National Office for Human Rights and Equality Policy

Webinar – 9th May 2024

HSE National Consent Policy 2022 - Considerations for Mental Health Services

1. **Can I ask about grey area of young person's age 16 and 17 years old with the Consent Policy? What if there is an incidence of an emergency situation in a social care organisation - can the organisation share information with parents if it's an emergency situation?**
   This complex area is addressed on pages 61 and 62 of the National Consent Policy, and (to a degree) pages 55 and 56. Professor Donnelly will also address this in a broader way. https://healthservice.hse.ie/staff/procedures-guidelines/hse-consent-policy/

2. **In the case of the National Ambulance Service, as an extension of HSE, if paramedics are on scene and form the decision that the patient doesn't have capacity, what avenues to provide care do we have if they decline? For Adult <18yrs, <16yrs and >16yrs.**
   There are no new powers to act under ADM. NAS I know very experienced in persuading/coaxing people in these situations. Doctrine of necessity allows emergency treatment to be given if this is practical - it may not be. Page 20 of the Consent Policy has (2.5) advice on emergency situations.

3. **Will copies of the presentations be shared?**
   A pdf of presentations will be available with the recording of this event in Mental Health Hub, on HSeLand.

4. **Have there been considerations for ensuring both the safety and respect of the dignity of persons in the general hospital setting who are awaiting a formal capacity assessment (however perspicuously have altered capacity due to a neurodegenerative disorder) but who by, for example, their refusal of medication to assist with the management and minimisation of distress arising from behaviours that challenge, pose an immediate threat to themselves, other patients and staff?**
   Doctrine of necessity allows emergency treatment to be given if this is practical - it may not be. Page 20 of the Consent Policy has (2.5) advice on emergency situations.

5. **Under Children First, all young people under the age of 18 are deemed to be children. Can you clarify the legal standing on these conflicts?**
   These legal measures apply to different issues. This means that the reporting obligations under Children First apply up to 18. However, consent to treatment is not covered by Children First.

6. **Should consent to attend community CAMHS be sought for all young people over the age of 16?**
   A young person aged over 16 may consent to attending CAMHS from the age of 16 years. So if someone reaches the age of 16, their consent should be sought.

7. **Can you clarify what types of decisions might be covered under the category of healthcare decisions as distinct from health treatment decisions**
   This is a challenging distinction to make. The starting point is the definition of treatment in the ADMA Act - see s. 82 which is 'an intervention that is or may be done for a therapeutic, preventative, diagnostic, palliative or other purpose related to the physical or mental health of the person, and includes life-sustaining treatment'. As you can see this is pretty broad. Healthcare decisions - which are not defined in the Act - but they basically cover anything that involves healthcare and doesn't fit within the legal definition of treatment.

8. **A tricky question but I wonder if the panel have any thoughts on situations that might arise within mental health settings where an AHD is in use and life-sustaining treatment stipulations are included within it, even in the case of suicide attempt. I.e. what implications would this have for a healthcare worker intervening in a case of a suicide attempt, for example providing CPR?**
   The Decision Support Service "Code of Practice on Advance Healthcare Directives for Healthcare Professionals" addresses the matter of Advance Healthcare Directives and suicide attempts on page 27: https://decisionsupportservice.ie/resources/codes-practice/code-practice-advance-healthcare-directives-healthcare-professionals#

9. **Is the WRAP planning, referred to by Trevor, recognised in ADM?**
   The ADM recognises elements of WRAP planning through an AHD - i.e. any elements relating to refusal of, or request for treatment - or the appointment of a Designated Healthcare Decision-Maker. WRAP planning is also important in indicating a person's will and preferences and so that is something which the ADM recognises. So while WRAP planning doesn't neatly map onto the ADM Act, there is a lot to support WRAP planning in the ADM Act

10. **Where can I find the consent policy? Also what supports/resources are available to staff in implementing the policy?**
    The resources are available on hse.ie/nationalconsentpolicy and the eLearning programme is here - https://healthservice.hse.ie/staff/training-and-development/assisted-decision-making-capacity-act-2015/#national-consent-policy-e-learning

11. **If a 16 year old is admitted voluntarily with both YP and parental consent to admission to approved centre, and YP and one parent consents to treatment eg medication, but one parent does not consent to this treatment option, does the YP consent override the one parent?** Yes - the YP's (i.e. over 16) consent is determinative - regardless of whether one or both parents are refusing.

