The Mental Health Act 2001: Delivering on best practice?

No. 5, 2012

Editorial

In advance of the publication of the Department of Health’s review on the operation of the Mental Health Act 2001, the Library & Research Service examines some of the key provisions of the 2001 Act in the context of international best practice, the Government’s own vision for Ireland’s mental health services (as outlined in A Vision for Change), and what commentators have said about the operation of the Act to date.

In 2011, 1,471 involuntary admission orders were made under the 2001 Act. Four hundred and twenty one admissions were made in respect of children, one third of whom were admitted to adult units.

This Spotlight looks, among other things, at the procedures involved in the involuntary admission and detention of persons under the Act and the protections afforded to them during these processes.

This Spotlight is the second in a series focusing on mental health issues. The Spotlight on Well-being: promoting mental health in schools which was published in March 2012 is available by clicking here.
Executive summary

Ireland’s mental health legislation was overhaul in 2001 to bring it in line with international human rights standards. The Mental Health Act 2001 provides safeguards for those involuntarily admitted and detained in approved centres, and puts in place mechanisms for the regulation and inspection of our mental health services.

Although some of the provisions in the Act were only commenced recently (e.g. the provisions on involuntary admissions, review of detention, and consent to treatment) concerns have been raised that the Act is already out of line with developments both domestically and internationally. Commentators have also raised concerns about the day to day operation and interpretation of the Act.

The Department of Health is in the process of finalising its review of the operation of the 2001 Act, which is a statutory requirement under the Act. Commentators have welcomed the opportunity to make submissions, and have expressed the hope that the review will bring about not only legislative change but also a cultural shift in how we deal with persons experiencing mental health problems.

Some of the concerns examined in this Spotlight include, that:

- in failing to implement A Vision for Change (AVFC) Ireland is not meeting international human rights standards, and may be depriving persons of their liberty unnecessarily;
- the 2001 Act focuses on involuntary detention with little or no reference to community based services;
- children are offered less and inferior protections under the 2001 Act;
- mentally incapacitated but compliant patients have little or no protections under the Act;
- the status of a voluntary patient is not determined by their legal capacity or ability to consent;
- the Act provides for the administration of electro-convulsive therapy and forced medication in circumstances where a patient is able but unwilling to consent; and
- the paternalistic approach and interpretation of the 2001 Act is contrary to the person centred approach as set out in AVFC.

Introduction and background

The World Health Organisation (WHO) has stated that governments are as responsible for the mental health of their citizens as they are for their physical health.¹

It is estimated that 44% of Irish people have directly experienced some form of mental health problem, either personally or through family and friends.² Given that almost half of the population will, at some point in their lifetime, have contact with mental health services it is essential that legislation underpinning these services be in line with international human rights standards and best practice.

Evolving standards and the Mental Health Act 2001

Before the enactment of the Mental Health Act 2001 the primary piece of mental health legislation dated back to 1945. The 2001 Act brought about major reform in the area of mental health law and practice in Ireland.

Despite bringing Ireland’s laws on mental health into line with international human right standards, concerns were raised even at the time of enactment that the Act did no more than the minimum required. Concerns continue to be expressed that the Act is outdated and fails to take into account developments both domestically and internationally, for example, the publication of Ireland’s policy document on

² Mental Health in Ireland, Mental Health Reform Promoting Improved Mental Health Services, http://www.mentalhealthreform.ie/home/mental-health-in-ireland/
mental health A Vision for Change in 2006 and the ratification by the EU of the UN Convention on the Rights of Persons with Disabilities (CRPD) in 2011.

Irish commentators are calling for the principles of the Convention to be adopted and incorporated into all our mental health legislation.3

**Box 1: The UN Convention on the Rights of Persons with Disabilities**

The CRPD places a new emphasis on the preservation of the dignity of those with disabilities. The Convention aims to ensure that people with disabilities can enjoy their rights on an equal basis with all other citizens.

Article 12 provides that States must recognise that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life. It also provides that States must take appropriate measures to provide access to supports which persons with disabilities may require in exercising their legal capacity (e.g. supported decision making, advocacy, and advanced planning directives).4

Although Ireland was one of the first countries to sign the Convention it has yet to ratify it. Minister for State, Kathleen Lynch, TD, has however, stated that the Mental Capacity Bill will be a key stone in Ireland’s ratification.5

Amnesty International Ireland (Amnesty) has highlighted a number of human rights concerns in relation to the 2001 Act, in particular:

‘…the lack of a recovery focus, the way the tribunal system works (where detention is reviewed), the lack of capacity safeguards, the overly paternalistic application of the law where the view of the psychiatrist is only really considered, and how treatment is currently allowed for against a capable person’s will under the Act. The 2011 report from the European Committee for the Prevention of Torture also highlighted a number of concerns. These include the lack of protection for voluntary patients, the need to amend the Act in relation to the use of electro-convulsive therapy, and the lack of an independent capacity assessment.’6

In June 2011, the UN Committee Against Torture also found that the Act was not human rights compliant and recommended that the State review it.7

**Departmental review and Legislative Programme 2012**

The Department of Health is currently in the process of reviewing the 2001 Act in consultation with service users, carers and other stakeholders. The expected date for publication of the review is June 2012.

