Report on the Operation of Part 2 of the Mental Health Act 2001

REPORT ON THE OPERATION OF PART 2 OF THE MENTAL HEALTH ACT 2001

April 2008

Report prepared by The Mental Health Commission

The Mental Health Commission is committed to ensuring the interests of those involuntarily admitted pursuant to the provisions of the Mental Health Act 2001 are protected and to fostering and promoting high standards in the delivery of mental health services.

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CHAIRMAN'S INTRODUCTION

I am pleased to introduce this report, prepared by the Mental Health Commission on the operation of Part 2 of the Mental Health Act 2001, and present it to the Minister for Health and Children.

The Mental Health Act 2001 has been described as the most significant legislative change for mental health services in Ireland for over 60 years. The 2001 Act, as its full title states, provides for the independent review of involuntary admissions. In addition, the 2001 Act provides for the establishment of the Mental Health Commission and the appointment of an Inspector of Mental Health Services. It also provides for the licensing of all in-patient facilities providing care and treatment for people with a mental illness or mental disorder. Other provisions in the Act refer to rules pertaining to treatment and regulations for approved centres. The 2001 Act has undoubtedly introduced radical reform within Irish mental health services. It has introduced comprehensive human rights protections for those admitted involuntarily, thereby leading to a high level of accountability and external scrutiny.

A key driving force underpinning Part 2 of the 2001 Act is the European Convention on Human Rights and Fundamental Freedoms. The 2001 Act, in providing for automatic legal representation and independent review of all involuntary admissions and renewal orders ensures Ireland's compliance with the Convention. The introduction of such legislation while welcome does not automatically guarantee that human rights are respected. Awareness, information and training were identified by the Commission as critical factors in maximising the impact and effectiveness of the legislation. To prepare for commencement the Commission embarked on a programme to raise awareness of the new provisions through workshops, meetings with stakeholders and the publication of the reference guide on the Mental Health Act in 2005. The Commission, with the key stakeholders, led a comprehensive training schedule on the provisions of the 2001 Act. This proved to be the correct approach, and there is no doubt that the 2001 Act could not have been successfully commenced without this. It is an approach that the Commission aims to use again to continually renew and refresh mental health training, attitudes and awareness and information campaigns. The Commission has made a number of recommendations in the report and within these there are key commitments to further strengthen training and awareness.

This report describes the extensive programme of work undertaken by the stakeholders in advance of commencement of the relevant provisions in November 2006 and their ongoing commitment and diligence to ensuring the effective implementation of the Act. Stakeholders in the mental health services have participated in a significant programme of reform during the last 18 months. Commencement of Part 2 of the 2001 Act has brought a greater level of openness to mental health services in Ireland. For example the 2001 Act has a statutory requirement that the Commission be informed of every admission and renewal order. This provides a national overview of what is a major component in acute inpatient care. The information that the Commission can now provide, as demonstrated in this report, addresses a long standing deficit in our knowledge of mental health care. This presents an opportunity to examine detailed data which will lead to a greater understanding of the factors associated with involuntary care and treatment. The Commission is committed to leading further programmes of research in this area. Ascertaining the views and experiences of service users and their families and carers will be a key priority in such research.

The Mental Health Commission would like to thank all those who have contributed in any way to the review and to the information provided in this report. Their contributions have assisted in highlighting areas that need to be addressed now that the 2001 Act has been commenced. The 2001 Act places a much needed focus on the human rights of people receiving care and treatment on an involuntary basis. Respecting and promoting the human rights of the service user must continue to be the principle underpinning future actions and developments.

Dr Edmond O'Dea, Chairman, Mental Health Commission.

FOREWORD

Section 42 (4) of the Mental Health Act 2001 requires the Commission to, not later than 18 months after the commencement of *Part 2*, prepare and submit a report in writing to the Minister on the operation of that Part together with any findings, conclusions or recommendations concerning such operation as it considers appropriate. Part 2 of the Mental Health Act 2001 is entitled *Involuntary admission of persons to approved centres* and was commenced on 1st November 2006. This statutory requirement, placed on the Commission by the legislation, is fundamentally linked to our Mission; ensuring that the interests of those involuntarily admitted under the provisions of the Mental Health Act 2001 are protected and fostering and promoting high standards in the delivery of mental health services.

When preparing the information to be included in its report to the Minister the Commission set out to conduct a comprehensive review of the operation of Part 2 of the Act. The review consisted of number of elements including;

1. an external commentary on the legislation,
2. an activity/information report from the Commission, and
3. a consultation exercise.

The first part of the report contains the external commentary on the legislation, followed by activity/information sections prepared by the Commission relating to the operational activity arising from the commencement of Part 2. There then follows a report on the findings from the consultation exercise and overall conclusions. Recommendations arising from the report are contained in the final section.

EXTERNAL COMMENTARY ON THE LEGISLATION

Report on the Compliance of the Mental Health Act 2001 with International Human Rights Law

Presented to the Mental Health Commission – March 2008

Kris Gledhill
School of Law, University of Auckland
Editor, Mental Health Law Reports

A. Introduction

The recurrent theme of the parliamentary process that led to the Mental Health Act 2001 was that it was necessary to introduce changes to the existing regime under the Mental Treatment Act 1945 in order to ensure compliance with the European Convention on Human Rights, at least in relation to the question of the need for an independent review of detention (as required by Article 5(4) of the Convention)[1]. Although the preamble to the 2001 Act does not mention the Convention, it does state that its purposes include the provision of independent reviews of involuntary admission and Tribunals for that purpose. The Tribunals are under the purview of the newly-created Mental Health Commission, which has a remit of improving standards.[2] In light of this background to the statute, this commentary seeks to outline the main obligations under international law, and in particular those arising from the case law of the European Convention in relation to detention: defects in the 1945 Act in this regard are contrasted with the new regime, and the 2001 Act and case law arising under it are analysed from a human rights perspective.

[1] *It had been recognised since the 1992 Green Paper on Mental Health that new legislation was needed to comply with the State's international law obligations. The 1999 Bill which in due course became the 2001 Act was the result of European Court proceedings relating to involuntary detention. The Government position was that "The necessity to provide urgently for a reform of our legislation regarding involuntary detention, in order to bring this country into line with the European Convention on Human Rights, has resulted in my bringing forward a Bill which is shorter than originally envisaged." (Dáil Éireann – Volume 517, page 1004.) The latter comment was an acceptance that the 1999 Bill did not deal with a number of the issues that had been discussed in the reform process, and in particular the 1995 White Paper.*

[2] *The Act also re-established the existing Inspector of Mental Hospitals as the Inspector of Mental Health Services. Its other main feature was the introduction of a process to regulate the circumstances in which treatment can be given to those in detention without their consent, which is in Part 4 of the Act: the most common treatment, medication, requires consent of the patient or the approval of a second opinion psychiatrist after 3 months. This aspect of the regime relating to those in detention remains on its face a matter for medical decision-making only despite its potential to interfere with autonomy rights: there is a similar regime in England, where the courts have established that they will subject such decisions to judicial review if there is a dispute about the propriety of the action: see R (Wilkinson) v RMO Broadmoor [2001] Mental Health Law Reports 224, [2002] 1 WLR 419.*

B. International Human Rights and Mental Health Law

The main source of specific obligations arising from international human rights law in Europe is the European Convention on Human Rights[3], which was signed and ratified by Ireland in February 1953. Article 1, headed "Obligation to respect human rights", provides that the signatories "shall secure to everyone within their jurisdiction the rights and freedoms defined in Section I of this Convention". In other words, the State gave a solemn undertaking to ensure that the basic rights would be respected. Until recently, this legal obligation[4] was not enforceable in Irish courts: this is because Ireland adopts a "dualist" view of international law, namely that it can be raised in domestic litigation only to the extent that a legislature has incorporated it[5]. This is formalised in the Constitution: Article 15 provides that the Oireachtas has the sole legislative power, and, more importantly, Article 29.6, provides that "No international agreement shall be part of the domestic law of the State save as may be determined by the Oireachtas". An important development which mitigates the impact of this dualist tradition is the European Convention on Human Rights Act 2003, which is discussed below: pursuant to this statute, the Oireachtas has allowed Convention rights to be enforced in domestic litigation.

A number of propositions are well-established in the case law of the Convention, which allows the "lawful detention" of "persons of unsound mind" (under Article 5(1)(e)), requires that reasons for detention be given (under Article 5(2)), and obliges a speedy habeas corpus review (under Article 5(4).[6] These points are:

(i) mental disorder may be interpreted widely, but does not include social nonconformity;

(ii) it has to be reliably shown by objective medical expertise (though a greater discretion may

[3] *Council of Europe, Convention for the Protection of Human Rights and Fundamental Freedoms, 1950: CETS No 5 (see conventions.coe.int). There is also the International Covenant on Civil and Political Rights, a UN sponsored treaty from 1966 designed to give further effect to the Universal Declaration, to which Ireland is a party. It includes a mechanism for complaints to be taken to the Human Rights Committee of the UN (via an Optional Protocol to which Ireland is a party): its substantive obligations are similar to those in the European Convention, though its case-law is less well-developed.*

[4] *The Convention gives rise to "hard" international law, which creates specific obligations: there is an enforcement mechanism through the European Court of Human Rights and the Council of Europe, albeit that the key is political pressure. Such "hard" law is supplemented by many examples of "soft" international human rights law relating to mental health, including, for example, the UN Principles for the Protection of Persons with Mental Illness, a declaration of the UN General Assembly of 17 December 1991, which was mentioned in the government papers discussing reform of the mental health system, i.e. the Green Paper of 1992 and the White Paper of 1995: this is soft law in the sense that it creates no clear legal obligation in international law, but it may be of assistance in interpreting what hard international law requires. Other examples of soft international human rights law relevant to mental health law are: The Guidelines for the Promotion of Human Rights of Persons with Mental Health Disorders (WHO/MNH/MND/95.4). It also produces guidance in the form of "Mental Health Legislation and Human Rights (Mental Health Policy & Service Guidance Package)", a 2003 document at www.who.int/mental_health/en.*

[5] *The concept is that there are two systems of law, international and domestic. In contrast, many civil law jurisdictions take a monist view, namely that there is one system of law and international legal obligations are part of that system and so enforceable in domestic courts. The effect of the dualist view is that a state can sign up to international obligations (which may well involve approval by the legislature) but then fail to implement them in domestic law.*

[6] *The Green and White Papers set out summaries of these main propositions: para 17.4 of the Green Paper, para 1.11 of the White Paper. Both also refer to various examples of "soft" international human rights law, making it clear that these concepts were central to the reform process.*

be allowed in emergency situations in relation to people capable of presenting a danger to others);

(iii) detention requires a disorder of a nature or degree to justify it, and it must persist for detention to remain valid;

(iv) detention must be in an appropriate institution;

(v) the patient (or his or her family or other representatives) must be informed of the fact of and reasons for detention;

(vi) detention must be imposed by a judicial process or, if an administrative process is used, subject to a prompt judicial review; a judicial review at reasonable intervals must also be allowed.

(vii) the patient has a right to be heard and be represented in these proceedings. involving his or her detention.[7]

It should be noted that other Convention articles are relevant, and also that the continuing evolution of the case law has established further propositions under Article 5:

(i) Article 3 prohibits inhuman or degrading treatment: treatment that is medically necessary will not in principle breach Article 3, though the vulnerable nature of psychiatric patients means that special vigilance is required and the medical necessity must be established convincingly[8]. This also requires an appropriate regime to ensure protection for patients[9]. It has been found to be breached where inadequate protection against self-harm was offered and a mentally-disordered prisoner committed suicide[10].

(ii) There is an interplay between Articles 3 and 5. Although the conditions of detention do not per se give rise to concerns about the legality of detention[11], it would be unlawful to detain someone in conditions that breach Article 3 (and so detention would have to be elsewhere). As noted above, detention has to be in a suitable clinical environment[12]: if the conditions breach Article 3, they can hardly be suitable for the purposes of Article 5.

[7] *These propositions are set out most clearly in the following cases: Winterwerp v The Netherlands (1979) 2 EHRR 387, Van der Leer v Netherlands (1990) 12 EHRR 567, X v UK (1981) 4 EHRR 188, E v Norway (1994) 17 EHRR 30, and Aerts v Belgium (2000) 29 EHRR 50.*

[8] *Hercegfalvy v Austria (1992) 15 EHRR 437*

[9] *Storck v Germany [2005] Mental Health Law Reports 211, at para 101: "The Court has consistently held that the responsibility of a State is engaged if a violation of one of the rights and freedoms defined in the Convention is the result of non-observance by that State of its obligation under Art 1 to secure those rights and freedoms in its domestic law to everyone within its jurisdiction. Consequently, the Court has expressly found that Art 2, Art 3 and Art 8 of the Convention enjoin the State not only to refrain from an active infringement by its representatives of the rights in question, but also to take appropriate steps to provide protection against an interference with those rights either by State agents or private parties."*

[10] *Keenan v UK [2001] Prison Law Reports 180*

[11] *Ashingdane v UK (1985) 7 EHRR 528 is authority for the proposition that the fact of detention not the circumstances of detention is what Article 5 covers.*

[12] *See Aerts v Belgium (2000) 29 EHRR 50: detention in a prison psychiatric wing was unlawful.*

(iii) The use of "voluntary" admissions in relation to those without capacity may be problematic for Article 5 if there is in fact detention: the use of the formal procedures, and hence the provision of the protections available in relation to involuntary detention, may be necessary to prevent the risk of arbitrariness[13]. Moreover, the right to liberty is such an important right that it cannot be given up by voluntarily entering custody: in other words, if it is in fact detention, it must be treated as such[14].

(iv) The needs of those who have a mental disorder may mean that special procedural protections have to be put in place in relation to judicial review procedures[15].

(v) Article 8 carries with it privacy rights that might be relevant to the question of the procedures to be followed around the imposition of or review of detention: so, for example, passing information to patients' relatives if that is contrary to the wishes of the patient requires a sufficient reason to breach the privacy rights of the patient.

C. The Landscape before the Mental Health Act 2001: The Mental Health Act 1945 and the Sean Croke Litigation

The process leading to the 2001 Act can be described as interesting, since there was a replacement statute in 1981, but it was not brought into effect; there was a Green Paper in 1992 and a White Paper in 1995, both of which accepted that there was a need for change in order to conform to international standards setting out fundamental rights, but at the same time (in the Croke v Smith litigation, described below) the government argued that the Mental Treatment Act 1945 was adequate from the point of view of the fundamental rights guaranteed in the Irish Constitution and the European Convention.

The 1945 Act[16] changed the process of detention: whereas previously committal to a psychiatric hospital required a decision by two peace commissioners, it became an administrative process, resting on medical certification. This represented a change in focus from removing those with mental disorder from society to ensuring that medical treatment was provided. Most admissions were voluntary but there were processes for involuntary admission, which in outline were:

- There were two types of detention: temporary (treatment for not more than 6 months, though that could be extended up to 2 years by renewal processes if the patient was certified as not having recovered); and reception order (more than 6 months' treatment required). The process involved the making of a recommendation by any doctor and then, in relation to the longer-term detention, the completion of a reception order by a doctor at the psychiatric hospital[17].

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[13] *HL v UK [2004] Mental Health Law Reports 236*

[14] *Storck v Germany [2005] Mental Health Law Reports 211: an 18 year old who went with her father to a clinic was nevertheless detained there and entitled to Article 5 protections.*

[15] *See Megyeri v Germany (1993) 15 EHRR 584: failure to provide a lawyer even though no request was made for one breached Article 5(4) because it prevented an adequately court-like review.*

[16] *For a history of the legislation prior to 1945, see O'Neill, Irish Mental Health Law, Firstlaw 2005, pp4 and following and the summary in Croke v Smith (No 2), 31 July 1995.*

[17] *There were slightly different procedures depending on whether the hospital was state or private: the latter required an additional medical report.*

- A reception order was open-ended in the sense that it had no statutory end date or renewal requirement: so the patient was detained until released (and the duty to release arose when he or she had recovered, or an application by the patient to become a voluntary patient was accepted; relatives and friends could offer to take over the care of a patient, but the hospital could prevent this if the patient was unfit to be discharged).

- The definitions of who was covered included "addicts": an addict was someone whose addiction to drugs or intoxicants meant that he was "dangerous to himself or others or incapable of managing himself or his affairs or *of ordinary proper conduct*," or whose addiction to drugs, intoxicants *or perverted conduct* was in serious danger of mental disorder: the emphasised words make plain that this is a very wide definition.

- There were a number of processes by virtue of which ongoing detention could be terminated by the Minister of Health.

- There was an Inspector of Mental Hospitals who was concerned with the conditions of detention but could also concern himself with the question of whether a patient was properly detained (and report to the Minister if appropriate).

- The President of the High Court also had a supervisory role, and the common law remedy of habeas corpus was available, as was the constitutional review process under Article 40 of the Constitution.

- There was no statutory provision as to the circumstances in which medication or treatment could be given without consent.

