

Mental Health Commission

Code of Practice

Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities

Issued Pursuant to Section 33(3)(e) of the Mental Health Act, 2001.

Disclaimer: This guidance should not be taken as legal advice. The purpose of this publication is to provide guidance to those working in mental health services with people with mental illness and intellectual disabilities. It is not intended to be a complete or authoritative statement on the area.

Published by the Mental Health Commission.

Vision

Working Together for Quality Mental
Health Services

Foreword

The Mental Health Commission was established under the Mental Health Act 2001. As determined by the Act [Section 33(1)], the principal functions of the Commission are *“to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres under this Act.”*

Code of Practice: Guidance for Persons working in Mental Health Services with People with Intellectual Disabilities

This Code of Practice has been prepared by the Mental Health Commission, in accordance with Section 33(3)(e) of the Mental Health Act 2001, whereby the Commission shall:-

“prepare and review periodically, after consultation with such bodies as it considers appropriate, a code or codes of practice for the guidance of persons working in the mental health services”.

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Glossary

Approved Centre

A “centre” means a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder. An “approved centre” is a centre that is registered pursuant to the Mental Health Act 2001. The Mental Health Commission establishes and maintains the register of approved centres pursuant to the Act.

Capacity

Capacity means 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 (See Part 1 and 4 of this code).

Child

A person under the age of 18 years other than a person who is or has been married.

Individual care and treatment plan

The care plan sets the direction for mental health treatment and support, identifies necessary resources and specifies outcomes for the service user. It consists of a documented set of goals collaboratively developed by the service user and the multi-disciplinary team. The care plan is recorded in the one set of documentation.

Intellectual disability

The World Health Organisation (I.C.D.-10) and the American Psychiatric Association’s (D.S.M-IV) diagnostic criteria for an intellectual disability outlines 3 core criteria a person must present with:

- A significant impairment of intellectual functioning
- A significant impairment of adaptive/social functioning
- Onset before adulthood.

Key worker

The person who co-ordinates the delivery of the individual care and treatment plan. The key worker is responsible for keeping close contact with the service user, family/carer and chosen advocate and for advising other members of the multi-disciplinary team of changes in the service user's circumstances.

Mental health problems

The full range of mental health difficulties that might be encountered from the psychological distress experienced by many people, to serious mental disorders and illnesses that affect a smaller population (Vision for Change, 2006).

Mental health service

A service which provides care and treatment to persons suffering from a mental illness or a mental disorder under the clinical direction of a consultant psychiatrist (Mental Health Act 2001, Section 2).

Mental illness

A state of mind of a person which affects the person's thinking, perceiving, emotion or judgment and which seriously impairs the mental function of the person to the extent that he or she requires care or medical treatment in his or her own interest or in the interest of other persons (Mental Health Act 2001, Section 3).

Person-centred service

A person centred service is one which is provided, organised and designed around what is important to the service user from his or her perspective (National Disability Authority, 2005).

Problem behaviours

For the purposes of this code, the term problem behaviours is used to indicate behaviour that is of such frequency, severity or chronicity, as to require clinical assessment and special interventions/support. The behaviour presents significant risks to the health and safety of the

person and /or others, or has a significant negative impact on the person's quality of life or the quality of life of others. Examples of problem behaviours include verbal aggression, physical aggression to self (self-injurious behaviour), others or property (adapted from Royal College of Psychiatrists, 2001).

Restrictive practices

Restrictive practices may include, but are not limited to, the use of mechanical restraint, physical restraint, psychotropic medication as restraint and seclusion.

The 2001 Act

Refers to the Mental Health Act 2001.

Part 1: Introduction

1. Purpose of the Guidance – Why have this guidance?

‘The process of service delivery of mental health services to people with an intellectual disability should be similar to that of every other citizen’

(Department of Health & Children, A Vision for Change, 2006)

Everyone has the right, including a person with intellectual disability, to receive a mental health service in the most appropriate setting for him/her. Since the 1980’s following the rise of the human rights movements and the emergence of self advocacy groups, there has been a growing emphasis and importance accorded to the human rights and in particular, the autonomy of people with intellectual disabilities. People with intellectual disabilities have the same rights as the general population and should be protected by the Constitution, national legislation, and international human rights law as it applies to all persons. However people with intellectual disabilities are a particularly vulnerable group, partly due to issues such as communication difficulties and the limited capacity of some individuals to make decisions for themselves. As a result, they do not always receive the appropriate or adequate mental health care and treatment (Chan et al, 2004). They are also at increased risk of being subjected to restrictive practices such as seclusion and restraint (UN, 2008).

The life expectancy of people with intellectual disabilities has increased in recent times, which has resulted in changing patterns of morbidity and mortality and an increasing recognition of the mental health and general health needs of this part of the population. This guidance has been produced as a result of the desire expressed by many health professionals working with people with mental illness and intellectual disabilities to have advice in relation to the issues presented. It is intended to further support mental health professionals and other professionals with implementation of the Quality Framework for Mental Health Services in Ireland by providing guiding principles and detailed good practice guidance on the important issues presented. The Quality Framework for Mental Health Services was issued by the Commission in 2007. It is a framework comprising of 8 themes and 23 standards for continually improving the quality of mental health services in Ireland.

Four guiding principles are highlighted which it is felt are particularly important when delivering care and treatment to this group: best interests, person-centred approach, the presumption of capacity and least restrictive intervention. The vignettes provided are purely for illustrative purposes designed to encourage and facilitate health professionals to provide care and treatment in line with these guiding principles.

One of the key issues addressed in this code is that of capacity to consent. At the time of publishing this code, there is no statutory definition of capacity in terms of consent. Limited legal safeguards exist in Ireland in relation to the process of decision making and consent for adults who lack capacity or with limited capacity. The primary legal mechanisms that exist are that of wardship and enduring powers of attorney, both of which have come under scrutiny for their shortcomings (Law Reform Commission, 2006). The Government published a Scheme of Mental Capacity Bill 2008 on 5th September 2008 which addresses the definition of capacity and the issues to be considered if a person lacks capacity. The Bill will not be published until the end of 2009 at the earliest and it is anticipated that a number of amendments will be made to it before it is published. In the intervening period, there has been a High Court Judgment of Miss Justice Laffoy, **Fitzpatrick and another -v- F.K. and another [2008 IHEC 104]**. The principles outlined in that case are found in Part 4 of this code.

The code also advocates a person-centred approach to mental health care and treatment and considers care and treatment planning, communication and environmental issues, and the use of restrictive practices. Access to appropriate mental health services is a concern for families, professionals and service providers alike (NDA, 2003). It is also acknowledged that the environment in which people are currently receiving services is often less than ideal. Therefore, this guidance will be of relevance to both policymakers and providers of services so that services can continue moving in a positive direction in terms of appropriate provision of mental health care and treatment in the most appropriate environment and through implementation of the recommendations espoused in the national mental health policy "A Vision for Change" (2006).

The guidance was developed by a multi-disciplinary working group (See Appendix 1) and was informed by good practice guidance in Ireland and other jurisdictions. In developing this guidance, the working group was mindful of the legislative framework within which the guidance was being developed as well as several key publications in existence at the time of preparation of the guidance. The working group took into account several principles enunciated in existing national legislation and publications such as the Mental Health Act 2001, the European Convention on Human Rights Act 2003, the Disability Act 2005, the Education of Persons with Special Educational Needs Act 2004, the Law Reform Commission's (2006) Report on Vulnerable Adults and the Law and the Scheme of Mental Capacity Bill 2008; and international conventions such as the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991), and the Convention on the Rights of Persons with Disabilities¹. The Commission endorses the fundamental principles contained in these important legislative guides (See appendix 2), which it sees as the foundations upon

¹ Ireland has yet to ratify the Convention

which all such guidance should follow. The working group also took account of the policy context including “Quality and Fairness: A Health system for you” (2001), the current national mental health policy A Vision for Change (Department of Health and Children, 2006) and the Quality Framework for Mental Health Services in Ireland (Mental Health Commission, 2007). At the time of development, the Health Information and Quality Authority were also in the process of developing standards for residential services for people with disabilities which have since been published and will no doubt go towards improving the quality and safety of such services.

