

**AMNESTY
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Submission to the Department of Health and Children in relation to the proposed amendment of section 59 of the Mental Health Act 2001 and related matters

4 March 2010

Amnesty International Ireland (AI) has a long-term goal of making real in Ireland Article 12 of the International Covenant on Economic, Social and Cultural Rights which states that “*every person has the right to the highest attainable standard of ... mental health*”. AI is a membership-based campaigning organisation whose mission is to uphold and defend human rights and has been campaigning in the area of mental health in Ireland since 2002.

As outlined by AI in a number of previous submissions to the Department of Health and Children (the Department), section 59 of the Mental Health Act 2001 (the Act) raises serious human rights concerns. By allowing electroconvulsive therapy (ECT) to be administered to an involuntary patient who is “*unable or unwilling*” to give consent the law does not respect the right of a competent patient to refuse treatment. Instead it allows such treatment to be imposed against a person’s will, regardless of their decision-making capacity. Moreover, section 59 does not contain the safeguards required by international human rights standards in the context of intrusive or irreversible treatments. The urgent need for effective safeguards is even more pertinent in light of the uneven levels of ECT usage throughout the country as shown most recently by the Mental Health Commission’s Report on the Use of Electroconvulsive Therapy in Approved Centres in 2008¹.

AI welcomes the recent decision by John Moloney TD, Minister for Equality, Disability and Mental Health, to consult with people with mental health problems, their representative organisations and other relevant stakeholders on how the administration of ECT should be dealt with under the Act. This submission sets out AI’s recommendations for the amendment of section 59 and related matters.

¹ Published by the Mental Health Commission, November 2009. Only 24 of the 64 approved centres (37.5%) administered ECT in 2008, with 28 centres (43.75%) indicating in their response to the MHC that they never administer ECT. For example, the rate of ECT per 100,000 population differed from 1.2 in Dublin North East to 11.4 in HSE West with an even wider variance in the number of programmes administered as between different Approved Centres within the catchment areas. While some patients are referred from one Approved Centre to another to receive ECT, it is not clear that this accounts for the extent of the variations in usage shown in the report.

1. International human rights position on ECT and informed consent

Adopting a human rights position, the World Health Organisation provides useful guidance on the administration of ECT in particular in its *Resource Book on Mental Health, Human Rights and Legislation: Stop exclusion, dare to care*.² It states very clearly that “**if ECT is used, it should only be administered after obtaining informed consent**”.³ Similarly, the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak, has stated that “[i]n its modified form, it is of vital importance that ECT be administered only with the free and informed consent of the person concerned, including on the basis of information on the secondary effects and related risks ...”.⁴

Informed consent has three essential components: firstly consent must be given without coercion, undue influence or misrepresentation; secondly consent must be given after the disclosure of the associated benefits, risks and alternatives to the medical procedure in question; and thirdly to give valid consent the person must have capacity to do so. Thus, the right of a patient who has capacity to refuse ECT must be unequivocally protected by section 59. The Act is clearly currently in breach of human rights standards as the use of the word ‘unwilling’ denies the right of a competent patient to refuse ECT. This is not just an academic point; 11 people who were deemed able but unwilling were administered ECT without consent in 2008.⁵

The requirement of informed consent presupposes capacity on the part of the patient to give such consent. The Act, including section 59, will have to be amended in light of the proposed new capacity legislation so that a functional approach to capacity is applied to any references to capacity, impaired decision-making or ability to consent in the Act.⁶ A functional approach means that a person’s capacity is assessed in relation to the specific decision at the time that decision needs to be made. In addition, specific safeguards will need to be inserted to ensure (i) that ECT is only administered where it is necessary as a last resort and there is no less intrusive treatment appropriate; (ii) that a person consenting to ECT has the capacity to and actually gives free and

² *Resource Book on Mental Health, Human Rights and Legislation: Stop exclusion, dare to care* (WHO Geneva 2005).

³ *ibid*, p 64.

⁴ Interim report of the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Manfred Nowak, UN Doc UNGA/A/63/175 (28 July 2008) para 61.

