Mental health policies and laws on the island of Ireland


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Abstract

This Working Paper provides a critical review of key policies, laws and institutional arrangements in the area of mental health in Northern Ireland and Ireland. This is done in order to map key similarities and differences as between the two jurisdictions. Drawing on the findings from such a review, it is suggested it would be useful to develop a joint research agenda in mental health policy and law as between the two jurisdictions. Key priorities for such agenda include developing an agreed common mental health dataset; facilitating approaches to support autonomy and reduce the need for compulsory intervention; examining the current laws and mental health service provision applicable to children and young people; and evaluating the implementation of new capacity-based laws in both jurisdictions. The development of such an agenda could provide a basis for considering what this might mean in relation to a potential shift over time towards greater alignment or integration, which would necessarily be informed by broader political developments on the island of Ireland.

Keywords

mental health, mental health policies, mental health laws, mental health policies, Northern Ireland, Ireland, island of Ireland
MENTAL HEALTH POLICIES AND LAWS ON THE ISLAND OF IRELAND

WORKING PAPER

Anne-Maree Farrell, Gavin Davidson, Mary Donnelly, Elizabeth Agnew,
Trisha Forbes and Rhiannon Frowde¹

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<tr>
<td>ADMCA</td>
<td>Assisted Decision-Making (Capacity) Act 2015</td>
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<td>AHD</td>
<td>Advance Healthcare Directives (Ireland)</td>
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<td>AVFC</td>
<td>A Vision for Change</td>
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<tr>
<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
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<td>CMHT</td>
<td>Community Mental Health Teams (Ireland)</td>
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<td>CRC</td>
<td>Convention on the Rights of the Child</td>
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<td>CRPD</td>
<td>Convention on the Rights of Persons with Disabilities</td>
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<td>DoLS</td>
<td>Deprivation of Liberty Safeguards (Northern Ireland)</td>
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<td>DSS</td>
<td>Decision Support Service (DSS) (Ireland)</td>
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<tr>
<td>ECHR</td>
<td>European Convention on Human Rights</td>
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<td>EU</td>
<td>European Union</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>GFA</td>
<td>Good Friday Agreement</td>
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<tr>
<td>GHQ</td>
<td>General Health Questionnaire (Northern Ireland)</td>
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<td>HIQA</td>
<td>Health Information and Quality Authority (Ireland)</td>
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<td>HSC</td>
<td>Health and Social Care (Northern Ireland)</td>
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<td>HSE</td>
<td>Health Service Executive (Ireland)</td>
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<td>MCANI</td>
<td>Mental Capacity Act (Northern Ireland) 2016</td>
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<td>MHA</td>
<td>Mental Health Act 2001 (Ireland)</td>
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<td>MHC</td>
<td>Mental Health Commission (Ireland)</td>
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<td>MHO</td>
<td>Mental Health (Northern Ireland) Order 1986</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NI</td>
<td>Northern Ireland</td>
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<td>NICCYP</td>
<td>NI Commissioner for Children and Young People</td>
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<td>NICO</td>
<td>Children (Northern Ireland) Order 1995</td>
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<td>NIGALA</td>
<td>Northern Ireland Guardian Ad Litem Agency</td>
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<td>NI PHA</td>
<td>Northern Ireland Public Health Agency</td>
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<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
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<tr>
<td>PCC</td>
<td>Patient and Client Council</td>
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<tr>
<td>PTSD</td>
<td>Post-Traumatic Stress Disorder</td>
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<td>RQIA</td>
<td>Regulation and Quality Improvement Authority (Northern Ireland)</td>
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<td>TUSLA</td>
<td>The Child and Family Agency (Ireland)</td>
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<td>UK</td>
<td>United Kingdom</td>
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<td>UNICEF</td>
<td>United Nations International Children’s Emergency Fund</td>
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Part I: Summary and Key Themes

1. This Working Paper provides a critical overview of key policies, laws and institutional arrangements in the area of mental health in Northern Ireland (NI) and Ireland. The objectives in doing so are two-fold: first, to map key similarities and differences as between the two jurisdictions; and second, to provide a basis for considering what this might mean in terms of a shift towards greater alignment or integration in the medium to longer term. In doing so, we recognise that consideration of any such options would necessarily be informed by broader political developments on the island of Ireland.

Part II: Political, Jurisdictional and Healthcare Context

2. The island of Ireland comprises two separate states: NI and Ireland. NI is a devolved nation of the United Kingdom (UK), comprising six counties in the North-East of the island of Ireland. It was established in 1921, following the creation of two separate jurisdictions on the island. It was originally envisaged on the part of British political leaders at the time that both jurisdictions would remain within what was then known as the UK of Great Britain and Ireland. However, demands for political and territorial independence subsequently led to the Irish War of Independence against British rule, which was brought to an end through the signing of the Anglo-Irish Treaty in 1921. The Treaty provided the formal basis for the founding of the Irish Free State in 1922, which subsequently became the Republic of Ireland in 1949 (Ireland).

3. Although originally founded in 1921, NI’s constitutional status, including whether it should remain part of the UK or form part of a united Ireland, remains contested. It was one of the factors in a violent sectarian conflict, commonly known as The Troubles, which lasted for over twenty-five years in the twentieth century. Although the conflict formally ended with the signing of the Good Friday Agreement (GFA) in 1998, NI power-sharing institutions have remained fragile, collapsing on successive occasions, resulting in the re-imposition of direct rule by the UK government. Political tensions persist over the border question on the island, which has been recently exacerbated due to the UK’s decision to leave the European Union (EU), colloquially known as Brexit. With Ireland being an EU Member State, the border separating the two jurisdictions on the island of Ireland is also now the only land border separating the EU and the UK. This has led to NI continuing to be subject to EU regulation of customs and the movement of goods as a result.

4. Cross-jurisdictional arrangements exist under the GFA to facilitate increased exchange and cooperation as between the Irish and NI governments in relation to health and social care. However, they have not operated effectively to date. One of the consequences of this lack of sustained cross-border engagement has been to impede the development of a shared public understanding of both the similarities and differences between the respective health and social care systems on the island of Ireland. This is regrettable given that both have much in common with respect to organisation, funding, policies and laws.

5. Although there is a greater role played by private health insurance in Ireland, both jurisdictions operate predominantly publicly funded health services, which are overseen by the Health Service Executive (HSE) in Ireland and Health and Social Care (HSC) in NI. Both have similar longstanding problems with the funding and sustainability of their health and social care systems, exacerbated by under-investment, poor workforce retention, long waiting lists and a reluctance to engage in much needed institutional and funding reform. While there is a greater degree of subsidisation (or free of charge) of primary care, prescriptions and dental care in NI, subsidisation also takes place in the Irish health service, albeit targeted to designated vulnerable populations. A key point...
of difference that is often highlighted is the fact that no payment is made to attend a general practitioner in NI, in contrast to the position in Ireland.

6. In both NI and Ireland, there is integration of health and social care, although the extent of such integration is much greater in NI and more limited in Ireland. In relation to NI, there has been formal integration of health and social care in policy and legal terms since 1972. From 1st April 2022, the Strategic Planning and Performance Group, in the Department of Health, takes over responsibility for commissioning services from the Health and Social Care Board which closed on 31st March 2022. The Strategic Planning and Performance Group commissions all health and social care services, from a mix of statutory (the five HSC Trusts), voluntary and private providers. In recent times, there has been a shift towards funding longer term social care needs. Access to some social care services, such as residential and nursing home care, is subject to means testing and there is currently a public consultation on a range of adult social care reforms. The general policy direction since 1990 has been to promote community services with increased individual involvement and choice in care planning although in practice the available options are often limited.

7. In Ireland, the HSE focuses on the provision of social care services predominantly for older persons and those with disabilities. Other social care services are provided by a range of community, residential and rehabilitative organisations, funded by a mix of individual voluntary payments and grant aid by the HSE. There are long waiting lists for access to a range of social care services, in particular disability assessments involving children. In both NI and Ireland, access to fully funded nursing and residential care services remain subject to means testing, involving a mix of public, voluntary and private sector providers.

8. In public health, the Institute of Public Health, established in 1998, has made some progress by better informing policy in Ireland and Northern Ireland, but high level, consistent cross-jurisdictional co-operation has been limited. This changed to some degree due to inter-governmental agreement on facilitating cross-border co-operation during the COVID-19 pandemic, which in turn facilitated interactions at institutional and professional levels. Long-standing political (and sectarian) divisions over the border question on the island have impeded the development of all-island institutional jurisdictional support structures and co-operation in health and social care, notwithstanding existing legal mechanisms to do so under the GFA.

Part III: Mental Health Policies

9. There are difficulties in obtaining current data on levels of mental ill-health in both NI and Ireland. What data is available points to significant levels of identified mental health problems on the island of Ireland. There is a disproportionate impact on young people, in particular young women, with those living in the most deprived areas being much more likely to suffer mental-ill health. Despite successive reviews of mental health policies and the provision of mental health services in both jurisdictions, their chronic under-funding persists involving both adult and children’s mental health services. This has led to long waiting lists, inadequate resourcing and staffing levels, and a lack of access to a diverse offering of community-based mental health services. Both NI and Ireland recently published their new ten-year Mental Health Strategies, committing to increases in funding and resourcing, with action points for delivery.

10. In NI, approximately a quarter of adults surveyed over the past ten years reported having mental health problems, with a third of such persons surveyed identified as coming from the most deprived areas. The legacy of violent sectarian conflict has been identified as contributing to a range of mental health problems, with elevated levels of Post-Traumatic Stress Disorder (PTSD).
Since the formal end to sectarian conflict over 25 years ago, high rates of suicide have been reported. The estimated lifetime prevalence of mental health problems is around 39 per cent, with a lifetime risk of just under 50 per cent. The Health Survey results for 2020-2021 included that 27 per cent of respondents reported a General Health Questionnaire score which could indicate a mental health problem (23 per cent men and 30 per cent women). This was significantly higher than in 2019-2020 (19 per cent overall; 18 per cent men and 21 per cent women). In the 2020-2021 results, 38 per cent of respondents also reported having concerns about their mental health in the past year which again was higher than previous years. This varied by age from 55 per cent of those aged 16-24 reporting concerns, which reduced with each age category, down to 15 per cent of those aged 75 and over.

11. A recently published survey showed that Ireland had one of the highest rates of mental ill-health in Europe, with just over 18 per cent of the population reported as suffering from a mental illness. Other surveys have pointed to young Irish people having relatively high rates of mental ill-health, resulting in self-harming behaviours, as well as alcohol and drug misuse. Gender and age differences have also been observed, with young Irish women being disproportionately impacted by mental ill-health. Those living in the most deprived areas were twice as likely to suffer mental ill-health than those living in the most affluent areas. This is against a background where just under 13 per cent of the total population are reported as being at risk of living in poverty, despite data showing that Ireland has a relatively high spend based on GDP per head basis.