The constitutionality of this regime and its compliance with the European Convention was considered in the litigation involving Mr. Croke. In the domestic litigation, Croke v Smith[18], the issue was the compliance of the detention provision of section 172 of the 1945 Act, namely a reception order, with various of the fundamental rights in Article 40 of the Constitution, including the right to liberty, the habeas corpus right and the right to equal treatment; also central was whether the process of detention was part of the administration of justice, which has to be carried out by the courts by reason of Article 34 of the Constitution. Overturning the ruling of Budd J in the High Court[19], the Supreme Court found that the 1945 Act met the requirements of the Constitution. The Court endorsed the view from previous case law[20] that the 1945 Act was of a paternal character. It went on to find that the medical decisions to recommend a reception order and then to make such an order, although leading to a deprivation of liberty:

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[18] *High Court, 31 July 1995 (transcript available at www.bailii.org); Supreme Court, 31 July 1996, [1998] 1 IR 101*

[19] *He held that the effect of a reception order "which allows for detention until removal or discharge by proper authority or death, without any automatic independent review, falls below the norms required by the constitutional guarantee of personal liberty. The State accordingly has failed to respect, and as far as practicable by its laws, to defend and vindicate the personal rights of the citizen, particularly the right to personal liberty. There are no adequate safeguards to protect the Applicant against an error in the operation of section 172..."*

[20] *In re Philip Clarke [1950] IR 235*

"cannot be regarded as part of the administration of justice but are decisions entrusted to them by the Oireachtas in its role of providing treatment for those in need, caring for society and its citizens, particularly those suffering from disability, and the protection of the common good."[21]

As the process of admission was not part of the administration of justice, it was outside Article 34 of the Constitution, and so did not require a judicial decision. Nor did the fact that detention was indefinite breach Article 40 of the Constitution in light of the features of the Act providing for discharge and the judicial oversight of Article 40 and the powers of the President of the High Court.

Mr Croke then took the matter to the European Court of Human Rights. His complaint that the regime breached Article 5 of the Convention was found admissible[22], following which there was a friendly settlement of the case[23] in which it was noted that the Government had undertaken to secure the passage of the Mental Health Bill 1999. There was also a private settlement in terms of compensation. This settlement was further considered by the Committee of Ministers of the Council of Europe on 24 February 2003, where it was said that the 2001 Act was designed to ensure compliance with the Convention.[24] In other words, there is confirmation in undertakings from the Government to an international court that the 2001 Act is designed to reflect the requirements of the Convention.

D. The Mental Health Bill 1999: the Purpose of the Oireachtas

When the Mental Health Bill 1999 was announced by Brian Cowen TD, the Minister for Health, the press release accompanying it[25] noted that The Mental Health Bill, 1999 will significantly improve existing provisions in relation to mentally disordered persons involuntarily admitted for psychiatric care and treatment and will bring Irish mental health law into conformity with the European Convention for the Protection of Human Rights and Fundamental Freedoms.

The main features were said to be:

- The establishment of the Mental Health Commission "to ensure that the interests of persons with a mental illness or a mental disorder are protected and to oversee the process of independent review of involuntary admission to psychiatric centres by Mental Health Tribunals".

- The duty of the consultant psychiatrist admitting a person to involuntary psychiatric care to inform the person of his or her legal rights under the legislation.

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[21] *At page 114.*

[22] *[1999] Mental Health Law Reports 118. The State argued that the features which had persuaded the Supreme Court that the regime was constitutional meant that Article 5 was not breached: as the case did not proceed to full argument, it must be assumed that the State was not persuaded that it would succeed on the merits.*

[23] *21 December 2000: www.coe.int case reference 33267/96*

[24] *see Resolution ResDH(2003)8 adopted at the 827th Meeting of the Committee of Ministers*

[25] *www.dohc.ie/press/releases/1999/19990922.html – 22 September 1999; a similar press release accompanied the publication of the Bill on 14 December 1999 – www.dohc.ie/press/releases/1999/19991214.html.*

- The length of detention was 28 days, with the possibility of renewal for 3 months, then 6 months, then 12 months at a time.

- The automatic review of detention and any renewal "within 28 days" by the Mental Health Tribunal "consisting of a lawyer and a consultant psychiatrist", which would determine whether the patient met the test for detention and whether correct procedures had been followed. Procedural provisions were set out, including the independent psychiatric report of the patient and the right to legal representation. "Accordingly, the requirements of the European Convention on Human Rights and European Human Rights Case Law for a review of the substantive grounds of detention automatically at reasonable intervals will be met". It was noted that appeals to the Courts would be possible.

The Bill commenced its substantive journey through the Oireachtas with its Second Reading in the Dail on 6 April 2000[26], when, before it was referred to the Select Committee for detailed consideration, the government and other parties were able to speak about the Bill in broad outline. The Minister for Health and Children, Mr Martin, spoke for the government. He noted that the purposes were twofold, namely to "provide a modern framework within which people who are mentally disordered and who need treatment or protection, either in their own interest or in the interest of others, can be cared for and treated" and which would comply with the European Convention; the 1945 Act was described as "innovative in the mid-1940s, and… enlightened for its time" but had been recognised by successive Governments as being "in need of substantial reform to bring it into line with current thinking and international norms on the detention and treatment of people with mental disorder"[27].

Its second purpose was to provide mechanisms for monitoring, inspecting and regulating the standards of care and treatment, to be achieved via the new independent Mental Health Commission (including the Inspector of Mental Health Services). The Minister emphasised the independent status of the Commission and Inspector as being "crucial in driving the agenda for change and modernisation in the mental health services in the coming years"[28]. The agenda for change was described as a process that had been ongoing for almost two decades, with the publication of Planning for the Future in 1984[29], a Green Paper in 1992 that generated more than a hundred submissions and a White Paper in 1995 that built on the general agreement that a new legislative framework was required and provided more detail on the proposals for legislation. Further consultation resulted in the 1999 Bill.

The Minister indicated that: *"At the core of the Bill is the need to address the civil and human rights of persons receiving care and treatment in our psychiatric services. The Bill focuses on: improving and*

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[26] *Dáil Éireann – Volume 517, page 997 and following*

[27] *Page 998.*

[28] *Page 997.*

[29] *Department of Health Study Group on the Development of the Psychiatric Services. The objectives included changing the structure of health service provision, particularly with more community services, and providing more targeted mental health service provision for the various groups in need (e.g., the elderly, those with an intellectual disability, children and adolescents).*

modernising the criteria and mechanisms for the involuntary detention of persons for psychiatric care and treatment; establishing a system of automatic and independent review of all detentions, including the provision of legal aid to all those who are detained; and putting in place a framework by which the standards of care and treatment provided in our in-patient mental health facilities can be supervised and regulated."[30]

E. The Current Legal Framework: the Mental Health Act 2001

1. Introduction

So, the outdated 1945 Act was replaced: the 1999 Bill became the 2001 Act, and it contained the elements referred to when the Bill was announced. There were some changes, most significantly that the 28 day period for the initial detention and for review by the Tribunal was reduced to 21 days, and a lay member added to each panel. A significant omission from the 2001 Act was an area that had been trailed in the Green and White Papers, namely the question of those with mental disorder within the prison system. This gap was filled by the Criminal Law (Insanity) Act 2006.[31] Another new element of the statutory regime is the incorporation into domestic law of the European Convention, which affects all laws relating to human rights, including mental health law.

2. The European Convention on Human Rights Act 2003

The European Convention on Human Rights Act 2003 is designed to provide for the giving of "further effect" to the Convention in Irish law, subject, naturally, to the provisions of the Constitution[32]. The format of the legislation can be traced to the Bill of Rights Act 1990 in New Zealand, which provided for fundamental rights that were already binding in international law to be guaranteed in domestic law but in a way which did not impinge on the sovereignty of Parliament to decide not to follow those international obligations. The technique is, in essence, to require public bodies to abide by the requirements of the relevant fundamental rights unless a statute prevents them from so doing, and combine this with a requirement that statutes be interpreted in accordance with the fundamental rights to the extent that such an interpretation can be reached.[33] The main operative provisions of the 2003 Act, which govern the approach to be taken to the 2001 Act, are:

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[30] *Page 999*

[31] *This regulates matters arising in the criminal process – fitness to stand trial, the insanity verdict, the question of diminished responsibility in relation to murder trials, and any consequent admission to a "designated centre" for treatment; the Act also establishes the Mental Health (Criminal Law) Review Board which has to review the detention of those held in a designated centre. Serving prisoners whose mental disorder is not dealt with adequately in prison can be transferred to a designated centre: the Review Board considers their ongoing detention.*

[32] *Preamble to the Act. An Explanatory Memorandum published with the Bill when it was introduced in 2001 explains why the choice was made to introduce the Act rather than to make an amendment to the Constitution.*

[33] *Other jurisdictions have followed the New Zealand lead: the UK has the Human Rights Act 1998, and the devolution legislation incorporates similar provisions; similar legislation has now been introduced into the Australian Capital Territory and Victoria.*

(i) The Interpretive Obligation: Section 2 of the 2003 Act provides that in interpreting any statute or rule of law "a court shall, in so far as is possible, subject to the rules of law relating to such interpretation and application, do so in a manner compatible with the State's obligations under the Convention provisions." The "Convention provisions" are defined in section 1 as Articles 2 to 14 of the Convention and various protocols (and they are set out in Schedules to the Act).

(ii) Interpretation of the Convention: In the context of a requirement to strive to interpret domestic law in accordance with the requirements of the Convention, there is the important question of what the Convention actually means. It is a transnational Convention which had as a major innovation a body that was able to give definitive interpretations of what its provisions meant, namely the European Court of Human Rights.[34] The 2003 Act requires that judicial notice is to be taken of the interpretations of the Convention by the Convention bodies, and the domestic courts must give them "due account" when considering a question arising (section 4 of the 2003 Act).

(iii) Duty on Public Bodies: The interpretive obligation is to be put alongside the duty on public bodies not to breach the Convention rights. Section 3 provides that "Subject to any statutory provision (other than this Act) or rule of law, every organ of the State shall perform its functions in a manner compatible with the State's obligations under the Convention provisions." There is a partial definition of "organ of the State" as including "a tribunal or any other body (other than the President or the Oireachtas or either House of the Oireachtas or a Committee of either such House or a Joint Committee of both such Houses or a court) which is established by law or through which any of the legislative, executive or judicial powers of the State are exercised." The Explanatory Memorandum to the Bill explains that the exclusion of "courts" from the definition of those exercising a State function – including a judicial function – is because the courts are required to administer justice pursuant to the Constitution. Consequently, the effect of the legislation should be that the Irish courts are duty-bound to apply the interpretive obligations of the statute.

It is worth noting that the case law arising under the 2001 Act, which is discussed in the next section, does not make any significant use of the 2003 Act as an aid to interpretation: this is only a matter of concern if the interpretations otherwise reached are problematic from the point of view of Convention compliance.

3. Analysis of the Mental Health Act 2001

There are various different parts of the 2001 that merit specific attention for the purposes of the section 42 review into the operation of Part 2 of the Act, including some provisions outside Part 2 that are essential to how Part 2 operates.

34 *Until its abolition in 1998 the European Commission on Human Rights was also involved.*

(i) Coverage and Governing Approach – sections 3 and 4

The Act's basic definition is that of "mental disorder", defined in section 3 as being mental illness, severe dementia or significant intellectual disability (all of which are defined)[35] resulting in (a) a serious likelihood of the person causing "immediate and serious" harm to self or others, or (b) impaired judgment such that a failure to admit the person to hospital would be likely to lead to a serious deterioration of the patient's condition or prevent the administration of appropriate treatment that could only be given as a result of an admission, and detention and treatment would be likely to provide material benefit. These two are phrased as alternatives, namely that if there is a serious likelihood of harm, that is all that has to be shown, but in the absence of that there has to be a finding of impaired judgment and a risk of deterioration from a failure to obtain treatment. However, in MR v Sligo Mental Health Services, O'Neill J, 2 March 2007, the judge commented that *"these two bases are not alternative to each other"*. He went on to make the point that they might well overlap in many cases.

The Minister of Health's Review of the Operation of the Mental Health Act 2001 contained a comment to the effect that it would be considered whether an amendment of the statute was desirable in the interests of clarity.[36] It is perhaps worth noting the context of the judge's comments: the argument put forward was that it was improper for a Tribunal to uphold detention on a basis different from that used by the doctor making the involuntary admission order. So O'Neill J was indicating that if an admission order is made on a finding of mental disorder on one basis, that does not mean that only that basis can be considered. What is perhaps needed, therefore, is a clearer understanding of what the judge said by putting it in its context.

Also determined in that case was that the requirement in the first basis that there be a "serious likelihood" of serious harm conveyed a standard of proof that was beyond a balance of probabilities though less than the criminal standard of beyond a reasonable doubt. However, O'Neill J went on to define the requirement of immediacy of harm as not requiring a conclusion that harm was about to occur: rather, it was sufficient if, for reasons such as the unpredictability of the patient, the harm could be inflicted without warning. Further, the seriousness of harm test did not require anything more than the potential to inflict physical injury.

As already noted, the legislative aim of providing compliance with the European Convention is not mentioned on the face of the statute. What is stated is that decisions under the Act should have as their "principal consideration" the "best interests" of the person (section 4(1)). This is not defined further. However, it is provided that "due regard" shall be given to the interests of other persons who may be at the risk of serious harm if a decision is not made (section 4(1)) and also to the need to respect the "dignity, bodily integrity, privacy and autonomy" of the person.

The failure to define "best interests" is unfortunate, because the lack of guidance from the legislature, which has the necessary democratic legitimacy to determine this, means that the matter falls to the courts. There are, after all, different approaches that could be taken: if

[35] *There are specific exclusions of personality disorder, social deviance or addiction to drugs or intoxicants in section 8 of the Act.*

[36] *Page 6 of the Report.*

paternalism is a guiding principle, then someone's best interests are those that are designated in their "objective" best interests (i.e. what supposedly reasonable people would describe as being what should happen); but if the guiding principle is that of autonomy, namely the right of people to make their own choices, then someone's best interests are governed by the question of what they would decide to do if they had the ability to make the choice (with the proposition that someone whose mental disorder clouds the ability to make a choice has to have some form of substitute decision maker, who will make a true choice). The latter approach rests on the basis that the differences between humans and what individuals value are such that there can be no "objective" best interests and so the only proper approach is one of substitute decision-making designed to secure what the patient would have decided had that been a possibility.

What has emerged from the case law is that the statute is viewed as having a paternal character. So, in MR v Sligo Mental Health Services, O'Neill J, 2 March 2007, the judge noted, having cited case law relating to the 1945 Act and its paternal character, that the preamble and text of the 2001 Act indicated that "it is appropriate that it is regarded in the same way as the Mental Treatment Act of 1945, as of a paternal character, clearly intended for the care and custody of persons suffering from mental disorder." He later commented that section 4 of the Act gave statutory expression to this approach. See also TO'D v Central Mental Hospital, Charleton J, 25 April 2007, in which the judge accepts the paternalistic purpose of the statute and comments at paragraph 25 of the judgment that the reference to autonomy and dignity rights is in case the professionals involved might ignore such rights.[37]

(ii) Involuntary Admission to Hospital and Renewal of Detention – sections 8-16

The Act modifies the previous process for admission to hospital. Under section 9, anyone may apply for a recommendation for admission (though relatives, authorised officers or members of the Garda are specifically mentioned, and the Garda have an additional power under section 12 to take a person into custody if there is a serious likelihood of immediate serious harm being caused). The application is made to a doctor, who need not be a psychiatrist. If the doctor is of the view that the person is suffering from mental disorder, the recommendation may be made (section 10): this is valid for 7 days, during which time the person concerned may be admitted to hospital under section 13. At that stage, a consultant psychiatrist examines the patient and may make an admission order if satisfied that the patient is mentally disordered (section 14), which authorises detention for 21 days (section 15).

The Convention requirement of objective medical expertise in relation to the evidence that the patient is in fact suffering from a mental disorder is provided by the final stage in the process, namely the involvement of a consultant psychiatrist. Further, there are a number of other procedural safeguards (time limits and the like) that provide protection against arbitrariness, which is the overriding aim of Article 5.

[37] *For the avoidance of doubt, the view that it is unfortunate that the legislature did not outline what approach was to be adopted in relation to "best interests" has to be put in the context that it cannot be said with any clarity that the European Convention prevents a paternalistic approach to substitute decision-making: at most, it can be noted that the concept of personal autonomy is central to some of core rights under the Convention and it might be thought that an approach which tries to make use of what the patient would have decided had they been able to is more consistent with this.*

It is possible for the admission order to be renewed: this can be for up to 3 months on the first renewal and then up to 6 months and then up to 12 months at a time. This is done by the responsible consultant psychiatrist, who must certify that the patient still meets the criteria for detention (also section 15): he or she can form a different view as to the alternative bases for detention (i.e. risk of harm or impaired failure to obtain treatment) on renewal, given that the patient's condition may change: see MR v Sligo Mental Health Services, O'Neill J, 2 March 2007. In WQ v Mental Health Commission and Others, O'Neill J, 15 May 2007, it was noted that whilst there might be more than one psychiatrist with responsibility (particularly in the context of vacation or illness cover), this could not extend to someone not attached to the particular hospital.[38]

Article 5(1) of the European Convention requires that the burden of proving the need to detain is on the authorities. The admission and renewal procedures under the 2001 Act are phrased in a manner that meets this test, and also the separate requirement that the nature or degree of the disorder be such as to merit detention.

The Mental Health Commission (established under Part 3 of the Act) has to be given a copy of the admission order and any renewal order. The patient must be notified that the order has been made and told of their rights in detention: in MD v St Brendan's Hospital, Supreme Court, 27 July 2007, it was emphasised that this is an absolute right of the patient, though non-compliance did not render detention unlawful. (The notification provisions are in section 16(2) of the Act: and include that details be given as to the treatment plan. The Commission has produced a set form to reflect the information to be given to the patient: this was revised in December 2007 to reflect a concern in the MD case that an earlier version did not indicate the date a renewal order came into effect.) An issue that remains open under Article 5(2) is whether the reasons must include just the legal basis for detention or the justification in fact (i.e. the medical opinion). The 2001 Act does not expressly require the provision to the patient of the reasons for the opinion formed, though all the set forms for decisions as to admission (issued by the Commission) require that the basis for the opinion be set out; and the Tribunal is required by section 18(5) to give reasons for its decision to, inter alia, the patient. In other words, the patient is notified of the proposed treatment at the time of admission or renewal but not of the basis for the opinion as to why it is thought that treatment is needed, though that will be provided when the Tribunal is set to meet (as it will be in the responsible psychiatrist's evidence to the Tribunal) and will be noted when the Tribunal decision is given. No doubt good clinical practice will be to provide patients with the relevant information when the psychiatrist and patient meet. Although the case law is not clear on this specific point, there is an obvious argument in favour of construing Article 5(2) to require the giving of reasons as well as the legal basis for detention at the time it is put in place, in case there are factual matters that the patient can easily explain so as to undermine the basis for detention. Since fair Tribunal procedures require that the patient be informed of the opinion by the time of the Tribunal, there seems little reason not to have a systematic process whereby the patient is provided with the opinion on the basis of which they are detained.