The Government in its Legislative Programme for 2012 has indicated that it will introduce a Mental Health (Amendment) Bill to provide technical amendments to the Act which are necessary to correct drafting errors, which are mandated by court rulings, or which are desirable in the interest of clarity.8

The Mental Capacity Bill, intended to reform the law on capacity, wards of court and enduring powers of attorney, is currently on the A list of the Legislative Programme and is expected to be published before the 2012 summer recess.

---


5 CBM, Briefing on UNCRPD highlights need for Irish ratification, 2011 http://www.cbm.ie/newsandpress/2011/05/26/briefing-on-uncrpd-highlights-need-for-irish-ratif/


The purpose of the Mental Health Act 2001 is twofold. Firstly, it provides safeguards for those involuntarily admitted and detained in approved centres. Secondly, it puts in place mechanisms whereby the standards of care and treatment in our mental health services can be monitored, inspected and regulated by the Mental Health Commission and the Inspector of Mental Health Services.

One of the key provisions of the Act is that every decision made to detain a person involuntarily must be independently reviewed by a Mental Health Tribunal. This review is automatic and must be completed within the statutory time periods (see section on review of detention p.12).

The Act also provides certain safeguards for patients in relation to their treatment. It requires that a patient’s consent must be obtained for treatment. This requirement is offset, however, to a large extent by the exceptions set out in the Act (see section on consent to treatment p.14).

Because the 2001 Act was introduced on a phased basis, provisions on involuntary admissions, review of detention, and consent to treatment did not commence until late 2006, almost one year after the publication of Ireland’s policy document on mental health - A Vision for Change.

Box 2: Defining Mental Disorder

Mental disorder includes mental illness, severe dementia or significant intellectual disability resulting in:

(a) a serious likelihood of the person concerned causing immediate and serious harm to themselves or other persons;

(b) the judgement of the person concerned being so impaired that failure to admit that person to an approved centre would be likely to lead to a serious deterioration in his condition or would prevent the administration of appropriate treatment that could only be given by such admission; and

(c) that the reception, detention and treatment of that person would be likely to benefit or alleviate the condition of that person to a material extent.

Mental illness

Means a state of mind of a person which affects that person’s thinking, perceiving, emotion or judgment and which seriously impairs the mental function of the person to the extent that he requires care or medical treatment in his interests or the interests of others.

Severe dementia

Means a deterioration of the brain which significantly impairs the intellectual function of a person thereby affecting thought, comprehension and memory and which includes severe psychiatric or behavioural symptoms such as physical aggression.

Significant intellectual disability

Means a state of arrested or incomplete development of mind of a person which includes significant impairment of intelligence and social functioning and abnormally aggressive or seriously irresponsible conduct.

2006 - A Vision for Change

A Vision for Change, the Report of the Expert Group on Mental Health Policy, was published in January 2006. It provides a blueprint for the development of a modern, high quality mental health service in Ireland.

Person centred approach

A central theme of AVFC is the adoption of ‘a person-centred treatment approach’ which addresses the many factors (i.e. biological, psychological and social) which contribute to a person experiencing mental health problems. It recommends that treatment be effected through an integrated care plan, agreed between service users and their carers, which reflects best practice.9

Some of the key recommendations of *A Vision for Change* include:

- the provision of an effective community-based service, offering care relevant to the needs of services users and their families;
- the implementation of a plan to bring about the closure of all mental hospitals, with the resources released being reinvested in mental health services;
- mental health services being organised nationally in catchment areas of between 250,000 and 400,000; and
- substantial extra funding being provided to finance this new mental health policy.

**Progress to date**

At the time of publication AVFC was widely welcomed. However, the Mental Health Commission noted that by 2009, much of the optimism regarding the potential for change had ‘been replaced by disappointment with the lack of progress in implementing the policy and the lack of any significant change in the services received by most service users.’

Although the Commission acknowledged the challenge involved in implementing AVFC, it expressed concern that the slow pace of implementation was impacting directly on the quality of mental health services available.

The Children’s Mental Health Coalition highlights that despite the ambitious recommendations made in AVFC in relation to children and mental health services, these services remain widely unavailable, fragmented and severely under-resourced.

Amnesty has stated that as long as Ireland fails to implement *A Vision for Change*, it will continue to fail to meet international standards and there will continue to be cases where people are deprived of their liberty under the Act, in situations which might not have arisen were adequate community-based services and supports available.