12. NI mental health policies have tended to follow those adopted elsewhere in the UK. From the time of partition over a hundred years ago, a range of in-patient asylums have existed which had originally been built in the Victorian era and are still in use. However, there has been a gradual shift from the 1960s onwards towards community care, although progress has been relatively slow. In the early to mid 2000s, the Bamford Review undertook a wide-ranging review of NI mental health and disability services and laws. This led to further reforms, which included the introduction of a stepped care model of mental health care service provision, ranging from self-directed help to high intensity services. Ensuring adequate funding for NI mental health care services remains an ongoing problem, with years of chronic underfunding of such services. The NI spends the lowest proportion of its overall health budget on mental health care (8 per cent), when compared to the rest of the UK (10-12 per cent). In 2021, a new ten-year Mental Health Strategy was published, which noted the relatively high level of mental health problems in NI and the relatively low level of expenditure. Against a background of long-term waiting lists, the NI Executive has committed to a significant increase in the mental health care budget to address the issue.

13. In 2006, Ireland published a comprehensive mental health strategy which committed to developing community-based, multi-disciplinary mental health services. Despite widespread stakeholder support, implementation has been patchy and incomplete, which has been highlighted in successive reviews. In 2020, the Irish government published its new Mental Health Strategy, which proposes a broad-based, whole system approach, focusing on recovery as the primary objective. As has also been the case in NI, Irish adult and child mental health services have been underfunded for many years. A low proportion (just over 5 per cent) of the overall health budget is dedicated to mental healthcare, making Ireland substantially out of line with other EU member States (10-13 per cent). As part of the new Strategy, the Irish government has now committed to a substantial increase in the budget to address these long-term under-funding issues.
Part IV: Mental Health Laws

14. Both NI and Ireland have traditional mental health legislation, as well as capacity legislation. Both jurisdictions have mental health legislation that is outdated, does not currently represent best practice and is not human rights compliant. They both employ a diagnosis plus risk-based approach (albeit with differing diagnostic definitions). They are also both predominantly focused on the minority of persons who are subject to involuntary detention for mental health treatment. There are concerns about the lack of safeguards in place in relation to the circumstances under which such treatment takes place including the right to regular reviews before an independent Tribunal. Where there is a substantial difference between the two jurisdictions is in relation to their respective capacity laws. While Ireland will soon introduce new capacity laws, NI has opted for a ground-breaking fusion approach towards mental health and capacity laws across all medical specialties.

15. NI’s mental health legislation, known as the Mental Health (Northern Ireland) Order 1986 (MHO), has been in force for over 35 years. Most in-patient admissions are on a voluntary basis and the MHO provides for involuntary admission and treatment based on mental disorder, plus risk-based model, where a failure to detain may lead to a substantial risk of serious physical harm to self or others. The number of involuntary admissions, including those detained after voluntary admission, has been gradually decreasing over recent years from 2059 in 2016/17 to 1570 in 2020-21. Certain safeguards exist where a person is being deprived of their liberty under the MHO, with times limits set for each stage of admission, as well as when applications can be made for review of detention to the Review Tribunal. In practice, the operation of time limits under the MHO have long been viewed as problematic, with concerns about patients being unlawfully detained within in-patient facilities over extended periods.

16. The MHO is no longer considered to be best practice and is not human rights compliant. Most of its provisions will remain in force, until NI’s new Mental Health Capacity (Northern Ireland) Act 2016 (MCANI) is fully enacted, which could take a number of years. Only the deprivation of liberty safeguards set out in the MCANI, and the provisions relating to research, offences and money and valuables in residential care and nursing homes, have been implemented to date in NI. The MCANI is ground-breaking legislation, fusing mental capacity and mental health laws across all medical specialties. This means that impairment of decision-making and best interests are the only criteria to be used when making decisions across health and social care. Arguably this does address, to some extent, the discrimination of disability-specific laws, such as mental health law, highlighted by the UNCRPD but this remains the subject of much debate. The MCANI also only applies to those aged 16 years and over, which means the MHO will continue to apply to children under the age of 16 years.

17. Ireland’s mental health legislation is known as the Mental Health Act 2001 (MHA). Most of the MHA only applies to patients who are involuntarily detained in what is known as an approved centre. In practice, it only applies to a minority of patients who are receiving in-patient mental health treatment by way of involuntary admission. Key principles underpinning the MHA include the person’s best interests being the principal consideration, with due regard being given to other persons who may be at risk of serious harm if the decision to detain is not taken. In making a decision to support involuntary detention, it is stated that regard should be given to a person’s rights to dignity, autonomy and privacy.
18. Admission under the MHA requires that the person must be suffering from a mental disorder, which is defined as being any mental illness, severe dementia or significant intellectual disability, in addition to this, there must be a risk of the person causing immediate and serious harm to themselves or others; or the person having such impaired judgement that a failure to admit would result in a serious deterioration of their condition and they would benefit from such admission. Safeguards which apply to involuntary treatment include a requirement for regular reviews of admission by a Mental Health Tribunal. Significant criticisms have been made as to how the MHA operates in practice. This has led to proposals for legislative reform, which were published by the Irish government in 2021.

19. The vast majority of admissions for in-patient mental health care treatment in Ireland occur by way of voluntary admission, which means that this category of patients does not enjoy the safeguards set out in the MHA in terms of an automatic right of review by a Mental Health Tribunal. If a person does not reach the standard for admission under the MHA, they may be admitted as 'voluntary' patients (which category includes patients lacking capacity who do not resist admission). A person who lacks capacity may also be admitted as a ward of the court (although wardship is not often used in the context of admission to approved centres). Wardship will be abolished once Ireland’s new capacity legislation, known as the Assisted Decision-Making (Capacity) Act 2015 (ADMCA), comes into force in mid-2022. The Act permits a person to appoint a designated person who has legal authority to access information and to provide support to them, or to do so jointly with such person. Provision is also made for a substitute decision-maker who can be appointed to act on behalf of the person. However, it is not clear how admission to an approved centre (where the MHA does not apply) will operate under the new regime.

Part V: Children, Young People and Mental Health

20. In both NI and Ireland, there is a lack of comprehensive data on the prevalence and impact of mental ill-health involving children and young people. Data is also patchy on whether and, if so how, children and young people access mental health services, the extent of involuntary and voluntary in-patient admissions, and the impact of mental health treatment on their health and wellbeing in the medium to longer term. Both jurisdictions operate children and adolescent mental health services (CAMHS) which suffer from chronic under-funding and staffing shortages, as well as long waiting lists. In both jurisdictions, mental health policies are not informed by a children’s rights approach, and the applicable mental health laws are fragmented and lack a holistic approach to ensuring human rights compliance for those under the age of 18 years.

21. Rates of mental ill-health among children and young people in NI are significantly higher than the rest of the UK, as is socio-economic disadvantage more generally. Decades of violent sectarian conflict have contributed to inter-generational trauma, adversely impacting the mental health of both parents and children. It is estimated that 13 per cent of children meet the criteria for a mood or anxiety disorder, with 10 per cent reporting self-harming behaviour. Other surveys have pointed to over 20 per cent of young people suffering from some sort of mental health problem or difficulties. Mental health services for children and young people are chronically under-funded, short-staffed and have long waiting lists, with a lack of suitable treatment pathways on offer for those most in need.

22. The current NI Mental Health Strategy commits to increasing funding for such services to 10 per cent of the overall mental health budget in order to provide better resourcing and support, more timely interventions, and better transitions between children and adult mental health services. While no mention is made of children’s rights in the new NI Mental Health Strategy, reference is made to such rights in the NI’s new Children and Young Person’s Strategy, which was published
in 2021. The absence of robust data regarding children’s services, including mental health services, has hampered the development of this Strategy.

23. There are a range of NI laws that are applicable to mental healthcare provision involving children and young people, with their welfare being the paramount consideration. Previous mention has been made of the MCANI, which only applies to young people aged 16 years and over with respect to determinations of capacity and the safeguards and protections set out under the Act. Once fully implemented, the MHO will no longer apply to those aged 16 years and over. However, the MHO will continue to apply to those aged under 16 years of age, which is outdated and not human rights compliant. As things stand, NI mental health laws applicable to children and young people involve a mix of common law and legislation.

24. In Ireland, data is patchy with regards to obtaining a comprehensive overview of mental ill-health impacting children and young people, as well as the extent to which they are able to access suitable treatment pathways and services. What survey evidence is available points to relatively high rates of mental ill-health amongst young people, involving mood, anxiety and substance abuse disorders. The vast majority of admissions for in-patient mental health treatment for children and young people are voluntary admissions. Treatment is provided through child and adolescent mental health services, which accept referrals from a variety of sources for moderate to severe mental health difficulties, that cannot be managed through primary care. Such services suffer from a lack of adequate funding and have long waiting lists. It has been recommended that the transition of young persons into adult mental health services should not take place until they are 25 years of age, rather than the current age of 18 years. Although Ireland is a signatory to the CRC, no reference is made to its Convention obligations in relation to the provision of mental health services for children and young people in the Irish government’s new mental health strategy.

25. In professional and institutional guidance, as well as under the Irish criminal law, reference is made to the fact that a young person aged 16 years and over can consent to surgical, medical or dental treatment. A child may be involuntarily admitted for mental health treatment under the MHA, following an application by the HSE on their behalf. Various other legislative and other guidelines are available to safeguard such admissions. Because the vast majority of in-patient admissions for mental health care treatment involving children are voluntary admissions, this means that they do not enjoy such protections. Various law reform proposals have been put forward to address this problem, but it currently remains unresolved.
Part II: Political, Jurisdictional and Healthcare Context

A. POLITICAL AND JURISDICTIONAL CONTEXT

26. It is important to first provide a brief overview of Northern Ireland (NI)’s political and constitutional dynamics, in order to situate the development of the existing framework for mental health laws and policy in the jurisdiction. This is because such dynamics provide context for understanding the fragmented and uneven development of the legal framework, as well as explaining why there may be ongoing challenges in proposing law reform in the area.

27. By way of background, NI is a devolved nation of the UK comprising six counties in the North-East of the island of Ireland. In 1921, two separate jurisdictions were formally established on the island of Ireland under the Government of Ireland Act 1920. This involved creating parallel self-governing arrangements for the six north-eastern countries which became Northern Ireland and the rest of the island which was described as Southern Ireland. Although it was originally envisaged on the part of British political leaders that both jurisdictions would remain within what was then known as the United Kingdom (UK) of Great Britain and Ireland, with provision made for reunification at some point in the future, it was a position that was increasingly at odds with Irish demands for political and territorial independence.

28. This subsequently led to the Irish War of Independence against British rule, and the signing of the Anglo-Irish Treaty in 1921 which was designed to bring an end to the war. The Treaty provided the formal basis for the founding of the Irish Free State in 1922, which subsequently became the Republic of Ireland in 1949. In contrast, Northern Ireland remained part of the United Kingdom, governed through devolved arrangements which provided for an NI government and Parliament which had originally been established by the 1920 Act.