The Mental Health Commission hopes that this document will stimulate the development of further guidance for those working with this vulnerable group and in particular the enactment of mental capacity legislation. Part 4 of this code may require revision in the event that the much needed legislation is introduced.

2. Scope of the Guidance – Who is it for and who should read this?

- 2.1** This guidance is intended for persons working in mental health services as set out by the Mental Health Act 2001 (Section 33). It is specifically directed at those working in the delivery of a mental health service to people with mental illness and intellectual disabilities. The delivery of a mental health service, regardless of the setting, should always be in accordance with mental health legislation and the guidance of the Mental Health Commission. A “*mental health service*” is defined in the 2001 Act as a service which provides care and treatment to persons suffering from a mental illness or a mental disorder under the clinical direction of a consultant psychiatrist (Mental Health Act 2001, Section 2).
- 2.2** This guidance is applicable to service providers and managers of services where a mental health service is being provided with “*Part 2: Enabling Good Practice through effective Governance*” being considered particularly relevant.
- 2.3** The guidance is not exhaustive. It does however provide advice in clear and simple language on some important issues for which direction has been sought. It is hoped that it will support mental health professionals and other health professionals in their work and enable them to work together on practical issues. (See MHC Discussion paper on multi-disciplinary team working, 2006). It is not concerned with questions of professional judgment which are more appropriately dealt with in a profession’s knowledge base and by professional representative and regulatory bodies.

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- 2.4** It is also for people themselves who have a mental illness and intellectual disabilities and are receiving care and treatment from a mental health service, and their families, carers and advocates so that they can see the manner in which care and treatment should be delivered.

Vignette no. 1*

Mary has a moderate intellectual disability and lives in supported accommodation with three other people with intellectual disabilities. She experiences episodes of depression from time to time and is visited in her accommodation by a Consultant Psychiatrist for care and treatment for her mental health issues.

Mary is receiving a “*mental health service*” as defined by the Mental Health Act because the care and treatment she receives for her mental health issues is under the clinical direction of a Consultant Psychiatrist. This code of practice is therefore relevant to her. The care and treatment she receives for her mental health issues should be in line with the principles and guidance contained in this code.

*This vignette is purely for illustrative purposes

3. Context of the Guidance

- 3.1** The Mental Health Commission acknowledges certain factors impacting on the delivery of mental health services to people with intellectual disabilities:

- ◇ Pathways to access mental health services are often unclear
- ◇ People with intellectual disabilities are more likely to have additional and often more complex health needs
- ◇ People with intellectual disabilities are more likely to have communication difficulties.
- ◇ There is currently no capacity legislation in Ireland and adults with intellectual disabilities have been identified as ‘vulnerable adults’ in relation to consent and capacity issues.

- 3.2** As required by Section 33(3)(e) of the 2001 Act, the Commission shall review codes of practice periodically, after consultation with appropriate bodies. It is intended that this code will be reviewed within 5 years from the date of issue.

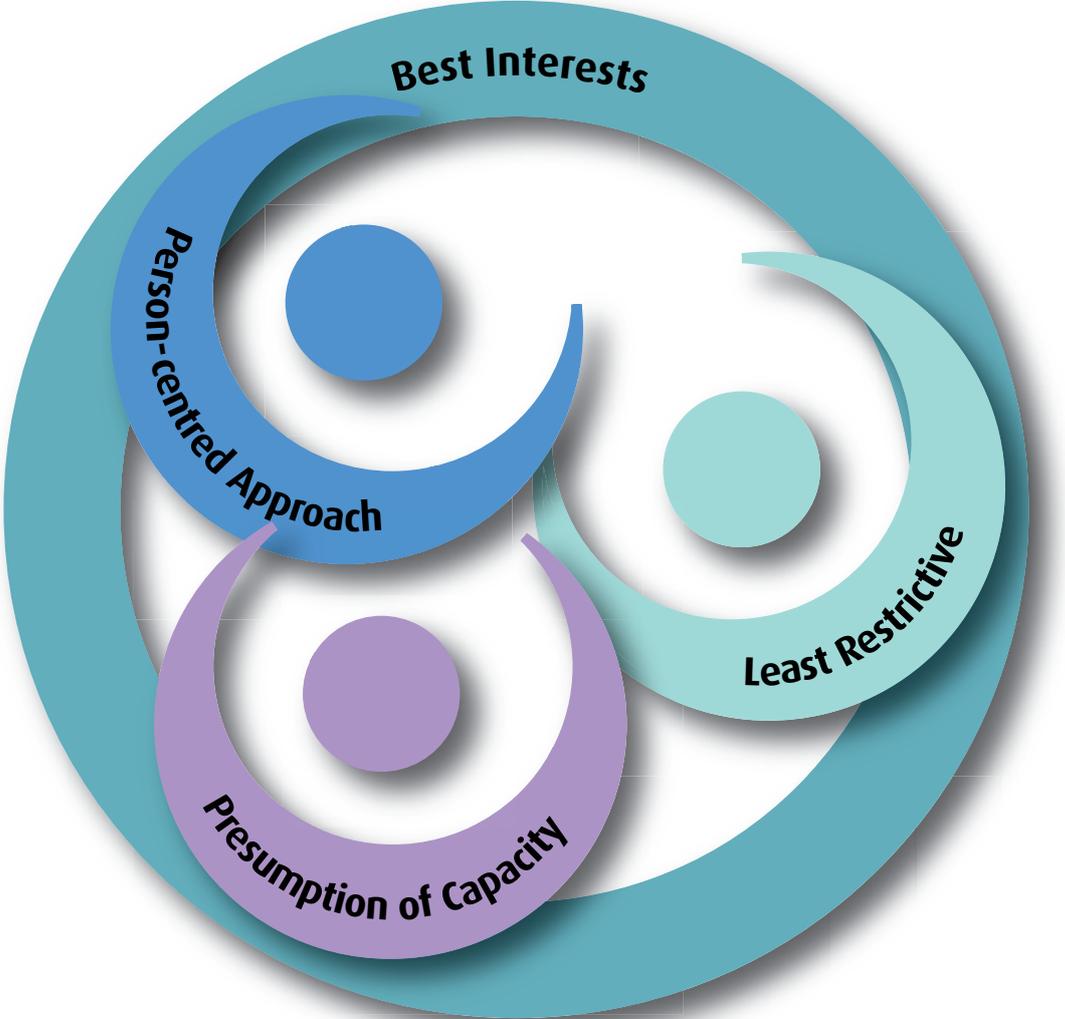
4. Guiding Principles

The guiding principles should at all times be considered when delivering mental health care and treatment to this service user group. The best interests of the person is the principal and overarching consideration which permeates throughout the entire guidance and informs all other principles.