**Box 3: The mental health of Irish children**

According to the recently published *My World Survey*, the number one health issue for young people in Ireland today is their mental health. Commenting on the findings of the Report, Minister for State Kathleen Lynch T.D stated that:

“approximately 70% of health problems and most mortality among young people arise out of mental health difficulties [and substance use disorders]. Almost three quarters of all serious mental health difficulties first emerge between the ages of 15 and 25.”

**Hindering factors**

The Independent Monitoring Group (IMG) established to oversee and report on the implementation of AVFC found that a lack of resources and the public sector moratorium were key factors in the lack of progress to date:

‘…AVFC will only be fully implemented when there is additional resource allocation, a redistribution of existing resources, significant change in how services are delivered and most importantly a cultural shift of attitude and practice by service providers and mental health professionals.’

---


14 *My World Survey Reveals Close to One in Three Young People Have Experienced Mental Health Distress* [http://www.headstrong.ie/content/my-world-survey-reveals-close-one-third-young-people-have-experienced-mental-health-distress](http://www.headstrong.ie/content/my-world-survey-reveals-close-one-third-young-people-have-experienced-mental-health-distress)

In 2011, the Programme for Government stated:

‘Our policy on mental health incorporates the recommendations of A Vision for Change. We are committed to reducing the stigma of mental illness, ensuring early and appropriate intervention and vastly improving access to modern mental health services in the community…Given the central role of primary care in our reforms, we will ensure that patients can access mental health services such as psychologists and counsellors in the primary care setting.

We will ring fence €35m annually from within the health budget to develop community mental health teams and services as outlined in A Vision for Change…We will close unsuitable psychiatric institutions moving patients to more appropriate community-based facilities and will develop specific strategies for elderly patients and those with intellectual disabilities who remain under the care of mental health services.

We will endeavour to end the practice of placing children and adolescents in adult psychiatric wards.’

The Government went further in 2012 stating that it would invest additional resources in the implementation of AVFC:

‘An additional €35 million will be invested in mental health services…This funding will enable the HSE to enhance the multidisciplinary composition of existing community mental health teams and focus on key priorities in mental health…’

**Legislating for AVFC**

Many commentators have suggested that AVFC should be put on a statutory footing. The IMG recommends that as part of its review the Department of Health might examine this issue.

The WHO has highlighted that the implementation of good mental health policies often requires legislation:

‘Mental health policy relies on the legal framework to achieve its goals, and protect the rights and improve the lives of persons affected by mental disorders.’

It emphasises the importance of political will in the implementation of both mental health legislation and policy:

‘…unless there is also political will, adequate resources, appropriately functioning institutions, community support services and well trained personnel, the best policy and legislation will be of little significance…All mental health policies require political support to ensure that legislation is implemented correctly. Political support is also needed to amend legislation after it has been passed to correct any unintended situations that may undermine policy objectives…’

The IMG recommends that in future all significant memoranda to Government should be mental health proofed to ensure that the proposals do not adversely affect people with mental health difficulties.

---


19 [ibid](http://www.dohc.ie/publications/pdf/review_mental_health_act07.pdf?direct=1)

The Department is currently in the process of carrying out a further review. Minister for State Kathleen Lynch T.D. stated that this review will examine:

(a) the general operation of the Act since its commencement;
(b) the extent to which the recommendations of A Vision for Change could or should be underpinned by legislation;
(c) the provisions of the UN Convention on the Rights of Persons with Disabilities; and
(d) the current economic environment.

Commentators have welcomed the Government’s commitment to review the Act against international human rights standards as an “opportunity to drive wider reform in mental health.”

The Act provides that any decision in relation to the care or treatment of a person must give due regard to that person’s right to dignity, bodily integrity, privacy and autonomy:

‘The loss by an individual of his or her mental capacity does not result in any diminution of his or her personal rights recognised by the Constitution...including self-determination, and the right to refuse medical treatment.”

The Act does not specifically define best interest nor does it set out what factors should be taken into account when making a decision in relation to a person’s care or treatment (e.g. the past wishes of the person). Rather it appears to leave it to the consultant psychiatrist in the first instance to determine whether a proposed course of action is in the best interest of the patient.

Mr Lauri Sivonen, Office of the Council of Europe Commissioner for Human Rights, suggests that the best interest’s model is the model of the past:

‘...we are still making decisions for persons, although the philosophy and the obligations of the UN Convention are clear that the starting point is that the person has capacity.”

The paternalistic approach to the best interest principle

The absence of a definition of best interest has resulted in the Courts interpreting and enforcing how the principle is to be applied on the facts of each individual case.