[38] *On the facts, the renewal in relation to a patient detained at the Central Mental Hospital was signed by a doctor from the patient's home region.*

(iii) Review of Detention – sections 17, 18, 19, 28, 48, 49

The psychiatrist in charge of treatment is required to discharge the patient from the admission or renewal order if he or she forms the opinion "that the patient is no longer suffering from a mental disorder". This provides an administrative review of detention. In carrying out this task, the doctor must have regard to the need to ensure that there is no inappropriate discharge but also that detention should continue "only for so long as is reasonably necessary for his or her proper care and treatment": see section 28(2)(b). If the latter phrase is interpreted to require release unless the nature or degree of the disorder mandates detention, this will comply with the Convention case law requirements: the European Convention on Human Rights Act 2003 should ensure that this is the interpretation used.

In addition, there is an independent review. On receipt of an admission or renewal order, the Commission has to make the necessary arrangements for a Mental Health Tribunal to review the detention (including arranging for an independent psychiatric examination): section 17. Section 18 requires that this be done no later than 21 days after the making of the relevant order (and not the date when it comes into effect: AMC v St Luke's Hospital, Peart J, 28 February 2007[39]). There is a power for the Tribunal to extend the period during which it considers the case for 14 days and then a further 14 days on request of the patient and if it is in the interests of the patient (section 18(4)): such a decision extends the period of the admission or renewal order until the date of the adjourned hearing.[40]

Sections 48 and 49 of the Act provide for the 3-person multi-disciplinary membership of the Tribunal, a term of office of 3 years that is renewable (though with a power in the Commission to remove them if they are incapable of acting, misbehave, or removal "appears to be necessary for the effective performance by the tribunal of its functions")[41], and various procedural powers. The patient need not attend the hearing if it might be prejudicial to his or her "mental health, well-being or emotional condition". Tribunal hearings are in private: this merits some consideration, since Article 6 of the Convention presumes that hearings relating to the determination of civil rights (including the right to liberty) should be in public. This is subject to the interests of the private lives of the parties, which clearly includes information as to someone's mental health. The privacy right belongs to the patient and it may be that the patient would prefer to have a public hearing, for which there is no provision in the legislation. (Legislative provision for a public

[39] *The renewal order takes effect on the expiry of the previous basis for detention, but the timing of the Tribunal review runs from the date of the making of the renewal order: see MD v St Brendan's Hospital, Supreme Court, 27 July 2007. This may mean that a renewal order is made before a Tribunal has sat to consider a detention under an admission order.*

[40] *There does not appear to be case law relating to the use of this power: the Tribunal must weigh the need for a speedy hearing (to comply with Article 5(4)) and the need for a fair hearing (both for the patient and the hospital).*

[41] *The Tribunal is a judicial body and one of the prerequisites of judicial independence is adequate security of tenure and independence from the parties. The independence of the Commission insulates Tribunal members from the parties (and in particular the detaining body); the three-year term is probably also sufficient. (In jurisprudence from Scotland, namely Starrs v Ruxton 2000 SLT 42, the Scottish High Court found that a one-year renewable term was not sufficient, but in the context of a part-time criminal judge appointed by the Executive, who were also a party to proceedings; in R (Brooke) v Parole Board [2008] EWCA Civ 29, the English Court of Appeal held that a three-year term for members of the Parole Board was inadequate in light of powers of removal, but again they were exercisable by a member of the Executive who was a party to proceedings in front of the Board.)*

hearing can be accompanied by restrictions on what can be reported, so as to provide protection for privacy interests.) There is no clear case law from the European Court, however, that this prospect should be available: it is an argument that might nevertheless arise.[42]

Section 18 provides that the Tribunal is required to either affirm or revoke the admission or renewal order: it may only affirm it if satisfied both that the patient is suffering from a mental disorder and either (a) that the necessary procedural requirements have been met or (b), if not, the substance of the order is not affected and no injustice has been caused: section 18. There has been litigation on the question of what the Tribunal may do to waive procedural irregularities[43]:

(i) in JQ v St Patrick's Hospital, O'Higgins J, 21 December 2006, it was held that it could not be used to waive a jurisdictional prerequisite to the making of an admission order (which, on the facts, was that a voluntary patient had not expressed an intention to leave, which is the prerequisite to the making of an order in relation to such a patient – see below);

(ii) in TO'D v Central Mental Hospital, Charleton J, 25 April 2007, the judge specifically upheld the proposition that the Tribunal could waive matters such as defects in compliance with time limits[44] (and if it did so, the detention would no longer be unlawful for the purposes of an Article 40.4 review), but that in considering whether there was an injustice caused, it had to look at matters such as whether there was a reckless failure to comply with time limits, or a reckless failure to respect the dignity of the patient or to leave him or her, in the words of the judge, "warehoused, without any proper review, and without any genuine attempt to comply with" the Act.

(iii) in WQ v Mental Health Commission and Others, 15 May 2007, O'Neill J, it was held that where there was a fundamental defect in an order renewing detention (which on the facts was that it was renewed by a consultant who was not involved in the care of the patient and that there had been an invalid preceding order), this could not be waived under section 18. The judge noted that flaws had to be of an insubstantial nature to be cured, and that "the best interests of a person suffering from mental disorder are secured by a faithful observance of and compliance with the statutory safeguards put into the 2001 Act". However, the judge then held that the failure to raise these issues before the Tribunal that had affirmed the order meant that the patient could not raise them in subsequent Article 40 proceedings.

(iv) It has also been noted, in MD v St Brendan's Hospital, Supreme Court, 27 July 2007, that the Tribunal should specify the failures of compliance and the effect of each of them.

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[42] *There has been litigation in England, where r21 of the Mental Health Review Tribunal Rules 1983 requires a private hearing unless the patient requests a public hearing and it is found that it would not be contrary to the patient's interests; the Tribunal may restrict what is reported. See R (Mersey Care NHS Trust) v Mental Health Review Tribunal [2004] Mental Health Law Reports 284.*

[43] *In MR v Sligo Mental Health Services, O'Neill J, 2 March 2007, the judge suggested that the Tribunal decision form be amended to allow the Tribunal to make plain its view as to whether or not there had been compliance with the relevant procedural requirements and, if not, whether there was injustice caused.*

[44] *See also JH v Jonathan Swift Clinic, Peart J, 25 June 2007*

Convention case law indicates that a detention must be lawful in both the sense that the requirements of the Convention are met and also that domestic law's procedures must be met[45]. But here the "domestic law" is both a set of procedures and a power in the Tribunal to waive them if they are insubstantial (and provided that the patient meets the substantive definition of mental disorder): so long as arbitrariness in detention is avoided, it is likely that there will be no "unlawfulness" from a Convention perspective if a Tribunal waives procedural irregularities, and the case law from the High Court is consistent with this approach.

As the Tribunal considers afresh the question of detention (TO'D v Central Mental Hospital, Charleton J, 25 April 2007), it may uphold detention on a different basis from that used when the admission order was made (so detention based on the risk of harm may be continued on a finding that a patient has limited capacity to obtain proper treatment.[46]) The Tribunal will consider further evidence than that available when detention was put in place, including the independent psychiatric report arranged by the Commission, and has a better picture of the patient's condition because the views of the treating psychiatrist will be tested in cross-examination. Articles 5(1) and (4) of the Convention require that the presumption of liberty be applied by the judicial body that reviews the merits of detention. The test applied by the Tribunal is phrased in terms that meet this presumption in that it must be satisfied that there is mental disorder: see section 18(1)(a).

The requirements of Article 5(4) that there be a court-like body that carries out an examination of detention at reasonable intervals is met by the Tribunal: it is a court-like body; it reviews all detentions and renewals, and has the power to order release, and indeed is under the duty to do so if the substantive criteria for detention are not made out. There are special procedural protections in the requirement that there be an independent psychiatric report and legal representation. One Convention question arising on which there has been no case law is that relating to the communication of the Tribunal decision: under section 18(5) the Tribunal decision is given to anyone whom the Tribunal thinks should receive it. The Article 8 rights of the patient have to be taken into account at this stage, and the European Convention on Human Rights Act 2003 will control the exercise of this power.

The statistics from the Commission indicate that there were 2248 Tribunal hearings during 2007, and that 256 patients were released from involuntary detention (which may have been on the basis that they remained voluntarily or on the basis of a finding that they did not require hospitalisation at the time). One issue worth noting is that if there is a discharge under section 28 before the Tribunal hearing, the patient may request that the section 18 review continue. It is apparent that there are a significant number of instances of patients being discharged before a Tribunal: there were 1444 such cases in 2007.

There is then the question of whether it is sensible for the section 18 hearing to continue despite the discharge of the patient. The purpose is to provide a forum for the patient to argue that they should never have been detained in the first place (it being part of the Tribunal's task to indicate

[45] *See, for example, Nakach v Netherlands [2006] Mental Health Law Reports 22: the failure to record a court hearing renewing detention, as required by domestic law, meant that there was a breach of Article 5(1): but note that the only remedy was a declaration that there had been a breach.*

[46] *This is what occurred in MR v Sligo Mental Health Services, O'Neill J, 2 March 2007.*

whether there has been compliance with the admission procedures)[47]: the argument against this being sensible is that the Tribunal can only revoke an order and this requires that there be an order in force. The equally legalistic argument the other way is that a finding that the patient should not have been detained in the first place can lead to an order of revocation as of an earlier date. This is no doubt something that merits further consideration: for example, it might be that the existence of the European Convention on Human Rights Act 2003 provides an adequate alternative for the situation where a patient should never have been detained (and it is worth noting that this would also cover the situation of a patient whose discharge should have been ordered earlier by the treating psychiatrist under section 28(1), a matter over which the Tribunal has no apparent jurisdiction).

An appeal against a section 18 decision to uphold detention lies to the Circuit Court under section 19, and the grounds are that the patient is "not suffering from a mental disorder" – which at first sight puts the burden of proof on the patient[48]. The Commission indicates that there have been 39 Circuit Court appeal cases filed in the period from commencement to 31 December 2007. Some of these cases have been withdrawn due to orders being revoked by the responsible consultant, patients not wishing to proceed or taking Article 40.4 proceedings. None of the appeals have resulted in an order being over-turned. The constitutional review under Article 40 remains an option for patients who feel that the outcome of Tribunal proceedings means that detention is wrong in law, and it has been used in a number of cases. There have been findings that patients were detained unlawfully (including, for example, in relation to the lawfulness of detention at the time the 2001 Act came into effect): these have been accompanied on some occasions by order for a delayed release to allow time for a fresh detention to be put in place when it was justified on the merits[49]; and on one occasion, noted above, namely WQ v Mental Health Commission and Others, 15 May 2007, O'Neill J, a fundamental defect was found not to justify Article 40 relief because it had not been raised before the Tribunal.[50]

(iv) Transfer between Hospitals; Leave of Absence – sections 20-22; 26-27

Sections 20-22 set out a regime for transfer between hospitals; of particular note is the need for the Tribunal to approve any transfer to the Central Mental Hospital, which can be authorised only if it is in the best interests of the patient. (There were 21 such requests in 2007, according to the Commission's statistics.) There are also provisions allowing a patient to be granted leave by the treating psychiatrist.

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[47] *See the Minister's Review of May 2007, pp21-22*

[48] *This raises an issue under Article 5 of the Convention, but at the time of writing there is litigation ongoing that deals with this point and so this issue is not addressed further.*

[49] *See, for example, JH v Clinical Director, Cavan General Hospital, Clarke J, 6 February 2007, AMC v St Luke's Hospital, Peart J, 28 February 2007, JD v Central Mental Hospital, Finlay Geoghan J, 20 March 2007, AM v Central Mental Hospital, Peart J, 24 April 2007*

[50] *Given the importance of Convention compliance in the regime for dealing with patients, one further aspect of the Article 40 review regime should be noted: it has been held that there is no requirement in the Constitution for the Article 40 inquiry to be completed forthwith, which calls into question its compliance with Article 5(4): see TO'D v Central Mental Hospital, Charleton J, 25 April 2007. In Reid v UK [2003] Mental Health Law Reports 226, a breach of Art 5(4) was found in the time taken for a case relating to the detention of a patient in Scotland to proceed through all the available appeal procedures in the UK.*

(v) Voluntary Patients – sections 23, 24, 29

Section 29 allows a patient to be admitted to hospital or remain there on a voluntary basis: no test is set for assessing the ability of the patient to be a volunteer. Case law from the European Court that post-dates the 2001 Act has made it plain that patients without capacity should not be detained[51] on the basis of voluntary provisions or even wardship-like provisions (i.e. under court control) if this is not sufficient to prevent the risk of arbitrariness when compared with the use of the formal procedures and the review processes this brings into play. The relevant case is HL v UK[52], which has led in England and Wales to both a new statutory regime to regulate the detention of otherwise compliant patients without capacity[53] and significant litigation pending the bringing into force of this complex legislation. Of course, there are wider issues than simply detention in relation to the treatment of those whose capacity is impaired, and the Irish Law Reform Commission has conducted such a review recently, leading to a Bill before the Oireachtas[54]. This Bill will allow the opportunity to ensure that any gaps in the legislative regime relating to the detention of incapacitated adults, of the sort revealed by HL v UK, are closed.[55]

If a voluntary patient wishes to leave but staff at the hospital believe the patient is suffering from a mental disorder and should remain, a holding order for up to 24 hours may be issued (section 23); this is to be strictly construed – see TO'D v Central Mental Hospital, Charleton J, 25 April 200756. If a second opinion is obtained that the patient meets the criteria for involuntary admission, the patient is then detained under section 24 as if an admission order had been made under section 14. In the case of JQ v St Patrick's Hospital, O'Higgins J, 21 December 2006, it was noted that the completion of the section 24 process could only occur if the patient had sought to leave and section 23 had been invoked: consequently, where the patient was voluntary and had not indicated an intention to leave, he could not be made a compulsory patient.

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51 *In other words, a situation that involves Article 5 as opposed to restrictions on freedom of movement, which is a question of degree on the facts.*

52 *[2004] Mental Health Law Reports 236. See also Storck v Germany [2005] Mental Health Law Reports 211, which emphasised that liberty cannot be given up voluntarily: an 18 year old who went with her father to a clinic was nevertheless detained there and entitled to Article 5 protections.*

53 *Provisions in the Mental Health Act 2007, which amend the Mental Capacity Act 2005; there is also legislation in Scotland.*

54 *See their final report Vulnerable Adults and the Law (83-2006), December 2006, which has led to a Private Member's Bill, the Mental Capacity and Guardianship Bill 2007: see www.lawreform.ie for details, under the Table of Implementation of Commission Reports.*

55 *It might be that the current language of the 2001 Act is adequate if the courts ensure that "admitted voluntarily" under section 29 requires an exercise of volition, such that a patient without capacity must be admitted as an involuntary patient.*

56 *But he went on to find that the Tribunal could waive the defect if the evidence on the merits indicated that detention should follow. This was followed in JH v Jonathan Swift Clinic, Peart J, 25 June 2007, in which it was held that the failure to complete an admission order until 20 minutes after the 24 hour holding period had expired was not sufficient to make the detention unlawful.*

(vi) Conditions of Detention – Part 3

Although the provisions relating to the conditions of detention are outside Part 2, they are relevant for this report because in JH v Clinical Director, Cavan General Hospital, Clarke J, 6 February 2007, an argument was put that detention was unlawful because of the failure to offer adequate treatment. The judge concluded at paragraphs 7.4 to 7.6 of his judgment that:

(i) "the conditions in which a person may be detained as a mental health patient might, in theory, fall so short of acceptable conditions so as render unlawful a detention which might otherwise be regarded as lawful… amongst the relevant conditions that might, theoretically, render such detention unlawful would be the treatment (or perhaps more accurately the lack thereof) being afforded to the person concerned…"

(ii) "However, … it does not seem to me that that anything other than a complete failure to provide appropriate conditions or appropriate treatment could render what would otherwise be a lawful detention unlawful";

He then noted that in circumstances falling short of a complete failure, other proceedings – such as judicial review – might be available[57].

This approach is consistent with the case law of the European Court that detention justified under Article 5(1)(e) must be in an appropriate clinical setting, a standard which will not be met if the conditions are not fit for purpose.

The statutory regulation of conditions involves the following elements: (i) under section 33(1), the Commission has a role to improve the quality of care and hospital conditions; this includes codes of practice; (ii) the Inspector of Mental Health Services has various functions, including reporting on the quality of care and treatment, and also of compliance with any codes of practice; under section 55, the Commission may request the Inspector to investigate specific units or the treatment of particular patients (and the Minister may initiate this process);[58] (iii) hospitals and psychiatric units have to be registered with the Commission, and questions of the conditions of the place and also the provision of care plans for patients are relevant to registration. So the 2001 Act clearly provides a regime for inspections and registration designed to ensure not only that conditions do not breach Article 3 but are consistent with high standards: further details of the approach adopted can be found in the Mental Health Commission's Quality Framework, which is designed to provide a framework for continuous improvement in services.