29. Although NI was formally created in 1921, its constitutional status, including whether it should remain part of the UK or form part of a united Ireland, was one of the factors in a violent conflict, commonly known as The Troubles which lasted for over twenty-five years in the twentieth century, with its legacy continuing to resonate in NI until the present day. During this period, direct rule was imposed by the UK government. In 1998, a peace accord known as the Belfast/Good Friday Agreement (GFA), led to devolved power-sharing institutions being re-established in NI. These institutions include the NI Executive, which represents the devolved administration, and the NI Assembly, which is the devolved legislature.

30. Since such time, there have been successive periods where direct rule has been re-imposed in NI by the UK government. This followed the collapse of power-sharing institutions due to the dynamics of local politics, which remain divided along sectarian lines. In January 2020, such

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institutions were again restored after a period of three years following an agreement between the main political parties. Nevertheless, the agreement remains fragile, with political tensions persisting over the border between NI and Ireland, which has been exacerbated as a result of the UK’s decision to leave the European Union, colloquially known as Brexit. As an EU Member State, Ireland is required to navigate an increasingly fractious relationship with the UK as a result of the NI Protocol, negotiated as part of Brexit. The Protocol involves NI remaining subject to EU regulation of customs and the movement of goods as part of managing the only land border now existing between the EU and the UK.

31. Cross-jurisdictional arrangements exist under the GFA to facilitate increased exchange and cooperation as between the Irish and NI governments in relation to health and social care. In public health, high level cross-jurisdictional co-operation has been minimal, although there has been evidence of some degree due to increased governmental cross-border co-operation during the COVID-19 pandemic. With some notable exceptions, long-standing political (and sectarian) divisions over the border question on the island have impeded the development of GFA supported cross-border structures and co-operation in public health, in addition to health and social care.

B NORTHERN IRELAND

1 Health care

32. The National Health Service (NHS) in NI is referred to as Health and Social Care (HSC). The key difference from the systems in the other UK nations, is that healthcare is provided as an integrated service with social care services, which are provided by local councils. Key bodies include the Strategic Planning and Performance Group in the Department of Health, six HSC Trusts, NI Public Health Agency (PHA), Patient and Client Council, and the Business Services Organisation. HSC is a universal publicly funded healthcare system operated through primary, community and hospital care, free at the point of access.

7 David Frost and Brandon Lewis, ‘David Frost and Brandon Lewis: We Must Find a New Balance in How NI Protocol is Operated’ The Irish Times (Dublin, 2 July 2021).
10 For a recent overview, see Deirdre Heenan, ‘Collaborating on Healthcare on an All-Island Basis: A Scoping Study’ (2021) 32(2) Irish Studies in International Affairs 413.
33. The Minister of Health and NI Department of Health is one of nine departments in the devolved NI Executive and is responsible for policy and legislation for health and social care.\textsuperscript{13} The Department of Health has overall responsibility for the allocation of funding for health and social care.\textsuperscript{14}

34. The Strategic Planning and Performance Group in the Department of Health is responsible for commissioning services, resource management, performance management, and service improvement for the NI health system. It deploys and manages funds allocated by the Department of Health and oversees the work of the six health and social care trusts. It also works to identify and meet the needs of the local population through five Local Commissioning Groups, which cover the same geographical areas as the HSC Trusts.\textsuperscript{15}

35. The PHA is the executive agency responsible for the provision of public health and social care services. It has overarching responsibility for improving health and wellbeing and health protection and works in partnership with local government, key organisations, and other sectors to improve health and wellbeing, and reduce health inequalities.\textsuperscript{16} It is jointly responsible with the Strategic Planning and Performance Group in the Department of Health for the development of a fully integrated commissioning plan for health and social care in NI.

36. There are six HSC Trusts, which are responsible for the day-to-day running of hospitals, health centres, residential homes, day centres, and other health and social care facilities. Five of these provide integrated health and social care services across Northern Ireland: Belfast HSC Trust, Northern HSC Trust, Southern HSC Trust, South Eastern HSC Trust and Western HSC Trust. These five HSC Trusts are responsible for managing and administering hospitals, health centres, residential homes, day centres and other health and social care facilities.\textsuperscript{17}

37. The sixth trust is the NI Ambulance Service, which operates an NI wide service to people in need.\textsuperscript{18} The Patient and Client Council (‘PCC’) is a regional body with local offices covering the geographical areas of the five HSC Trusts. The objective of the PCC is to provide an independent voice for patients, clients, carers, and communities on health and social care issues.\textsuperscript{19} The Business Services Organisation is responsible for the provision of a range of business support and specialist professional services to the whole of the Health and Social Care sector (e.g., HR, finance, legal services, procurement, ICT).\textsuperscript{20}

38. Hospital waiting targets are set by the HSC Board and are less demanding than in the rest of the UK, with waiting times set at 52 weeks which is much longer than the allocated 18 weeks waiting time in other parts of the UK NHS, such as England, for example. NI regularly does not meet its


\textsuperscript{15} Health and Social Care online, ‘Our Work’ \url{http://www.hscboard.hscni.net/our-work/} last accessed 25 March 2022.


\textsuperscript{17} Health and Social Care online, ‘Health and Social Care Trusts’ \url{http://online.hscni.net/hospitals/health-and-social-care-trusts/} last accessed 25 March 2022.

\textsuperscript{18} Northern Ireland Ambulance Service Health and Social Care Trust \url{http://www.niamb.co.uk/} last accessed 25 March 2022.


\textsuperscript{20} Health and Social Care, Business Services Organisation \url{https://hscbusiness.hscni.net/} last accessed 25 March 2022.
52-week target in any case. A report by the Nuffield Trust published in 2017 showed that 16 per cent of the NI population were on a waiting list, compared with about 7 per cent for the rest of the UK. In 2018, NI hospital performance was the worst in the UK. All five HSC trusts failed to meet their annual targets for Accident and Emergency, cancer and routine operations for the year 2017–18. In 2021, the NI Health Minister launched a new Elective Care Framework, with a view to tackling NI’s lengthy hospital waiting lists.

39. There are currently 321 general practitioner (GP) practices in NI. Primary care provided by a GP is the first point of contact and a gateway to secondary care and a wider variety of services within primary care itself. While a private healthcare sector exists, the vast majority of the population use the HSC, the publicly funded health service.

2 Social care

40. In NI, social care has been formally integrated with healthcare since 1972. At the time, this was done partly to address concerns about sectarian discrimination in local government, but there was also recognition of the benefits of an integrated approach to meeting the full range of people’s needs. The HSC Board is the commissioning body for all social care services in NI (along with healthcare). The five HSC Trusts having responsibility for delivering social care, which they commission using a mix of statutory, voluntary and private providers.

41. While the NI Department of Health has overall responsibility for the allocation of funding for social care, there has been a shift in responsibility (and cost) between health care, social security and social care with aspects of long-term care now being categorised as social care, rather than health care. For example, care for dementia, Parkinson's disease and end of life care. Adult social care is available to any person with eligibility needs who requires assistance. Informal, unpaid care comprises a significant proportion of social care in NI; in 2016, it was estimated at £4.4 billion per annum.

42. HSC Trusts also have the power to charge for domiciliary social care services, but ordinarily do not do so, with the exception being ‘meals-on-wheels’, which is a flat fee service. Adult social care can be means tested and in recent years there has been an increasing focus on encouraging NI citizens to be responsible for their own care needs. This has included the development of approaches to publicly funded social care, such as self-directed support and direct payments


27 ibid.
where there is a greater emphasis placed on individual responsibility and choice about how it is allocated for social care.

43. Residential and nursing home care is also means tested and this includes reviewing an individual’s capital levels, such as savings and property. There is an upper capital cap of £23,250, above which the individual is responsible for the full cost of their care. Below £14,250, an individual’s capital is not taken into account. Between these two caps, there is a sliding scale in terms of determining an individual’s financial contribution towards their social care.28

44. It has long been recognised that the NI’s health and social care system is in need of reform. Over the past twenty-five years, there have been at least seven system reviews which have recommended major reforms to policy direction, organisational structure, workforce and funding arrangements. In light of this and the COVID-19 pandemic, a further consultation on reform is underway.29 This has included the need to reduce reliance on secondary care (hospitals), centralise specialist services and focus more on public health prevention and redressing health inequalities. Political dysfunction created by persisting sectarian divisions has resulted in the periodic collapse of NI power-sharing institutions, undermining attempts at strategic reform of the system.30

45. The following select public sector organisations are involved in the oversight and/or delivery of NI health and social care (including mental health care):

- Regulation and Quality Improvement Authority (RQIA), independent NI health and social care regulatory body.31
- NI Guardian Ad Litem Agency (NIGALA) responsible for safeguarding and promoting the interests of children by providing independent social work investigation and advice in specified legal proceedings.32
- NI Blood Transfusion Service supplies blood and blood products to the HSC.33
- NI Social Care Council acts as the regulatory body for the NI social care and seeks to ensure the protection of those using social care services, their carers and the public.34
- NI Practice and Education Council for Nursing and Midwifery, which supports the practice, education, and professional development of nurses and midwives in NI.35
- NI Medical and Dental Training Agency which is responsible for funding, managing, supporting postgraduate medical and dental education within the NI Deanery.36

28 ibid.
C  IRELAND

1  Health care

46. The Irish government is responsible for the setting of strategic policy in health and social care. The Department of Health is responsible for advising on the strategic development of the health and social care system, including policy and legislation. The Department of Children, Equality, Disability, Integration and Youth also plays a role in the development of policy for the populations covered.

47. Health and social care services are delivered by the Health Service Executive (HSE). Established in 2004, the HSE is funded by the Irish government though an annually agreed service plan that sets out the quantum and nature of services to be provided. The HSE manages the delivery of health and social care services as a single national entity through four HSE administrative areas: HSE Dublin Mid-Leinster, HSE Dublin North-East, HSE South, and HSE West. In turn, these are divided into thirty-two Local Health Offices.

48. The public health and social care system is funded by the Irish government from general taxation, with a large proportion of expenditure going towards hospital and ambulatory healthcare providers, of which rehabilitation and long-term care receive the largest financial support. Alongside the State funded system, Ireland has an extensive private healthcare system, funded through private health insurance. Based on data from the Central Statistics Office as at the end of end September 2021, 47 per cent of the population had inpatient private health insurance plans.

49. To receive fully funded health care services, a person must be legally entitled to hold a Medical Card. A person would need to demonstrate that they are in receipt of income below a designated threshold and are ‘ordinarily resident in Ireland’ (i.e. they have been living in Ireland for at least a year or that they intend to be resident for at least a year). Free services available through the Medical Card scheme include GP visits, drug and medicine prescriptions, hospital services, dental, optical, and aural services, maternity and infant care, some community care and personal social services, and short-term counselling services.

50. Where a person is eligible for a Medical Card, a dependent spouse or partner, and children are also usually covered. Where someone does not qualify for a Medical Card, they may qualify for a GP Visit Card. This has an income test with a higher limit than that for Medical Cards and is also available to all children aged 7 year and under, as well as all those over 70 years old. Prescription drugs are subsidised under the Drugs Payment Scheme (based on the cost of the drugs).