- 4.1** As stated in the Mental Health Act 2001 (Section 4), the **best interests** of the person should be the principal and overarching consideration when making a decision concerning the care or treatment of a person. Due regard should also be given to the interests of other persons who may be at risk of serious harm if the decision is not made. Subsection (2) provides for the statutory duty in relation to any proposal to administer treatment to a person, to properly notify such person of that proposal and to take due account of their representations before making any decision in that regard. Subsection (3) further states that in making a decision concerning care or treatment of a person due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy. This principle should be applied across all mental health services in providing care and treatment to service users.
- 4.2** A **person-centred approach** to care and treatment should be adopted. Interventions should be aimed at maximising recovery from mental illness and building on the resources within the service user and within their immediate social networks to allow them to achieve full and effective participation and inclusion in society.
- 4.3** A person who has reached the age of majority (i.e. 18 years of age) should be **presumed to have full capacity** to make a decision affecting him or her until the contrary is established. Capacity means 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. When determining capacity one should take into consideration the Report of the Law Reform Commission in 2006² and the recent High Court decision of Laffoy J in Fitzpatrick and another -v- F.K. and another (2008) [see Part 4 of this code].
- 4.4** Any intervention employed should be the **least restrictive** to the person's freedom while remaining appropriate to the person's needs and the need to protect the safety of himself/ herself and others.

²Law Reform Commission (2006). Vulnerable Adults and the Law LRC 83-2006.

Figure 1: Guiding Principles



Part 2: Enabling Good Practice through Effective Governance

It is imperative that appropriate governance structures are put in place to enable implementation of this principles and good practice guidance. The ultimate responsibility for governance lies with the Chief Executive Officer and board of the relevant organisation /mental health service.

5. Policies

5.1 Service providers should put in place evidence-based policies and protocols (Standard 8.1 of the Quality Framework for Mental Health Services) and ensure that the principles contained in this code are reflected in these policies and protocols.

5.2 Service providers should ensure that a policy is in place in relation to the delivery of person-centred mental health care and treatment planning³. This policy should include:

- timeframes for assessment, planning, implementation and evaluation of plans
- the roles and responsibilities of multi-disciplinary team members

5.3 a) Service providers should ensure that restrictive practices are only used in the context of a comprehensive policy and procedures on the management of problem behaviours⁴ consistent with the law.

b) Service providers should ensure that the use of restrictive practices in their service is periodically reviewed in accordance with the services' policy. Such reviews should be carried out by an organisational committee or by an independent monitoring group.

5.4 Service providers should ensure that the service's policies are reviewed as required and in any event at least every 3 years.

In addition, the following applies to service providers of mental health services for children with intellectual disabilities and mental illness.

5.5 Child protection policies and procedures should be in place, which are in line with relevant legislation and regulations made thereunder e.g. Child Care Act 1991, Children Act 2001 and Children First Guidelines 1999.

5.6 A policy and procedure should be in place to address appropriate training for staff in relation to child protection.

³ See the Quality Framework for Mental Health Services in Ireland for further guidance on care and treatment planning.

⁴ See glossary for definition

- 5.7** Service providers should ensure that parents and guardians are informed of the service's policies on the management of problem behaviours. A written confirmation of same should be signed by parents or guardians.

6. Education and Training

Education and training should be provided to support the principles and guidance in this code and enable professionals with the effective day to day delivery of mental health care and treatment. The following recommendations are made.

- 6.1** Service providers should ensure that evidence informed education and training, (accredited programmes, where possible), are made available to staff in the following areas:

- person-centred approaches to mental health care and treatment
- relevant human rights principles
- training that focuses on both preventative and responsive strategies to problem behaviours

- 6.2** Service providers should have a policy and procedures for training staff. This policy should include, but is not limited to, the following:

- Induction training for all new staff, including induction training for those new to working with people with intellectual disabilities
- who should receive training based on identified needs of service users and staff
- the areas to be addressed within the training programme with emphasis on areas of mandatory training
- the frequency of training
- identifying appropriately qualified person(s) to give the training
- evaluation of training programmes to ensure they are evidence informed and up to date

7. Inter-Agency Collaboration

- 7.1** Inter-agency collaboration should take place to ensure a smooth transition from one service to another.

- 7.2** Service providers should ensure that a robust communication protocol is in place to ensure appropriate and relevant communication and close liaison with relevant external agencies for people with intellectual disabilities e.g. intellectual disability services.
- 7.3** The key worker⁵ may be ideally placed to facilitate inter-agency collaboration.

⁵ See glossary for definition



Part 3: Person-Centred Approach to Care and Treatment

“People are not simply placed in existing services and expected to adjust, rather the service strives to adjust to the person.” (Routledge and Sanderson, 2001).

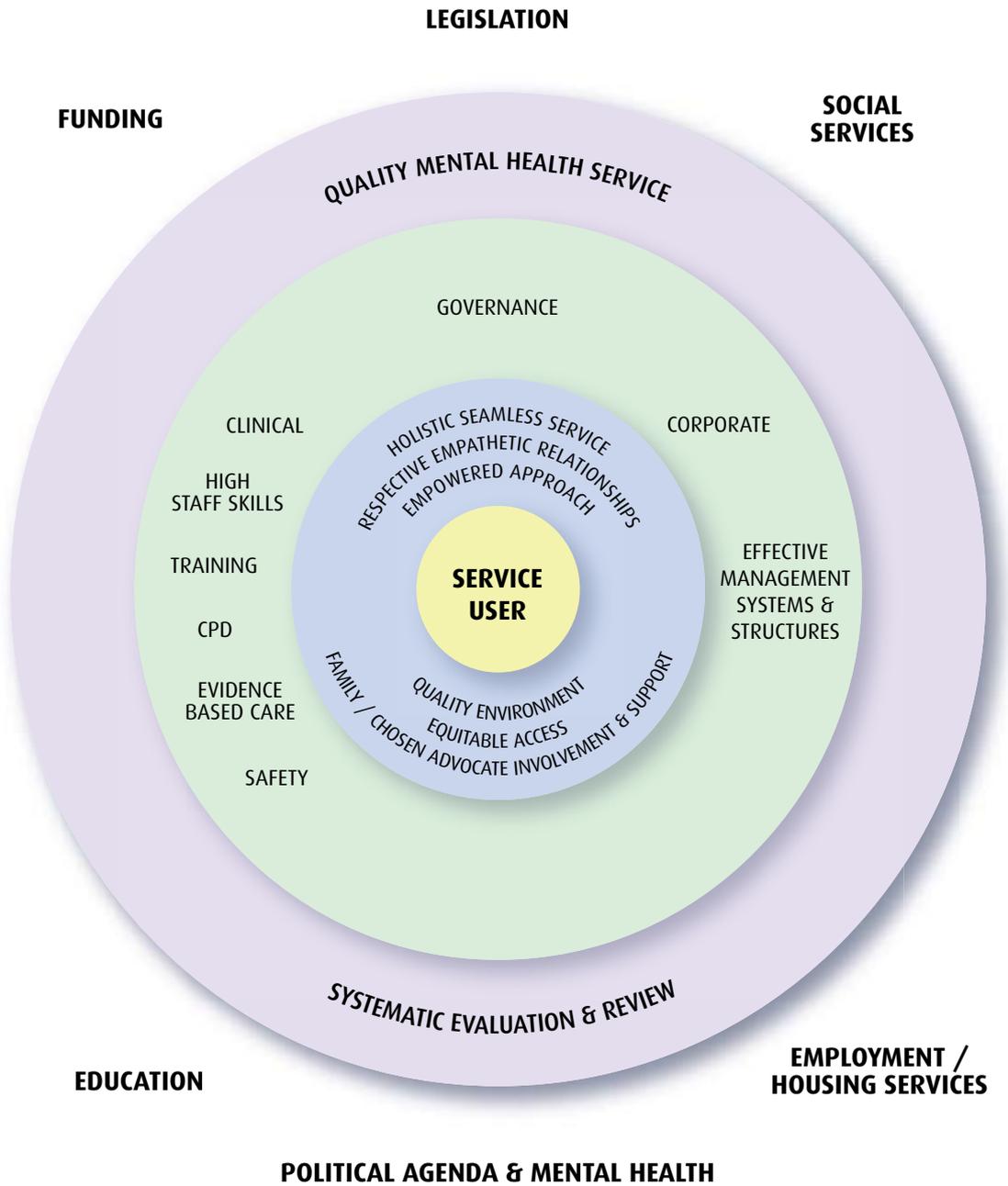
People with intellectual disabilities and mental illness do not constitute a homogenous group. The care and support required by persons with intellectual disabilities can vary depending on a person’s level of ability. Therefore, each person’s needs must be considered using a person centred approach. What is central to achieving a true person centred approach is instilling the awareness of person-centred orientation and person-centred values such as sharing power and self determination.