[57] *And that the narrow question raised under an Article 40.4 review meant that it would not be suitable forum, since for example complex questions such as resources might be relevant.*

[58] *It is worth commenting that criminal law sanctions to guard against deliberate neglect or exploitation of patients which were contained in sections 253 and 254 of the Mental Treatment Act 1945 were repealed by section 6 of the Schedule to the 2001 Act without replacement. There is, however, an offence in section 69 of using bodily restraints or seclusion otherwise than in accordance with Rules made by the Commission).*

(vii) Other Parts of the Act

There are special provisions for children in sections 23 and 25 of the Act (relating to voluntary and involuntary admission); very few children have been detained under the Act and so it is difficult to make any comments on its operation in so far as it affects them. The Act also contains a Part 4, which relates to the circumstances in which treatment can be given to patients (for which there was no framework in the 1945 Act); there is also specific regulation of the use of seclusion or restraints (section 69), no doubt designed to ensure that there is no breach of Article 3 of the Convention.

Finally, as noted above, the 2001 Act did not deal with the issue of patients from the criminal justice system, a gap now filled by the Criminal Law (Insanity) Act 2006: but filled without dealing fully with the interplay between the two statutes, in particular in relation to serving prisoners whose mental health needs mean that they have to be transferred to a "designated centre" under the 2006 Act. These centres include the Central Mental Hospital (see section 3 of the 2006 Act). But the only route to the Central Mental Hospital under the 2001 Act is by transfer authorised by a Tribunal (section 21). This means that if a serving prisoner in the Central Mental Hospital reaches the end of his or her sentence but needs ongoing detention and treatment as a civil patient, their detention cannot simply continue with the completion of an admission order. It would clearly be possible to ensure that the procedural safeguards of an admission order and Tribunal decision on ongoing detention in the Central Mental Hospital are met (for example, by requiring the relevant civil detention and transfer paperwork to be done in advance of the end of the sentence and hence the detention under the 2006 Act, with a Tribunal hearing shortly before the change in status from criminal to civil); but this, or whatever other process is felt best, will require an amendment to the language of section 21 of the 2001 Act.

F. Conclusions and Recommendations

The 2001 Act was designed to secure compliance with the European Convention, at least in relation to civil detention: it is clearly fit for that purpose in broad terms, and has the advantage of being joined by the European Convention on Human Rights Act 2003, which emphasises the need for public bodies to live up to the requirements of the Convention. There are a number of instances where any doubts as to what should happen can be resolved by reference to this Act – for example, the discretion as to who should receive the Tribunal decision under section 18(5), or the test for whether the responsible psychiatrist should discharge an admission or renewal order under section 28.

The only significant area of concern[59] is one of omission in the Act to deal with the question of those who are "detained" when classified as voluntary when they do not have the capacity to be volunteers: this is hardly a criticism of the Act because it is a question on which the guidance from the European Court post-dates the legislation. Nevertheless, it is now an established feature of the Article 5 jurisprudence and so must be addressed in light of the provision in section 29 of

59 *Except that arising in relation to the burden of proof under section 19, which is subject to litigation at present.*

the 2001 Act that preserves voluntary admissions: having said that, as is noted above, judicial interpretation may resolve this issue.

There are two other specific provisions that merit some consideration:

(i) whether the rights of patients to have reasons for detention should include the opinion of the psychiatrist involved (i.e.) not just the legal basis for detention, namely that there is mental disorder, but the reasons for that opinion): see section E.3.(ii) above;

(ii) whether there should be a provision for the patient to apply to have the Tribunal hearing in public: see section E.3(iii) above.

Kris Gledhill
Auckland, March 2008

1 THE MENTAL HEALTH COMMISSION

MENTAL HEALTH COMMISSION: STATUTORY REGULATORY FUNCTIONS

The Mental Health Commission is a statutory independent body established under Part 3 of the Mental Health Act 2001. On March 19th 2002, the Minister for Health and Children, Mr Micheál Martin, T.D., signed a commencement order thereby enacting from 5th April 2002, sections 1 to 5, 7 and 31 to 55 of the Mental Health Act 2001. These sections refer primarily to the establishment of the Mental Health Commission and the appointment of the Inspector of Mental Health Services. The 2001 Act requires the Commission and the Inspector to arrange for the provision of a broad range of regulatory, inspection and review functions in relation to mental health services and the establishment of mental health tribunals. The functions of the Commission are provided for in section 33 of the 2001 Act. The principal functions of the Commission are to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres under this Act. This encompasses the broad spectrum of mental health services and includes statutory and independent sector providers.

MEMBERSHIP OF THE COMMISSION

Members of the Mental Health Commission

Section 35 of the Mental Health Act 2001 provides that the Commission shall consist of 13 members who shall be appointed to be members of the Commission by the Minister. As required by Section 35, a 13 member Commission was appointed including a chairperson and the first meeting was held on April 16th 2002. The current Commission members, appointed in April 2007, are;

Dr. Edmond O'Dea – Chairman (Principal Clinical Psychologist HSE)
Dr. Mary Keys – Lecturer NUI Galway
Mr. Brendan Byrne – Director of Nursing Carlow Kilkenny Mental Health Services, HSE
Mr. Padraig Heverin – Clinical Nurse Manager II, HSE
Ms. Emile Daly – Barrister at Law
Dr. Martina Kelly – General Practitioner
Dr. Brendan Doody – Consultant Child Psychiatrist HSE Dublin Mid-Leinster
Ms. Vicki Somers – Principal Mental Health Social Worker HSE Kildare/West Wicklow
Mr. Martin Rogan – Assistant National Director – Mental Health HSE
Mr. John Redican – Chief Executive Officer Irish Advocacy Network
Ms. Marie Devine – Bodywhys
Mr. John Saunders – National Director Schizophrenia Ireland
Dr. Eamon Moloney – Consultant Psychiatrist HSE South

The inaugural Commission consisted of:

Dr. John Owens – Chairman
Dr. Anne Byrne Lynch – Principal Clinical Psychologist, HSE
Mr. Joe Casey – Mental Health Ireland
Mr. Gerry Coone – Psychiatric Nurse, HSE
Mr. Padraig Heverin – Clinical Nurse Manager II, HSE
Mr. Diarmaid McGuinness – Senior Counsel
Dr. Deirdre Murphy – General Practitioner
Dr. Finbarr O'Leary – Consultant Child & Adolescent Psychiatrist, HSE
Mr. Diarmuid Ring – Lecturer on Mental Health issues and Service User
Ms. Annie Ryan – Campaigner on Mental Health Issues
Ms. Vicki Somers – Principal Mental Health Social Worker HSE Kildare/West Wicklow
Mr. Mike Watts – National Co-ordinator Grow and former Service User
Ms. Maureen Windle – former CEO Northern Area Health Board

The term of office for a member of the Commission is 5 years and members are eligible for re-appointment. The Chief Executive Officer, Ms. Brid Clarke was appointed in December 2002 and in September 2003 the Inspector of Mental Health Services, Dr. Teresa Carey was appointed.

OFFICE OF THE INSPECTOR OF MENTAL HEALTH SERVICES

The Mental Health Act 2001 established for the first time the office of the Inspector of Mental Health Services. Dr Teresa Carey, consultant psychiatrist, was appointed as the Inspector of Mental Health Services in September 2003. Section 54 refers to Assistant Inspectors of Mental Health Services, whose function is to *"assist the Inspector in the performance of his or her duties"* (S54(1)). The assistant inspectors perform their functions under the general direction of the Inspector of Mental Health Services (S54(3)). A team of 3 whole-time equivalent assistant inspectors was appointed in 2004. The team consists of professionals with extensive experience in mental health services; one full-time nurse, two part-time consultant psychiatrists, one part-time occupational therapist, one part-time social worker and one part-time clinical psychologist. The Inspector of Mental Health Services and the assistant inspectors use the collective title the Inspectorate of Mental Health Services.

Functions of the Inspector of Mental Health Services

The functions of the Inspector of Mental Health Services are stated in Section 51(1)a:

"to visit and inspect every approved centre at least once in each year... and to visit and inspect any other premises where mental health services are being provided as he or she thinks appropriate..."

As specified in Section 51(1)(b), a report from the Inspector of Mental Health Services has been prepared for the Commission each year from 2003 to 2006, and this report has been published in the Annual Report of the Mental Health Commission. The duties of the Inspector of Mental Health Services when making inspections are described in Section 52.

COMMENCEMENT OF ALL REMAINING PARTS OF THE ACT

In 2006 the Minister for Health & Children announced that the remaining parts of the Mental Health Act, 2001 would commence on 1st of November 2006. The remaining parts for commencement were;

Part 1 Preliminary and General
Part 2 Involuntary admission of persons to approved centres
Part 4 Consent to Treatment
Part 5 Approved Centres, and
Part 6 Miscellaneous

The commencement of the remaining parts of the 2001 Act introduced new procedures and practices in relation, in particular, to involuntary admissions, thereby enhancing and protecting the rights of the individual service user.

Part 2 of the Mental Health Act, 2001 provides for automatic independent review of all involuntary admission and renewal orders. This is an important right and is fundamental to the Commission's Strategic Priority Number Two which is to promote and protect the rights and best interests of persons availing of mental health services. Within 21 days of an admission or renewal order being signed a three person mental health tribunal, consisting of a lawyer as chair, a consultant psychiatrist and a lay person review the order. Prior to this review a legal representative is appointed by the Mental Health Commission for each person (patient) admitted involuntarily, unless s/he proposes to engage one. An independent medical examination by a consultant psychiatrist, appointed by the Commission, will have been completed before the mental health tribunal sits and a report given to the tribunal. More details on the Act's procedures for involuntary admission and the related activity information are provided in later sections of this report.

SELECTION AND TRAINING FOR COMMENCEMENT

In preparation for commencement the Mental Health Commission appointed panels from which mental health tribunal members could be drawn; a lay persons panel, a panel of consultant psychiatrists and a panel of chairpersons (practising barristers and solicitors). Tribunal clerks were appointed to assist in the running of tribunals. In addition a mental health legal aid scheme was prepared by the Commission and panels of solicitors were appointed to act as legal representatives the patients. Panels of consultant psychiatrists were also appointed to provide the independent reports required under Section 17(c). Recruitment to all the Commission's panels was conducted using a competitive process. Advertisements were placed seeking applications for membership, and selection interviews, reference checks and a Garda vetting process were compulsory. Over 350 interviews were conducted prior to commencement and selection interviews continued for some of the panels during 2007.

The Commission took the view that significant investment in induction and refresher training for panel members was essential if their input to the operation of the Act was to be of a high quality.

Training programmes were designed based on research by the Commission on best practice in this area and national and international experts were engaged for specific topics. Training programmes were accredited by the relevant medical and legal bodies to qualify for professional development status under their regulations.

In preparation for their roles under Part 2 of the Act a total of 281 people received induction training (on average 3 days each). This encompassed the mental health tribunal members, independent medical examiners, legal representatives, and tribunal clerks. For this training the Mental Health Commission organised detailed familiarisation sessions on the Act, role play of a mental health tribunal, speakers from other jurisdictions and key Irish legal and medical practitioners. Initial training involved introduction to mental health issues from a service user and clinical perspective. Further panel members were trained throughout 2007, bringing the total numbers trained for the panels up to 390.

In the months immediately after commencement specific sessions were also arranged on legal issues from court judgments associated with the 2001 Act. Mental health tribunal chairs and legal representatives received this training in the early stages of implementation to inform them of developments in this new area of jurisprudence which is set in the context of vulnerable people, best interest and a non-adversarial approach.

THE REGISTER OF APPROVED CENTRES

The 2001 Act sets out a new statutory regime for the registration and monitoring of centres that provide care and treatment for persons suffering from mental illness or mental disorder. It introduced the term *"approved centre."* According to the 2001 Act an approved centre is a centre that is registered pursuant to the Act. The Mental Health Commission establishes and maintains the register of approved centres. Registration and inspection is now in place and is regarded as a positive means of improving quality of care. During 2005 and 2006 the Commission advanced the preparatory work for the establishment of the Register and prepared advice for the Minister on Regulations for approved centres. Part 5 of the Mental Health Act 2001, *"Approved Centres"*, was commenced on the same date as Part 2. This was essential as Part 2 refers throughout to the *"involuntary admission of persons to approved centres."*

Section 63 sets out provision for the prohibition of unregistered centres and section 64 provides for the registration of approved centres. In section 64(1) it is stated that the Commission shall establish and maintain a register which shall be known as "the Register of Approved Centres" and is referred to subsequently in the Act as "the Register". The Register of Approved Centres has been in place from the commencement date. There are 61 approved centres registered at time of reporting, see Appendix 2. Forty of these centres were deemed to be approved under section 72(6) and twenty-one were registered in accordance with section 64. At commencement of part 2 of the Mental Health Act 2001 on 1st November 2006 centres that had a person receiving care and treatment for mental disorder were deemed to be approved centres pursuant to Section 72(6)[60]. The period prescribed

[60] *72(6) During the period of 3 years from the Commencement of Part 2, or such shorter period as may be prescribed, a hospital or other in-patient facility for the care and treatment of persons with a mental disorder which, immediately before such commencement, was providing such care and treatment, shall, for the purposes of this Act, be deemed to be an approved centre.*

by the Minister was reduced by Statutory Instrument (S.I. Number 44 of 2008) in February 2008 to one year and four months. This meant that in order for the 40 centres deemed to be approved to continue operating from 1st March 2008 they were required to be registered pursuant to Section 64 of the Mental Health Act 2001 and this involved a comprehensive application process. Centres that were not providing care and treatment to a person with a mental disorder immediately prior to the commencement date were required to apply for registration under Section 64.

In 2007 only 47 centres of the 61 registered have been actively involved in admitting patients subject to involuntary admission orders.

REGULATIONS FOR APPROVED CENTRES

Within Part 5 Section 66 provides the statutory basis for the Act's regulations in relation to approved centres. The Act provides that the Minister shall, after consultation with the Commission, for the purpose of ensuring proper standards in relation to centres, including adequate and suitable accommodation, food and care for residents while being maintained in centres, and the proper conduct of centres, make such regulations. The regulations as prescribed by the Minister in S.I. No. 551 of 2006 came into operation on 1st November 2006.

RULES

The 2001 Act required the Commission to make Rules in relation to a number of specific aspects of treatment before it could be fully commenced. These were developed in collaboration with key stakeholders and were sent to mental health services providers for comment and consultation before being finalised. The Commission is required to make Rules in relation to electro-convulsive therapy (Part 4) and the use of seclusion and mechanical means of bodily restraint on a patient (Part6). Compliance with Rules arising from the Act is a statutory requirement[61].

In accordance with section 59(2) the Commission has made Rules providing for the use of electro-convulsive therapy and the Act states that a programme of electro-convulsive therapy shall not be administered to a patient except in accordance with such Rules.

The rules are kept under periodic review by the Mental Health Commission, and they will be revised as required. They are referenced as follows:

1. Section 59(2) Rules Governing the Use of Electro-Convulsive Therapy *(Ref. no. S59(2)/01/2006)*

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[61] *For example section 59(1) within Part 4, provides that a programme of electro-convulsive therapy shall not be administered to a patient unless either—*
(a) the patient gives his or her consent in writing to the administration of the programme of therapy, or
(b) where the patient is unable or unwilling to give such consent—
(i) the programme of therapy is approved (in a form specified by the Commission) by the consultant psychiatrist responsible for the care and treatment of the patient, and
(ii) the programme of therapy is also authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist.

2. Section 69(2) Rules Governing the Use of Seclusion and Mechanical means of Bodily Restraint *(Ref no.S69(2)/02/2006)*

Part 6 of the Mental Health Act 2001, *"Miscellaneous",* was commenced on the same date as Part 2. This part contains sections 69 to 75. Section 69(1) states that a person shall not place a patient in seclusion or apply mechanical means of bodily restraint to the patient unless such seclusion or restraint is determined, in accordance with the rules made under *subsection (2),* to be necessary for the purposes of treatment or to prevent the patient from injuring himself or herself or others and unless the seclusion or restraint complies with such rules. Section 69(2) requires that the Commission shall make rules providing for the use of seclusion and mechanical means of bodily restraint on a patient. Under section 69(3) a person who contravenes this section or a rule made under this section shall be guilty of an offence and shall be liable on summary conviction to a fine not exceeding €1,875. It is of note that in section 69(4) it states that in this section ''patient'' includes:

(a) a child in respect of whom an order under *section 25* is in force, and
(b) a voluntary patient.

CODES OF PRACTICE

Part 3 of the Mental Health Act 2001, *"Independent Review of Detention"*, was commenced on March 19th 2002. Within Part 3 section 33(3)(e) states that the Commission shall prepare and review periodically, after consultation with such bodies as it considers appropriate, a code or codes of practice for the guidance of persons working in the mental health services.

This was the first occasion that mental health legislation in Ireland provided for the use of codes of practice for the guidance of persons working in the mental health services. Codes of practice are guidelines to assist service providers in attaining high quality provision of services. There have been 4 Codes of Practice issued by the Commission. These are:

1. Code of Practice Relating to Admission of Children under the Mental Health Act 2001 Reference Number: COP-S33(3)/01/2006
2. Code of Practice on the Use of Physical Restraint in Approved Centres Reference Number: COP-S33(3)/02/2006
3. Code of Practice for Mental Health Services on Notification of Deaths and Incident Reporting: COP-S33/01/2008
4. Code of Practice governing the Use of Electro-Convulsive Therapy for Voluntary Patients: COP-S33/02/2008

The Mental Health Commission, in collaboration with the HSE and the independent sector approved centres, provided information sessions on the regulations, rules and codes of practice in 2007 to raise awareness of the statutory obligations under the 2001 Act.

2 COMMENCEMENT OF PART 2

INFORMATION AND TRAINING

Information

Training and information for those who have a statutory role in the operation of Part 2 of the Act and those involved in providing services had been identified by the Commission as critical factors in facilitating effective implementation. This was reflected by the priority given to this area of the work programme by the Mental Health Commission.

- In August 2005 the Mental Health Commission published a Reference Guide on the Mental Health Act, 2001. Over 7,000 copies and CD Rom versions have been produced and circulated.

