ACQUIRED BRAIN INJURY IRELAND

Submission on the Deprivation of Liberty: Safeguard Proposal Consultation

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Introduction

Acquired Brain Injury Ireland (ABI Ireland) welcomes the opportunity to input into the consultation in relation to the Deprivation of Liberty Heads of Bill. This submission is based on our real world experience from a clinical perspective working in acquired brain injury specific services.

Acquired Brain Injury (ABI) and Deprivation of Liberty legislation

This legislation is highly relevant to people with ABI. Brain injury may impact on an individual's capacity to make decisions and to provide consent. Given the impact an ABI can have on a person's life, some are living in a variety of residential settings including nursing homes for older people, residential settings for people with disabilities, as well as ABI-specific residential settings. In some of these settings, they are under continuous supervision and control and/or not free to leave.

Head 1 - Definitions

1.1 Do you have any views on the definitions currently included in this draft Head?

A good definition of chemical restraint is outlined. It is also welcome that Section 39 residential services appear to be included; however, the wording could be clearer around Section 39 residential services being definitively included under the legislation.

1.2 Do you have any views on the types of healthcare professionals that should be included within the definition of "other medical expert"?

As per Explanatory Note 6, Chartered Psychologists (on a Specialist Register with the Psychological Society of Ireland and registered with CORU) should be included. Their specialist training (usually at doctorate level) makes them well-qualified to assess questions around functional aspects of capacity as defined in the ADM Capacity Act 2015 i.e. verbal and non-verbal comprehension (understanding information relevant to a decision), verbal and non-verbal memory (retaining information long enough to make a decision), verbal and non-verbal reasoning (using or weighing information) and verbal and non-verbal communication (of a decision).

Head 2 – Application and purpose of this part

2.1 Do you have any views specific to Head 2?

In terms of the application and purpose it would be useful at a practical level to disambiguate whether the "under continuous supervision and control" part is necessary over and above what would seem to be the paramount criteria of "not be free to leave". In real-world settings it is entirely possible to have one or the other and not both. A person could be under continuous supervision and control (with 24/7 staffing) and free to leave, or the person may have very little supervision and control but not be free to leave (a locked setting with few staff). Is it one or both or either?

The Wards of Court are all due to be reviewed within three years as per the ADM Capacity Act 2015 and will be either discharged from Wardship or reassigned somewhere on the decision making spectrum so while it may not apply to Wards now it will apply to some current Wards in the future.

Head 2 does suggest that an option from the decision making spectrum will need to be identified and formalised for many residents in Section 39 organisations.

In relation to "is not or will not be free to leave", in many instances a person could be theoretically free to leave but in actuality cannot leave, and this may be tantamount to being deprived of their liberty. The absence of the necessary community supports, or alternative residential placements for people with ABI means that it is not realistic for them to leave a residential setting. In essence, they would be making a choice between staying or leaving a relevant facility to become homeless.

Head 3 – Person's capacity to make a decision to live in a relevant facility in advance of an application to enter the relevant facility

3.1 Do you have any views specific to Head 3?

Head 3 appears to be very coherent and sensible as it requires the healthcare professional (HCP) to establish whether there is already someone on the decision making spectrum as per the ADM Capacity Act 2015, and requires them to formally notify the person who may be admitted and anyone else they nominate. It is also very clear that if there is a CDM or DMR or EPA, or a Court-order, there must also be clarity that they were "including a decision that the relevant person should live in a relevant facility". If the decision to admit wasn't pre-agreed the HCP must still inform the assisted decision maker, and the person, so as they may make an application to court.

Head 4 – Procedure for routine admission of a relevant person to a relevant facility

4.1 Do you think the terms "under continuous supervision and control" should be defined?

Yes, see the comment made under Head 2. There needs to be much more clarity on this clause and whether it is dependent on or independent of "not free to leave".

4.2 Who should be notified… affording them the opportunity to make an application to court?

If the HCP believe a relevant person requires relevant admission, and where there is no one on the assisted decision making spectrum already in place, they notify the relevant person, and whoever they ask to be informed. It may be problematic for the relevant person to identify who they want notified at a time when they lack capacity to decide on an admission for themselves. It would be good if the legislation could list some obvious people like the General Practitioner and the person's solicitor if they have one. If they don't have one, perhaps the person needs referral to a local FLAC.

4.3 Do you have any other views specific to Head 4?

Overall, it is sensible in that people suspected to not have capacity cannot be admitted to a relevant facility without someone on the assisted decision making spectrum, including the court itself, making a legal decision. It would be well worth reiterating here clauses from earlier in the act that state (paraphrased here) that the decision maker who takes the decision to admit has to have had it pre-agreed at a time the person entered into the AHD, EPA, or when the court made a DMO, or appointed a DMR… that the possible future decision to admit to a relevant setting where the person would be under continuous supervision and control and not free to leave is clearly in writing beforehand. So a DMA, CDM, DMR, or EPA cannot admit someone unless it was pre-agreed that the decision to admit was one they could make down the line when the person lost capacity.