Interventions should be delivered within a person-centred context, which are aimed at maximising recovery from mental illness and building on the resources within the service user and within his/her immediate social networks to allow him/her to achieve meaningful integration and participation in community life.

One means by which service providers and staff can address the mental health needs of people with intellectual disabilities is within the context of an individual care and treatment plan (See Section 8). Having a mental health care and treatment plan is one of the standards in the Quality Framework for Mental Health Services in Ireland. Such a plan should acknowledge that a person interacts with his/her environment. The plan need not be a stand alone plan but rather may form part of an existing holistic or personal plan that the individual has.

Several key elements have been identified in practice as underpinning person centred planning (NDA, 2005). These include the following: the person is at the centre of his/her plan (See Figure 2) and planning is from that person’s perspective on his or her life, and his or her wishes and needs are taken as the single most important points of reference for the entire planning process. Person-centred planning entails a creative approach to planning which asks *‘what might this mean?’* and *‘what is possible?’* rather than assuming common understandings and limiting itself to what is available. It takes into consideration all the resources available to the person – it does not limit itself to what is available within specialist services, and it requires serious and genuine commitment and cooperation of all participants in the process as it may take considerable time and effort to develop plans that are meaningful for the person let alone begin to realise these plans. Person centred planning is an art – not a science. It is best viewed as an organic, evolving process where time is taken to get to know people and build relationships. It must be borne in mind that a person centred plan is really only of value when a deep-rooted person-centred context has been secured. Furthermore, the development of a plan is not the objective of person centred planning, rather it is about making real, positive differences to someone’s life through actioning and achieving the goals in the plan.

Figure 2: Quality Framework for Mental Health Services in Ireland (2007)



8. Individual care and treatment plan

8.1 Each service user should have an individual mental health care and treatment plan. **Standard 1.1 of the Quality Framework** should be followed in terms of the nature and content of the care and treatment plan developed.

8.2 A **comprehensive assessment** should form the basis of the plan. This may include reference to an Independent Assessment of Need (Disability Act, 2005; Epsen Act, 2004) where one has been carried out. The assessment should include, but is not limited to:

- medical, psychiatric and psychosocial history
- medication history and current medications
- current mental health assessment
- detailed risk assessment
- social, interpersonal and physical environment related issues
- communication difficulties, if not assessed elsewhere
- performance capacities and difficulties, if not assessed elsewhere

8.3 The care and treatment plan should describe the **levels of support and treatment** required to support the service user's journey to recovery, which are in line with the person's assessed needs and in consideration of his/her environment, available resources and supports.

8.4 A **key worker** should be identified within the service to ensure continuity in the implementation of a person's care and treatment plan and close collaboration between services. The key worker should make himself/herself known to the individual and relevant others.

9. Communication Issues

People with intellectual disabilities may have communication difficulties which impact on their comprehension, expression, social communication and literacy skills. Therefore, staff may need to support an individual to communicate using the method of that person's choice. A person may, for example, require assistance to communicate a decision relating to a particular aspect of his/her mental health care or treatment. The following advice is given to assist staff in taking

practical steps to enable a person to communicate his/her decision where communication difficulties are present⁶.

- 9.1** The person's **preferred ways** of receiving and giving information should be established (See example of communication passport overleaf).
- 9.2** It should be agreed **how** the information is given and received. Information should be made **appropriate and accessible**. Non verbal communication approaches such as sign language, picture exchange communication systems and easy to read forms should be provided, where necessary.
- 9.3** The types of **environment** in which the person communicates best should be identified.
- 9.4** The person's **previous experience** of giving and receiving information should be considered.
- 9.5** The **information** the person needs to know, **when** he/she needs to know it, and the rationale for providing such information should be agreed.
- 9.6** A person's **understanding** of the information given should be documented.
- 9.7** It should be decided **who is the best person** to give or receive information.
- 9.8** The **involvement of the person's family, carer or advocate** should be actively encouraged to facilitate communication, particularly for those with reduced decision making capacities.

⁶ Extracted from Rodgers et al (2004)

At a service level, communication for all can be supported by:

- ◇ Using plain language
- ◇ Preparing easy to read summaries of written documents*
- ◇ Using visual and audio formats to aid communication
- ◇ Listening
- ◇ Creating a relaxed environment and allowing adequate time for people to process information and formulate their response.
- ◇ Enabling one to one communication if preferred (National Institute for Mental Health, 2004)

Refer to www.easyinfo.org.uk for more comprehensive guidelines.

* For an example of an easy to read summary of a written document, see University of Birmingham website on medication guideline. www.ld-medication.bham.ac.uk

Example – Communication Passport

Communication Passports are designed to support those who are unable to communicate in a conventional way, so that their preferences and views are expressed through the Communication Passport.

Every individual with intellectual disability and/or mental health issues should have a personalised Communication Passport, relating to all aspects of their life. In this regard, communication passports are often linked in with behaviour support plans and individual care and treatment plans. To ensure best practice, the individual, their family and significant others must be consulted when drawing up a Communication Passport.

The outcome should be:

- ethical
- promote rights and quality of life
- be current and accurate
- be owned by the individual, rather than professionals

Vignette no. 2*

Kevin is a young man with an intellectual disability and concomitant mental health issues. Kevin has much to communicate, but his verbal skills are poorly developed – articulation is unclear and language incoherent. Kevin nonetheless has a strong desire to engage with people, being perceptive and able to tune in to facial expression, attitudes and behaviours. Definite preferences and personality traits have emerged over time. Those advocating on Kevin’s behalf have compiled a Personal Communication Passport entitled “What you should know about Me”, as a safeguard and support for Kevin. The following is a sample of some of the items that have been included in his Communication Passport.

- I get frustrated when my intentions are misunderstood. I want to connect with you, so please be patient and try other approaches.
- Regular contact with my family is essential to my mental well being, help me maintain close links.
- I want to be involved, along with my family, in decision making and future planning.
- My image and how I look are important to me. Allow me to select my own clothes and make colour choices.
- I enjoy the company of other people and especially camaraderie with male staff. Please nurture my sense of humour with jokes and slap stick comedy.
- Some days I feel sad and angry, support me through such times.

Kevin has a complex medical history, so key details of his care and treatment plan such as medication, are also documented in his communication passport. He has been assessed for a high-tech communication aid. In the interim, Kevin has his Communication Passport in place to ensure that his wishes are respected and those close to him supported.

* This vignette is provided purely for illustrative purposes designed to encourage and facilitate health professionals to provide care and treatment in line with the guiding principles.