- To augment the Reference Guide information leaflets on the involuntary admission process were designed for service providers, An Garda Síochána and registered medical practitioners. 5,000 of each were printed and distributed and a further 2,500 of each was required.

- An information booklet *"Your Guide to the Mental Health Act 2001"* for service users was prepared and circulated widely by the Mental Health Commission. Over 34,000 copies were printed and distributed.

- The Commission also developed a comprehensive web site for ease of access to information on the Act and to the e-learning site. All information resources are placed on the site along with relevant judgments, summaries of judgments, and monthly admission order, adults and children, and mental health tribunal activity figures. Service user information on the provisions of the Mental Health Act has also been translated into the following languages: Irish, French, Russian, Polish, Chinese and Arabic. These translated versions are available on the website.

- An important element to the range of information provided by the Commission in the lead up to the full commencement of the 2001 Act on 1st November 2006 was an Information Line operated by staff of the Commission from 31st October, 2006. Almost 1,000 calls were received on the Information Line in the four week period, the majority of calls coming from personnel in the Health Service Executive (HSE).

Training

From 2005 the Commission embarked upon an extensive multifaceted training and information programme to support mental health professionals in providing quality mental health services. The overall objective of the programme was to equip mental health care professionals, families, carers, advocates and the general public with knowledge of the Mental Health Act 2001. From the outset, it was the Commission's intent to develop, deliver and evaluate a programme that would incorporate a local sustainable approach. The approach adopted included the following key elements:

- Train the Trainers Programme. A four day course – resulted in 288 registered trainers by the end of 2007. These come from multi-disciplinary backgrounds throughout the Health Service Executive and independent sector, By the date of commencement over 7,000 people were trained on the provisions of the Act.

- A joint training programme organised by the Mental Health Commission and the Irish College of Psychiatrists (ICP) commenced in November 2005. This continued during the early months of 2006 and in total 403 doctors attended. The Commission and the ICP are currently conducting further discussion as to how to update this training.

- The commissioning and development of an e-learning programme on the Mental Health Act, 2001 has been available from March 2006, and is readily accessed on the Commission's website at www.mhcirl.ie. The e-learning programme is designed to meet individual needs, ranging from individual modules to a ten hour programme which leads to a certificate of training.

- The Mental Health Commission and the Irish College of General Practitioners (ICGP) agreed on an information exchange programme for general practitioners. This resulted in the development of a customized e-mail address for mental health queries on the ICGP website, participation by the Commission in the ICGP Mental Health Awareness Week, participation in workshops at ICGP meetings and Annual General Meetings and the dissemination of the Reference Guide and other literature.

- Meetings were held with An Garda Síochána in relation to training on the Mental Health Act, 2001. Training on the Act is provided by An Garda Síochána both for probationers and as part of their ongoing in-service training programme. The Commission has had an input to the development of these programmes. Garda sergeants with training responsibilities have, on request, been given access to the training resources of the Commission's e-learning site which assists in the organising of training.

- Training was provided by the Mental Health Commission for 95 people initially appointed as authorised officers within the Health Service Executive, pending the implementation of a fully developed authorised officer service.

- The e-learning programme was translated for sign language and is available on DVD. This is a unique learning tool for the Irish mental health system and has been widely circulated to all relevant bodies.

STATUTORY AND NON-STATUTORY FORMS

Full commencement of the Mental Health Act, 2001 introduced a new suite of prescribed forms issued by the Mental Health Commission in relation to the statutory provisions in the Act. These were developed in draft and refined at workshops and in a number of pilot sites in consultation with service users and providers. Names and identifying numbers of each statutory form are listed in Table 1 below.

TABLE 1 Mental Health Act 2001 Statutory Forms Prescribed by the Mental Health Commission

FORM 1	Application (to a Registered Medical Practitioner) by Spouse or Relative for a recommendation for involuntary admission of an adult (to an approved centre)
FORM 2	Application (to a Registered Medical Practitioner) by Authorised Officer for a recommendation for involuntary admission of an adult (to an approved centre)
FORM 3	Application (to a Registered Medical Practitioner) by a member of the Garda Síochána for a recommendation for involuntary admission of an adult (to an approved centre)
FORM 4	Application (to a Registered Medical Practitioner) by a member of the public for a recommendation for involuntary admission of an adult (to an approved centre)
FORM 5	Recommendation (by a Registered Medical Practitioner) for involuntary admission of an adult (to an approved centre)
FORM 6	Involuntary Admission Order for up to 21 days
FORM 7	Renewal Order by Responsible Consultant Psychiatrist
FORM 8	Decisions of the Mental Health Tribunal
FORM 9	Decision of the Mental Health Tribunal to Extend by 14 days
FORM 10	Notice of Patient transfer to another Approved Centre (other than the Central Mental Hospital)
FORM 11	Proposal by the Clinical Director to Transfer Patient to the Central Mental Hospital
FORM 12	Notice of transfer of a Patient to the Central Mental Hospital
FORM 13	Certificate & Admission Order to Detain a Voluntary Patient (adult)
FORM 15	Proposal to Perform Psychosurgery Involuntary Patient (adult)
FORM 14	Revocation of an Involuntary Admission or Renewal Order
FORM 16	Treatment Without Consent Electroconvulsive Therapy Involuntary Patient (adult)
FORM 17	Treatment Without Consent Administration of Medicine for more than 3 months Involuntary Patient (adult)
FORM 18	Treatment of a Child in Respect of Whom an Order under Section 25 is in Force

The forms are available in English and Irish on the Commission's web site. Resulting from a number of High Court judgments and a ruling in a Supreme Court decision the Commission revised a number of forms and re-issued them for use from 1st December 2007. The list of revised forms is summarised in Table 2 below.

Table 2 Revised Mental Health Act 2001 Statutory Forms Prescribed by the Mental Health Commission

FORM 5	Recommendation (by a Registered Medical Practitioner) for involuntary admission of an adult (to an approved centre)
FORM 6	Involuntary Admission Order for up to 21 days
FORM 7	Renewal Order by Responsible Consultant Psychiatrist
FORM 8	Decisions of the Mental Health Tribunal
FORM 9	Decision of the Mental Health Tribunal to Extend by 14 days
FORM 13	Certificate & Admission Order to Detain a Voluntary Patient (adult)
FORM 15	Proposal to perform psychosurgery involuntary Patient (adult)
FORM 16	Treatment without consent electroconvulsive therapy involuntary Patient (adult)
FORM 17	Treatment without consent administration of medicine for more than 3 months involuntary Patient (adult)

In addition to forms prescribed by the Act a number of clinical practice forms were introduced to facilitate consistency in recording certain aspects of the procedures associated with involuntary admissions and treatments. These are primarily used by approved centres, but in response to a request from centres these have also been prepared and circulated by the Mental Health Commission. These are as follows:

- Patient Notification of the Making of an Admission Order or Renewal Order Mental Health Act Section 16(2)
- Clinical Practice Form Mental Health Act Section 23(2) and 23(3) Power to Detain Voluntary Patient (Child) in an Approved Centre
- Clinical Practice Form Mental Health Act Section 14(2) Detention of a Person (Adult) for the Purpose of Carrying out an Examination
- Clinical Practice Form Mental Health Act Section 23(1) Power to Prevent Voluntary Patient (Adult) from Leaving an Approved Centre
- Notification to the Mental Health Commission of the Admission of a Child to an Approved Centre for Adults.
- Notification to the Mental Health Commission of the Discharge of a Child from an Approved Centre for Adults.

The form *Patient Notification of the Making of an Admission Order or Renewal Order Mental Health Act Section 16(2)* was revised on foot of a written judgement of the High Court that was upheld by the Supreme Court[62]. Copies of all forms are available on the Commission's web site *www.mhcirl.ie.*

[62] *MD v St Brendan's Hospital, MHC, MHT (Respondents) Judgement of Mr Justice Peart delivered 24th May 2007. Appeal to the Supreme Court – Judgement of Mr Justice Hardiman delivered 27th July 2007. (Fennelly, J., & Macken J.)*

COURT RULES

New court rules were required in relation to District and Circuit court cases arising from the Act, the most common being appeals of mental health tribunal decisions under section 19 and the involuntary admission of children under section 25. The Commission worked with the Department of Health & Children in its liaison with the Court Rules Committee arising from the work associated with putting the rules in place.

OTHER PREPARATORY ISSUES

- The Commission established a National Implementation Group in 2004 to *".. plan and co-ordinate the implementation of the Mental Health Act 2001 as directed by the Mental Health Commission."* There were many different strands of work to co-ordinate on a national basis. Membership was drawn from the Health Service Executive, Independent Psychiatric Hospitals, Intellectual Disability Services, Irish College of General Practitioners and Irish Advocacy Network.

- A bespoke information system, SIAT (System for Involuntary Admissions and Tribunals) was designed and implemented by the Commission in preparation for commencement of Part 2 of the Act. This system enables the Commission to record and track all administrative workflow associated with the involuntary admission process.

- A legal aid scheme was implemented by the Commission in preparation for commencement of Part 2 of the Act. The Mental Health Commission with the assistance of the Legal Aid Board, progressed the development of a legal aid scheme specifically for those who are admitted involuntarily as defined in the Mental Health Act 2001, Section 33(3) (c)

- Discussions with the Department of Finance in relation to fees for the operation of the Independent Review System – legal representation, mental health tribunals and independent consultant psychiatrist were completed in mid 2004.

- The 2001 Act introduces the role of "authorised officer", who is an officer of the Health Service Executive in a prescribed rank or grade, authorised to make an application for an involuntary admission (Section 9(8)). The Mental Health Commission formed a working group which included representatives from the Health Service Executive and service user organisations to consider operational, training, resource and implementation issues and inform the Commission's advice to the Minister on the regulations to be made by the Minister for Health and Children in this regard. Statutory Instrument (S.I.) 550 of 2006 – Mental Health Act 2001 (Authorised Officer) Regulations 2006 prescribes the rank and grade of an authorised officer as Local Health Manager, General Manager, Grade VIII, Psychiatric Nurse, Occupational Therapist, Psychologist or Social Worker. Training was jointly provided by the Mental Health Commission and the HSE for those people initially appointed as authorised officers.

TRANSITIONAL PROVISIONS

Section 72(1) to (5) Mental Health Act 2001 outlines the transitional provisions for patients who remained detained at midnight 31st October, 2006 pursuant to the Mental Treatment Act 1945. The Mental Health Commission collated monthly returns from service providers detailing the level of involuntary admissions to each facility and the number of patients subject to Person of Unsound Mind (PUM) or Temporary Reception Orders at the end of each calendar month during 2005.

Detention periods for involuntary admission under the 1945 Act were significantly longer when compared with current practice in comparable jurisdictions. Under the 1945 Act there were two types of detention order. The shorter period of detention, a Temporary Reception Order, allowed the person to be detained;
"...for a period of six months from the date on which the order is made..." (Section 186 Mental Treatment Act 1945)

This order could be extended by further periods none of which could exceed six months and the aggregate of which should not have exceeded eighteen months. The other type of involuntary admission order provided by the 1945 Act was used if the person was considered to be a "Persons of Unsound Mind" (PUM), and this allowed for the person to be detained:
"...until his removal or discharge by proper authority or his death..."
(Section 172 Mental Treatment Act 1945)

In accordance with Section 72(5), a letter was sent to all Clinical Directors on 19th October, 2006 requesting that they furnish the Mental Health Commission with particulars of the persons so detained at midnight 31st October, 2006. The Mental Health Commission received notification of 388 patients who remained detained pursuant to the provisions of the Mental Treatment Act 1945. The provisions of the Mental Health Act 2001 in relation to independent review of involuntary admissions were applicable to these patients. Table 3 below provides further details on the number of patients notified to the Commission as detained at midnight 31st October 2006 and the number who were still subject to the same involuntary admission episode at 31/12/2007.

Table 3 Number of Adults Detained at Midnight 31st October 2006

Type of order – Mental Treatment Act 1945 (Became Part 2 involuntary admissions on commencement of 2001 Act)	Number notified to the Commission 1/11/2006	Number still subject to the same involuntary admission episode at 31/12/2007 (Under 2001 Act)
Temporary Reception Order	371	56
Person of Unsound Mind	17	4
Total	388	60

3 INVOLUNTARY ADMISSION OF ADULTS

NEW PROCEDURES FOR INVOLUNTARY ADMISSION (ADULTS)

Unlike the 1945 Act the Mental Health Act 2001 defines mental disorder, section 3, and sets out criteria for involuntary admission to approved centres, section 8. From 1st November 2006 the 2001 Act introduced provisions for a system of free legal representation for adults and independent reviews during their episode of involuntary admission[63]. This is completed by a mental health tribunal during each period of detention. Under the 2001 Act the detention periods last up to 21 days, then periods of three months, six months and thereafter periods of up to 12 months, referred to as renewal orders. **Involuntary admission procedures for children differ from those for adults and are dealt with later in this report.**

The first detention orders were notified to the Commission from 1st November 2006 and the Commission began the process of referring them to mental health tribunals. Table 4 below provides a summary of activity from 1st November to 31st December 2006. **It is important to note that the 2001 Act has provisions for two methods of initiating detention;** an *Involuntary Admission Order for up to 21 days*, (Form 6) and a *Certificate & Admission Order to detain a Voluntary Patient (Adult),* (Form 13) which also detains for up to 21 days.

Table 4 Involuntary Admission (Adults) 2006

	NOVEMBER 2006	DECEMBER 2006
Form 6, Involuntary Admission Order for up to 21 days,	95	112
Form 13, Certificate & Admission Order to detain a Voluntary Patient (Adult)	50	55
Renewals Orders	38	77
Proposals to transfer to CMH	0	1
Form 14 Revoke before hearing by RCP	127	122
MENTAL HEALTH TRIBUNAL HEARINGS 2006		
Hearings held	31	147
Revoked at hearing	4	20

The remaining parts of this section of the report provide activity information relating to the calendar year 2007, the first full calendar year of operating Part 2 of the Act, as this provides data that is more readily used for comparative analysis with previous and future years' activity.

[63] *An episode is a patient's unbroken period of involuntary admission*

INVOLUNTARY ADMISSION (ADULTS) 2007

Analysis was completed on the number of adults who were involuntarily admitted using the provisions of sections 9, 10, & 14 of the Act in the period 2007. In such admissions the admission order is made by a consultant psychiatrist on statutory *Form 6, Involuntary Admission Order for up to 21 days*, which must be accompanied by an application (Form 1, 2, 3, or 4) and a recommendation by a registered medical practitioner, (Form 5). There were 1,503 *Form 6 Involuntary Admission Orders for up to 21 days* notified to the Commission in 2007.

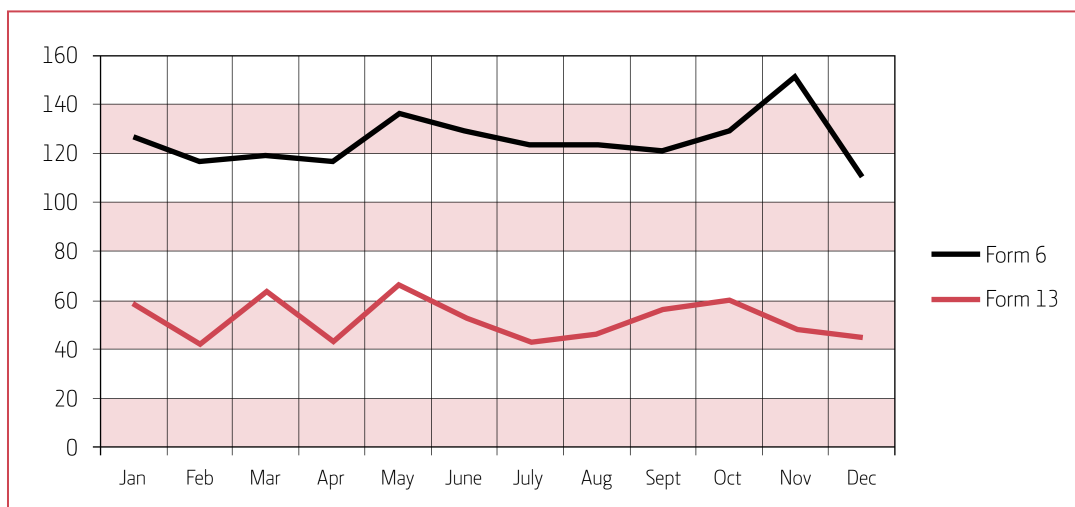
DETENTION OF A VOLUNTARY PATIENT; SECTION 24 MENTAL HEALTH ACT 2001

Section 24 Mental Health Act 2001 outlines the procedures relating to a decision to re-grade a voluntary patient to involuntary status. Following a High Court decision in relation to a Habeas Corpus application on the 21st December 2006, clarification on the use of Section 24 was issued (JQ v St Patrick's Hospital 2006). As section 24(1) states "Where a person (other than a child) is detained pursuant to Section 23..." the outcome of the High Court Ruling was that Section 24(1) cannot be invoked unless Section 23(1) has been revoked. Analysis was completed on the number of voluntary patients who were detained using section 24 of the Act in the period 2007. In such admissions the admission order is made on a statutory form, *Form 13 Certificate & Admission Order to Detain a Voluntary Patient (Adult)*, signed by two consultant psychiatrists. There were 623 such admissions notified to the Commission in 2007.