12. **Where a person is admitted involuntarily under the 2001 Mental Health Act, under part (b), the therapeutic intervention part, what is the situation if AHD states no medication desired, as often medication is clinically indicated for therapeutic benefit for those admitted with serious relapse of severe and enduring mental illness.**
    Stating "no medication" is unlikely to be sufficiently specific to be valid in an Advance Healthcare Directive. However, if a series of specific refusals in a valid and applicable AHD mean that the person detained under Section 3(1)(b) cannot be effectively treated, they might no longer meet the benefit criteria of that section, and need to have the order revoked.

13. **My question was where someone has stipulated they don't want life-sustaining treatment even in the case of a suicide attempt in an AHD, and then while receiving mental health treatment in a mental health setting a suicide attempt is made. Does this preclude a health worker from intervening with CPR for example?**
    If the AHD specifies a refusal of life-sustaining treatment following self-harm, and if the AHD is valid and applicable in the circumstances, then it is to be respected, unless the potential intervener has reason to believe that the directive-maker lacked capacity at the time they made the AHD (p. 27 of the DSS document).

14. **Can you talk to what the policy says in respect of need to seek both parents consent in respect of community based MH services when parents are separated but both have guardianship rights?**
    So the general policy of the National Consent policy is that the consent of one parent (presuming both have guardianship rights) is sufficient unless:
    Both parents have indicated that they wish to be involved intervention is high right and/or likely to have serious consequences for the child. The Policy also emphasises the best interests of the child - and recognises that if a parent cannot be contacted, treatment may proceed on the basis of one parent's consent - even in high risk situations - See generally Pt. 2, section 4.1
    https://media.childrenshealthireland.ie/documents/consent-policy-national_unWu5yu.pdf

15. **In response to the above anonymous question regarding one parent and YP consent for medication administration. A similar situation arose here in the community, legal advice was sought and the advice given was that The Mental Health Act 2001 over rules the National Consent Policy, a YP is unable to consent to treatment under the age of 18 years. Court action would be required to administer prescribed medications to the YP as one parent was not consenting. Can you please clarify this further?**
    The Mental Health Act applies to admission to an approved centre and most of it applies only to someone who has been involuntarily admitted. So where it applies, it absolutely is most be respected. However, the Mental Health Act says nothing about the age of consent to treatment in the community and so this matter is covered by the National Consent Policy.

16. **Is it sufficient for a decision making assistant to say that they got the relevant person's consent when liaising with the MDT? (I know they must get consent but do we seek proof)**
    The DMA should be able to provide the decision-making assistance agreement listing the relevant decisions. This should have been notified to but not formally registered with the Decision Support Service. But the appointer still makes the decision so if any doubts check with them.

17. **If a patient is involuntarily detained under the MHA in an approved centre but then must transfer to an acute facility for emergency treatment and has to be admitted, do the conditions of the involuntary detention follow them into the acute setting, i.e. as per Section 22 (3) of the MHA: (3) The detention of a patient in a hospital or other place under this section shall be deemed for the purposes of this Act to be detention in the centre from which he or she was transferred.? And if there are capacity issues in terms of consenting to that treatment or consent to remaining in the acute facility (for example, an Emergency Department), does the NCP apply or are there provisions under the MHA?**
    Yes, conditions of MHA 2001 detention follow them, as do all the Sections of the MHA 2001 pertaining to treatment for mental illness (i.e., Part 4). For treatment of physical illness, NCP applies in the usual way, as do the provisions of the Assisted Decision-Making (Capacity) Act, 2015, if applicable.