Essentially there are two ways in which the best interest principle can be interpreted:

- The first involves a subjective examination of the patient’s past and present wishes;
- The second involves an objective examination of what is in the best

---

21 http://www.dohc.ie/consultations/closed/mental_healthact2011/
24 In Re a Ward of Court [1996] 2 I.R. 79
25 Committee Debates, Mental Capacity Legislation, 29 February 2012 http://debates.oireachtas.ie/JUJ/2012/02/29/00004.asp
interests of the patient from an abstract rights approach (i.e. a paternalistic approach).

The paternalistic approach, which is seen by commentators as at odds with the person-centred ethos of A Vision for Change, seems to be the approach favoured by the Irish courts. This can be seen in the case of MR v Byrne:

‘having regard to the nature and purpose of the Act…it is appropriate that it is regarded in the same way as the Mental Treatment Act 1945, as of paternal character, clearly intended for the care and custody of persons suffering from mental disorder.’

The paternalistic approach, which is seen by commentators as at odds with the person-centred ethos of A Vision for Change, seems to be the approach favoured by the Irish courts. This can be seen in the case of MR v Byrne:

‘having regard to the nature and purpose of the Act…it is appropriate that it is regarded in the same way as the Mental Treatment Act 1945, as of paternal character, clearly intended for the care and custody of persons suffering from mental disorder.’

The concern expressed by commentators, in particular legal commentators, is that this approach has resulted in only serious breaches of due process and procedures being considered sufficient to overturn the detention of a patient:

‘…an incessantly objective approach has been applied by the courts in Ireland which utilises the best interests principle to defend the failure of doctors to adhere to procedural due process as prescribed.’

Although the courts must weigh the failure to preserve proper procedure against the need to detain a patient to ensure he/she receives the necessary treatment, the paternalistic approach adopted by the courts does not negate the duty on medical personnel and others to fully comply with all the procedures set out under the 2001 Act.

Both the College of Psychiatry of Ireland (CPI), and Amnesty, have recommended that the 2001 Act be amended so as to ensure that only minor procedural breaches (i.e. those deemed to be of an insubstantial nature and which do not cause injustice) can be excused.

**Approaches to the principle of best interest**

In Canada the best interest principle is applied only in circumstances where the wishes, values and beliefs of the patient are not known or where these wishes cannot be followed (for example in circumstances where they would endanger the health or safety of the patient).

Amnesty has recommended that the definition of best interest as set out in the Scheme of the Mental Capacity Bill be applied to the 2001 Act. The Scheme has adopted an autonomy based approach which identifies a number of factors that must be taken into consideration when determining what is in a person’s best interest (e.g. taking into account the views of someone named by the patient as a person to be consulted on the issue).

**Box 4: Factors taken into account in England and Wales**

The Mental Capacity Act 2005 in England and Wales provides for the subjective wishes of a patient to be taken into consideration when making a health care decision.

The Act sets out a list of factors which must be considered when determining what is in a patient’s best interest, including:

- a patient’s past and present wishes;
- whether it is likely that the patient will at some time in the future have capacity in relation to the matter in question; and
- the beliefs and values that would be likely to influence his decision if he had capacity.

Commentators have called for the introduction of similar statutory guidelines in Ireland.

**Involuntary admission**

A person may be involuntarily admitted and detained in an approved centre on the grounds that he is suffering from a mental disorder. In 2011, 1,471 involuntary admission orders were made under the 2001 Act. A further 21 involuntary admission orders were made in

---

26 Mr Justice O’Neill in M.R. v Byrne [2007] 3 I.R 211
respect of children, and 586 voluntary patients had their status re-graded from voluntary to involuntary.

**Procedures**

An application to have a person involuntarily admitted can be made to a registered medical practitioner by:

(a) a spouse or relative;\(^{29}\)
(b) an authorised officer;\(^{30}\) or
(c) a member of An Garda Síochána.

The Act sets down a number of procedures which must be followed when making such an application (e.g. the applicant must have observed the person concerned in the previous 48 hours).

The Act does not preclude the making of further or indeed unlimited applications to involuntarily admit a person in circumstances where one or more registered medical practitioner has refused to make a recommendation, provided the previous application(s) and refusal(s) are disclosed.

**Renewal orders**

An involuntary admission order allows for the detention and treatment of a person for a period of 21 days from the making of the order. This period may be extended initially for a period of up to 3 months, then for a period of up to 6 months, thereafter annually by order of the consultant psychiatrist responsible for the care and treatment of the patient. These orders are referred to as renewal orders. The Mental Health Commission supports limiting the maximum time period for which renewal orders can be made to 6 months.\(^{31}\)

The CPI however, believes that the periods between renewals are too short given that three Tribunal hearings must be held within the first 19 weeks of a person’s detention. They propose that the first period of a person’s detention be for three months with a Tribunal hearing within three weeks. The first renewal would then be for a further period of six months with a Tribunal hearing within three weeks of the renewal and all subsequent renewals would be for twelve month periods.