COMPARISONS 2005 - 2007

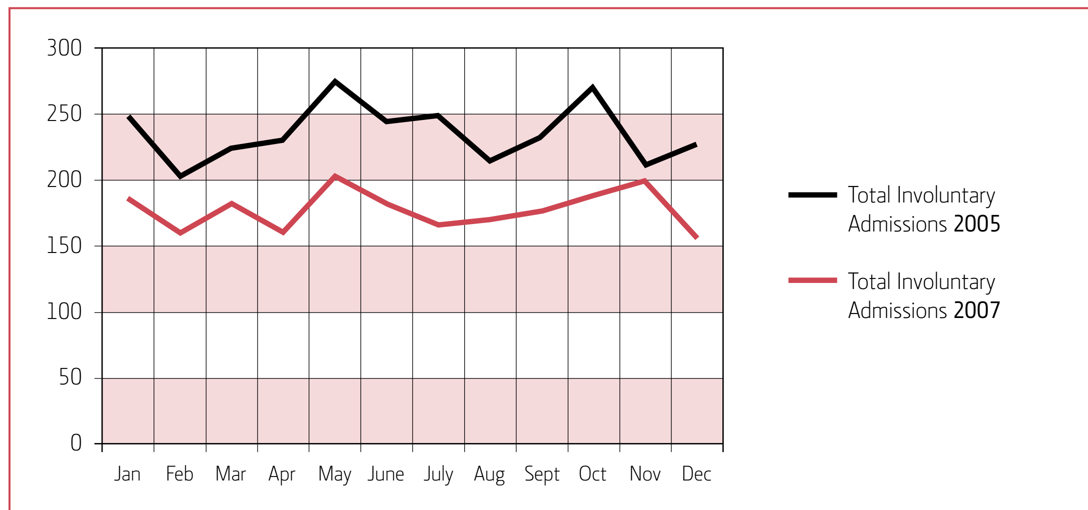
Figure 1 below summarises on a monthly basis both the above categories of involuntary admission for 2007, i.e. – *Form 6 Involuntary Admission Orders for up to 21 days, and Form 13, Certificate & Admission Order to Detain a Voluntary Patient (Adult).*

Figure 1 Monthly Involuntary Admissions 2007: Form 6 Involuntary Admission Orders for up to 21 days, and Form 13, Certificate & Admission Order to Detain a Voluntary Patient (Adult)



Comparison was made of 2007 involuntary admission activity with that for 2005 under the 1945 Mental Treatment Act. The year 2005 was chosen for comparison to allow for the effect of the commencement of the 2001 Act in 2006 artificially distorting admission rates in the months immediately before and after the commencement date. Figure 2 below summaries this comparison on a monthly basis and shows a decrease of 25% in overall involuntary admission activity.

Figure 2 Comparison of Total Involuntary Admissions 2005 and 2007



Further comparison of 2007 with 2005 shows the decrease in activity is accounted for by a reduction in the category *Form 6 Involuntary Admission Order for up to 21 days*, (-34%) as opposed to *Form 13, Certificate & Admission Order to Detain a Voluntary Patient (Adult)* where the numbers have risen (+15%). Scotland by comparison also had significant reductions in the number of involuntary admissions in the period immediately following reform of their legislation. Lyons (2008) reports that for the year 2006-7 there were significantly reduced numbers of emergency detention certificates (- 60%) but more people were detained for more than 72 hours (+8%).

Table 5 (A) and (B) below provides further analysis of involuntary admissions in 2007 by each approved centre, by HSE region, and the independent sector.

TABLE 5(a) Involuntary Admissions by HSE Regions 2007 (Adults)

HSE WEST	Form 6[a]	Form 13[a]	Total
Ballytivnan Sligo/Leitrim Mental Health Services	47	23	70
St. Conal's Hospital Letterkenny	0	0	0
Acute Psychiatric Unit Carnamuggagh Letterkenny	45	26	71
Adult Mental Health Unit Mayo General Hospital Castlebar	75	11	86
St Brigid's Hospital Ballinasloe	40	12	52
Department of Psychiatry County Hospital Roscommon	26	13	39
Psychiatric Unit University College Hospital Galway	59	21	80
Unit 9A Merlin Park University College Hospital Galway	0	0	0
Acute Psychiatric Unit 5B Midwestern Regional Hospital Limerick	55	18	73
St Josephs Hospital Limerick	0	1	1
Acute Psychiatric Unit Midwestern Regional Hospital Ennis	37	13	50
Orchard Grove Ennis	0	0	0
An Coillin Castlebar	0	0	0
Teach Aisling Castlebar	1	1	2
TOTAL HSE WEST	385	139	524
HSE SOUTH	Form 6	Form 13	Total
St. Finans Hospital Killarney	5	0	5
St Stephens Hospital Glanmire Cork	26	12	38
Acute Mental Health Admission Unit Kerry General Hospital Tralee	74	12	86
South Lee Adult Mental Health Unit, Cork University Hospital	86	33	119
St. Michaels Unit Mercy Hospital Cork	66	19	85
St Finbarr's Hospital Cork	0	0	0
Carraig Mor Centre Cork	13	7	20
Acute Psychiatric Unit Bantry General Hospital	19	9	28
St. Dymphna's Hospital Carlow	0	0	0
St. Canice's Hospital Kilkenny	0	0	0
St. Luke's Hospital Clonmel	6	2	8
St. Michael's Unit South Tipperary General Hospital Clonmel	66	25	91
St. Senan's Hospital Enniscorthy	30	17	47
Department of Psychiatry St. Luke's Hospital Kilkenny	20	11	31
Department of Psychiatry Waterford Regional Hospital	46	17	63
St Otteran's Hospital Waterford	5	3	8
TOTAL HSE SOUTH	462	167	629

[a] *Form 6 Involuntary Admission Order for up to 21 days. Form 13, Certificate & Admission Order to Detain a Voluntary Patient (Adult)*

TABLE 5(b) Involuntary Admissions by HSE Regions & Independent Sector 2007 (Adults)

HSE DUBLIN NORTH EAST	Form 6 [a]	Form 13 [a]	Total
Acute Psychiatric Unit Cavan General Hospital	20	4	24
St. Davnet's Hospital Monaghan	12	1	13
Department of Psychiatry Our Lady's Hospital Navan	32	18	50
St Brigid's Hospital Ardee	44	19	63
St. Vincents Hospital Fairview	52	28	80
St. Ita's Hospital Mental Health Services Portrane	40	18	58
St Joseph's Intellectual Disability Services St Ita's Hospital Portrane	0	0	0
Acute Psychiatric Unit , St Aloysius Ward Mater Misericordiae Hospital Dublin	8	11	19
St. Brendan's Hospital Dublin	20	7	27
Sycamore Unit Connolly Hospital	4	0	4
Department of Psychiatry Connolly Hospital	38	6	44
TOTAL DUBLIN NORTH EAST	270	112	382
HSE DUBLIN MID LEINSTER	Form 6	Form 13	Total
St. Loman's Hospital Palmerstown	0	1	1
Jonathan Swift Clinic	49	19	68
Acute Psychiatric Unit AMNCH	56	33	89
Lakeview Unit Naas General Hospital	47	16	63
Department of Psychiatry Midland Regional Hospital Portlaoise	35	11	46
St. Lomans Hospital Mullingar	38	10	48
St Fintan's Hospital Portlaoise	3	1	4
Newcastle Hospital	20	8	28
Elm Mount Unit St.Vincent's University Hospital	40	17	57
Central Mental Hospital	0	2	2
TOTAL HSE DUBLIN MID LEINSTER	288	118	406
INDEPENDENT SECTOR	Form 6	Form 13	
St John of God Hospital Stillorgan	66	38	104
St Patrick's Hospital Dublin	32	48	80
St Edmundsbury Hospital Dublin	0	0	0
Palmerstown View, Stewarts Hospital Dublin	0	1	1
Highfield Private Hospital	0	1	1
Hampstead Private Hospital	0	0	0
Bloomfield Wing Dublin	0	0	0
Kylemore Clinic Ballybrack	0	0	0
TOTAL INDEPENDENT SECTOR	98	88	186

[a] *Form 6 Involuntary Admission Order for up to 21 days. Form 13, Certificate & Admission Order to Detain a Voluntary Patient (Adult)*

Table 6 below shows Total Involuntary Admission Rates for 2007 (Adults) by HSE region and independent sector, with rates per 100,000 of total population. Boundary difficulties when defining some catchment areas makes any further breakdown of rates unreliable as full details of all mental health catchment areas have not been provided to the Commission. Rates per 100,000 cannot therefore be calculated for each approved centre.

Table 6 Total Involuntary Admission Rates for 2007 (ADULT) by HSE Region & Independent Sector

	Total Involuntary Admission Rate 2007 (ADULT)	Population [A]	Involuntary Admission Rate per 100,000 total population
HSE WEST	524	1,012,413	51.76
HSE SOUTH	629	1,081,968	58.13
HSE DUBLIN NORTH EAST	382	928,619	41.14
HSE DUBLIN MID LEINSTER	406	1,216,848	33.36
INDEPENDENT SECTOR	186	N/A	N/A
TOTAL (Exclusive of Independent sector)	1,940	4,239,848	45.76
TOTAL (Inclusive of Independent sector)	2,126	4,239,848	50.14

[A] *Population figures taken from CSO census 2006*

Analysis of Ireland's involuntary admission rates in 2007, the first calendar year of commencement, reveals that involuntary admission rates per 100,000 of total population are significantly lower than in previous years. The national rate for 2007 is 50.14 per 100,000 of total population, including involuntary admissions to independent sector approved centres. HSE South has the highest rates at 58.13 per 100,000 of total population while HSE Dublin Mid Leinster has the lowest at 33.36 per 100,000 of total population.

When comparing involuntary admission activity it is important to note that data collection procedures may vary. Daly et al (Health Research Board 2007) reported an involuntary admission rate for Ireland of 51.2 per 100,000 of population for the year 2006, however their method of data collection did not include data on Admission Orders to Detain Voluntary Patients. The Mental Health Commission (2006) reported an involuntary admission rate of 75.6 per 100,000 of population for the year 2005. Their method of data collection did include data on Admission Orders to Detain Voluntary Patients. Salize and Dressing (2004) found that the frequency of admission and compulsory admission rates for people with a mental disorder vary remarkably across the European Union (EU). Their study was based on data obtained from relevant agencies in 15 countries on rates of involuntary admission of people with mental illness. The findings suggest that the variations may be due to the influence of different legal frameworks and procedures. Time series analysis suggests an overall tendency towards more or less stable quotas in most EU states. The effect of reform to the legal framework for involuntary admission, which has happened in Ireland, Scotland and more recently England and

Wales, was not examined. Rates of involuntary admission for mental disorder in EU countries ranged from 6 per 100,000 of population in Portugal to 218 per 100,000 in Finland, (Salize and Dressing 2004). The available year of data collection varied from country to country over a period from 1998 to 2000 and it was acknowledged that data collection procedures varied from country to country. Ireland reported a rate of 74 involuntary admissions per 100,000 of population for the year 1999 to the study.

AGE AND GENDER

Analysis of age and gender was completed on the figures for episodes of involuntary admission in 2007. Tables 7 and 8 below summarise these findings.

Table 7 Analysis by Age – Involuntary Admissions 2007 (Adults)

AGE	FORM 6	FORM 13	TOTAL	%
18 -64	1,251	551	1,802	85%
65 and over	252	72	324	15%
Total	1,503	623	2,126	100%

TABLE 8 Analysis by Gender – Involuntary Admissions 2007 (Adults)

GENDER	FORM 6	FORM 13	TOTAL	%
MALE	831	330	1,161	55%
FEMALE	672	293	965	45%
TOTAL	1,503	623	2,126	100%

RE-ADMISSIONS 2007

Analysis of involuntary admissions for 2007 showed there were 245 people who had more than one episode of involuntary admission in the period. Of these 34 had 3 involuntary admissions, and 5 had 4 or more. Table 9 below provides a summary.

Table 9 Episodes of Involuntary Admission/ Involuntary Re-Admission 2007 (Adults)

	One episode	Two episodes	Three episodes	Four or More Episodes
Number of Patients	1,581	206	34	5

Excludes transitional episodes

TYPE OF APPLICANT

Analysis was undertaken of the categories of persons who applied for a person to be involuntarily admitted under section 9 of the Act in the period 2007. Table 10 below summarises this analysis.

Table 10 Analysis of Applicant: Involuntary Admissions 2007 (Adults)

Form Number	Type	Number	%
1	Spouse/Relative	1,034	69%
2	Authorised Officer	102	7%
3	Garda Síochána	235	15%
4	Any other Person	132	9%
	TOTAL	1,503	100%

Analysis was undertaken of the number of each type of applicant by HSE region and Independent Sector. Table 11 below summarises this analysis.

Table 11 Analysis of Applicant for Involuntary Admissions by HSE Region & Independent Sector 2007 (Adults)

	HSE WEST	HSE SOUTH	HSE DUBLIN NORTH EAST	HSE DUBLIN MID LEINSTER	INDEPENDENT SECTOR
Spouse/Relative	272 (70%)	318 (69%)	178 (66%)	188 (65%)	78 (80%)
Authorised Officer	27 (7%)	26 (5%)	26 (10%)	20 (7%)	3 (3%)
Garda Síochána	60 (16%)	67 (15%)	49 (18%)	47 (16%)	12 (12%)
Any other Person	26 (7%)	51 (11%)	17 (6%)	33 (12%)	5 (5%)
Total	385 (100%)	462 (100%)	270 (100%)	288 (100%)	98 (100%)

Further analysis was undertaken of the category of applicant "Any Other Person" (Form 4) and this is summarised in Table 12 below.

Table 12 Analysis of Any Other Person Applicant (Form 4)

	Number	%
Health/Care staff	45	34%
Prison staff	10	8%
Garda	3	2%
Friend	12	9%
Partner	2	1%
Business/professional	6	5%
Relative	6	5%
Not stated on the form	47	36%
Total	131	100%

Analysis of applicant and comparisons between regions indicates the number of applications by HSE authorised officers appears low (n = 102 : 7% of total) whereas those by members of the Garda Síochána are more than double that figure (n= 235 : 16% of total). There are also differences between regions in the number of Garda applications, ranging from 47 to 67. Research on applicants by the Commission and the Health Research Board on the pathways into involuntary admissions (MHC/HRB 2004) in 2002 showed 76% were performed by a relative, 7% by a health board official, 9% by members of the Garda, and 5% by others.

LENGTH OF PERIOD OF INVOLUNTARY ADMISSION

Analysis was undertaken of how long each episode of involuntary admissions lasted. This analysed the duration of each episode (number of days) that commenced in 2007. Table 13 below provides a summary of this analysis.

Table 13 Length of Episode of Involuntary Admission (Adults)

LENGTH OF EPISODE			Number	%	Cumulative %
21 day period	1 to 5	days	114	5.36%	5.36%
	6 to 10	days	260	12.23%	17.59%
	11 to 16	days	416	19.57%	37.16%
	17 to 21	days	343	16.13%	53.29%
21 days to 3 months	22 to 28	days	70	3.29%	56.59%
	29 to 84	days	557	26.20%	82.78%
3 to 6 months	85 to 168	days	213	10.02%	92.80%
6 to 12 months	169 to 365	days	133	6.26%	99.06%
Over 12 months	366 to 395	days	20	0.94%	100.00%
	Total		2,126	100%	

Unfinished episodes at year end were calculated at time of reporting, i.e. 12/02/2008.

Analysis of length of period of involuntary admission shows that 53% of these episodes in 2007 lasted less than 21 days, and less than 1% lasted more than 1 year. This is a similar finding to research by the Commission and the Health Research Board on pathways to involuntary admissions (MHC/HRB 2004) and to statistics used in the White Paper on Mental Health (DoH & Children 1995). Admission orders are for a period of up to 21 days and the renewal orders are for periods up to 3 months, 6 months and 12 months.

DIAGNOSIS

When the episode of involuntary admission ends the responsible consultant psychiatrist is requested to provide details to the Commission of the patient's diagnosis using ICD-10 diagnostic groups on statutory Form 14, *Revocation of an Involuntary Admission or Renewal Order.* At any given time there will always be patients subject to involuntary admission orders, and these episodes are referred to as unfinished. Some 181 finished episodes were not reported as coded and 294 of the 2,126 episodes commenced in 2007 were unfinished at time of reporting. Details of diagnoses reported to the Commission are summarised in Table 14 below.

Table 14 ICD 10 Diagnostic Group Coded at Close of Episode (Adults)

ICD-10 diagnostic groups	ICD-10 Code	Form 6	Form 13	Total Number of Episodes
1. Organic Disorders	F00-F09	84	18	102
2. Alcoholic Disorders	F10	26	13	39
3. Other Drug Disorders	F11-F19, F55	31	12	43
4. Schizophrenia, Schizotypal and Delusional Disorders	F20-F29	585	215	800
5. Depressive Disorders	F31.3, F31.4, F31.5, F32, F33, F34.1, F34.8, F34.9	84	74	158
6. Mania	F30, F31.0, F31.1, F31.2, F31.6, F31.7, F31.8, F31.9, F34.0	313	124	437
7. Neuroses	F40-F48	22	9	31
8. Eating Disorders	F50	4	2	6
9. Personality and Behavioural Disorders	F60-F69	9	7	16
10. Intellectual Disability	F70-F79	6	3	9
11. Development Disorders	F80-F89	0	0	0
12. Behavioural and Emotional Disorders of Childhood	F90-F98	*See children sections*		
13. Other Diagnosis	F38, F39, F51-F54, F59, F99	7	3	10
14. Unrecorded		332	143	475
Total		1,503	623	2,126

It is of interest to note that the diagnostic group with the highest rates of involuntary admission is the grouping *"Schizophrenia, Schizotypal & Delusional Disorder"*s followed by that for *"Mania"*. This is similar to the findings of Daly et al for the Health Research Board (2006). A number of involuntary admission episodes have been coded as *Alcoholic Disorders, Other Drug Disorders,* and *Personality & Behavioural Disorders*. It is important to note that the 2001 Act states at subsection 8(2) that nothing in subsection 8(1) shall be construed as authorising the involuntary admission of a person to an approved centre by reason only of the fact that the person is (a) suffering from a personality disorder, (b) is socially deviant, or (c) is addicted to drugs or intoxicants. Involuntary admissions are coded by diagnostic grouping at close of episode and this may differ from the patient's diagnosis on admission.