10. Environmental Considerations

‘A poor fit between the individual’s needs and his/her environment may result in limited opportunities to gain social attention, escape from or avoid excessive demands, gain access to preferred activities or objects, gain alternative forms of sensory feedback, reduce arousal and anxiety by other means, exert control over environment, understand and communicate with the person’ (Royal College of Psychiatrists, 2007, p24-25).

Theme 4 of the Quality Framework for Mental Health Services (2007) talks about a quality physical environment that is appropriate for those accessing mental health services (Figure 3 overleaf). A person centred approach to care and treatment views an individual within his/her environment and looks at the impact of the person’s environment as part of his/her comprehensive assessment. An individual’s social and physical environment can impact on his/her ability to participate, engage and communicate not to mention his/her overall quality of life.

The design of both in-patient and outpatient services is a particularly key issue for persons with mental illness and intellectual disabilities and can be a critical factor in the prevention of problem behaviours. Irish studies have identified the importance of environmental accommodations as a key factor, for example, in the reduction of very severe challenging behaviours and accompanying quality of life enhancement (e.g. McClean, Grey, & McCracken, 2007). The environment in which people with intellectual disabilities are currently receiving mental health services is often less than ideal. Services should however continue moving in the right direction in terms of appropriate provision of mental health care and treatment in the most appropriate environment. Staff perceptions and attitudes can also create environments in which meaningful activities are encouraged. The following environmental factors should be considered by service providers when providing a mental health service to people with intellectual disabilities.

- 10.1** All mental health care and treatment should be provided in the **least restrictive environment** consistent with the person’s needs. This may require a creative and flexible approach to adapt a restrictive environment to meet a person’s needs.
- 10.2** The design of the physical environment should offer maximum opportunity to maintain and improve mental and general health status. The design and layout of environments can reduce the need for restrictive practices (Mental Welfare Commission for Scotland, 2006). Environmental factors to consider include:

- ◇ Access to personal space
- ◇ Temperature
- ◇ Noise levels/acoustics
- ◇ Lighting
- ◇ Orientation aids
- ◇ Sufficient spaces to move including outdoor spaces-enclosed gardens/patios
- ◇ Ease of observation
- ◇ Ratio of people within an environment
- ◇ Opportunities for privacy
- ◇ Safety –avoiding large open spaces, steps and stairs, slippery floors, hard and sharp edges, hard or rough surfaces, things to trip over.

10.3 Environments should create and provide opportunities for **engagement in meaningful activities**.

Figure 3: Theme 4 – Quality Framework for Mental Health Services in Ireland



11. Considering the Use of Restrictive Practices

Many actions by staff consciously or unconsciously can unnecessarily limit the freedom of those for whom care is provided (Mental Welfare Commission for Scotland, 2006). Such limits to freedom can occur through the application of various forms of restrictive practices such as mechanical restraint, physical restraint, psychotropic medication as restraint and seclusion. The use of restrictive practices is often not in the best interests of the person. Furthermore, the evidence base as to the efficacy of some of these practices, for example, physical restraint and seclusion, is weak with evidence that some practices are potentially dangerous having both physical and psychological risks inherent in their use.

Article 40.4.1 of the Constitution explicitly provides for personal liberty:

“No citizen shall be deprived of his personal liberty save in accordance with the law.”

The Commission is strongly of the view that a person must not intentionally or unintentionally be deprived of his/her liberty through the use of restrictive practices except in accordance with the law. Section 69 of the 2001 Act authorised the Commission to develop rules for the use of seclusion and mechanical restraint in approved centre settings. The Commission also issued a code of practice on the use of physical restraint in approved centres under Section 33 of the 2001 Act. The Health Information and Quality Authority have, in addition, developed standards for residential services for people with disabilities, which include standards for behaviour management and the use of restrictive practices in residential centres.

The Commission believes that focus needs to be directed towards preventative measures that eliminate or minimise the use of restrictive practices. Changing the culture of services including staff attitudes and practices can help reduce or eliminate the use of these practices.

When a person's behaviour is such that a restrictive practice is being considered a key focus should be to assess the person and ascertain why the person is acting in the way that is causing concern. The term problem behaviours⁷ is used in this code to refer to behaviours that present significant risk to the health and safety of the person and/or others and require assessment and some form of intervention or support. The Commission acknowledges though that various terms are used in the literature, including challenging, abnormal, aberrant and maladaptive behaviours, to refer to this type of behaviour with no one agreed definition.

Problem behaviours can often be a symptom of some underlying physical or psychological problem. Factors such as physical illness, discomfort or pain, side effects of medication,

⁷ See glossary for definition

psychological distress, poor relationships and incompatibility between the person and his/her carers, other residents and environment all need to be considered. Much problem behaviour is intermittent rather than constant, so it is preferable that staff learn how to anticipate episodes of problem behaviours and defuse the situation, or divert the person into other activities thereby avoiding the need for employing restrictive practices.

Example of Some Factors that may contribute to Problem Behaviours

- Physical illness
- Discomfort or pain
- Side effects of medication
- Psychological distress
- Incompatibility between the person & his/her carers, other residents or environment

11.1 Restrictive practices should only be used where a person poses an **immediate threat of serious harm to self or others**.

11.2 The use of restrictive practices should only be considered as a **last resort** when all alternative interventions to manage the person's problem behaviours have been considered.

11.3 A **multi-disciplinary assessment** should be carried out, where feasible, which looks at both reasons within the person for the problem behaviours as well as service issues that may be contributing to the behaviour. This can include:

- Past assessments of the person
- Risk assessment and risk management plan for the person
- Physical illness, discomfort or pain; effects of drugs; psychological distress
- Environmental factors
- Staffing levels and the approach utilised by staff

The assessment should also attempt to predict and understand **how the person is likely to feel** if a restrictive practice is used. A person should not be restricted in a way that causes greater distress than the original problem.

11.4 Any intervention employed affecting a person's liberty should be the least **restrictive** and safest intervention to manage the situation and should be **in proportion to the risk** posed.

11.5 The use of a restrictive practice should be for **as short a time as possible**.

11.6 Restrictive practices should never be used to ameliorate operational difficulties such as where there are staff shortages or defects in the environment.

Examples of Restrictive Practices*

Restrictive practices may include any direct interference with the movement of a person by:

- Mechanical restraint
- Physical restraint
- Psychotropic medication as restraint; and
- Seclusion

*This is not an exhaustive list

Part 4: Decision making & Capacity to Consent

The issue of capacity is particularly pertinent to people with intellectual disabilities. Enabling adults with intellectual disabilities identified as having reduced capacity to exercise their rights presents a complex problem, highlighting both the vulnerabilities of the persons themselves and those who may make decisions on their behalf.

At the date of publication of the code there is no statutory definition of capacity. The Law Reform Commission (2006) proposes the following legal definition of capacity:

“Capacity means 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. Where a decision requires the act of a third party in order to be implemented, a person is to be treated as not having capacity if he or she is unable to communicate by any means. Any question as to whether a person has capacity shall be decided on the balance of probabilities”.

The Scheme of Mental Capacity Bill 2008 published on 5th September 2008 states that capacity means *“the ability to understand the nature and consequences of a decision in the context of available choices at the time decision is to be made”*. It proceeds to state *“(2) for the purposes of this head a person lacks the capacity to make a decision if he or she is unable –*

- (a) to understand the information relevant to the decision,*
- (b) retain that information,*
- (c) to use or weigh that information as part of the process of making the decision, or*
- (d) to make his or her decision (whether by talking, using sign language or any other means) or, if the decisions requires the act of a third party to be implemented, to communicate by means with that third party.”*

The above mirrors exactly what is in Section 3 of the English Mental Capacity Act, 2005.