⁵ In addition 6 people who were deemed ‘unwilling’ by either their treating consultant psychiatrist or the second consultant psychiatrist were also administered ECT without consent during that period. Mental Health Commission *Report on the Use of Electroconvulsive Therapy in Approved Centres in 2008* (Mental Health Commission, November 2009) 16.

⁶ In line with the recommendations of the Law Reform Commission in its Report *Vulnerable Adults and the Law* (LRC 83-2006), the Scheme of the Mental Capacity Bill adopts a time-specific and issue-specific functional approach to capacity, which marks a welcome movement away from the traditional approaches to capacity, which tended to focus either on the diagnosis or label attached to the person (the status approach) or the perceived rationality of the decision made (the outcome approach). Under the Scheme all that is important is whether the person has the ability to understand the nature and consequences of a decision in the context of available choices at the time the decision is to be made.

informed consent to ECT; and (iii) that in the case of a person who lacks capacity, the determination of incapacity is reviewed and the administration of ECT does not conflict with a valid advance directive or proxy refusal on the person's behalf.

Safeguards where a person consents to ECT

The UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (MI Principles)⁷ state that intrusive and irreversible treatments for mental health problems may be administered only where "the patient has given informed consent and an independent external body has satisfied itself that there is genuine informed consent and that the treatment best serves the health needs of the patient" (Principle 11(14)).

Accordingly, section 59 should be expanded to provide that, where a person consents in writing to ECT, an independent review body (most likely the Mental Health Tribunal⁸) should review:

- if the person has the necessary functional capacity to make the treatment decision. In reviewing the patient's functional capacity, the independent review body should be required to take into account of the views of at least two members of the multi-disciplinary care team in addition to the view of the treating consultant psychiatrist⁹;
- if the person has given free and informed consent to the programme of ECT. The importance of this being verified by the independent review body should not be underestimated. A study commissioned by the UK Department of Health and conducted by Service User Research Enterprise of the Institute of Psychiatry at King's College London concluded that approximately 50 per cent of consumers who participated in that research felt they were inadequately informed about ECT and a significant number of those who signed consent forms did not feel that they freely consented to ECT¹⁰; and
- if the treatment is necessary as a last resort and constitutes the least intrusive treatment or therapy appropriate to the patient's health needs (taking into account, among other things the clinical view of an *independent* consultant psychiatrist).

⁷ Adopted by UN General Assembly Resolution 46/119 of 17 December 1991.

⁸ The Mental Health Tribunals already have a role in reviewing any decision to administer psychosurgery to consenting patients under section 58 of the Act.

⁹ For example, the Mental Health Act 1983 (England and Wales) as amended requires in section 58A (electro-convulsive therapy etc) that before giving a certificate that ECT be administered in the best interests of a person who lacks capacity, the independent medical practitioner is required to "consult two other persons who have been professionally concerned with the patient's medical treatment" of whom "one shall be a nurse and the other shall be neither a nurse nor a registered medical practitioner...".

¹⁰ Institute of Psychiatry, King's College London, Service User Research Enterprise *Review of Consumers Perspectives on Electro Convulsive Therapy* Final Report July 2002, p60 (conclusions). It is worth noting that this report also concluded that felt compulsion and inadequate information were not specific to dissatisfied consumers.

The Act should provide that ECT may only be administered to a patient who has capacity if all of these criteria are fulfilled to the satisfaction of the independent review body. If it is found that the person lacks capacity, then the safeguards set out below must apply before ECT may be administered. If it is found that the person has functional capacity but either the person has not given free and informed consent or ECT is not necessary as a last resort, then it may not be administered.

Safeguards where a person lacks capacity to consent to ECT

Where a person does not have the capacity to give informed consent to ECT, then a number of criteria must be satisfied before it can be administered and section 59 should be amended accordingly:

- The treatment must be necessary as a last resort and constitute the least intrusive treatment or therapy appropriate to the patient's health needs. Both of these criteria, as well as the person's incapacity to make the treatment decision, should be certified by the treating consultant psychiatrist and confirmed by a second *independent* consultant psychiatrist. The second independent consultant psychiatrist should be required to consult with at least two persons from different disciplines who have been involved with the patient's treatment (in addition to the treating consultant psychiatrist)¹¹. A simple requirement that a second opinion be obtained, without any requirement that the second opinion be independent (as exists under section 59 at present) does not provide adequate protection to a person who lacks capacity.¹²
- Before the ECT can be administered an independent review body (most likely the Mental Health Tribunal¹³) should review:
 - The patient's functional capacity (to be defined in accordance with the new capacity legislation). In reviewing the patient's functional capacity, the independent review body should be required to take into account of the views of at least two members of the multi-disciplinary care team in addition to the view of the treating consultant psychiatrist.¹⁴ If he/she is found to have capacity, then treatment should only be administered with free and informed consent. The guiding principles of the new capacity legislation including especially that a person should not

¹¹ See note 9 above.

¹² While the requirement of a second opinion was likely introduced to act as a safeguard against the inappropriate administration of ECT, the fact that the second opinion is not required to be independent renders it very weak. As Mary Donnelly has pointed out "[t]here is nothing on the face of the Act to prevent a consultant psychiatrist from referring the matter to a second consultant whom he or she knows will agree with the treatment decision made. Even presuming that a psychiatrist would not deliberately choose the second psychiatrist on this basis, it is a natural aspect of professional relationships that professionals will often be drawn to colleagues who take a similar approach to their own". See Donnelly M 'The Mental Health Act 2001, Consent and the Role of Rights' (2005) 40 Irish Jurist 220, 236.

¹³ As stated above, the Mental Health Tribunals already have a role in reviewing any decision to administer psychosurgery to consenting patients under section 58 of the Act.

¹⁴ See note 9 above.

“be treated as unable to make a decision unless all practicable steps to help him or her to do so have been taken without success” (i.e. supported decision-making) are particularly relevant here¹⁵; and

- The necessity of the treatment as a treatment of last resort, having regard to the opinion of the independent psychiatrist and such other evidence or reports as are produced by the patient/his or her representative or requested by the independent review body as it sees fit.
- Even where the above criteria are satisfied the independent review body may not permit the administration of a programme of ECT to a person if to do so would conflict with either:
 - A valid advance directive of the person as regards ECT; or
 - A valid proxy refusal by a personal guardian or a donee of an enduring power of attorney duly appointed under the capacity legislation.

This is in line with the CRPD and the recent recommendation adopted by the Committee of Ministers of the Council of Europe in December 2009, which recommended that States “promote self-determination for capable adults in the event of their future incapacity, by means of continuing powers of attorney and advance directives” and that “[i]n accordance with the principles of self-determination and subsidiarity, states should consider giving these methods priorities over other measures of protection”.¹⁶ “Advance directives” are defined by the Council of Europe as instructions given or wishes made by capable adults concerning issues that may arise in the event of his or her incapacity.¹⁷

An example of this approach can be found in section 58A(5)(c) of the Mental Health Act 1983 (England and Wales) (as amended), which provides that ECT not be administered to a person who lacks capacity if to do so would conflict with an advance decision or a decision made by a donee or deputy or by the Court of Protection. A similar provision could be included in the Act by cross-referring to the new capacity legislation’s provisions on enduring powers of attorney and advance directives.¹⁸

¹⁵ See Head 1 of the Scheme of the Capacity Bill 2008, in particular Head 1(c).

¹⁶ Principle 1 of Council of Europe Recommendation 2009(11) of the Committee of Ministers to member states on principles concerning continuing powers of attorney and advance directives for incapacity adopted by the Committee of Ministers on 9 December 2009 at the 1073rd meeting of the Ministers’ Deputies.

¹⁷ Principle 2 Council of Europe Recommendation 2009(11).

¹⁸ While the Scheme of the Capacity Bill 2008 proposed to extend the scope of Enduring Powers of Attorney to cover treatment decisions, the Scheme does not provide a legal framework for advance directives whereby a capable person could give binding instructions concerning situations (including, in particular, advance refusal of certain treatments) that may

The above safeguards must apply in all cases where a person lacks capacity to consent to ECT. The WHO Resource Book expressly states that emergency treatment should not include ECT. Thus the law should not allow the administration of a programme of ECT in an “emergency situation” without recourse to the safeguards set out above.