REMOVAL OF PERSONS TO APPROVED CENTRES

Section 13(2) provides that the Clinical Director of an approved centre may arrange for the removal of a person to that approved centre by members of staff of the approved centre, where the applicant is unable to do so. This is known as the Assisted Admissions service and an issue arose in relation to this in the RL[64] case. In this case the patient's legal team alleged that the patient was removed from her residence in breach of section 13(2) of the 2001 Act, as it was carried out by an independent contractor rather than a member of staff. The HSE's legal advisors have stated that members of staff do not attend the removal of persons to approved centres under this section for industrial relations reasons. In the Supreme Court, Mr Justice Hardiman in refusing the appeal and upholding the legality of the patient's detention stated that on its face, there was a breach of section 13(2). He commented that the inclusion of the words *"members of staff"* in the relevant section was extraordinary as the need to remove people may arise suddenly. Mr Justice Hardiman specifically stated that those responsible for the legislation should consult with those who implement the legislation to achieve a system where the statutory requirements are realistic.

The Commission has established a committee to examine issues connected with the implementation of section 13(2). The committee has requested from the HSE information on the number of times the assisted admission service has been used and type of service provided. The HSE has provided the following approximate figures to the Commission. In the year 2007 there were 575 instances of removal of a person to approved centres; 413 of these provided by HSE staff and 162 carried out by an independent contractor.

TRANSFER FROM ONE APPROVED CENTRE TO ANOTHER

The 2001 Act provides that where a patient or the person who applied for a recommendation applies to the clinical director of the centre for a transfer of the patient to another approved centre, the clinical director may, if he or she thinks fit, arrange for the transfer, with the consent of the clinical director of the second-mentioned approved centre. Such transfers can also happen where the clinical director of an approved centre is of opinion that it would be for the benefit of a patient detained in that centre, or that it is necessary for the purpose of obtaining special treatment for such patient, that he or she should be transferred to another approved centre (other than the Central Mental Hospital). In instances where a patient is transferred to another approved centre the clinical director of the centre from which he or she has been transferred gives notice in writing of the transfer to the Commission. In the period 1st January 2007 to 31st December 2007 the Commission received 311 notices of transfer. A further 9 were received in relation to transfers to the Central Mental Hospital.

Under the 2001 Act transfer to the Central Mental Hospital must first be proposed by the clinical director of the approved centre where the patient is being detained. The proposal goes before a mental health tribunal which can authorise or refuse to authorise the transfer and the patient can appeal the decision of the tribunal to the Circuit Court (s21). There has been comment as to the length

[64] *Unreported decision of Mr Justice Feeney dated 17.01.08 and unreported Supreme Court decision of Mr Justice Hardiman dated 15.02.08*

of time it takes to expedite these transfers. There has also been criticism arising from cases where a patient's detention in the Central Mental Hospital under the Criminal Law Insanity Act (2006) comes to an end and a complex procedure of admission to another approved centre and the instigation of the procedures for a proposal to transfer the Central Mental Hospital have to occur. The risks associated with this flaw in the interaction between the 2001 Act and the Criminal Law Insanity Act (2006) are that delivery of the appropriate care to patients could be disrupted.

A number of transfers have been the subject of Article 40.4 cases; Mr Justice McMenamin in JB(2)[65], Mr Justice Sheehan in NB[66] and Mr Justice Peart in MM[67]. The issue in contention has principally been in relation to who is the responsible consultant psychiatrist, and taking into account subsection 21(4) which states that *"the detention of a patient in another approved centre 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."* An amendment may allow some flexibility to clinical staff where the patient remains in the other approved centre for an extended period of time. There will be situations where a patient is transferred back to his/her home service and ongoing input from that service will be desirable.

REVOCATION BY RESPONSIBLE CONSULTANT PSYCHIATRIST

Section 28 requires the consultant psychiatrist responsible for the patient to revoke an order where they become of opinion that the patient is no longer suffering from a mental disorder as defined in the Act. Where the responsible consultant psychiatrist revokes an order detaining a patient under section 28 they must give to the patient concerned and his or her legal representative a notice to this effect, a statutory form number 14, *Revocation of an Involuntary Admission or Renewal Order*. Analysis of orders revoked by the responsible consultant psychiatrist under the provisions of section 28 shows that there were 1,444 such instances in 2007. A patient may leave the approved centre at this stage or stay to receive treatment on a voluntary basis. The number of orders revoked by the responsible consultant psychiatrist under the provisions of section 28 is not out of line with previous trends. Analysis of length of period of involuntary admission shows that 53% of episodes of involuntary admission in 2007 lasted less than 21 days, and only 1% lasted more than 1 year (Table 13 above). This reflects the situation where patients' conditions improve over time and the Act's requirement that the patient is detained pursuant to an admission order or a renewal order only for so long as is reasonably necessary for his or her proper care and treatment (s28(2)(b)).

[65] *Unreported decision of Mr Justice McMenamin dated 15.06.07*

[66] *Extempore decision of Mr Justice Sheehan dated 05.11.07*

[67] *Unreported decision of Mr Justice Peart dated 01.02.08*

4 REVIEW BY A MENTAL HEALTH TRIBUNAL

INDEPENDENT REVIEW BY A MENTAL HEALTH TRIBUNAL

The Mental Health Act 2001 provides for the patients' right to an automatic independent review of an involuntary admission. Within 21 days of an admission (or renewal) order, a three person mental health tribunal consisting of a lawyer as chair, a consultant psychiatrist and a lay person review the admission (or renewal) order. Prior to the independent review, a legal representative is appointed by the Mental Health Commission for each person admitted involuntarily (unless s/he proposes to engage one) and an independent medical examination by a consultant psychiatrist, appointed by the Commission, will have been completed. The first mental health tribunal was held on 16th November, 2006. There were 178 hearings in 2006 and 2,248 in 2007.

SECTION 17 INDEPENDENT MEDICAL EXAMINATIONS

As an admission or renewal order must be reviewed by a mental health tribunal within 21 days of the order being signed, the Commission must assign a consultant psychiatrist to conduct an independent medical examination as soon as possible after the order has been notified to the Commission. Additionally, in accordance with section 21 of the Act, all proposals to transfer a patient to the Central Mental Hospital must be reviewed by a mental health tribunal within 14 days.

In 2007 the Commission assigned 3,353 independent medical examinations to consultant psychiatrists for completion in accordance with section 17 of the Act. Table 15 below provides further details of the type of order for which the reports were required.

Table 15 Type of Order for Which Section 17 Reports Were Assigned 2007 (Adults)

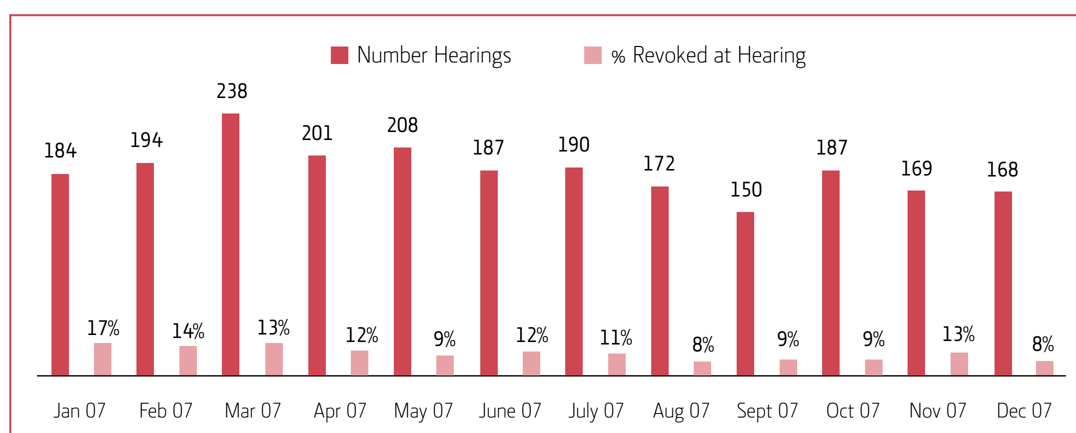
TYPE OF ORDER	NUMBER OF REPORTS ASSIGNED
Involuntary Admission Order Form 6	1,398
Involuntary Admission Order Form 13	612
3 Month Renewal Order	1,030
6 Month Renewal Order	234
12 Month Renewal Order	52
Proposal to Transfer to Central Mental Hospital	26
Total	3,352

REVOKE AT HEARING

Analysis was undertaken of the number of orders revoked at a mental health tribunal. Figure 3 below shows the number of hearings on a month by month basis for 2007 and the number of orders revoked (%) in each month. It can be seen that there was a higher percentage of orders revoked at

hearing in the first six months of 2007 and for the remainder of the year the percentage reduced. The initial rise appears to be linked to a number of the transitional cases and decisions in a number of the earlier High Court challenges that interpreted procedural aspects of the involuntary admission process.

Figure 3 Number Hearings & Revoked (%) At Hearing 2007



Decisions to revoke an order at the mental health tribunal have been analysed by individual file review and this shows that decisions can be grouped into the following categories shown in Table 16 below.

Table 16 Analysis of decision to revoke an order at the mental health tribunal 2007

Reason	%
Patient not suffering from mental disorder at time of hearing	60%
Provisions of the Act have not been complied with	39%
Other, e.g. Patients AWOL	1%
Total	100%

TIMING OF THE MENTAL HEALTH TRIBUNAL HEARING

In 2007 the Commission was notified of 2,126 involuntary admission orders and 1,296 renewal orders for referral to a mental health tribunal. The 2001 Act requires the mental health tribunal to review the detention of a patient not later than 21 days after the making of the order. Once notified the Commission aims to arrange the mental health tribunal hearing at the earliest possible opportunity. Before a hearing can take place the patient must be appointed a legal representative. In the vast majority of cases this is done by the Commission under its legal aid scheme which is free to the patient. The legal representative meets with the patient to prepare the case. The Commission must also appoint a consultant psychiatrist to conduct an independent medical examination and prepare a report for the mental health tribunal within 14 days. The patient and the approved centre are

also notified of the hearing and the three mental health tribunal members are circulated papers in advance. Hearings for involuntary admission orders were monitored by the Commission as to when in the 21 day period of the order the mental health tribunal occurred. For example in the month of March 2007 there were 41% of these hearings occurring at or before day 18 of the order. This increased to 46% for September 2007 and to 66% for December 2007.

SECTION 28 DISCHARGE OF PATIENTS

The Act provides that where a patient is discharged under section 28 and a review by a mental health tribunal under section 18 has not yet occurred, the patient can request one by submitting a notice in writing within 14 days of his or her discharge. There were 16 requests for such reviews in the year 2007.

CASES BROUGHT BEFORE THE COURTS

The 2001 Act has an appeals mechanism in relation to a decision of a mental health tribunal and this is set out in Section 19 of the 2001 Act. Section 19(1) states that a patient may appeal to the Circuit Court against a decision of a tribunal to affirm an order made in respect of him or her on the grounds that he or she is not suffering from a mental disorder. There have been 39 Circuit Court appeal cases filed in the period since commencement to 31st December 2007. Ten of these cases came before the Court in relation to interlocutory matters or for a full hearing. One of the ten related to an appeal of a transfer to the Central Mental Hospital. The remainder of the cases were withdrawn due to orders being revoked by the responsible consultant, patients not wishing to proceed or Article 40.4 proceedings. None of the appeals have resulted in an order being revoked.

Additionally where a person believes that they are unlawfully detained they, or another person on their behalf, may have recourse to the common law writ of *Habeas Corpus* which is embodied in Article 40.4 of the Constitution. Article 40.4 of the Constitution is a self contained constitutional mechanism to test the lawfulness of a person's detention and empowers the High Court to examine whether the person is being detained in accordance with the law. Since commencement to 31st December 2007 there have been 34 Article 40.4 cases filed that have involved the Commission and/or a Mental Health Tribunal. Of these one, MD v St Brendan's Hospital, MHC, MHT (Respondents), was appealed to the Supreme Court. The decision of the High Court, where the patient was found to be in lawful detention, was upheld.

There have also been 3 Judicial Review cases brought in 2007, two in relation to appeals under section 19 and one in relation to a transfer to the Central Mental Hospital. One resulted in a reserved judgment that is awaited, one was struck out as the transfer was addressed, and one is awaiting a date for hearing.

The above figures relate to the period up to 31 December 2007 and not thereafter.

FEES ASSOCIATED WITH MENTAL HEALTH TRIBUNALS

In 2004 consent of the Minister for Finance was issued in relation to the fees paid to panel members associated with the process of independent review by mental health tribunals under the 2001 Act. Sections 33 & 48 refer to payment *"with the consent of the Minister and the Minister for Finance"*. The fees have been adjusted since then in line with general round increases. A summary of the relevant gross fees that are paid in association with the operation of mental health tribunals during 2007 is provided in Table 17 below. Fees are paid on a per-case basis to reflect the various inputs to the process by the 342 panel members. The independent consultant psychiatrist and the legal representative are assigned on receipt of a notification and the mental health tribunal members are assigned when a hearing is arranged. The unclaimed fees figure will be adjusted to take into consideration claims for all mental health tribunal cases heard between 1st December 2007 and 11th January 2008 and submitted between these dates as a fee increase was granted on 1st December 2007 but not available on the system until 11th January 2008.

Table 17 Mental Health Tribunal Gross Fees for the Year Ended 31st December 2007*

	Panels	No. on Panel	Fees	Travel & Subsistence	VAT	Total
			Euros	Euros	Euros	Euros
1	MH TRIBUNAL LEGAL CHAIR MEMBERS	66	1,766,819	159,104		1,925,922
2	MH TRIBUNAL CONSULTANT PSYCHIATRISTS MEMBERS Includes sum apportioned to salaried consultants	54	1,457,883	185,175		1,643,058
3	MHT INDEPENDENT CONSULTANT PSYCHIATRIST MEMBERS Includes sum apportioned to salaried consultants	48	1,845,565	132,277		1,977,842
4	MH TRIBUNAL LAY MEMBERS	84	875,011	140,606		1,015,618
5	MH TRIBUNAL CLERKS	25	472,964	154,452		627,416
6	MH TRIBUNAL LEGAL REPRESENTATIVES	65	2,675,117		479,017	3,154,134
7	UNCLAIMED FEES RELATING TO 2007 MHT CASES		341,298	**		341,298
	TOTAL	342	9,434,657	771,614	479,017	10,685,288

* *Gross figures include PRSI and PAYE amounts for MH Tribunal members and PSWT for legal representatives and independent consultant psychiatrists.*

** *T&S to be determined on receipt of outstanding claims.*

AVERAGE UNIT COSTS

During the year 2007 there were 3,443 statutory orders notified to the Commission that potentially required review by a mental health tribunal. As a result of these notifications 2,248 mental health tribunal hearings were completed in 2007. This indicates an average unit cost of €3,103 per notification and if a case proceeds €4,753 per hearing.

5 ADMISSION OF CHILDREN

CHILDREN – VOLUNTARY AND INVOLUNTARY ADMISSIONS

There are separate provisions in the Mental Health Act 2001 in relation to the involuntary admission of children that require the HSE to make an application to the District Court. Details of the involuntary admission process are provided in the Commission's Code of Practice relating to the admission of children under the Mental Health Act 2001, *(Reference Number: COP-S33(3)/01/2006)*. The Mental Health Act 2001 Section 2(1) states that *"child"* means a person under the age of 18 years other than a person who is or has been married. A total of 325 voluntary admissions of children and 3 involuntary admissions were reported to the Commission in 2007.

The Mental Health Commission, since its establishment, has consistently highlighted the lack of sufficient child and adolescent in-patient and day hospital facilities. The Mental Health Commission is of the view that the provision of age appropriate approved centres for children and adolescents must be addressed as a matter of urgency. The admission of children to units in approved centres that primarily provide care and treatment to adults is undesirable. In situations where there is no available alternative, such admissions may be necessary. In arriving at such a decision due consideration should be made of the risks to the child; of not admitting him or her and the potential adverse effects of such an admission. The admission of 16 and 17 year olds, pursuant to the Mental Treatment Act 1945, was to adult mental health in-patient units/ hospitals. In the absence of appropriate facilities, the Commission was of the view that it would be unlikely that that situation would change in the immediate future upon full commencement of the Mental Health Act 2001. It was considered important, therefore, to ensure that appropriate interim arrangements were put in place to ensure the protection and safety of such children. If children are admitted of necessity to approved centres for adults the provisions of the Code of Practice Relating to Admission of Children apply and these include a requirement to notify the Commission of such admissions.

Table 18 below summarises 2007 activity related to the notification of all admissions of children by approved centre. Thirty five units[68] in 34 approved centres admitted children in 2007.

[68] *St John of God Hospital (adult unit) and Ginesa Suite, St John of God Hospital (child unit) are counted as two separate units for the report.*

Table 18 Total Number of Admissions Children 2007

	Number & Type of Unit Used	Number of Admissions	Percent
HSE DUBLIN MID LEINSTER	7 Adult Units	28	9%
HSE WEST Activity for Children Unit relates to period 25th May (date of registration) to 31st December	7 Adult Units 1 Children Unit	49 20	15% 6%
HSE SOUTH	10 Adult Units	60	18%
HSE DUBLIN NORTH EAST	6 Adult Units 1 Children Unit	25 46	8% 14%
Independent Sector	2 Adult Units 1 Children Unit	31 69	9% 21%
Sub-Total	32 Adult Units 3 Children Units	193 135	
Total	**35 Units**	**328**	**100%**

Fifty nine per cent (n=193) of these admissions were to adult units and 41% (n=135) were to children's units. The majority of admissions 99% (n=325) were on a voluntary basis. The remaining 1% (n=3) were involuntary admissions under section 25 of the 2001 Act. Table 19 below provides the total number of episodes of voluntary admissions/re-admissions in 2007.