41 Health Services Executive, ‘GP Visit Cards’ <https://www2.hse.ie/services/gp-visit-cards/gp-visit-cards.html> last accessed 25 March 2022.
51. Under the HSE’s Maternity and Infant Care scheme, people who are pregnant and ordinarily resident in Ireland are entitled to maternity care. The scheme provides a specified care programme of care, which is provided by a GP of your choice and a public hospital obstetrician. This is provided regardless of whether a person has a Medical Card or not. Most GPs have agreements with the HSE to provide these services and they do not have to be part of the GPs and Medical Card system. The Scheme also provides for two postnatal GP visits.43

52. People who are not Medical Card holders are entitled to receive public hospital services, but there is a payment for inpatient and outpatient care. Persons without Medical Cards or private health insurance may receive medical services free or at a subsidised rate from the Treatment Benefit Scheme. This scheme provides dental, optical and aural services to insured workers, the self-employed, retired people and their dependant spouse/partner who have the required number of social insurance contributions.44

53. There are long waiting lists in place for health care through the publicly funded health care system in Ireland, with patient accessibility to the system rated to be the worst in Europe.45 As part of tackling extended waiting lists, the Irish Government established the National Treatment Purchase Fund, which involves the government paying for public patients to be treated for free in a private hospital in Ireland, or abroad if necessary.46 As hospital waiting lists have extended, adverse public commentary on the need to reform health care system has become much stronger in recent years.47 Health care also proved to be a key issue for voters at the General Election held in 2020.48

54. A significant proposal for reform of the system has been in development for some years now.49 The proposed Sláintecare framework is designed to ‘achieve a universal single-tier health and social care system where everyone has equal access to services based on need, and not ability to pay. Over time, a person would be entitled to a comprehensive range of primary, acute and social care services.50 Its overarching objectives are to improve patient and service user experience; improve clinician experience; lower costs; and achieve better health and social care

47 Conor Pope, ‘More than 900,000 People on Hospital Waiting Lists’ The Irish Times (Dublin, 10 September 2021).
Although it was originally envisaged that Sláintecare would be established in 2019, the reform has been delayed on several occasions and there is no definite delivery date in sight.

2 Social care

Social care is integrated into Ireland’s health and care system and is publicly financed, with the deficit paid through voluntary healthcare payments. The HSE’s Social Care Division oversees the provision of ongoing service to older persons and those with disabilities. While some social services are provided directly by the HSE, community, residential and rehabilitative training services are provided by voluntary organisations with grant aid from the HSE.

People with disabilities are entitled to general health services, which may include Medical Cards, prescribed drugs and medicines, medical and surgical aids and appliances, hospital services, dental, optical and aural services. The HSE also provides assessment, rehabilitation, income maintenance, community care and residential care respite, home care and day care. Community care services to which people with disabilities may have priority access to include public health nurses, home help, personal assistance, psychological services, speech and language therapy, occupational therapy, social work services, physiotherapy, day care and respite.

There are also early intervention multi-disciplinary teams, which focus on families and children with complex development needs who are aged 6 years and under. There has been much criticism of the current waiting lists for children to receive a disability assessment, with repeated calls for a major overhaul of access criteria for diagnostic and assessment services, as well as clearer pathways for services and treatment with children ‘according to need’.

In relation to older persons, there are a range of agencies involved in the delivery of nursing and residential care services. The HSE liaises with applicants, assessing their eligibility for the scheme and determining financial co-payment arrangements between nursing homes and individual residents, and disbursing State payments to private nursing homes. The Health Information and Quality Authority (HIQA) is the independent regulatory body which sets nursing home standards and inspects facilities to ensure that these standards are being met.

59. There is also a nursing home support scheme, known as the Fair Deal scheme, which was established in 2009.\textsuperscript{57} It replaced the previous system of public nursing home charges and the private nursing home subvention scheme. Subject to approval, a person may apply for financial support to help pay for the cost of care in a nursing home under the scheme. A person can elect to pay for such care privately pending approval, but it will not be backdated. Under the scheme, the National Treatment Purchase Fund is the government authorised body responsible for negotiating with nursing homes run by the private and voluntary care sectors to agree on the maximum prices to be charged for the provision of long-term care services to the Nursing Homes Support Scheme residents.\textsuperscript{58} These agreements are known as Approved Nursing Home Agreements.\textsuperscript{59}

60. The following select organisations are involved in the oversight and/or delivery of health and social care (including mental health care) in Ireland:

- Health Information and Quality Authority (HIQA) is the independent authority responsible for driving high quality and safe care for people using health and social care services in Ireland. HIQA’s role is to develop standards, inspect and review health and social care services and support informed decisions on how services are delivered.\textsuperscript{60}
- The Child and Family Agency (TUSLA) is the independent authority responsible for improving outcomes and wellbeing for children, focused on child protection, early intervention and family support services in Ireland.\textsuperscript{61}
- Mental Health Commission (MHC) is established under the Mental Health Act 2001 to promote, encourage and foster high standards and good practices in delivering mental health care in Ireland.\textsuperscript{62}
- Decision Support Service (DSS) is established under the Assisted Decision-Making (Capacity) Act 2015 to oversee the operations of the Act, which comes into force in mid 2022.\textsuperscript{63}

\textsuperscript{57} Health Services Executive, ‘Fair Deal Scheme’ <https://www2.hse.ie/services/fair-deal-scheme/about-the-fair-deal-scheme.html> last accessed 25 March 2022.
\textsuperscript{58} The National Treatment Purchase Fund authorisation to reach such agreements is derived from s 41, Nursing Homes Support Scheme Act 2009.
\textsuperscript{60} Health Information and Quality Authority (HIQA) https://www.hiqa.ie/ last accessed 25 March 2022.
Part III: Mental Health Policies

A NORTHERN IRELAND

1 Prevalence of mental health problems

61. There are a number of indicators of the prevalence of mental health problems in Northern Ireland. One key source of data is the NI Health Survey, which has been conducted annually by the NI Department of Health since 2010/11. It includes a General Health Questionnaire (GHQ), which explores recent and current mental health, with a score of 4 or more suggesting the person may have a mental health problem. The sample is a random sample of addresses from the NI Statistics and Research Agency’s address register, with everyone aged 16 years and over eligible to participate within each household surveyed.

62. The findings from surveys conducted in the 2010-20 period showed that between 17-20 per cent (average of 18.3 per cent) of participants reported a score of 4 or more. It is important to note that this includes 23 per cent of men and 30 per cent of women, and a third (33 per cent) of those in the most deprived areas compared with about a quarter (23 per cent) in the least deprived areas. In 2020-21, there was a significant rise in the score of 4 or more at 27 per cent. However, this should be considered with some caution as it needs to be set in the context of the initial waves of the COVID-19 pandemic during this period. In addition to deprivation and gender, age appears to be an important factor. In the 2020-2021 Health Survey results, 38 per cent of respondents reported having concerns about their mental health in the past year and this varied by age from 55 per cent of those aged 16-24 reporting concerns, reducing with each age category, down to 15 per cent of those aged 75 and over.

63. Relatedly, it also meant that the survey was conducted by telephone rather than face-to-face, which had previously been the case. This resulted in a much lower response rate (4085 interviews, with a response rate of 59 per cent in 2019-20; 1408 interviews, with a response rate of 18 per cent in 2020-21). Nonetheless, the consistent finding over the past ten years of the survey has been that approximately 1 in 5 of the sample of the NI population aged 16 years and over report a GHQ score that suggests they have recently experienced, or are currently experiencing, a mental health problem.

64. In 2020, the main findings of the first population level prevalence study of the mental health of children and young people in NI were published. The study included more than 3,000 children and young people, as well as 2800 parents. It found that one in eight young people (12.6 per cent) met the criteria for a mood or anxiety disorder. This was in addition to one in six young people (16.2 per cent) reported patterns of eating which may indicate a problem, in addition to almost one in ten (9.4 per cent) of those aged 11-19 years reporting some form of self-injurious behaviour.


65. Of the parents surveyed, 22 per cent reported a previous diagnosis of some form of mental health problem. Despite the overall reduction in sectarian conflict since the signing of the GFA in 1998, more than 2 in 5 (43.6 per cent) agreed or strongly agreed that paramilitary groups created fear and intimidation in the areas in which they lived.

66. The impact and the legacy of violent sectarian conflict in Northern Ireland, commonly referred to as the Troubles, has been identified as contributing to a range of mental health problems.\(^{67}\) Although it could be argued that most people were affected in some way by the Troubles, a number of patterns have been observed since the signing of the GFA in 1998. First, deaths attributable to mental health problems were not evenly distributed across time and place; instead, they were more concentrated in socially deprived areas.\(^{68}\) In such areas, it was also found that 12 per cent of those surveyed met the criteria for Post-Traumatic Stress Disorder (PTSD).\(^{69}\) In the first epidemiological study focusing on trauma in NI, two-thirds of participants reported having experienced at least one traumatic event and half of those events related to the Troubles.\(^{70}\) Second, there is a high rate of prescriptions for anti-depressants on a per capita basis in NI, with data published by the Royal College of Psychiatrists in 2010 showing it was twice the figure for England.\(^{71}\) Finally, World Mental Health Survey Initiative published findings from data collected in the 2004-08 period reported a lifetime prevalence of mental health problems to be 39.1 per cent in NI, with a projected lifetime risk of 48.6 per cent.\(^{72}\) In addition, 39 per cent of those surveyed in NI reported experiencing a traumatic event relating to the Troubles and a lifetime and 12-month PTSD prevalence of 8.8 per cent and 5.1 per cent respectively, the highest rates among comparable estimates from the Survey.\(^{73}\)

67. NI also experiences high rates of suicide, which have increased since 1998.\(^{74}\) Although there have been some uncertainties about the number of deaths properly recorded as suicide, which were attributable to how drug related deaths were recorded and a change from the criminal to the civil standard of proof used for suicide in 2018, there were nevertheless 209 deaths recorded as suicide in 2019, and a provisional figure of 263 for 2020.\(^{75}\)


\(^{68}\) Marie-These Fay, Mike Morrissey, and Marie Smyth, Northern Ireland’s Troubles: The Human Costs (Pluto Press 1999).


\(^{70}\) Finola Ferry, David Bolton, Brendan Bunting et al, Trauma, Health and Conflict: A Study of the Epidemiology of Trauma-Related Disorder and Qualitative Investigation of the Impact of Trauma on the Individual (Northern Ireland Centre for Trauma and Transformation 2008).

\(^{71}\) Royal College of Psychiatrists, ‘Press Release: Psychiatrists Say Promises for Psychological Therapies in Northern Ireland Must Not Be Watered Down’ (Royal College of Psychiatrists, 2010).


2 Mental health policies and funding

68. NI mental health policy has tended to follow the main developments in the rest of the UK. Between 1825 and 1898, six psychiatric hospitals were opened with bed numbers peaking in 1961 at approximately 6500, two years after the peak in England. Since the 1960s, the focus has gradually shifted to community care in NI, although this process has been relatively slow.76 By 1997, there were 1500 available beds; this had reduced to approximately 600 by 2020-21. All six Victorian hospital sites are still in use along with some general hospital psychiatric wards.