In addition, there should be a right to appeal (exercisable either by the patient, or in some cases a representative or next of kin) to the Circuit Court against any decision by the independent review body to allow a programme of ECT to be administered to a person who lacks capacity (MI Principle 11(16)).

There should also be a provision stating that for the avoidance of doubt, if a person regains capacity at any stage, the programme of ECT must be discontinued unless the person gives his or her free and informed consent to its continuation.

The WHO has also stated that “there are no indications for the use of ECT on minors, and hence this should be prohibited through legislation”. AI understands that while the administration of ECT to minors is permitted under the section 25(13) of the Act with the approval of the District Court, it is not used on minors in Ireland. Nevertheless its use on minors should be expressly prohibited in line with the WHO’s guidance.

As is the case with the provisions on seclusion and restraint set out in section 69 of the 2001 Act, the provisions on ECT should apply to both involuntary and voluntary patients. As a patient should not be administered ECT against their capable wishes (whether they are voluntarily or involuntarily admitted to an approved centre), it makes sense that the same safeguards would apply to both categories of patients. This is all the more relevant when one considers that the majority of in-patients who were administered ECT in 2008 were ‘voluntary’ patients (over 80 per cent in each quarter)¹⁹.

Recommendations:

Section 59 of the Act should be amended to provide that ECT should never be administered to a person who has capacity without first obtaining informed consent in writing. In addition safeguards (detailed above) must be put in place to ensure that the person has the necessary capacity and that the treatment is necessary in the circumstances.

Section 59 should also be amended to provide that where a person lacks capacity to consent to ECT, effective procedural safeguards (detailed above) must be followed to ensure that the administration of ECT is appropriate in the circumstances.

arise in the event of his or her incapacity. The “Best Interests” provisions in Head 3 of the Scheme require that the person’s past and present wishes and feelings (and, in particular, any relevant written statement made by him or her when he or she had capacity) be considered insofar as they are reasonably ascertainable.

¹⁹ Mental Health Commission Report on the Use of Electroconvulsive Therapy in Approved Centres in 2008 (Mental Health Commission 2009), p 10.

Section 59 should be linked to the new capacity legislation so that the functional definition of capacity would apply and, where a person lacks capacity, the advance wishes of the person would be taken into account and any personal guardian or donee of Enduring Power of Attorney would be able to refuse the treatment on the patient's behalf.

Section 25(13) should be amended so that the use of ECT on minors is expressly prohibited by the Act.

The Act should give a right to appeal against any decision to allow ECT to be administered to a person who lacks capacity.

All of the above provisions should apply to all patients, regardless of whether they are voluntary patients or involuntarily detained under the Act.

2. The wording of the Mental Health (Involuntary Procedures) (Amendment) Bill 2008

The Mental Health (Involuntary Procedures) (Amendment) Bill 2008 (the 2008 Bill) was introduced by Senator Dan Boyle (Green Party) on 19 June 2008.²⁰ While AI welcomes efforts to amend section 59, we have some concerns with the possible consequences of the amendment proposed in the 2008 Bill.

It is AI's view that there are two possible interpretations of the proposed amendment to section 59 if the 2008 Bill is enacted as currently proposed.²¹

Interpretation A: that ECT cannot be administered without informed consent (i.e. a total prohibition on ECT without express written consent). This would mean that ECT could not be administered to a person who lacks capacity to make a treatment decision. If this position were adopted, incapacitated patients could in effect be denied a treatment that might be necessary as a last resort. AI is not a medical organisation and therefore we do not have a position on the efficacy or otherwise of ECT. AI urges the Department to consider the legal and human rights implications of such an interpretation.

Interpretation B: that in the case of a person who lacks capacity, the question of whether ECT may be given has to be dealt with under the common law doctrine of necessity. The common law doctrine of necessity basically provides that if a person lacks the capacity to consent to a treatment, it may be administered if it is deemed by the clinician to be in the patient's best interests, i.e. to save the person's life or protect their health. There is no requirement under the common law that a second independent opinion be obtained or that the matter be referred to an independent review body. This situation would not provide adequate protection of the human rights of

²⁰ See Seanad Debates, Volume 190 No. 4 available at <http://debates.oireachtas.ie/DDebate.aspx?F=SEN20080619.xml&Page=1&Ex=203#N203>.