**Box 5: The number of involuntary admission orders made in 2011**

In 2011, 1,471 involuntary admission orders were notified to the Mental Health Commission. The use of involuntary admission remains at around 10% of all admissions. The Commission was also notified of a further 586 ‘re-grade’ admissions (i.e. changes in a patient’s status from voluntary to involuntary). These are increases on 2010 figures.

Source: Mental Health Commission Annual Report 2011

The Mental Health Commission must be sent a copy of any admission or renewal order within 24 hours of it being made. As soon as possible following receipt of an admission or renewal order the Commission must:

(1) refer the matter to a Mental Health Tribunal;
(2) assign a legal representative to represent the patient; and
(3) direct a member of the panel of consultant psychiatrists to determine whether the patient is in fact suffering from a mental disorder.

Commentators have expressed concern that the 2001 Act focuses on the involuntary detention and treatment of persons with little or no reference to community based services as recommended in AVFC. Commentators have called for the amendment of the Act to

---

\(^{29}\) Section 9 of the 2001 Act specifies persons disqualified from making an application (e.g. a spouse who is living separately and apart from the person concerned).

\(^{30}\) For more details see the Mental Health Act 2001 (Authorised Officer) Regulations 2006 (S.I. No 550 of 2006). The CPI suggests that the definition of authorised officer should be extended so as to include mental health social workers, other members of community mental health teams and hospital multi-disciplinary teams.

specifically reflect the policy objective of moving to a community care model for mental health services:

‘The 2001 Act [does] not contain a framework for the delivery of mental health services needed to reflect a community-based comprehensive and integrated service as recommended in successive mental health policy documents…Mental health laws can help to achieve the goals set out in mental health policy by providing a legal framework for implementation and enforcement.’

Amnesty maintains that Ireland’s over-reliance on inpatient care results in persons being deprived of their right to liberty unnecessarily. Similar concerns have also been expressed by the Council of Europe Committee on the Prevention of Torture.

**Involuntary admission of children**

There appears to be consensus among commentators that the provisions of the 2001 Act offer children less and inferior protection than that afforded to adults in similar situations. The CPI states that this is particularly true in respect of admission procedures, treatment without consent and detention of voluntary patients.

The Children’s Mental Health Coalition highlights that unlike the case of adults:

‘Mental Health Tribunals do not review admission or renewal of admission orders relating to children under the 2001 Act. Neither do Mental Health Tribunals have any role to play regarding the administration of treatment in the case of children. The Act gives little voice to children to have a say in their admission or treatment – consent is given or withheld by the parent in the case of all children up to the age of 18 years.’

The CPI states that nowhere in the Act is it explicitly stated that the voice of the child will be given due consideration or the child’s wishes respected. They recommend that a specific process for substituted decision making on the part of a child be provided, and that a child’s wishes be respected in all cases, except where it is necessary to substitute another choice in the best interests of the child.

They also recommend that the status of a child who is admitted as a voluntary patient should be reconsidered as part of the Department’s review, given the problems regarding a child’s capacity to consent. There appears to be an inconsistency between the Non-Fatal Offences Against the Person Act 1997 which allows a child of 16 years to consent to treatment, and the Mental Health Act 2001 which defines a child as a person under 18 years. The 2001 Act therefore does not permit a 16 year old to consent to treatment.

EPIC recommends that young people between 16 and 18 years of age should be presumed to have the capacity to make decisions regarding their admission and treatment unless proven otherwise. They also recommend that a ‘mature minor rule’ should be introduced to allow for the evolving capacities of children and young people under the age of 16 years.

In the United Kingdom those aged 16 and over are presumed in law to have the capacity to consent to treatment unless there is evidence to the contrary. The courts have determined that children under 16 years of age may have capacity where they have sufficient understanding and maturity to enable them to fully understand what is proposed. In Scotland, the right of those under 16 years of age to consent to treatment is governed by the Age of Legal Capacity (Scotland) Act 1991. This Act provides that a competent person under the age of 16 can consent to medical treatment once

---

33 Ibid
they are capable of understanding the nature and consequences of the treatment.

Many commentators recommend that children be provided with access to independent second opinions concerning their detention and treatment and that provision be made for a specialist advocacy service for children. In Scotland, independent advocacy is provided for all young people under the Mental Health (Care and Treatment) (Scotland) Act 2003.

Amnesty has made extensive recommendations regarding children and young people. In particular they feel:

- the provisions relating to children and young people should be set out in a standalone section of the Act;
- no child or young person should be admitted to an adult inpatient unit unless there are exceptional circumstances indicating that it would be in their best interests to do so;
- that best interests should be defined so as to include the views of the child or young person taking into account their age and maturity;
- that a third category of patient should be included in the Act to cater for children admitted by parental consent (i.e. an informal patient), and these patients should have their detention reviewed in the same way as involuntary patients.