The High Court decision of Laffoy J in Fitzpatrick and another -v- FK and another, 2008 considered the test for assessing capacity. An Irish Court had not considered previously how capacity to refuse consent to medical treatment on the part of an adult should be tested. It should be emphasised that the facts in this case did not involve a person with a mental disorder/mental illness or with an intellectual disability. The Court sets out what, in its view, are the principles applicable to the determination of the question of capacity.

- “1. There is a presumption that an adult patient has the capacity, that is to say, the cognitive ability, to make a decision to refuse treatment, but that presumption can be rebutted.*

2. *In determining whether a patient is deprived of capacity to make a decision to refuse medical treatment whether –*
 - (a) *by reason of permanent cognitive impairment; or*
 - (b) *temporary factors...*

3. *The three stage approach to the patient’s decision – making process adopted in the C case [Re. C. [1994] 1 ALL ER 819] is a helpful tool in applying that test. The patient’s cognitive ability will have been impaired to the extent that he or she is incapable of making the decision to refuse the proper treatment if the patient –*
 - (a) *has not comprehended and retained the treatment information and, in particular, has not assimilated the information as to the consequences likely to ensue from not accepting the treatment;*
 - (b) *has not believed the treatment information and, in particular, if it is the case that not accepting the treatment is likely to result in the patient’s death, has not believed that outcome is likely; and*
 - (c) *has not weighed the treatment information, in particular, the alternative choices and the likely outcomes, in the balance of arriving at the decision.*

4. *The treatment information by reference to which the patient’s capacity is to be assessed is the information which the clinician is under a duty to impart – information as to what is the appropriate treatment, that is to say, what a treatment is medically indicated, at the time of the decision and the risks and consequences likely to flow from the choices available to the patient in making the decision.*

5. *In assessing capacity it is necessary to distinguish between misunderstanding or misperception of the treatment information in the decision-making process (which may sometimes be referred to colloquially as irrationality) on the one hand, and an irrational decision or decision made for irrational reasons, on the other hand. The former may be evidence of lack of capacity. The latter is irrelevant to the assessment.*

6. *In assessing capacity, whether at the bedside in a high dependency unit or in court, the assessment must have regard to the gravity of the decision, in terms of the consequences which are likely to ensue from the acceptance or rejection of the proffered treatment. In the private law context this means that, in applying the civil law standard of proof, the weight to be attached to the evidence should have regard to the gravity of the decision, whether that is characterised as the necessity for “clear and convincing proof” of an enjoinder that the Court “should not draw its conclusions lightly”.*

Laffoy J refers in her conclusion to the *“the implementation of the recommendations of the Law Reform Commission in legislative form...”*. Elsewhere the Court noted that the views of the Law Reform Commission were consistent with the views of certain English cases, which the Court sought to rely upon.

The Mental Health Act 2001 provides the legal framework for the process of involuntary admission to approved centres (Part 2) and provisions for consent to treatment for those involuntarily admitted (Part 4). However, according to the Irish College of Psychiatrists (2001), many people with intellectual disabilities accessing mental health services are *‘neither voluntarily or compulsorily detained within their residential centres and have no capacity to give informed consent to any type of medical or psychiatric intervention and between thirty to fifty percent are on psychotropic medication without consenting to same’*. The National Disability Authority more recently re-iterated a similar viewpoint: *“the vast majority of individuals with intellectual disabilities who reside in community accommodation, and who also may be receiving medication or other psychiatric treatment to which they have not had the capacity to consent, are “de facto detained” and are not subjected to any formal independent monitoring”* (2003 p34, cited in A Vision for Change, 2006).

This situation is further compounded by the present lack of mental capacity legislation in Ireland and the fact we have no statutory definition of capacity. Every adult has the right to make his or her own decisions. However, not all adults are able to make decisions on their own. The current legal framework for supported or substitute decision-making in Ireland on behalf of those who may lack capacity is limited in its approach with the majority of persons admitted to Wardship having senile dementia or some other mental infirmity associated with old age (Law Reform Commission, 2003). This leaves adults with mental illness and intellectual disabilities who have reduced capacity exposed and without appropriate legal safeguards when issues of capacity and consent to mental health care and treatment present. The recent High Court decision of Laffoy J provides some guidance on how these matters might be determined by the Courts.

The Mental Health Commission has attempted to assist with this complex area (in the absence of relevant legislation and in anticipation that it will be brought into law next year) by providing some practice guidance in the area of decision making and capacity to consent to care and/or treatment for adults with mental illness and intellectual disabilities. The Mental Health Commission supports the implementation of the Law Reform Commission’s proposed legislative framework (Law Reform Commission, 2006) and the approach they outlined in the proposed legislation. The Mental Health Commission similarly believes that emphasis should be placed on capacity rather than lack of capacity and enabling decision making through the provision of appropriate support rather than restricting it. It is important to remember that people with

decision making difficulties *'should not be expected to make better or wiser decisions than anyone else'*. With the continuing absence of capacity legislation, the protection alongside the promotion of the rights of vulnerable adults in our society will remain a challenge for mental health services.

12. Main Recommendations

- 12.1 The presumption of capacity:** every adult should be presumed to have capacity to make a decision affecting him/her unless the contrary is established.
- 12.2** If a person's capacity is in doubt, **an assessment of capacity** should be carried out and documented (See Assessing Capacity – Some Important Points). A clear, transparent method of assessing capacity should be used that promotes the facilitation of people to use the decision making capabilities they have.
- 12.3** A **functional approach** to assessing a person's capacity to make choices regarding his/her treatment within mental health services should be adopted. This is where capacity is determined following an *'issue specific'* and *'time specific'* assessment of a person's decision-making ability. This approach is related to the person's ability to make a particular decision at the time it is to be made. The more important the decision, the more thorough the assessment of capacity to make such a decision should be.
- 12.4** A person should be given **assistance** to make his/her own decisions where possible.
- 12.5 Advocacy services** should be made available to service users to facilitate the decision-making process.
- 12.6 Family and carers** should be involved as advocates for a person with reduced decision making capacity. However family, carers and advocates have **no automatic legal authority** to make decisions on behalf of adults with mental illness and intellectual disabilities.
- 12.7** The more important the decision, the **wider the consultation**, where appropriate, on what might be in the person's best interests.
- 12.8** Before an act is carried out or the decision made, regard should be had as to whether the purpose for which it is needed can be as effectively achieved in a way that is **less restrictive** to the person's right and freedom of action.

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- 12.9** A person should not be treated as unable to make a decision merely because he/she makes an **unwise or unconventional decision**.

13. Assessing Capacity – Some Important Points*

- ◇ Does the person understand in simple language what the proposed care and/or treatment is, its purpose and nature and why it is being proposed
- ◇ Can the person understand the main benefits, risks and possible alternatives, and consequences of not receiving the proposed care and/or treatment
- ◇ Can the person retain the information for a sufficient period of time in order to consider it and arrive at a decision
- ◇ Does the person believe the care/treatment information given
- ◇ Can the person communicate his/her decision

* The above is not a comprehensive note of matters to be taken into consideration

Extracted in part from the Reference Guide to the Mental Health Act, 2001 (Mental Health Commission, 2005)

Vignette no. 3

Amended and reproduced with the kind permission of the British Psychological Society.
BPS (2006) Assessment of Capacity in Adults: Interim guidance for Psychologists

Background information

Sean was referred to the Psychology Services for People with Learning Disabilities by a Community Nurse from the Community Team for People with Learning Disabilities. Sean lived alone in warden-supported accommodation and received support from community-based services (10 hours per week). The Community Nurse requested support in establishing whether Sean was able to make a decision about receiving medical treatment (the application of two different types of creams to his legs). Although Sean was generally happy for staff to apply this medication, he had on occasion refused to accept this support. The Community Nurse reported that this refusal had a cyclical nature. Whilst Sean's legs were healed he refused medication. However, refusal to accept medication resulted in open sores developing rapidly, leading to infection and, on one occasion, hospitalisation. Sean would then accept the need for medication and his legs would heal. It was felt that this behaviour could ultimately be life threatening. Support workers reported Sean becoming verbally and physically aggressive towards them whilst they were supporting him to accept his medication. In order to take a view as to Sean's capacity to make this decision regarding his health the following steps were taken:

- A. Interview with the client, psychometric/skills-based assessments (Wechsler Adult Intelligence Scale III, Wechsler, 1999, Vineland Adaptive Behaviour Scales, Sparrow, 1984), Speech and Language therapy assessment.
- B. Multi-disciplinary meeting (as part of a Risk Taking Planning Process) which involved a discussion about client's ability to understand and comprehend the nature of the proposed treatment including the consequences of no treatment.
- C. Decision taken regarding his capacity to make a decision about medical treatment.
- D. Review date set.