²¹ It is our understanding that the proposed deletion of section 58 of the Mental Health Act 2001 (the Act), which deals with psychosurgery, will be removed. This note addresses only the proposed amendment to section 59 of the Act, which deals with the administration of ECT to persons admitted involuntarily under the Act.

individuals who lack capacity. In addition, it would fail to provide safeguards for people who consent to ECT. Therefore it is clear that the common law would not provide sufficient safeguards for patients against the inappropriate use of ECT. Accordingly, the simple deletion of section 59B is not sufficient and a more detailed amendment, including the safeguards set out in detail in Part 1 above, is called for.

3. Problems with section 60 of the Act from a human rights perspective

While the current debate is focused on ECT, AI would also like to raise the serious human rights concerns with section 60 of the Act, which relates to the administration of medication to an involuntary patient for a period in excess of three months.

This provision is framed in identical language to section 59 and could easily be amended in the same amendment Bill. At present the provisions of section 60 of the Act allow medication for a period in excess of three months to be administered to an involuntary patient where the patient is *'unable or unwilling to give consent'*. Like section 59, while section 60 requires that a second consultant psychiatrist approve of the course of treatment, there is no requirement that that psychiatrist be independent, rendering the practical value of this "safeguard" highly questionable.

Referring to section 60, the 2007 Report of the of the Department of Health and Children's review of the Act stated at page 28:

Again, submissions recommend that the reference to 'unwilling' be deleted from this section. Where capacity exists any refusal to accept treatment should be respected and this right protected by law. The Minister accepts the principle and is of the view that this requires to be considered in the context of any new capacity legislation.

Not only does section 60 (like section 59) allow an unjustified interference with the right of a competent patient to refuse treatment, but it also creates the anomalous situation whereby a competent person may not be given medication without informed consent for an initial period of up to three months (as section 57 applies)²² but thereafter may be given medication against their competent refusal.²³ It would appear that this anomaly arose as a result of an

²² Section 57 provides: "The consent of a patient shall be required for treatment except where, in the opinion of the consultant psychiatrist responsible for the care and treatment of the patient, the treatment is necessary to safeguard the life of the patient, to restore his or her health, to alleviate his or her condition or to relieve his or her suffering, and by reason of his or her mental disorder the patient concerned is *incapable of giving such consent.*" (emphasis added).

²³ For a detailed discussion see M Donnelly 'Treatment for a Mental Disorder: The Mental Health Act 2001, Consent and the Role of Rights' (2005) 40 Irish Jurist 220, 236-238.

error in drafting rather than a policy decision and it should be amended accordingly.²⁴

Long-term medication should only be allowed to be continued with the consent of the patient or, where the person lacks the capacity to consent, with similar safeguards to those set out above in relation to the ECT provisions.²⁵ In addition, the appropriateness of the three-month period which must elapse before this section kicks in should be examined, especially given the fact that in 2008 ninety-four per cent of discharges occurred within three months of admission.²⁶ Consideration should be given to reducing this period to ensure that this safeguard against inappropriate prolonged administration of medication is effective in practice.

Recommendation:

AI urges the Department to consider amending section 60 of the Act in order to address the pressing human rights concerns with that provision.

4. The need for a substantive review of the Mental Health Act 2001

Section 59 is only one aspect of the Act that raises concerns from a human rights perspective. While AI acknowledges that the Act marked an improvement in the protection of the human rights of persons with mental health problems compared to the situation that prevailed under the Mental Treatment Acts 1945-1961, there have been a number of developments, nationally and internationally, in light of which the Act must be substantively reviewed and amended.

The international human rights framework has continued to evolve since the Act was drafted. This evolution is illustrated most clearly by the adoption of the UN Convention on the Rights of Persons with Disabilities (CRPD) in December 2006.²⁷ The CRPD is seen as marking a “paradigm shift” in how disability is perceived by moving towards a social model, which recognises that “disability resides in society, not in the person”.²⁸ A review of the Act must take into account the provisions of the CRPD as well as recent decisions of the European Court of Human Rights, which have implications for mental health legislation.