Box 6: The number of child admissions in 2011

The Mental Health Commission was notified of 421 admissions relating to 326 children in 2011. Of these, 132 admissions were made to adult units (i.e. 31.4%).

In 2011, two purpose-built child and adolescent units were opened; one in Galway and one in Cork. Although the provision of these additional child units resulted in a decline in the number of child admissions to adult units, almost a third of child admissions in 2011 were to adult units.

The Mental Health Commission states that ‘the provision of age appropriate mental health services must be addressed as a matter of priority.’

Voluntary admission

A voluntary patient, as defined in the Act, is a person receiving care and treatment in an approved centre who is not the subject of an admission order. The fact that their status, as a voluntary patient, is not determined by reference to their legal capacity or ability to consent has given rise to much debate. The Irish Human Rights Commission has expressed concern that this definition is not human rights compliant.

Commentators are particularly concerned that the Act affords no protection to mentally incapacitated but compliant patients. Although the exact number is unclear Amnesty suggests that there could be between 5,000 and 6,000 incapacitated but compliant patients in Ireland whose rights are not being adequately protected. In the case HL v UK (2004) the European Court of Human Rights found that the informal admission to a psychiatric hospital of a compliant but incapacitated adult was in contravention of Article 5 of the European Convention on Human Rights.

Commentators recommend that the definition of a voluntary patient be amended to include only persons who have the capacity to make a decision and who have genuinely consented to their admission to an approved centre, and who continue to consent to their detention.

Re-grading of patients – voluntary to involuntary

The description of patients as ‘voluntary’ is misleading in that it suggests that these patients can exercise free choice as to when they leave or what treatment they may wish to receive. The reality is quite different - voluntary patients are not free to leave an approved centre whenever

---

38 Committee debates, Mental Capacity Legislation, 29 February 2011 http://debates.oireachtas.ie/JUJ/2012/02/29/00004.pdf
they choose to. Where a voluntary patient indicates they wish to leave the centre they may be detained against their will for a period of up to 24 hours if a consultant psychiatrist, registered medical practitioner or registered nurse of the centre is of the opinion that they are suffering from a mental disorder. The consultant psychiatrist responsible for their care and treatment must then either discharge the patient or have him/her examined by another consultant psychiatrist. If the second consultant psychiatrist, is satisfied that the patient is suffering from a mental disorder, he/she must issue a certificate in writing to the effect that because of the mental disorder this person should be detained. An admission order is then made and it is at this point that the status of the patient changes from being a voluntary to an involuntary patient.

The CPI states that it should not be necessary for a voluntary patient to indicate that he/she wishes to leave an approved centre before the process leading to their re-grading is commenced. They recommend that it should be sufficient that a consultant psychiatrist, registered medical practitioner or registered nurse on the staff of the approved centre is of the opinion that the person is suffering from a mental disorder and as such meets the criteria for detention. This could however led to a huge increase in the re-grading of patients, and discourage people from voluntarily admitting themselves to such centres for treatment.

**Voluntary admission of children**

Where the parents of a child, who is admitted as a voluntary patient, wish to remove that child from an approved centre but a consultant psychiatrist, registered medical practitioner or registered nurse of the centre is of the opinion that the child is suffering from a mental disorder that child may be detained and placed in the custody of the Health Service Executive (HSE). If the HSE decides that the child is suffering from a mental disorder and requires treatment it must apply to the District Court for an order authorising the detention of that child.

If the court is satisfied (having considered the report of the consultant psychiatrist) that the child is suffering from a mental disorder, it can order that the child be admitted and detained for treatment for up to 21 days. This order can be extended initially for a period of up to 3 months; thereafter it can be renewed indefinitely for periods of up to 6 months. An order extending the detention of a child must not be made unless the child is examined by a consultant psychiatrist and the court is satisfied that the child continues to suffer from a mental disorder.

Commentators have expressed concern that the Act does not provide for due consideration to be given to the wishes of the child in these cases.

**Review of detention**

The 2001 Act ensures that all involuntary admission and renewal orders are subject to automatic and independent review by a Mental Health Tribunal.

An involuntary patient is entitled to have his detention reviewed by a Tribunal within 21 days of the making of an admission order or any subsequent renewal order. Commentators have recommended that this 21 day period be reduced (e.g. to 10 days) given the possibility that many involuntary patients will have improved and been discharged, or had their status changed from involuntary to voluntary before the 21 day period expires (see section on revoking admission orders p.13).

The Tribunal review focuses on two issues:

1. whether the person concerned is experiencing a mental disorder; and
2. whether the correct procedures were followed in detaining him/her.

The Tribunal may affirm or revoke the admission or renewal order.

**Box 7: Mental Health Tribunal Statistics 2011**

In 2011, the Mental Health Tribunal held 1,771 hearings. Of these, 63% were heard before day 18 of the 21 day period. Only 8% of the orders reviewed by the Tribunal were revoked.