Assessment process

Ability to understand the information relevant to the decision and to use and or weigh that information as part of the process of making a decision.

This was assessed using the notion of vignettes (Arscott, 1999). A brief description of the situation was presented to Sean. This included the following information: that he was required to use two different types of creams on his feet and legs due to a skin condition called eczema: what would happen if he stopped taking this medication (i.e. open sores would develop, become infected); and what would happen if he continued to allow staff to apply the medication.

This short paragraph was read to Sean who then answered a series of questions, for example:

Q: 'What would happen if your creams were not applied to you on a daily basis?'

A: 'My legs will flare up.'

Sean was also able to describe to the psychologist the result of not taking the medication for his legs (i.e. he would be hospitalised).

Retention of the information

The psychologist visited Sean one week later and the same questions were put to Sean. He appeared able to understand the information regarding his medical condition and his medication. He was aware of the consequences that he may face should he not accept his medication on a daily basis.

Ability to communicate the decision

In this case example Sean was able to communicate well and showed a full understanding of the issues presented. It was, therefore, not necessary to choose other means (e.g. pictures or the process of modelling a behaviour) to explain the situation. The Speech and Language Therapy Service reported on Sean's level of verbal comprehension and expression. The assessment suggested that he was able to understand sentences containing more than three information carrying words. The assessment concluded that information did need to be presented in simple sentences using literal terms.

Multi-disciplinary discussion

The assessment of a person's capacity to make a decision about medical treatment took place as part of a wider Risk Taking Planning Procedure. The results of the information gathering process were presented at a multidisciplinary Risk Taking Planning Review meeting. In accordance with best practice the group considered Sean's ability to understand and retain information and his ability to appreciate the consequences of both accepting the medication and not accepting the medication. The group also considered the evidence of ability to reason and manipulate relevant information (i.e. weigh up the risks and benefits of different options). Finally the group considered what Sean was actually saying about what he wanted to happen. The group's view was that Sean did appear to understand the information regarding his medical condition and the fact that the medication was necessary to prevent this condition becoming serious. He was aware of the consequences that he may face should he not take the medication on a daily basis. The group questioned whether Sean really did understand the information presented or if he merely had a good memory and repeated 'parrot fashion' what he felt people wanted to hear (i.e. acquiescence). Continued support and discussion with Sean on a casual basis may help provide further support for the group's decision.

The group considered if there was any reason for Sean's refusal to accept medicated creams. He was unable to explain the reason even though he was able to state the consequences of his actions. He had not expressed a dislike for particular staff or a preference to apply the medication himself. The application of medication did not delay or prevent Sean from doing something that he liked.

The group concluded that Sean did have the capacity to understand the nature and consequences of his proposed treatments. He was able to make a decision about the application of creams to his legs. Therefore, if he did refuse treatment staff should accept his decision. The group also noted that because of the cyclical nature of the issue, if Sean did refuse medication, and his legs became infected, he was likely to accept medication again, if support continued on a regular basis. Staff agreed to continue to encourage Sean to use the medicated creams. Photographs (with his permission) of his infected legs would be used to remind Sean of what happened when he did not accept his medication.

Review date

A review date was set.

* This vignette is provided purely for illustrative purposes designed to encourage and facilitate health professionals to provide care and treatment in line with the guiding principles.

References

Available on request.



Appendices

Appendix 1 – Working Group Members

The following are the members of the working group who developed this document.

Mr. Michael Kelly	Chair of Group	Higher Education Authority
Mr. Paul Alford	Service User Perspective	Inclusion Ireland
Ms. Michelle Bergin	Senior Occupational Therapist	Association of Occupational Therapists of Ireland
Mr. Brendan Broderick	Nominated representative	National Federation of Voluntary Bodies
Ms. Caroline Cannon	Senior Social Care Worker	Irish Association of Social Care Workers
Mr. Gerry Cobbe	Director of Nursing	HSE Nominee
Dr. Mary Davis	Principal Psychologist	Psychological Society of Ireland
Dr. Philip Dodd	Consultant Psychiatrist	Irish College of Psychiatrists
Ms. Bríd Leahy	Principal Social Worker	Irish Association of Social Workers
Mr. Gerry Raleigh	General Manager	HSE management representative
Ms. Annie Ryan	Carer Perspective	Inclusion Ireland
Dr. Mary Staines	Clinical Director	Irish College of Psychiatrists
Ms. Olive Potterton	Speech and Language Therapist	Irish Association of Speech and Language Therapists
Ms. Patricia Gilheaney	Director Standards & Quality Assurance	Mental Health Commission
Ms. Lisa O'Farrell	Policy Officer	Mental Health Commission

Appendix 2 – Principles

The Commission endorses the fundamental principles contained in the following important legislative guides.

Mental Health Act 2001, Section 4

- 4.-(1) In making a decision under this Act concerning the care or treatment of a person (including a decision to make an admission order in relation to a person), the best interests of the person shall be the principal consideration with due regard being given to the interests of other persons who may be at risk of serious harm if the decision is not made.*
- (2) Where it is proposed to make a recommendation or an admission order in respect of a person, or to administer treatment to a person, under this Act, the person shall, so far as is practicable, be notified of the proposal and be entitled to make representations in relation to it and before deciding the matter due consideration shall be given to any representations duly made under this subsection.*
- (3) In making a decision under this Act concerning the care or treatment of a person (including a decision to make an admission order in relation to a person) due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy.*

Scheme of Mental Capacity Bill 2008, Head 1 Guiding principles of this Act

The following principles apply for the purposes of this Act and every person (including the court concerned in the implementation of the Act or in making any decision, declaration or order or giving any direction under the Act shall have regard to them:

- (a) it shall be presumed unless the contrary is established that a person has capacity,*
- (b) no intervention is to take place unless it is necessary having regard to the needs and individual circumstances of the person, including whether the person is likely to increase or regain capacity,*

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- (c) *a person shall not 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,*
 - (d) *a person is not to be treated as unable to make a decision merely because he or she makes an unwise decision,*
 - (e) *any act done or decision made under this Act must be done or made in the way which is least restrictive of the person's rights and freedom of action,*
 - (f) *due regard must be given to the need to respect the right of a person to his or her dignity, bodily integrity, privacy and autonomy,*
 - (g) *account must be taken of a person's past and present wishes, where ascertainable,*
 - (h) *account must be taken of the views of any person with an interest in the welfare of a person who lacks capacity, where these views have been made known, and*
 - (i) *any act done or decision made under this Act for or on behalf of a person who lacks capacity must be done or made in his or her best interests.*

UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care

Principle 1

Fundamental freedoms and basic rights

1. *"All persons have the right to the best available mental health care, which shall be part of the health and social care system.*
2. *All persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person.*
3. *All persons with a mental illness, or who are being treated as such persons, have the right to protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment.*

5. *Every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights as recognized in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, and in other relevant instruments, such as the Declaration on the Rights of Disabled Persons and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment”.*

Principle 8

Standards of care

1. *“Every patient shall have the right to receive such health and social care as is appropriate to his or her health needs, and is entitled to care and treatment in accordance with the same standards as other ill persons.*
2. *Every patient shall be protected from harm, including unjustified medication, abuse by other patients, staff or others or other acts causing mental distress or physical discomfort”.*

Principle 9

Treatment

1. *“Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient’s health needs and the need to protect the physical safety of others.*
2. *The treatment and care of every patient shall be based on an individually prescribed plan, discussed with the patient, reviewed regularly, revised as necessary and provided by qualified professional staff.*
3. *Mental health care shall always be provided in accordance with applicable standards of ethics for mental health practitioners, including internationally accepted standards such as the Principles of Medical Ethics adopted by the United Nations General Assembly. Mental health knowledge and skills shall never be abused.*
4. *The treatment of every patient shall be directed towards preserving and enhancing personal autonomy”.*

Principle 11

Consent to treatment

1. *No treatment shall be given to a patient without his or her informed consent, except as provided for in paragraphs 6, 7, 8, 13 and 15 below.*
2. *Informed consent is consent obtained freely, without threats or improper inducements, after appropriate disclosure to the patient of adequate and understandable information in a form and language understood by the patient on:*
 - (a) *The diagnostic assessment;*
 - (b) *The purpose, method, Likely duration and expected benefit of the proposed treatment;*
 - (c) *Alternative modes of treatment, including those less intrusive; and*
 - (d) *Possible pain or discomfort, risks and side-effects of the proposed treatment.*
3. *A patient may request the presence of a person or persons of the patient's choosing during the procedure for granting consent.*
4. *A patient has the right to refuse or stop treatment, except as provided for in paragraphs 6, 7, 8, 13 and 15 below. The consequences of refusing or stopping treatment must be explained to the patient.*
5. *A patient shall never be invited or induced to waive the right to informed consent. If the patient should seek to do so, it shall be explained to the patient that the treatment cannot be given without informed consent.*
6. *Except as provided in paragraphs 7, 8, 12, 13, 14 and 15 below, a proposed plan of treatment may be given to a patient without a patient's informed consent if the following conditions are satisfied:*
 - (a) *The patient is, at the relevant time, held as an involuntary patient;*
 - (b) *An independent authority, having in its possession all relevant information, including the information specified in paragraph 2 above, is satisfied that, at the relevant time, the patient lacks the capacity to give or withhold informed consent to the proposed plan of treatment or, if domestic legislation so provides, that, having regard to the*

patient's own safety or the safety of others, the patient unreasonably withholds such consent; and

(c) The independent authority is satisfied that the proposed plan of treatment is in the best interest of the patient's health needs.

- 7. Paragraph 6 above does not apply to a patient with a personal representative empowered by law to consent to treatment for the patient; but, except as provided in paragraphs 12, 13, 14 and 15 below, treatment may be given to such a patient without his or her informed consent if the personal representative, having been given the information described in paragraph 2 above, consents on the patient's behalf.*
- 8. Except as provided in paragraphs 12, 13, 14 and 15 below, treatment may also be given to any patient without the patient's informed consent if a qualified mental health practitioner authorized by law determines that it is urgently necessary in order to prevent immediate or imminent harm to the patient or to other persons. Such treatment shall not be prolonged beyond the period that is strictly necessary for this purpose.*
- 9. Where any treatment is authorized without the patient's informed consent, every effort shall nevertheless be made to inform the patient about the nature of the treatment and any possible alternatives and to involve the patient as far as practicable in the development of the treatment plan.*
- 10. All treatment shall be immediately recorded in the patient's medical records, with an indication of whether involuntary or voluntary.*
- 11. Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient's medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient.*
- 12. Sterilization shall never be carried out as a treatment for mental illness.*

13. *A major medical or surgical procedure may be carried out on a person with mental illness only where it is permitted by domestic law, where it is considered that it would best serve the health needs of the patient and where the patient gives informed consent, except that, where the patient is unable to give informed consent, the procedure shall be authorized only after independent review.*
14. *Psychosurgery and other intrusive and irreversible treatments for mental illness shall never be carried out on a patient who is an involuntary patient in a mental health facility and, to the extent that domestic law permits them to be carried out, they may be carried out on any other patient 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.*
15. *Clinical trials and experimental treatment shall never be carried out on any patient without informed consent, except that a patient who is unable to give informed consent may be admitted to a clinical trial or given experimental treatment, but only with the approval of a competent, independent review body specifically constituted for this purpose.*
16. *In the cases specified in paragraphs 6, 7, 8, 13, 14 and 15 above, the patient or his or her personal representative, or any interested person, shall have the right to appeal to a judicial or other independent authority concerning any treatment given to him or her.*

Principle 12

Notice of rights

1. *“A patient in a mental health facility shall be informed as soon as possible after admission, in a form and a language which the patient understands, of all his or her rights in accordance with these Principles and under domestic law, which information shall include an explanation of those rights and how to exercise them.*
2. *If and for so long as a patient is unable to understand such information, the rights of the patient shall be communicated to the personal representative, if any and if appropriate, and to the person or persons best able to represent the patient’s interests and willing to do so.*

3. *A patient who has the necessary capacity has the right to nominate a person who should be informed on his or her behalf, as well as a person to represent his or her interests to the authorities of the facility”.*

European Convention on Human Rights Act 2003

Article 3

Prohibition of torture

No one shall be subjected to torture or to inhuman or degrading treatment or punishment.

Article 5

Right to liberty and security

1. *Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:*
 - a) *the lawful detention of a person after conviction by a competent court;*
 - b) *the lawful arrest or detention of a person for non-compliance with the lawful order of a court or in order to secure the fulfilment of any obligation prescribed by law;*
 - c) *the lawful arrest or detention of a person effected for the purpose of bringing him before the competent legal authority on reasonable suspicion of having committed an offence or when it is reasonably considered necessary to prevent his committing an offence or fleeing after having done so;*
 - d) *the detention of a minor by lawful order for the purpose of educational supervision or his lawful detention for the purpose of bringing him before the competent legal authority;*
 - e) *the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants;*
 - f) *the lawful arrest or detention of a person to prevent his effecting an unauthorised*

entry into the country or of a person against whom action is being taken with a view to deportation or extradition.

2. *Everyone who is arrested shall be informed promptly, in a language which he understands, of the reasons for his arrest and of any charge against him.*
3. *Everyone arrested or detained in accordance with the provisions of paragraph 1.c of this article shall be brought promptly before a judge or other officer authorised by law to exercise judicial power and shall be entitled to trial within a reasonable time or to release pending trial. Release may be conditioned by guarantees to appear for trial.*
4. *Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.*
5. *Everyone who has been the victim of arrest or detention in contravention of the provisions of this article shall have an enforceable right to compensation.*

Convention on the Rights of Persons with Disabilities

Article 3 – General principles

The principles of the present Convention shall be:

- a. *Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;*
- b. *Non-discrimination;*
- c. *Full and effective participation and inclusion in society;*
- d. *Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;*
- e. *Equality of opportunity;*
- f. *Accessibility;*
- g. *Equality between men and women;*
- h. *Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.*









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