²⁴ *ibid.*

²⁵ For example, medication will not be required to be a last resort but will be required to be necessary and the least intrusive treatment or therapy appropriate to the patient in the circumstances.

²⁶ Half of all discharges occurred within two weeks of admission; 20% occurred within two to four weeks and 24% occurred within one to three months as per *National Psychiatric In-Patient Reporting System (NPIRS) Preliminary National Bulletin Ireland 2008* (Health Research Board, Dublin July 2009), p 1.

²⁷ The CRPD, which has been signed but not yet ratified by Ireland, entered into force on 3 May 2008.

²⁸ United Nations *Disabilities – From Exclusion to Equality – Realizing the Rights of Persons with Disabilities* (2007 United Nations, New York) 4.

There have also been a number of developments at the national level that highlight the need for a full review and subsequent amendment of the Act. These include:

- the completion of initial reviews of the Act by both the Department and the Mental Health Commission²⁹, both of which highlighted issues with the Act that require amendment,
- the numerous cases which have been taken to the Irish courts, which raise issues with the Act and its operation in practice,
- the preparation of the proposed new Mental Capacity Bill, the provisions of which will need to be reflected in the Act,
- the publication of a Consultation Paper on Children and the Law: Medical Treatment by the Law Reform Commission³⁰, which makes provisional recommendations for amendments to the provisions of the Act relating to children, and
- the publication by the Irish Human Rights Commission of a Policy Paper concerning the definition of “voluntary patient” under the Act³¹, which calls for amendments to the Act and the proposed new capacity legislation.

The Department conceded the less than comprehensive nature of its first review of the Act (published in May 2007)³² and committed to undertaking a detailed review within five years of the full implementation of the Act, that is, on or before 1 November 2011.³³ We urge the Department to commence this review at the earliest possible opportunity.

If this review is to yield meaningful analysis and reforms, its scope must be broader than the operation of the Act. A comprehensive substantive review of the Act is called for, line by line, section by section. Its provisions, and their implementation in practice, must be examined against the Act’s object and purpose and against international human rights law and standards, in particular the CRPD.

²⁹ Mental Health Commission *Review of the Operation of Part 2 of the Mental Health Act 2001* (Mental Health Commission, April 2008). The Mental Health Commission’s review was confined to a review of the operation of Part 2 of the Act (in accordance with section 42(4) of the Act.

³⁰ Available at <http://www.lawreform.ie/>.

³¹ Available at <http://www.ihrc.ie/>

³² “The limited timeframe for the review did not allow for a comprehensive review as the full provisions of the Act have only been in operation since 1 November 2006.” Department of Health and Children, *Review of the Operation of the Act 2001: Findings and Conclusions* (May 2007). Similarly the review conducted by the Mental Health Commission (MHC) in 2007/2008 was limited to the operation of Part 2 of the Act (Involuntary Admission of Persons to Approved Centres) pursuant to section 42(4) of the Act.

³³ Department of Health and Children, *Review of the Operation of the Act 2001: Findings and Conclusions* (May 2007), recommendation 50.

It is also critical that this review be conducted in consultation with service users, their representative organisations, carers, and health care professionals, as well as relevant nongovernmental organisations, statutory bodies, human rights expertise and international bodies such as the World Health Organisation.

Recommendations:

While AI is pleased that the Department is considering an amendment to section 59 of the Act, this is only one of many provisions of the Act that raise concerns from a human rights perspective.

It is important that a substantive review of the Act be commenced at the earliest opportunity so that it can be completed on schedule by November 2011 in a sufficiently robust and comprehensive manner.

It is imperative that up to date human rights standards be used as a benchmark for the review of the Act.

This comprehensive review must take place in consultation with service users, carers and other relevant stakeholders. And up to date human rights standards, in particular the CRPD, must form that basis of the review.

A clear Terms of Reference for the review of the Act and for consultation with service users and other relevant stakeholders should be made publicly available.

5. Capacity Legislation and the ratification of the CRPD

Ireland was one of the first States to sign the CRPD in March 2007. However, despite the fact that it has since been ratified by some 80 countries³⁴, including the United Kingdom³⁵, Ireland has not yet ratified the CRPD or its Optional Protocol.