69. Between 2002 and 2007, the Bamford Review undertook a wide-ranging examination of mental health and disability policies and laws in NI, with a view to making recommendations for reform.77 The recommendations of the Review were operationalised through two action plans 2009-201178 and 2011-2015,79 although not all aspects of the plans have been fully implemented. Further developments have included the introduction of an NI Regional Mental Health Care Pathway, which involves a stepped care model of service provision from self-directed help to high intensity services.80

70. In 2019, the UK Parliament’s Northern Ireland Affairs Committee undertook a review of health care funding in NI. As part of the review, it also considered the position with regards to the funding of mental health care. It found that: ‘funding for mental health as a proportion of the health budget in Northern Ireland has remained comparatively low, despite the higher prevalence of need. In 2015-16, spending on mental health totalled £255 million, which represents 5.5 per cent of the overall health budget. In 2016–17, 5.2 per cent of the NI health budget was spent on the Mental Health Programme of Care by HSC Trusts (not including spend on mental health services delivered by GPs or the Public Health Agency, which the Department does not collect data on).

71. By comparison, 13 per cent of total expenditure by clinical commissioning groups and specialised commissioning services (not including direct commissioning such as that by GPs) was spent on mental health by NHS England in 2015–16, with 13.3 per cent spent in 2016–17 and 2017–18. NHS Wales allocated 11.4 per cent of expenditure to mental health in 2017–18 and NHS Scotland allocated 7.6 per cent in 2019–20.81 Against a background of ‘years of underfunding’, it recommended that the NI Department of Health increase ‘its level of investment in mental health

as a share of the overall health budget in line with recent increases in other UK jurisdictions, with the aim of reaching 13 per cent in the long-term.\(^{82}\)

72. In mid-2021, the NI Department of Health published its new 10-year Mental Health Strategy. It is organised into three main themes: promoting mental wellbeing, resilience and good mental health across society; providing the right support at the right time; and new ways of working. It sets out 35 specific actions to be taken as part of implementing the strategy, which includes an emphasis on mental health promotion, prevention and addressing the social determinants of mental health problems. It also indicated government policy will be developed with respect to Advance Care Planning.\(^{83}\)

73. The new Strategy makes clear there is a relatively high prevalence of mental health problems in NI but also a relatively low level of spending to address such problems. It stated that: ‘In 2018/19 approximately £300m was allocated to mental health in Northern Ireland, representing around £160 per person. During the same period, spend in England was £12.2bn, or £220 per person, whilst in Ireland investment equated to over £200 per person.’\(^{84}\) It also reported that: ‘Across Northern Ireland, targets for access to services are regularly missed, with almost 2,000 people waiting more than 9 weeks for access to adult mental health services, 170 children and young people waiting more than 9 weeks for core CAMHS and more than 1,800 people waiting more than 13 weeks for psychological therapies.’\(^{85}\)

74. The NI Department of Health recognises ‘that a significant investment is required in mental health services’ in order to implement the new mental health strategy. The recurrent revenue cost when all actions are implemented is estimated between £112.36m and £158.15m per year, in addition to a ‘one-off revenue cost of £0.75m.’ The financial plan to support the strategy ‘also identifies a capital investment requirement of £284.97m – £287.07m’, of which ‘£206m [of this total amount] represents an existing commitment to build three new mental health hospitals.’\(^{86}\)

\(^{82}\) Ibid, para 119.


\(^{84}\) ibid 15.

\(^{85}\) ibid 17.

B IRELAND

1 Prevalence of mental health problems

75. In 2019, an OECD report found that Ireland had one of the highest rates of mental ill-health in Europe. It was noted that 18.5 per cent of the population was recorded as having a mental illness, placing it third highest out of thirty-six countries surveyed, although it was noted it had below average suicide rates. In 2016, the Healthy Ireland Survey found that mental health problems were most prevalent among young people aged 15 to 24 years. In particular, young women were reported as being more vulnerable to poor mental health than young men, with 16 per cent found to have mental health problems. Gender and age-related differences in relation to rates of mental health problems were also echoed in the Mental Health Ireland 2018 report, where women were found to have a lower wellbeing score on average than men, and that young people scored lower than adults.

76. Gender and age differences were also reported in relation to self-harm leading to hospital presentation. The peak rate for women was in the 15- to 19-year-old cohort, and for men in the 20- to 24-year-old cohort. The data revealed that one in every 138 women aged 15-19 years and one in every 206 men aged 20-24 years have presented to hospital as a consequence of self-harm. In terms of types of self-harm, 2 in every 3 involved an overdose; 3 in every 10 involved alcohol use; and 3 in every 10 involved self-cutting.

77. Rates of mental health problems are also not evenly distributed amongst the Irish population, with the 2016 survey previously referred to showing that persons living in the most deprived areas were twice as likely to have mental health problems as those living in the least deprived areas. This is against a background where 12.8 per cent of the population have been recorded as being at risk of poverty in 2020. Although Ireland has a very high spend based on Gross Domestic Product (GDP) per head data, it is below the EU average for its population being at risk of poverty or social exclusion, defined as involving at least one or more of the following: at risk of poverty after social transfers; severely materially deprived; or living in a household with low work intensity. The greatest risk of poverty or social exclusion was from income poverty.

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92 This GDP per head capita is skewed by accounts data for multi-national corporations based in Ireland, see Cliff Taylor, ‘Ireland Ranks 13th in EU Living Standards Survey’ The Irish Times (Dublin, 21 June 2021).
93 The EU average was noted to be 20.9 per cent, with Ireland at 20.6 per cent, see Eurostat, Key Figures on Europe 2021 edition, 24 (https://ec.europa.eu/eurostat/documents/3217494/13394938/KS-EL-21-001-EN-N.pdf/ad9053c2-debd-68c0-2167-f2646e9eeae1?t=1632300620367) last accessed 25 March 2022.
2 Mental health policies and funding

78. In 2006, the foundational statement for contemporary Irish mental health policy was set out in *A Vision for Change* (AVFC). It outlined a comprehensive policy framework for mental health services to take place over a seven-to-ten-year period. This included a commitment to developing community-based, multi-disciplinary mental health services. Although the AVFC was generally welcomed by all stakeholders involved in mental health care in Ireland, its implementation was viewed as poor and incomplete. The lack of progress with respect to implementation was noted in a series of stakeholder reviews and submissions prepared by bodies such as the Mental Health Commission (MHC), Psychiatric Nurses Association of Ireland, Amnesty International Ireland, and Mental Health Reform Ireland.

79. In 2020, the Irish government published a new ten-year national mental health strategy, entitled *Sharing the Vision*. Although this replaces AVFC, it retains the policy focus on community-based, multi-disciplinary care. The new strategy proposes a broad-based, whole system approach for mental health policy for the Irish population, focused on recovery as the primary objective. It also sets out a proposed completion timeframe for every recommendation or associated action is identified as short (18 months), medium (36 months) or long (36 months – 10 years).

80. Irish mental health services have been underfunded for many years. The charity Mental Health Reform, which tracks mental health funding, has reported that funding for mental health services has stalled and currently sits at 5.1 per cent of the national health budget. This percentage allocation means that Ireland is substantially out of line with the budgetary allocation in comparable jurisdictions, such as 10-13 per cent in Sweden, the Netherlands, Germany, France and the UK (apart from NI). It is also well below the recommendation of the World Health Organisation for a minimum allocation of 12 per cent to mental health. The Irish government is attempting to make inroads into addressing this historical funding deficit, with a total of €1,149 billion allocated to mental health in the 2022 budget.

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100 Ibid.

Part IV: Mental Health Laws

A NORTHERN IRELAND

1 Mental Health (Northern Ireland) Order 1986

81. There are two key pieces of NI mental health legislation, namely the Mental Health (Northern Ireland) Order 1986 (MHO) and the Mental Capacity (Northern Ireland) Act 2016 (MCANI). The MHO has been described as ‘traditional mental health legislation’, having been in force for over thirty-five years.\(^\text{102}\) Given the passage of time, it no longer represents best practice, showing a lack of due respect for the principles of autonomy, justice and benefit, as well as failing to incorporate appropriate human rights protections.\(^\text{103}\)

82. The MHO provides the legal basis for the involuntary treatment of a ‘mental disorder’, which is defined as ‘mental illness, mental handicap and any other disorder or disability of mind’.\(^\text{104}\) Although a declaratory order must be obtained from the courts where involuntary treatment is sought under the MHO,\(^\text{105}\) it has long been argued that the wide-ranging definition justifying involuntary treatment has the potential to result in persons being detained due to ‘moral, social, political, or cultural judgements’, rather than for reasons of safety or necessity.\(^\text{106}\)

83. The decision to opt for involuntary treatment is based on diagnosis and risk, the presence of mental illness or severe mental impairment, and where a failure to detain may lead to substantial risk of serious physical harm to self or others.\(^\text{107}\) The MHO is accompanied by a short Code of Practice, which provides further information about the provision of mental healthcare in line with the MHO.\(^\text{108}\)

84. Despite involuntary treatment under the MHO being based on diagnosis and risk, it is relatively rare in practice that a formal diagnosis is given to children under 16 years. It has been suggested that this reflects a ‘tentative approach’ on the part of NI medical practitioners based on concerns about the potential impact a formal mental health diagnosis might have on a child’s ‘emerging identity.’\(^\text{109}\)

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\(^\text{104}\) Mental Health (Northern Ireland) Order 1986 (MHO), Art 3(1).


\(^\text{106}\) Gavin Davidson, Maura McCallion and Michael Potter, Connecting Mental Health and Human Rights (Northern Ireland Human Rights Commission, 2003), 20.

\(^\text{107}\) Mental Health (Northern Ireland) Order (n 103), Arts 3-4.