Source: Mental Health Commission Annual Report 2011
A patient may appeal the decision of a Tribunal to the Circuit Court but only in very limited circumstance (i.e. on the ground that he/she is not suffering from a mental disorder). He/she cannot however appeal the Tribunal’s reasons for its decision.

**Revoking admission orders**

Concern has been raised about the number of cases which never reach a Mental Health Tribunal hearing due to involuntary patients being discharged, or re-graded to voluntary patients before the expiry of the 21 day period. Former Minister for Health and Children, Mary Harney, expressed concern in 2007 about the high level of revoked admission orders that did not progress to hearing:

“In the first four months of the operation of Part 2 a total of 505 admission orders were revoked by the responsible consultant psychiatrist before the Mental Health Tribunal was held.”

Amnesty cites research which suggests that, in some cases, involuntary admission orders are being revoked to avoid Tribunal hearings. If true, this would clearly be in breach of a patient’s right to review and contrary to the spirit of the Act. Amnesty recommends that in every case where a patient’s status has changed from involuntary to voluntary in advance of a Tribunal hearing that the re-grading should be reviewed in order to determine whether the patient has capacity and freely gives his informed consent to remaining in the approved centre as a voluntary patient.

Although the Act makes provision for a review where an involuntary admission order has been revoked, in practice this provision is very rarely used. Commentators have recommended that the Department of Health examine as part of their review the reasons for the high number of revocations of involuntary admission and detention orders prior to Tribunal hearings.

The figures below indicate that a significant number of patients involuntarily admitted between 2007 and 2011 did not have a Tribunal review their detention.

**Figure 1: Number of involuntary admission orders revoked between 2007 and 2011**

![Graph showing the number of revoked admission orders between 2007 and 2011]

**Validity of continued detention**

A patient has no right to have his/her detention reviewed between admission and subsequent renewal orders. This provision has raised concerns that patients may continue to be detained in circumstances where the reasons warranting their detention no longer exist. Commentators have warned that this provision may not be in compliance with recent European Court of Human Rights judgments which have found that the validity of continued detention under the European Convention on Human Rights depends on the continued presence of a mental health problem warranting such detention. This finding suggests that the relevant authorities may have an obligation to keep a patient’s involuntary detention under continuous review.

**Box 8: The Convention for the protection of Human Rights and Fundamental Freedoms**

Article 5.4 of the Convention for the Protection of Human Rights and Fundamental Freedoms states that “everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if his detention is not lawful”.

---


43 Ibid
Amnesty recommends that a patient who is the subject of an involuntary admission order lasting three months or more should have the right to review their detention on the ground that they no longer fulfil the criteria for involuntary detention.

**Mental Health Tribunal procedures**

Commentators such as the CPI have raised concerns in relation to the procedural operation of Mental Health Tribunals. Concern has also been expressed that the Act incorrectly places the burden of proof in an appeal on the patient to prove to the Court that he/she is not suffering from a mental disorder. Commentators suggest that this amounts to an inequality of arms (i.e. it places the patient at a significant disadvantage vis-à-vis his/her medical opponents) and have recommended that the onus be placed on those seeking to detain the person so as to ensure greater parity between the parties and full compliance with the European Convention on Human Rights.

In particular, the CPI recommends that:

‘Either additional sections or a set of procedural rules should define the burden and standard of proof in accordance with ECtHR [European Court of Human Rights] and Irish case law…and the order in which evidence is to be taken, who attends, the need for advocacy and the rights of family members to attend, particularly if capacity is an issue.’

**Treatment and the requirement for consent**

Consent, as defined in the Act, means consent freely obtained from a patient without threats or inducements where the consultant psychiatrist responsible for their care and treatment has provided them with adequate information:

- in a form and language that the patient understands; and
- which sets out the nature, purpose and likely effects of the proposed treatment.

The consultant psychiatrist must be satisfied that the patient is capable of understanding the nature, purpose and likely effects of the treatment.

Although the Act provides that a patient’s consent must be obtained, an exception is provided where the consultant psychiatrist responsible for their care and treatment believes that treatment is necessary:

- to safeguard the life of the patient;
- to restore his health;
- to alleviate his condition; or
- to relieve his suffering; and
- the patient is incapable of giving his consent by reason of the mental disorder.

Specific provisions are set out in relation to the requirement for consent to psycho-surgery, electro-convulsive therapy and the administration of medicine (see below).

**Box 9: Treatment as defined in the 2001 Act**

**Treatment**

Includes the administration of physical, psychological and other remedies relating to the care and rehabilitation of a patient under medical supervision, intended for the purpose of ameliorating a mental disorder.