18. **Can a 17 year old CAMHS (community) case refuse care if parent's consent?**
    If a 17 year old refuses cares parental consent will not suffice. The Court can override a refusal by someone under 18 - but simple parental consent will not suffice here.

19. **Can a 15 year old CAMHS (community) case refuse care if parent's consent**?
    No - parental consent will suffice here - but it is important to remember that the child's views are important here - and so these must be taken into account - so they must be involved in the decision-making, consulted and it should be considered if any form of compromise which might work for the child might work.

20. **What specific rights do family members/supporters have around to access to information and involvement in decisions re a loved ones care in acute severe mental health crises attending adult mental health services in particular? Unfortunately, in certain cases, a person's capacity may be diminished and their supporter/family member can provide a valuable, extremely important perspective that is an important consideration for clinicians in determining care plan and treatment.**
    Unless you have the explicit consent of the person to speak to their family members/supporters then it should not happen. Family members/supporters who are official decision supporters as per ADM and the DSS have the rights linked to the decision-support level. This is why AHDs and advance planning is really important. When the person is well have the conversation with them about who to contact if there should be a situation such as described here. We need to remember that sometimes (maybe rarely, but possible) that family members/supporters can contribute to the persons mental health difficulties

21. **In an acute setting can a patients consent be overruled when a person is so mentally unwell that their decision making is impaired? At these times the service may need to get collateral from family members despite patient withdrawing consent**
    Valid consent (or refusal of consent) by definition is from someone with decision making capacity. Depends on what treatment is being proposed/refused and how urgent. The doctrine of necessity - see consent policy Pg 20 and elsewhere - allows care to preserve life and health to be given in emergencies.

22. **If a patient comes to the ED and there are capacity issues and they are unable to give their consent because they are actively having a psychotic episode, is there provision for restraint under the MHA (Section 57?) and how does the ADMCA interact with this? Also, is there any provision for restraint under common law since the AC case?** The MHA does not mandate restraint in this situation, unless the patient is already an involuntary patient under the 2001 Act. The ADMCA does not authorise coercion or restraint, but the doctrine of necessity remains in place.

23. **What about vulnerable patients who don't have social supports/spouse/carers, don't consent to long term care but are ready for discharge from acute approved centres. There aren't really home care packages for them?**
    People have to make decisions in the context of the choices available to them and, sadly, in some cases this means a choice between LTC and home with an inadequate package of care. The latter choice is not necessarily 'unwise' - understandable that many will prefer their own home. And detention can only occur following lawful process - see pg 49 of consent policy.

24. **In relation to safeguarding concerns for adults that are older at home, it is important not to adopt a default positon of removing the older person to a place of safety. e.g. a nursing home. Once this step is taken, it will become very difficult for the older person to return home, e.g. deconditioning, length of time away from home etc. All avenues including therapeutic and holistic engagement with the service user and family member causing concern, recognition of caregiver stress and communicating the presenting safeguarding concerns and offering advice, guidance and solutions including access to carer training, carer support, community Garda, protection orders, Alone, Age Action and much more as the community supports can empower and support effective safeguarding planning in the home.**
    Agreed

25. **My resident with severe Dementia (unable to express wishes) has been admitted to an acute hospital and a DNR status has been applied by the medical team (not in place in residential facility). What guidelines should be adhered to prior to this decision making of DNR?**
    Part 3 and Appendix 10 of HSE National Consent Policy 2022 provide guidance on DNA-CPR decision-making. The National Office of Human Rights and Equality Policy will shortly publish a research report on DNA-CPR policy and practice with a view to producing a standalone HSE policy on DNACPR. Please email national.consentpolicy@hse.ie to receive future updates on this work.

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