\(^\text{109}\) Bunting, McCartan and Davidson et al (n 66).
85. The MHO also provides certain safeguards for a person who is being deprived of their liberty, with time limits set out for each stage of compulsory admission for assessment and treatment, as well as how and when applications can be made to the Review Tribunal.\textsuperscript{110} Prescribed forms are completed by the treating medical practitioner providing holding powers for assessment and/or treatment.\textsuperscript{111} The completed forms are then sent to the NI Regulation and Quality Improvement Authority (RQIA), which is empowered to scrutinise and monitor all MHO forms.\textsuperscript{112} Once submitted, a detained patient’s representative may challenge their detention under the MHO which can be done within the assessment period (i.e. the first 14 days), or any time after that. A patient’s detention for treatment is then monitored at set intervals until the treating medical practitioner deems it safe for them to be discharged. If a request for detention is left unchallenged, the case will automatically come before the Review Tribunal after two years.\textsuperscript{113}

86. The operation of time limits under the MHO have long been viewed as problematic, with concerns expressed about patients being unnecessarily detained within in-patient facilities for years.\textsuperscript{114} This has been exacerbated with the COVID-19 pandemic, with the implementation of an emergency MHO Code of Practice which further extended time limits for detention and holding powers (now withdrawn).\textsuperscript{115} This added to existing concerns that (extended) time limits under the MHO interfere with a patient’s human rights due to delays to an appeal, for example.\textsuperscript{116} This is quite apart from the fact that even in non-emergency times, the potential exists for a patient’s involuntary detention to remain unchallenged for up to two years under the MHO, which in any case represents a violation of their CRC rights.\textsuperscript{117}

2 Mental Capacity Act (Northern Ireland) 2016

87. In the early 2000s, the Bamford Review began what would be a lengthy examination of law, policy and provisions affecting people assessed with mental health needs and learning disabilities in NI. The Review produced several reports, including one which recommended comprehensive reform of NI’s mental health laws.\textsuperscript{118} One of the guiding principles underpinning the Review was to incorporate a human rights approach to mental health services and law reform,\textsuperscript{119} given that they failed to respect the dignity of the person and did not promote individual autonomy.\textsuperscript{120} Following

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\textsuperscript{110} MHO, (n 104) Arts 9; 12; 71.
\textsuperscript{111} ibid, Part II, Forms 7-11.
\textsuperscript{113} RQIA, (n 108).
\textsuperscript{114} Davidson, McCallion and Potter, (n 106); Children’s Law Centre, ‘Northern Ireland NGO Stakeholder Report to Inform the UN Committee on the Rights of the Child’s List of Issues Prior to Reporting’ (Children’s Law Centre, 31 December 2020).
\textsuperscript{115} Coronavirus Act 2020, s10, Schedule 10; Mental Health (Northern Ireland) Order 1986 Code of Practice Coronavirus Act 2020.
\textsuperscript{117} Specifically, UN Commission on Human Rights, Convention on the Rights of the Child (1990) (CRC) E/CN.4/RES/1990/74, Art 37(b), which states that a child should only be deprived of their liberty ‘for the shortest appropriate period of time’.
\textsuperscript{118} Northern Ireland Department of Health, (n 105).
\textsuperscript{119} Ibid, 3.
\textsuperscript{120} Davidson, McCallion and Potter (n 106).
\end{flushleft}
the publication of the Bamford Review reports, there ensued a lengthy consultation period regarding mental health law reform.

88. This eventually resulted in adoption of the MCANI. The Act is an innovative and ground-breaking piece of legislation, adopting a ‘fusion approach’ which brings together capacity and mental health law across medical specialities.121 What this means in practice is that impairment of decision-making capacity and best interests are now the only criteria to be used when making decisions across health and social care.122

89. The MCANI only applies to those aged 16 years and over. While the default legal position in NI is that a child is ordinarily defined as someone under the age of 18 years,123 the age limit applied in the MCANI reflects in large part the approach taken in other pieces of NI and UK legislation, which recognises that young people 16 years and over can give consent to surgical, medical and dental treatment. This recognition of the evolving maturity of young people in specified respects was also recognised during the consultation process leading up to the adoption of the MCANI, where it was accepted that those aged 16 years and over should come within its remit and that additional safeguards should be put in place, given the existing definition of a ‘child’ under domestic and international laws.124 Once the MCANI is fully implemented, it is anticipated that the MHO will no longer apply to young people aged 16 and 17 years (in addition to those who have reached the age of majority), although it will continue to apply to those under 16 years of age.

90. There has only been partial enactment of the MCANI to date, involving the Deprivation of Liberty Safeguards (DoLS) scheme.125 The scheme is accompanied by a Code of Practice that affirms that mental capacity is to be presumed and the burden of proof (balance of probabilities) is on those seeking to assert incapacity to show otherwise and on the basis of reasonable belief, taking account of specific factors including their ability to understand, use, weigh and appreciate, communicate and retain the information relevant, or required, to (the process of) making the decision in question.126 The test for capacity is whether or not a person aged 16 years or over is unable to make a decision for themselves because of ‘an impairment of, or disturbance in the function of the mind or brain’, whether temporary or permanent and whatever its origin.127 A determination of incapacity is time and decision specific,128 and any intervention must be taken on a best interests basis.129

123 Age of Majority Act (Northern Ireland) 1969, s 4.
126 ibid, ch 5, s 4.
127 Mental Capacity (Northern Ireland) Act 2016 (MCANI), s 3(1); 3(2)(a).
128 ibid, s 3(1).
129 Northern Ireland Department of Health, (n 124), ch 7, ss 2, 7.
B IRELAND

1 Mental Health Act 2001

91. The foundational mental health legislation in Ireland is the Mental Health Act 2001 (MHA). Most of the MHA applies only to people who are detained in an ‘approved centre’ on an involuntary basis, referred to in the MHA as ‘patients.’ This means that the MHA framework applies only to a minority of patients (approximately 15 per cent) who are receiving inpatient mental health treatment.

92. The MHA sets out the legislative requirements for the care and treatment of involuntary patients and outlines the process for involuntary admission to an ‘approved centre’. The key principles are set out in section 4 of the Act. They include that the best interests of the person is 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.’ There is also a requirement that the person must ‘so far as is reasonably practicable’ be notified of any proposed decision and entitled to make representations in respect of it. In making a decision under the MHA, respect must be given to the person’s rights to dignity, autonomy and privacy.

93. Involuntary admission under the MHA requires that the person must be suffering from a mental disorder, which is defined as being ‘any mental illness, severe dementia, or significant intellectual disability’, in addition to meeting one of the following criteria:

- Because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons;
- Because of the severity of the illness, disability or dementia, the judgement of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission, and the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent.

Certain conditions are expressly stated not to provide a basis for involuntary admission under the MHA. These are personality disorders; social deviance; and addiction to drugs or intoxicants.

94. Various procedural protections apply to involuntary admission. The most significant of these is the requirement that all admissions must be reviewed by a Mental Health Tribunal (comprising a consultant psychiatrist, a lawyer and a lay member) within 21 days of the making of the admission.

131 In 2019, 14 per cent of admissions were involuntary while in 2020, this had increased to 16 per cent, see Antoinette Daly and Sarah Craig, Annual Report on the Activities of Irish Psychiatric Units and Hospitals 2020, HRB StatLink Series 5 National Psychiatric In-patient Reporting System, Health Research Board, Dublin, Ireland, July 2021 <https://www.drugsandalcohol.ie/34575/> ast accessed 25 March 2022.
132 MHA, s 4(1).
133 ibid, s 4(2).
134 ibid, s 4(3).
135 ibid, s 3(1)(a).
136 ibid, s 3(1)(b).
137 MHA, s. 8(2).
order. Detention must be reviewed again initially at three months, and thereafter at six-month intervals.

95. Where a person has been admitted under the MHA, the legal framework regarding treatment for the mental disorder is set out by Part IV of the MHA. This requires that, where an involuntary patient has capacity, their consent to treatment must be obtained. Capacity is determined by the consultant psychiatrist responsible for the patient’s care and is determined by reference to whether the person is able to understand the nature, purpose and likely effects of the proposed treatment.

96. Treatment may be provided without consent 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 or to restore the patient’s health, alleviate their condition or relieve their suffering and by reason of their mental disorder, the patient is incapable of giving consent.

97. In the absence of current data on this issue, there is anecdotal evidence that in the vast majority of cases, treatment is provided under the MHA on the basis that the patient lacks capacity. Where treatment for a mental disorder has been provided for a continuous period of three months, then there is a requirement that a second opinion in respect of the treatment provided be obtained from another consultant psychiatrist.

98. Although when enacted, the MHA constituted a substantial improvement, it has been subject to significant criticism, with a detailed review of the Act being published in 2015. There have also been a number of subsequent amendments, although many of these have not yet commenced. A more comprehensive proposed reform comprising draft Heads of a Bill to amend the Mental Health Act was published by the Irish Government in July 2021 and is expected to progress in 2022.

99. It has been estimated that approximately 85 per cent of admissions to inpatient care occurs by way of voluntary admission. Section 2 of the MHA defines a voluntary patient as ‘a person receiving care and treatment in an approved centre who is not the subject of an admission order or a renewal order.’ This means that this category encompasses admissions where the person has capacity and gives their consent to admission, as well as admissions where the person lacks capacity and does not object to the admission.

100. The admission protections, including the automatic right to a hearing before a Mental Health Tribunal, do not apply to voluntary patients, including those who lack capacity to consent to admission. This is clearly incompatible with Article 5 of the ECHR, as established in HL v United Kingdom [2004] ECHR 471. Proposals for a mechanism to provide legal protection in relation to hospital admissions involving people who lack capacity were published in 2017. At the time it was

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138 ibid, s18(2).
139 ibid, s 15, as amended by Mental Health (Renewal Orders) Act 2018, s 4.
140 ibid, s 56.
141 ibid, s 57(1).
143 MHA, s 60.
144 Government of Ireland, Department of Health (n 142).
intended that the proposals would form Part 13 of the Assisted Decision-Making (Capacity) Act 2015 (ADMCA), which comes into force in mid 2022. However, the proposed measures were not favourably received by stakeholders, and it has not progressed any further to date. This leaves a highly problematic legal lacuna for the reasons set out below.

101. Where a person objects to admission to an approved centre and lacks capacity, admission must be under the MHA. If the person does not meet the standard for admission under the MHA, they can only be admitted if they are made a ward of court. This would take place pursuant to the Lunacy Regulation (Ireland) Act 1871, although the Irish Supreme Court has held that a short-term admission or detention is permissible under the common law doctrine of necessity.

102. All in-patient care – both voluntary and involuntary – is covered under the Mental Health Act (Approved Centres) Regulations 2006, which set out requirements for the care and treatment of ‘residents’ in approved centres.

2 Assisted Decision-Making (Capacity) Act 2015

103. Under current Irish law, consent is required for treatment for all persons with decision-making capacity aged over 18 years. The standard for capacity to consent to treatment is set out in Fitzpatrick v K [2008] IEHC 104. This requires that the person must be able to comprehend and retain information about the treatment; believe this information; and weigh the information in the balance in reaching a decision. This case also affirms a presumption of capacity.

104. Where an adult lacks capacity to consent, no other person can give or refuse consent on their behalf, unless they are a ward of court. Although some health services have in the past sought consent from a person’s ‘next-of-kin’, there is no legal basis for this practice. It is generally accepted that treatment in this context may proceed on the basis of the doctrine of necessity, provided this is in the best interests of the person.


148 PL v Clinical Director of St Patrick’s University Hospital and Ors [2018] IECA 29.

149 AC v Hickey and Ors [2019] IESC 73.


151 There are approximately 2,000 wards of court in Ireland. For people in this category, all significant medical decisions are made by the High Court, see Shauna Bowers, ‘Almost 2,000 Wards of Court Since Assisted Decision Laws Brought in Six Years Ago, (Irish Examiner, 1 August 2021) <https://www.irishexaminer.com/news/aidr-40350371.html> last accessed 25 March 2022.