**Electro-convulsive Therapy (ECT)**

ECT ‘is a medical procedure in which an electric current is passed briefly through the brain via electrodes applied to the scalp to induce generalised seizure activity. The person receiving treatment is placed under general anaesthetic and muscle relaxants are given to prevent body spasms. Its purpose is to treat specific types of major mental illnesses.’

**Psycho-surgery**

Psycho-surgery is defined as any surgical operation that destroys brain tissue or the functioning of brain tissue and which is performed for the purpose of ameliorating a mental disorder.

---


Psycho-surgery

Where treatment involves the performance of psycho-surgery a patient must consent to this procedure in writing and it must also be authorised by a Mental Health Tribunal. A patient can appeal a decision of the Tribunal to the Circuit Court, and the surgery cannot be carried out until the court reaches its decision or the time limit for bringing the appeal has expired.

While some commentators such as Amnesty recommend prohibiting the use of psycho-surgery altogether others like the CPI state that although the section on psycho-surgery has probably never been used to date, it is necessary to ensure that future surgical interventions such as the ‘implantation of various forms of pacemaker for Parkinsonism, or [the] use of bone marrow stem cells…come within the definition of psychosurgery.’

Electro-convulsive therapy (ECT)

Where treatment involves the administration of a programme of ECT a patient must give his consent in writing. However, where a patient is unable or unwilling to give his consent the treatment can be administered where it has been approved by the consultant psychiatrist responsible for his/her care and treatment and authorised by a second consultant psychiatrist. The Act does not require that the second consultant psychiatrist be independent of the treating psychiatrist. Nor does it provide any mechanism for reviewing or appealing this decision. Some commentators have suggested that only a Mental Health Tribunal should be empowered to authorise the use of ECT.

The approval of the District Court is required before either psycho-surgery or ECT can be administered to a child detained under the Act. Commentators such as Amnesty have called for the prohibition on the use of psycho-surgery and ECT on children.

Box 10: Use of ECT in 2010

In 2010, the Mental Health Commission was notified of the administration of 347 programmes of ECT which is equivalent to 8.2 programmes per 100,000 total population.

More than 80% of the patients that were administered ECT were voluntary patients [closer to 90%]. The majority were administered one programme of ECT, with the average number of treatments per programme being 6.8.

The majority of programmes were administered to patients who were capable of giving consent, with 84.3% of programmes administered to those diagnosed with depressive disorders.

The majority of the patients administered ECT were female.

Thirty-five of the 347 programmes (10.1%) were administered to 32 involuntary patients who were either unable or unwilling to give consent. Two of these patients were administered more than one programme of ECT without their consent.

The Mental Health Commission has highlighted the fact that there are currently no national clinical guidelines for ECT use in Ireland. Guidelines produced in the United Kingdom recommend that ECT is used only to achieve rapid and short-term improvement of severe symptoms after an adequate trial of other treatment options has proven ineffective and/or when the condition is considered to be potentially life-threatening, in individuals with severe depressive illness; catatonia; or a prolonged or severe manic episode.

Administration of medicine

Where medicine has been administered to a patient for a continuous period of 3 months it must be discontinued unless the patient gives his consent in writing to its continued use. Where the patient is unwilling or unable to give his consent, the medication can continue to be administered where it is approved by the consultant psychiatrist responsible for his/her care and treatment and is authorised by a second consultant psychiatrist. There is no provision for reviewing or appealing this decision.

Commentators have expressed concern that the provisions of the Act dealing with consent to treatment are not compliant with international

human rights. In particular, the Act authorises the administration of forced medication and ECT in circumstances where a person is able but unwilling to consent thereby disregarding their right to bodily integrity, autonomy, and privacy, and placing excessive power in the hands of psychiatrists.

The Psychiatric Nurses’ Association recommend that independent psychiatrists should assess the capacity of a person to consent to medical treatment to avoid accusations of bias and conflict of interest.

The National Disability Authority recommends that Mental Health Tribunals should review the long-term administration of medication at regular intervals.47

Commentators recommend that where a person has the capacity to consent to treatment but is unwilling to do so that this refusal should be respected and protected by the law. The former Minister for Health and Children accepted this suggestion in principle but wished to consider it further in light of the proposed Mental Capacity legislation.48 The Mental Health Commission has highlighted the need for synergy between our mental health legislation and our capacity legislation.

Concern has also been raised that the Act does not deal with situations of chemical restraint where medication is used to control patients rather than to aid their recovery.

Amnesty believes that in its current form the 2001 Act:

‘encourages a culture of exclusion and non-participation (by service users) in treatment decisions, which is firmly at odds with the recovery ethos advocated by A Vision for Change, as well as provisions of international law, including in particular the CRPD [UN Convention on the Rights of Persons with Disabilities].’49

---

47 National Disability Authority’s Submission to the Review of Mental Health Act 2001
50 http://www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_96405_01