Head 5 – Procedure for admission of a relevant person to a relevant facility in urgent circumstances

5.1 What are your views on the proposed circumstances in which an urgent admission can be made?

Notionally, it is sensible in terms of the circumstances of the individual but there needs to be clarity as to how this piece of legislation will interact with the Mental Health Act 2001 (MHA 2001). It is critical that Section 39 organisations do not become default admitters for MHA 2001 exclusions (i.e. people with personality disorders, social deviance, or addictions).

5.2 Should a health professional, other than a registered medical practitioner be able to provide medical evidence?

Yes, Chartered Psychologists (as per details provided in Head 1).

5.3 Who should make the application to the court if no-one else does? Do you have a view on the proposed role of the Director of the Decision Support Service?

The Director of the Decision Support Service should make the application. However, it is likely to have to make a significant number of applications in the short term as it is very likely that people will not have co-decision makers, decision maker representatives, enduring powers of attorney, or court decision making orders in the early years after the ADM Capacity Act 2015 is enacted. This will certainly have implications for the resources available to the Decision Support Service.

Head 6 – Procedure for making an admission decision

6.1 Is the evidence of one medical expert sufficient?

No, at a minimum it is reasonable that it should be two experts (as it used to be to start the process of making a person a Ward of Court).

Head 7 – Person living in a relevant facility

7.1 Fluctuating Capacity

This is extremely difficult to assess in terms of offering a prognosis of whether and when capacity may return, even for a Clinical Psychologist or Psychiatrist. It is very unlikely that a PIC or their HCP team-leader will be able to professionally evaluate this. They should contact a medical practitioner.

7.2 Do you have any views on the length of time that would be considered a "short period"?

One month would be a reasonable short timeframe from loss of capacity to expected demise. This is based on the existing practice timeframe within which a GP doesn't have to notify the coroner following a patient's death, if they had a condition from which they were expected to die, and the GP had seen them in the last month. Again this should be a medical practitioner call, not the PIC/HCP.

7.3 Do you have any other views Specific to Head 7?

There is a very heavy burden placed on the Person in Charge in terms of temporarily preventing the relevant person from leaving the relevant facility.

Head 8 – Transitional arrangements for existing residents on commencement of this part

8.1 Do you have any views specific to Head 8?

This is a sensible precaution to protect existing residents who may not have the capacity.

Head 9 – Review of admission decisions

9.1 Do you have any views specific to Head 9?

The clauses that require the court to review its findings on a person's capacity is a good safeguard. In fact this is absolutely vital to the entire deprivation of liberty process.

Head 10 – Chemical restraint and restraint practices

10.1 Do you have any views specific to Head 10?

We note that there is a slightly different / shorter definition in Head 10 versus the one referred to in Head 2, and perhaps the longer Head 2 definition should be duplicated in the text in Head 10.

Head 11 – Records to be kept

11.1 Do you have a view on the types of records that must be kept under this Head?

11.2 Do you have any other views specific to Head 11?

ABI Ireland has no specific comment on this head. Excellent record keeping is best practice

Head 12 - Regulations

12.1 Do you think that the Minister should be empowered to make regulations on any other aspect of the Heads?

ABI Ireland has no specific comment on this head.

12.2 Do you have a view on any other policy and procedure that should be included in this subhead?

ABI Ireland has no specific comment on this head.

12.3 Do you have any other views specific to Head 12?

ABI Ireland has no specific comment on this head.

Heads 13 – Offences

13.1 Do you have a view on the proposed offences set out in this Head?

ABI Ireland has no specific comment on this head.

13.2 Do you have any other views specific to Head 13?

ABI Ireland has no specific comment on this head.

14 – General questions

14.1 Do you have any views on the proposed timeframes?

ABI Ireland has no specific comment on this head.

14.2 Should those with mental illness be treated differently to others?

ABI Ireland has no specific comment on this head.

14.3 Do you have any other views on the draft provisions?

ABI Ireland has no specific comment on this head.

Supporting Information

About ABI Ireland

ABI Ireland is a dedicated provider of community-based neuro-rehabilitation services for people with an acquired brain injury (ABI) and their families. As a brain injury can affect a person's ability to manage their own life, ABI Ireland works in communities across Ireland to support and empower people to rebuild their lives. ABI Ireland also campaigns, educates and advocates for the rights and needs of this hidden group in society.

ABI Ireland Services

ABI Ireland provides a diverse range of accredited neuro-rehabilitation services. The core services include:

- Clinical neuro-rehabilitation teams
- Residential rehabilitation
- Transitional living
- Day resource/clubhouse
- Home and community rehabilitation
- Case management

Additional support services are also provided and include ABI information, family support and carer training.

Key Facts on ABI

- There are many ways in which a person can acquire a brain injury. These include, among others, a fall, assault, accident, infection, stroke or tumour.
- Depending on what part of the brain is injured, and the extent of the injury, the person will have to live with different consequences.
- Many of the consequences of brain injury may be hidden, others not. They range from physical and sensory to cognitive and psychological affecting how a person feels, thinks, acts and relates to others.
- Each year it is estimated that 13,000 people in Ireland acquire a brain injury. However, there are no official statistics on ABI in Ireland.
- ABI is one of the leading causes of disability and can have life-long consequences
- Neuro-rehabilitation is a clinical and social process to aid recovery after a brain injury. It is about relearning, compensating and regrowth so the person lives a life of their own choosing. It supports the person to live a meaningful everyday life.

Contact Details

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