152 See Mary Donnelly and Shaun O’Keeffe, ‘Who Decides? Consent, Capacity and Medical Treatment’ in Donnelly and Gleeson (n 147) 39-43.
105. The HSE National Consent Policy sets out the relevant questions to be asked in this context as follows:

- Is this an emergency situation where the decision is a matter of urgency?
- Is there someone with the legal authority to make the decision on behalf of the person?
- Is the person’s lack of capacity temporary or is capacity fluctuating?
- Is there someone who can help the person participate in decision-making?
- What are the past and present will and preferences of the person and what beliefs and values or other factors would he or she likely consider important in making a decision?
- What options, including the option not to intervene, would provide overall benefit for the person?
- Is there a valid and applicable advance statement or directive?  

106. Irish capacity law will be substantially changed when the Assisted Decision-Making (Capacity) Act 2015 (ADMCA) comes into force at the end of June 2022. The ADMCA adopts a functional approach to capacity, requiring that a person’s capacity be assessed on the basis of his or her ability to understand, at the time that a decision is to be made, the nature and consequences of the decision to be made by him or her in the context of the available choices at that time.  

107. One of the most important innovations in the Act is that it allows a relevant person to appoint someone to act as their supporter in order to assist them in reaching the standard for capacity. A person can appoint either a Decision-Making Assistant or a Co-Decision-Maker. In the case of a Decision-Making Assistant, this person has the legal authority to access information and to provide support to the relevant person. In the case of the Co-Decision-Maker, this person is able to access information and make decisions jointly with the relevant person.  

108. Where the relevant person has appointed a supporter, the supporter must be involved in the consent process. The ADMCA also makes provision for the involvement of someone close to the person to make decisions on their behalf, where a person lacks capacity. This substitute decision-maker is known as a Decision-Making Representative who acts on behalf of the relevant person and, provided they have been authorised to do so by the Court, they may give consent on behalf of the person lacking capacity. In making decisions for a person who lacks capacity, a Decision-Making Representative and/or a healthcare professional must act in accordance with a series of principles set out in s. 8 of the ADMCA. These principles include respecting the person’s past and present will and preferences and acting for the benefit of the person and in good faith.  

109. A framework for Advance Healthcare Directives (AHDs) has also been created under ADMCA, which sets out clear guidelines to allow a person to make a legally binding refusal of treatment and to make treatment requests. A directive maker may also appoint someone to act as their Designated Healthcare Representative and may give this person authority to consent to and refuse treatment, including life-sustaining treatment, always with reference to the AHD. However, these provisions do not apply where a person has been involuntarily admitted under the MHA.  

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154 ADMCA, s. 3(1).

155 Assisted Decision-Making (Capacity) Act 2015 (ADCMA), s 85(7).
Part V: Children, Young People and Mental Health

A NORTHERN IRELAND

1 Prevalence, policies and funding

110. Rates of mental ill-health among children and young people in NI are 25 per cent higher than the rest of the UK. Decades of violent sectarian conflict have contributed to a legacy of inter-generational trauma, adversely affecting family relationships and impacting children’s mental health. Indeed, it is estimated that over 40 per cent of young people in NI are currently living with parents who have ‘high or moderate experience of the conflict’, placing them at significant risk of poor mental health. For many such young people, this has occurred against a background of longstanding social and economic deprivation, which is much higher than the UK average.

111. What data is available points to the consequences of these systemic, societal and economic factors on children and young people in NI in terms of their mental health. Emergency hospital attendance for mental health treatment has tripled in the past ten years, with an estimated 20 per cent of young people suffering from ‘significant mental health problems’ by the time they reach 18 years of age. It is likely that successive lockdowns arising from the COVID-19 pandemic have also exacerbated a range of mental health problems, which will persist over time.


160 ibid, 6.


Accessing suitable treatment pathways is difficult with long waiting lists, against a background of children and young people’s mental health services being fragmented, chronically under-funded, poorly resourced and not of a standard to meet their needs.

112. For persons under 18 years of age in NI, mental healthcare treatment is provided by the NI Child and Adolescent Mental Health Services (CAMHS), which is organised at an individual Trust level and at regional level. There are specialist services for young people including an eating disorder service and an intellectual disability service, amongst others. All these services are combined to provide the CAMHS stepped care model which can be accessed through referrals from general practitioners, social services, paediatric services, voluntary agencies and education.

113. While the CAMHS framework aspires to provide care pathways that recognise the importance of a child-centred approach, it suffers from chronic underfunding and is currently functioning at a lower level/capacity than required. CAMHS has been significantly underfunded for many years, despite burgeoning demand. For example, in 2016-17 only 5.2 per cent of the health budget was spent on the Mental Health Programme of Care by HSC Trusts, of which only 7.8 per cent was allocated to CAMHS. It was estimated that this needed to be increased to at least 13 per cent, in order to bring it into line with the equivalent spend on CAMHS in other UK health systems, such as NHS England.

114. As things stand, it has been estimated that NI CAMHS is currently underfunded by at least £4.8 million per annum. Apart from this significant financial shortfall, the Service has also experienced significant managerial and resourcing problems, which has led to gaps in workforce planning, less than robust data collection and monitoring; inadequate support in and for schools; difficulties in ensuring equal availability and accessibility to services, including transitions between CAMHS and adult mental health services; and a lack of participation by children and young people in the development of their own health care plans. The current NI Mental Health Strategy includes a commitment to increase CAMHS funding to 10 per cent within the overall mental health budget in order to better meet the needs of young people and their support networks.

164 As of February 2021, published data showed that 170 children and young people are waiting more than 9 weeks for step 3 CAMHS and over 15 children and young people are waiting beyond 26 weeks, see NI Department of Health, Mental Health Strategy 2021-31, 45 (Northern Ireland Department of Health, 29 June 2021) <https://www.health-ni.gov.uk/publications/mental-health-strategy-2021-2031> last accessed 25 March 2022.

165 Children’s Commissioner, (n 159) 25-27.


167 ibid.

168 ibid. UK Parliament, House of Commons, Northern Ireland Affairs Committee (n 14).

169 ibid.


171 ibid.

172 ibid, 27.

115. In the new NI Children and Young People’s Strategy 2020-30, there is a commitment to tackling the stigma attached to having poor mental health while working towards improving mental health services for children and young people, through more effective and timely interventions, help and support. The new NI Mental Health Plan has been published which sets out 38 actions to be taken forward, including several that are targeted at addressing the mental health needs of children and young people. One of the actions included the development of a ten-year Mental Health Strategy, which the NI Health Minister claimed would offer the opportunity to ‘put mental health on an even footing to physical health’ and ensure that NI has ‘a world class mental health system.’

116. Following a consultation process in relation to implementation of the Strategy, a number of key action points have now been taken forward, which aim to improve children and young people’s mental health care and provision. As noted previously, this includes a commitment to increasing NI CAMHS funding to 10 per cent within the overall mental health budget in order to better meet the needs of young people and their support networks; incorporating infant mental health (0-3 years) as part of the development and delivery of CAMHS; initiating a ‘no wrong door approach’ to prevent children from being ‘bounced around’ government services; creating crisis services for children and young people to provide more timely interventions and appropriate care, and incorporating better transitions between CAMHS and adult mental health services.

117. While it has been recognised in the new Mental Health Strategy that children and young people’s views and experiences are important to consider in the development of NI mental health policy and services, there is in fact no reference made at all to children’s rights, as provided for under the UN Convention of the Rights of the Child (CRC) and other relevant international human rights instruments. While the key action points noted above should lead to better mental health care and provision for children and young people over time, the lack of attention paid to incorporating children’s rights in the context of their mental health care plans and in line with evolving capacities remains problematic.

2 Mental health laws applicable to children and young people

118. There are a range of laws that are directly, and indirectly applicable, to mental healthcare provision involving children and young people in NI. They include NI-specific laws, such as the Children (Northern Ireland) Order 1995 (NICO), which in general terms provides the legal framework for the care, upbringing and protection of children in NI. Under the NICO, the child’s welfare is ‘the paramount consideration’, which is determined by reference to specified criteria including the child’s ascertainable wishes and feelings in light of their age and understanding; their physical, emotional and educational needs; the likely effect of any change in their circumstances; their age, sex, background and any characteristics which the court considers


177 Northern Ireland Department of Health, (n 175) Actions 10-13, 44-50.

178 The five principles of the Children (Northern Ireland) Order 1995 (NICO) are paramountcy, partnership, parental responsibility, protection and prevention.

179 Children (Northern Ireland) Order 1995, s 3(1).
relevant; any harm suffered or which is at risk of being suffered; and how capable their parents are of meeting their needs.¹⁸⁰

119. The Children’s Services Co-operation Act (Northern Ireland) 2015¹⁸¹ imposes a statutory duty on children’s authorities, as well as between such authorities and the NI Executive, to facilitate co-operation with respect to functions which may contribute to the well-being of children and young persons. This also includes their mental health. As part of its statutory obligations, the NI Executive is required to publish a Children and Young Person’s Strategy setting out how it proposes to improve the well-being of children and young persons.¹⁸²

120. The current Strategy was published in January 2021, which references the CRC and aims for improvements in a range of children’s services covering information-sharing, monitoring and evaluation processes.¹⁸³ As the NI Commissioner for Children and Young People (NICCYP) has pointed out, however, the publication of the Strategy was well overdue and is in any case hampered by an ‘absence of robust data’ regarding gaps in children’s services, particularly in relation to mental health services.¹⁸⁴

121. The MCANI only applies to those aged 16 years and over. While the default legal position in NI is that a child is ordinarily defined as someone under the age of 18 years,¹⁸⁵ the age limit applied in the MCANI reflects in large part the approach taken in other pieces of NI/UK legislation, which recognises that young people 16 years and over can give consent to surgical, medical and dental treatment. The Act applies to all those aged 16 years and over with respect to determinations of capacity, and those aged 16 and 17 years of age enjoy the additional safeguards and protections that are in place under the MCANI. Once the MCANI is fully implemented, it is anticipated that the MHO will no longer apply to young people aged 16 and 17 years, in addition to those who have reached the age of majority.

122. The MHO applies, and will continue to apply, to children under the age of 16 years. As previously discussed, the MHO is considered to be outdated legislation, not meeting current best practice in relation to adults, let alone in relation to children in relation to mental healthcare. As things stand, children under the age of 16 years of age remain subject to what have been recognised as problematic time limits under the MHO, against a background of longstanding concerns about children and young people being unnecessarily detained within in-patient facilities for years.¹⁸⁶ In addition, children under the age of 16 years are not able to enjoy the safeguards built into the MCANI, in circumstances where the use of MHO is not human rights compliant and in particular is in violation of CRC rights.¹⁸⁷

123. In terms of determining capacity for children under the age of 16 years, the common law applies under the NI mental health legal framework. Assessing capacity is determined by reference to

¹⁸⁰ ibid, s 3(3)(a)-(f).
¹⁸¹ Children’s Services Co-operation Act (Northern Ireland) 2015.
¹⁸² ibid, s 3.
¹⁸³ Northern Ireland Department of Education, (n 174).
¹⁸⁵ Age of Majority Act (Northern Ireland) 1969, s. 4
¹⁸⁶ Davidson, McCallion and Potter, (n 106); Children’s Law Centre, (n 114).
¹⁸⁷ Specifically, Art 37(b) CRC which states that a child should only be deprived of their liberty ‘for the shortest appropriate period of time’.
what is known as Gillick competence, which holds that a child under the age of 16 years who has ‘sufficient intelligence and understanding’ can consent to medical treatment. However, it is a presumption of capacity, which can be rebutted in the face of evidence to the contrary. A series of cases in recent years has shown that UK courts remain uncomfortable with finding that a child under the age of 16 years is Gillick competent to refuse medical treatment, particularly where such a refusal may result in serious illness or the death of the child as a result.