AI welcomes the Government's intention to introduce new capacity legislation.³⁶ However, AI is concerned at the continuing delay in the publication of a draft capacity Bill. It is important that the legislation comply with Article 12 of the CRPD in order that Ireland is able to ratify the CRPD.

³⁴ 51 States have also ratified the Optional Protocol, which allows individuals and groups to petition the UN Committee on the Rights of Persons with Disabilities once all national recourse procedures have been exhausted. See: <http://www.un.org/disabilities/countries.asp?id=166>.

³⁵ The United Kingdom ratified the Convention and its Optional Protocol on 8 June 2009 and 7 August 2009 respectively.

³⁶ The Department of Justice, Equality and Law Reform has published an outline of the proposed mental capacity legislation in the form of the Scheme of the Mental Capacity Bill 2008. It is expected that a draft Bill will be published later this year. AI's submission to the Department of Justice, Equality and Law Reform on the Scheme is available at: <http://www.amnesty.ie/>.

In order that section 59 (and in due course, the other provisions of the Act) can be amended in line with the CRPD, it must reflect and possibly cross reference the proposed new capacity legislation. This was acknowledged by the Department in its 2007 report on the Act.³⁷ Thus, it is imperative that the Mental Capacity Bill be introduced by the Department of Justice, Equality and Law Reform without further delay to facilitate a comprehensive amendment to section 59 of the Act.

Furthermore, introduction of the capacity legislation is urgently called for to clear the way for Ireland's long overdue ratification of the CRPD and its Optional Protocol.

Recommendations:

A Mental Capacity Bill that fulfils Article 12 of the CRPD must be introduced by the Department of Justice, Equality and Law Reform without further delay both to facilitate a comprehensive amendment to section 59 of the Mental Health Act and to clear the way for Ireland's speedy ratification of the CRPD and its Optional Protocol.

The capacity legislation should clarify the interplay between its provisions and the provisions of the Mental Health Act, 2001.

6. Conclusion

AI welcomes the Department's decision to consult with people with mental health problems, their representative organisations and other relevant stakeholders on how the administration of ECT to involuntary patients should be dealt with under the Act. The current situation whereby a person may be administered ECT despite their competent refusal is not acceptable. As set out in detail above, the international human rights framework requires effective safeguards to be put in place to prevent the inappropriate administration of ECT. These provisions should apply to both voluntary and involuntary patients. It is imperative that the Department ensure that any amendment to section 59 includes such safeguards.

In order to properly address the issue of ECT and involuntary treatment generally, it is imperative that the proposed new capacity legislation be introduced without further delay and that the provisions of the Act be amended in light of that legislation. The swift introduction of the capacity legislation is also vital to clear the way for Ireland's overdue ratification of the CRPD.

Section 59 is only one of many aspects of the Act that require urgent review and amendment. For example, section 60 of the Act, which permits the administration of medication to an involuntary patient for a period in excess of

³⁷ The report of the Department's 2007 review states: "The Minister also accepts that the review of mental health legislation is an ongoing process and may need to be revisited in the context of any proposed new capacity legislation or other developments. In addition, the Act must be monitored on an ongoing basis by the Department of Health and Children, in the context of legal challenges and court judgements".

three months where the patient is “*unable or unwilling to give consent*”, also raises serious human rights concerns.

As well as a number of important developments in Ireland, the continued evolution of the international human rights framework necessitates a comprehensive and substantive review of the Act against up to date human rights law and standards. This review needs to be commenced at the earliest opportunity so that it can be completed on schedule by November 2011. In addition it must be carried out in consultation with service users and their representative organisations and other relevant stakeholders, including carers, and health care professionals, as well as relevant nongovernmental organisations, statutory bodies, human rights expertise and international bodies such as the World Health Organisation.

ENDS//

For further information, please contact Mary Forde, Legal Officer (Mental Health), Amnesty International Ireland, First Floor, Ballast House, Westmoreland Street, Dublin 2 (tel: 01 – 8638300; email: mforde@amnesty.ie).