- **Proposal:** Formal assessment of capacity to be completed within 24 hours by person with the 'required competencies'.
- **Legal Implications**
- Is it impractical (and does that create dangers)?
 - External MHP: requirement that the 2nd psychiatrist (in the section 23/24 re-grading procedure) be 'independent' was '*extremely impractical and even dangerous in many of the more urgent cases*'.
[Hedigan J; (CC v Clinical Director of St Patrick's Hospital (No. 2) [2009] IEHC 47)]
 - Internal MHP
 - Does this add value?
 - Still tight window

Authorised Officers (section 2.9)

- **Proposal:** Radical expansion of their role (9% vs 100%):
 - The AO will make **all** Applications for involuntary admission (including those made by AGS via section 12);
 - The AO will make **all** applications for involuntary admission after section 23 has been invoked (section 23/24 change of status from voluntary to involuntary);
 - The 'new' AOs will be '*experienced Mental Health Professionals*'.

Authorised Officers (section 2.9)

- **Cost and Practical Implications**
- **Legal implications**
- **What is the legal status of the AO?**
 - Are the decisions of the AO judicially reviewable?
 - How will the AO be indemnified?
 - Will the AO be professionally regulated (in the manner that others in the chain such as GPs, psychiatrists and mental health nurses are)?
- **Is it potentially dangerous?**
 - Involvement in s. 23/24 re-grading procedure
 - Effective veto of a service user's consultant psychiatrist (or other MHP)

Take Homes

- Much to welcome – and much overdue - in the proposals
- Some measures that need further consideration
- Biggest concerns
 - Service user *with capacity who* refuses every treatment option offered
 - Involvement of AO in section 23/24 procedure

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The contents of this Presentation are necessarily expressed in broad terms and limited to general information rather than detailed analyses or legal advice. This Presentation may be tailored to your specific needs. If you would like to discuss this option please contact Kevin Power, Partner, Mason Hayes & Curran (016142398 or 0866815385). Specialist professional advice should always be obtained to address legal and other issues arising in specific contexts