124. The recent case of Re D (A Child) is instructive with respect to how the UK courts view competing rights between children and young people under Article 5 of ECHR (right to liberty and security) and those of the parents, which is grounded in Article 8 of the ECHR (right to private and family life), as well as common law and statutory provisions, such as the Children Act 1989. The legal issue at stake in the case was whether parental consent with regards to the living arrangements for a 16-year-old boy contravened his Article 5 rights. While the court recognised that the child’s welfare should be ‘the paramount consideration’, it nevertheless went on to find that parental rights were not absolute and that the degree of supervision to which the child was subjected was ‘not normal for a child of his age.’ In the circumstances, a parent/guardian could not authorise what would be a breach of their child’s Article 5 rights, regardless of whether a child has a mental disability or not.

125. In the context of NI mental health laws, such as the MCANI, which only applies to those aged 16 years and over, the Re D judgment brings into stark relief the fact that, as things stand, the human rights of this group of young people are different to the rights of those aged under the age of 16 years. Under the terms of the MCANI, parents are still allowed to consent to their 16 or 17 year old children being deprived of their liberty, contravening not only Re D but also a range of other human rights instruments.

126. Indeed, concerns about human rights protections increasingly form part of legal challenges in NI over decision-making and orders involving questions of children’s capacity, involuntary treatment for mental disorders, and detention for other reasons. The ECHR rights which are of particular relevance to mental healthcare provision to children and young people include Article 3 (prohibition of torture, inhuman or degrading treatment or punishment); Article 5 (right to liberty and security); Article 8 (right to respect for family and private life); and Article 14 (right not to have ECHR rights secured in a discriminatory way). Other relevant international human rights instruments include the CRC and the CRPD.

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188 Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112, [186] per Scarman LJ.
189 See for example Re R (A Minor) (Wardship: Consent to Treatment) [1992] Fam. 11; Re W [1993] Fam. 64; L (Medical Treatment: Gillick Competence), Re [1998] 2 F.L.R. 810; An NHS Foundation Hospital v P [2014] EWHC 1650 (Fam); A NHS Trust v X (In the matter of X (A Child) (No 2)) [2021] EWHC 65 (Fam).
190 In doing so, reliance was also placed on Article 7 of the UN Convention on the Rights of Persons with Disabilities (CRPD) UN General Assembly, 24 Jan 2007, A/RES/61/10, see Re D (A Child) [2019] UKSC 42, para 45.
191 Ibid.
192 McAlister, Scraton and Haydon (n 157), 21.
194 CRPD (n 190).
B IRELAND

1 Prevalence, policies and funding

127. Data is patchy regarding the numbers of children and young people with mental health difficulties in Ireland and it is not easy to piece together an accurate picture of prevalence. However, piecing together available data, it seems clear that there are significant levels of mental health problems. A UNICEF report published in 2017 found that 22.6 per cent of adolescents (aged 15–19 years) reported two or more mental health symptoms more than once a week.\textsuperscript{195} A 2015 study found that 19.8 per cent had a current mental disorder, 56 per cent had a lifetime mental disorder of whom 28.4 per cent had mood disorders, 27.1 per cent had anxiety disorders, 22.7 per cent had substance use disorders; and, 25.4 per cent had lifetime multi-morbidity.\textsuperscript{196} There is clearer data on in-patient admissions: 486 children and young people were admitted to psychiatric facilities in 2020, which was down from 497 in 2019.\textsuperscript{197} Of these admissions, the vast majority were voluntary admissions.

128. HSE child and adolescent mental health services (CAMHS) are the first line of specialist mental health services for children and young people in Ireland. Children and young people may be directly referred to the CAMHS team by their general practitioner, as well as through other agencies and organisations. These include Childline, Jigsaw, BeLongTo, SpunOut.ie, and ReachOut.com. CAMHS accept referrals for moderate-to-severe mental health difficulties that cannot be managed within primary care, providing such services in partnership with agencies such as HSE Primary Care and the Children’s Disability Network Teams.

129. A Vision for Change report (AVFC) provided a number of recommendations in relation to child and adolescent mental services. This included a recommendation that CAMHS provides mental health services to all young persons aged 0-18 years, with a significant proportion being provided as part of primary care. Other recommendations included that child and adolescent mental health services should be provided through multidisciplinary Community Mental Health Teams (CMHTs) with two teams for each sector with a population of approximately 100,000 residents; and that one further child and adolescent CMHT should be provided per catchment area involving a population of 300,000 residents in order to provide liaison cover. The report did not specifically refer to a need for a youth-oriented mental health service but stated that the overall policy focus was to provide accessible, community-based, specialist services for people with mental illness.

130. The Irish government’s current mental health strategy, set out in Sharing the Vision, makes recommendations for the transition of young persons from CAMHS to adult services, suggesting a 25-year age limit. As things currently stand, a young person makes the transition from CAMHS to adult services at the age of 18 years. This is a period of uncertainty for the young person and a poor transition can lead to disengagement and consequently poorer health outcomes.\textsuperscript{198}


\textsuperscript{196} Michelle Harley et al, Prevalence of Mental Disorder Among Young Adults in Ireland: A Population Based Study (Cambridge University Press, 2015).

\textsuperscript{197} Daly and Craig (n 131).

2 Mental health laws applicable to children and young people

131. The MHA defines a child as meaning ‘a person under the age of 18 years other than a person who is or has been married.’ In order to be admitted under the MHA, a child must meet the criteria for involuntary detention, previously referred to under the mental health laws section of the working paper. In addition, admission of children must be in accordance with section 25 of the MHA, which requires that all such applications for involuntary admission to be made by the HSE. Such an application may only be made where it appears to the HSE that the child requires treatment which they are unlikely to receive unless an order authorising the child’s detention in an approved centre is made. All applications must be made to the District Court.

132. Child protection legislation, such as the Child Care Act 1991, also applies to involuntarily admitted children. Section 24 of the Child Care Act places the child’s welfare as the primary consideration, with due consideration being given to the child’s wishes, having regard to their age or understanding. This reinforces the best interests principle set out in section 4 of the MHA. Section 26 of the Child Care Act also makes provision for the appointment of a guardian ad litem to act on behalf of the child.

133. The MHC’s Code of Practice (2006) provides guidance about how the MHA applies to children admitted under the MHA, which includes setting out principles such as the provision of the least restrictive care for the minimum period in line with the best interests of the child in the context of an involuntary admission, in conjunction with the importance of ascertaining the child’s views depending on their age and maturity.

134. The MHA does not include a requirement for consent to treatment for a mental disorder for children who have been involuntarily admitted. However, it does include a requirement that a second opinion must be obtained after treatment has been administered to a child for a continuous period of 3 months. The vast majority of children admitted to approved centres are voluntary patients. In 2020, for example, just 39 children were admitted for involuntary treatment under the MHA. Voluntary admission of a child or young person is usually based on consent of the child’s parents or legal guardians. Where a child is voluntarily admitted, the legal protections of the MHA and the Child Care Act 1991 do not apply. The Council of Europe’s Committee for the Prevention of Torture has expressed concern at the lack of safeguards for voluntary child patients. The Irish Law Reform Commission has also recommended the introduction of a new category of ‘informal admission’ for children admitted under the MHA 2001 by parental consent. The Expert Group Review on the MHA recommended that the law be amended so that a young person aged 16 and 17 years of age should only be admitted voluntarily on the basis of their own consent.

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199 MHA, s 2(1).
200 ibid, s 25(1).
201 ibid, s 25(1).
202 ibid, s 61.
204 Council of Europe, Report to the Government of Ireland on the visit to Ireland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) (Council of Europe 2011) CPT/Inf (2011) 3, 60.
206 Government of Ireland, Department of Health, (n 142) 71.
135. Section 23 of the Non-Fatal Offences against the Persons Act 1997 states that the consent of a minor aged 16 years to any surgical, medical or dental treatment shall be as effective as if the minor were of full age. For various reasons, including that the relevant provision is contained in a criminal law statute, there has been some uncertainty about the scope of this provision and its application to treatment for a mental disorder. However, the HSE National Consent Policy now clearly states that the age of consent to treatment for a mental illness (for someone who has not been admitted under the MHA) is 16 years.\textsuperscript{207} In addition, the High Court decision has confirmed that the refusal of treatment – in this case for a mental disorder – should be distinguished from consent to treatment.\textsuperscript{208} Nevertheless, the Court emphasised that this was not ‘to suggest that the views of a minor of that age ought not to be treated with respect, they most certainly should be.’\textsuperscript{209}

\textsuperscript{207}Health Service Executive (n 153) para. 8.1.
\textsuperscript{208}HSE v JM and Anor [2013] IEHC 12.
\textsuperscript{209}ibid, para 23.
Part VI: Learning and Future Research

136. There have been considerable developments in mental health laws and policies on the island of Ireland in recent years. The introduction of new legal frameworks and strategic policy frameworks in both jurisdictions provides excellent opportunities for collaborative and comparative research, going forward. In order to facilitate such joint learning and future research, it would be useful to consider a number of current issues and we highlight three key ones below.

137. **The need for agreed common mental health dataset** At present, there is no agreed common mental health dataset including: the need for services; the resources for services; the services provided; and the outcomes for service users and carers. There is an excellent opportunity to agree a set of indicators which would be directly comparable and, ideally enable comparison both between the two jurisdictions, and with other countries.

138. **An agreed approach to the evaluation of implementation of capacity-based laws** It seems remarkable that new mental capacity based laws and new mental health strategic policy frameworks were developed in parallel, with what appears to have been very little discussion and cooperation between the two jurisdictions. It would be useful to develop opportunities across all levels for policy-makers, service providers, service users, carers and researchers working in the field to meet, learn from each other and explore opportunities for joint working and research. In the short term, identifying an agreed approach to evaluating the implementation of capacity based laws.

139. **The development of a joint research agenda in mental health law and policy** A crucial aspect of these developments could involve the identification of a joint research agenda and, based on this report, there are a number of areas which should be prioritised. Research priorities include:

(i) the legal frameworks and service provision for children and young people;

(ii) the implementation and effectiveness of the new capacity based laws;

(iii) the development and effectiveness of approaches to support autonomy and reduce the need for compulsory intervention;

(iv) the provision of specialist services and opportunities for all island cooperation.