Table 19 Voluntary Admissions/Re-admissions Children 2007

	1 Admission	2 Admissions	3 Admissions	4 or more Admissions
Number of Children Admissions to Adult Units	125	15	6	4
Number of Children Admissions to Children's Units	116	8	1	0
Total	**241**	**23**	**7**	**4**

CHILDREN INVOLUNTARY ADMISSION, AGE & GENDER

Tables 20 and 21 below provides details of the Involuntary Admission of Children in 2007 by age and number of admissions in the period and duration of involuntary admission. All three of these admissions were to adult approved centres.

Table 20 Involuntary Admission Children 2007 (Number & Age)

Age	One Episode of Detention	More than One Episode of Detention
Number of Children (All three children were aged 17 years)	3	0

Table 21 Duration of Involuntary Admission Children (days) 2007

Length of Period of Section 25 Order (days)	Duration of Involuntary Admission (days)
19	19
20	20
21	18

There have been a small number of involuntary admissions of children (n=3). In each case these have been to adult units. There have been a large number of children (n=193) admitted on a voluntary basis to a large number of adult units (n=32). For example, in the HSE South Region 60 voluntary admissions were made to 10 adult units.

6 EVALUATION AND QUALITY IMPROVEMENT

To enhance the effective operation of the 2001 Act the Commission prioritised a number of evaluation and quality improvement projects during 2007. Details of these are provided in this section.

FOCUS GROUPS AND INTERVIEWS

As part of its requirement under section 75 to conduct a review of the operation of the 2001 Act a number of semi-structured interviews and focus groups were carried out early in 2007. These have been reported to the Minister in an earlier report (MHC March 2007). In total 17 interviews were conducted; 8 with consultant psychiatrists, 5 with psychiatric nurses and 4 with registered proprietors. In addition, Mental Health Act Administrators in two centres participated in part of the interviews with two clinical directors, and a consultant psychiatrist contributed to the clinical director interview in another case. The Commission also worked with the Irish Advocacy Network to organise focus groups with service users and advocates. Twelve advocates took part in a focus group, and two focus groups were held with service users. A number of matters of particular and unique concern were raised, many of which were due to the initial settling in period of the new legislative provisions. During 2007 the Commission has been working to address issues connected to the operation of Part 2, for example issues relating to the scheduling of mental health tribunals, provision of more information and training.

MENTAL HEALTH COMMISSION ANNUAL CONFERENCE

In November 2007 the Commission held its first annual conference linked to the changes associated with commencement of the Act, with the theme "Making a Difference." Almost 400 people attended and they had a range of involvement in mental health issues such as the Commission's panels, service user, advocacy and service provider backgrounds. Over 2 days the conference focused on three themes;

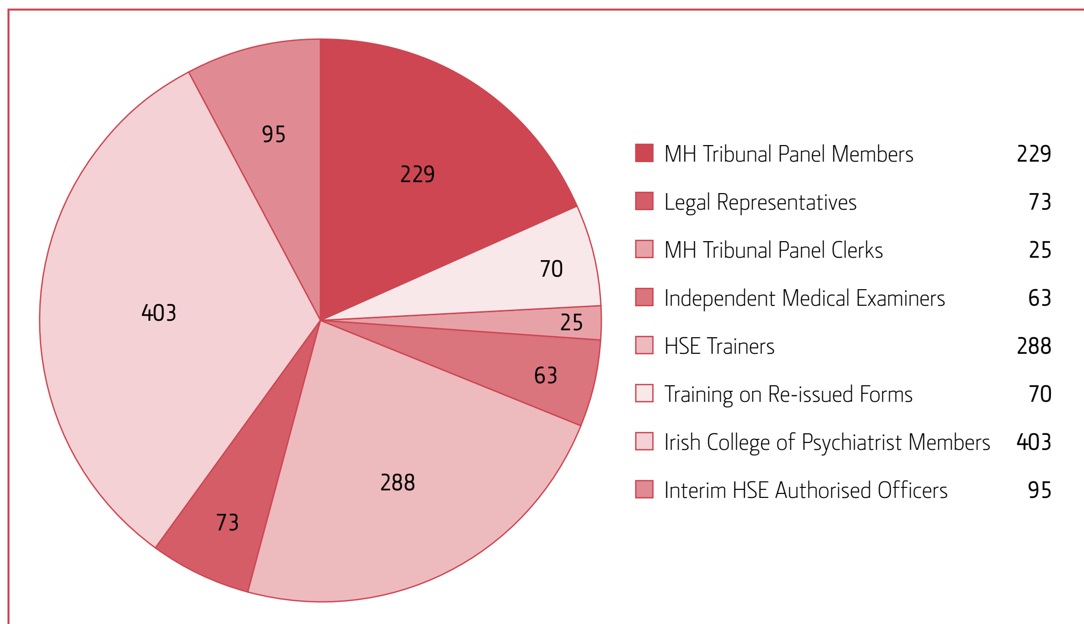
- human rights & mental health legislation,
- Service users' experiences and research involvement, and
- quality initiatives & raising standards in mental health services.

This event was launched by Dr Jimmy Devins, Minister of State with responsibility for Disability and Mental Health.

TRAINING

Figure 4 below summarises the total number of persons directly trained by the Commission in relation to the Act in the period 2004 to 2007. A total of 1,246 people attended direct training.

Figure 4 Number of Persons Directly Trained by Commission on 2001 Act (2004-2007)



- The Commission organised training on the 2001 Act for those appointed as Authorised Officers as referred to in section 9 of the Act. The Authorised Officer training ran over two days and a total of 95 HSE staff attended.

- In 2007 nine workshops were organised by the Commission to raise the awareness of staff in approved centres of the statutory provisions of SI 551/2006 (Regulations for Approved Centres). This was also used as an opportunity to raise awareness of the Rules and the Codes of Practice.

- In November 2007, to link in with the Commission re-issuing the revised statutory forms and the patient notification form, two training sessions were organised with service providers to explain the changes that were required as a result of case law. Seventy people attended.

- In December 2007 the Commission commenced a training needs analysis of all the panel members, by individual survey, to inform its training strategy for 2008 – 2011. It is planned that the training strategy will be developed to combine an academic and a practice approach within a multi-professional framework based on best practice.

- The Commission aims to devise a strategy in conjunction with the HSE, professional bodies and the training organisations for professions in mental health that will place the objectives of the Quality Framework within their training syllabi.

THE QUALITY FRAMEWORK

In 2005 the Commission's published "Quality in Mental Health – Your Views" for consultation. During 2006 this work on developing a quality framework for mental health services was advanced and "The Quality Framework for Mental Health Services" was published in March 2007. The Quality Framework, developed in response to the views expressed in the consultation document, has also drawn upon quality initiatives in other countries and also on the expert advice of an International Expert Panel. Following extensive consultation with all the stakeholders involved in mental health services, the publication specified the determinants of a quality mental health service as defined by the stakeholders.

The Quality Framework incorporates the Mental Health Act 2001 (Approved Centres) Regulations 2006, prescribed by the Minister for Health and Children, which came into effect on 1st November 2006. The regulations set out minimum standards for approved centres, necessary in order to provide quality and safety in the provision of inpatient mental health services. The Minister has provided for the enforcement of these regulations by the Commission [Mental Health Act 2001 (Approved Centre) Regulations 2006, Reg. 35]. The Quality Framework is, however, much broader and more challenging than the regulations, as it aims to deliver the highest standards and best practices across all mental health services.

EVALUATION OF SECTION 17 REPORTS

The Commission is conducting an evaluation of a randomised sample of the reports assigned under the Act's section 17 requirements for an independent medical examination by a consultant psychiatrist. The evaluation is supported and managed by staff of the Commission in conjunction with a consultant psychiatrist who is not a member of the panels and was engaged to jointly carry out blind reviews on anonymised reports. The evaluation is guided by the principles of clinical audit and aims to develop standards for the panel's work in keeping with international professional guidelines.

LEGAL REPRESENTATIVE BEST PRACTICE STANDARDS

To ensure that a quality service is being provided, the Commission has set out proposals to carry out a number of quality assurance measures in relation to the Mental Health Legal Aid Scheme.
These include:

- best practice directions for legal representatives;
- reviewing of case files;
- satisfaction surveys of clients provided with legal representation.

The Commission has carried out consultation with members of the legal representatives panel and the Law Society on the implementation of these measures and aims to finalise their introduction in 2008.

7 CONSULTATION ON THE OPERATION OF PART 2

APPROACH TO THE CONSULTATION PROCESS

During 2007 the Mental Health Commission began to prepare for a consultative process as part of a review of the operation of Part 2 of the 2001 Act. A template to guide submissions was designed which provided a range of questions to elicit responses on the operation of the legislation. Analysis below is structured around these responses. The guidance explicitly signalled that positive and/or negative opinions, views or critical appraisals might be expressed. Notice of the opening of the consultation process was made by the publication of announcements in the print media on Thursday 24th of January 2008. This was accompanied by press announcements and by notices on the Commission's website. The final deadline for submissions was 27th of February 2008.

Simultaneous to the public announcements, 620 individual letters were mailed to '*stakeholders*' in the field of mental health, inviting them to make submissions. The stakeholders encompassed service providers, all persons sitting on the mental health tribunal panels, professional bodies, representative bodies, and voluntary and public bodies active in the field of mental health or human rights. Notices for display were also forwarded to all approved centres.

RESPONSE RATE

The consultation received 253 responses by e-mail, fax or letter, the vast majority of which were accompanied by a submission on the guidance template; see Appendix 3 for list of those organisations who made submissions. The analysis relates to 238 submissions. Response rates are illustrated in Table 22 below.

Table 22 Submissions to Consultation Process 2008

Category	Numbers
Number of responses	253
Number of responses accompanied by submission	239
Number of invalid submissions	1
Number of submissions analysed	238

In making their submissions, respondents were asked to describe themselves or their organisation, the capacity in which they were making a submission (for example as a carer), and their involvement with Part 2 of the Act (for example as a service user). Answers to these three questions are summarised in Table 23 below. The majority of those who made submissions were from persons or bodies active in the field of mental health in general. The number of mental health service users (n=5), who made submissions was relatively small, but a number of bodies representing them (n=9) also made submissions.

Table 23 Category of Submissions

Category	Number	Percent %
Individual	6	2.5
Service User	5	2.1
Carer/relative	3	1.3
Representative Body	16	6.7
Professionals	35	14.7
Lay Persons Panel	30	12.6
Chairpersons Panel	22	9.2
Psychiatrists Panel	13	5.5
Clerks Panel	4	1.7
Independent Psychiatrists Panel	7	2.9
Legal Representatives Panel	14	5.9
Voluntary and Community Organisations (of which 9 are representative of service users)	13	5.4
Public Sector Bodies and Mental Health Services	24	10.10
Clinical Directors	7	2.9
GPs and Out of Hours Cooperative Representatives	38	16.0
Other	1	0.4
Total	238	100

The following sections provide an overview of the content of submissions under the headings provided in the guidance template for submissions.

SAFEGUARDING THE RIGHTS OF PEOPLE WITH MENTAL HEALTH PROBLEMS

The guidance template asked:
"In your view has the operation of Part 2 of the Mental Health Act, 2001, resulted in improved or weakened safeguards for people with mental health problems?"

Table 24 below summarises the responses to this question. The majority of those who provided a response had a positive view of the safeguards contained in the Act. Some 72% of submissions believed that the Act had improved safeguards of rights compared with 18% who considered the rights of people with mental health difficulties were weakened.

Table 24 Submissions on the Safeguarding of Rights

Response	Numbers	Percent %
Improved safeguards	172	72.3
Weakened safeguards	43	18.0
Don't know, no reply and other	23	9.7
Total	238	100

Examples of some of the submissions are provided below.

Overall Part 2 of the Mental Health Act has improved the safeguards for people with mental health problems, particularly for those who meet the criteria for mental disorder under the Act
Consultant Psychiatrist Group

Following consultation within our group, it is generally agreed that the Act has improved safeguards for people with mental health problems....(and) welcome the improved human rights protection afforded by the new Act and the accountability, which was not as evident under previous legislation
Nurse Managers

The generally positive endorsement of the Act, however, was conditional in about 18% of submissions who considered that a number of safeguards had been weakened. A number of those who were positive went on to express and identify reservations in relation to particular groups of persons with mental health difficulties as follows.

Intellectual Disabilities

Admission for service users dual diagnosed with intellectual disability and mental health difficulties have been better facilitated due to the operation of Part 2 of the Mental Health Act
Intellectual Disability Service Provider

People with learning disability and mental health problems find it increasingly more difficult to gain access to Mental Treatment Units for treatment. People with learning disabilities are being denied their rights to treatment which is a human rights violation.
Consultant Psychiatrist in Learning Disabilities

The Absence of Safeguards for Children

(We are) *particularly concerned that despite this section of the Act having a 5 year lead in period, little was done to ensure sufficient care for patients aged under 18 years with the result that children are still being admitted to adult psychiatric services. This contravenes Section 4 of the Mental Health Act 2001 which confirms that the best interests of the patient shall be the principle consideration*

concerning their treatment and care. However due to insufficient child specific treatment centres, children are often placed inappropriately in adult psychiatric facilities or in general paediatric wards.
Voluntary organisation

Emergency Departments

The provisions of the Act cause enormous delay in access care for vulnerable distressed patient resulting in one recent case of a patient being forcibly detained on a trolley in A + E (Accident and Emergency) for 29 hours
Consultant Liaison Psychiatrist

Patients with Dementia

...patients who were formerly detained under the 1945 Act had at least a 6 monthly review of their detention by their consultant...Now however, these patients who cannot consent to treatment or consent to their continued stay in an approved centre are left in limbo
A Nurse Manager

Length of Time at Pre-Admission Stage

Significant deterioration in management of acute mental health issues to such an extent that it is my honest opinion that this new Act is affecting the most vulnerable mentally ill patient and putting their lives at risk, causing delay in immediate treatment and access to acute psychiatric intervention...
The Act has made this committal order much more difficult and puts lives of patient/health care workers/GP/family at risk
General Practitioner

Removals to Approved Centres

Major concerns regarding assisted admissions and the current process of how an assisted admission is organised. (In their opinion) *this results in: disempowerment of individual/families with the introduction of assisted admissions*
Senior Nurse Mental Health Services

Choice for Patients

If consideration is given to depriving a person of their liberty, we urge that the Commission review the degree to which the availability of adequate, appropriate and accessible community-based services and therapies may have had an impact in the operation of Part 2 of the Act.
Voluntary Organisation

OPERATION OF HUMAN RIGHTS PROTECTIONS

The guidance template asked:
"The operation of Part 2 of the Mental Health Act, 2001 provides human rights protections concerning involuntary admission/treatment of patients. In your view does the operation of Part 2 support these protections?"

Respondents were asked to comment on the actual operation of Part 2 of the Mental Health Act, as opposed to its intent. Table 25 below provides a summary of the responses. The majority of submissions (almost 67%) support the view that Part 2 of the Act provides protections for involuntary admissions and treatment of persons with a mental illness. Some 11% of submissions could not, or did not, reply to this question.

Table 25 Human Rights Protections

Response	Number	Percent %
Yes – supports protections	159	66.8
No – does not support protections	52	21.9
Don't know, No reply	27	11.3
Total	238	100

Example of some of the submissions are provided below.

For the majority of patients the operation of Part 2 provides human rights protections, there are a number of areas where in our view the Act actually interferes with the patients human rights... Sections 21 (2), Section 23/24, Section 25 the whole issue of treatment of children
Psychiatrist Group

The Act provides safeguards in relation to human rights for...patients but this does not necessarily serve their best interests in times of acute illness and the delivery of appropriate services at such times
General Practitioner

Adults admitted under the Act can revert to voluntary status during their admission if their clinical condition improves and they are willing to remain under treatment. In order for a child to revert to admission on a voluntary basis, interested parties have to return to the District Court
Representative body

Concerns were expressed in submissions in relation to specific groups, such as those with intellectual and learning disabilities, people with dementia and children. These groups were cited as a concern due to their lack of capacity in consenting to certain treatments as part of the Act.

While we welcome the human rights provisions for adults, the act is seriously deficient in human rights protections for children and young people...The involuntary admission of an adult requires the

agreement of two medical practitioners and once admitted an adult has access to review/appeal procedures. These represent effective human rights safeguards for adults. However children and young people do not have access to such safeguards
Representative Body

UNINTENDED CONSEQUENCES, POSITIVE OR NEGATIVE, OF THE OPERATION OF PART 2 OF THE MENTAL HEALTH ACT, 2001

The guidance template asked:
"In your view has the operation of Part 2 of the Mental Health Act, 2001 had any unintended consequences, positive or negative?"

Table 26 below summarises responses. Of those who answered, more than half (57 %) believed that there were unintended negative consequences. These views were dispersed across submissions and no group or category was particularly disposed to considering negative consequences.

Table 26 Unintended Consequences, Positive or Negative

Response	Number	Percent %
Positive consequences	44	18.5
Negative consequences	136	57.1
No positive or negative consequences	26	10.9
Don't know, no answer	32	13.4
Total	238	100

More than half of those who believed that the Act had unintended negative consequences, had earlier stated that the Act had strengthened safeguards for people with mental health problems. Examples of responses from this section are as follows.

Positive Consequences

More awareness of human rights, more emphasis on patient consent, Advocacy services directed towards involuntary patients.
Public Sector Body

The positive consequences of the Act include the development of local and national policies, highlighting the need for ongoing training for Mental Health Professionals, and has led to the development of national minimum standards
Public Sector Body

Negative Consequences

I feel the time-span for a second tribunal (three weeks after the first) is too short to allow patients to recover. A period of six weeks in my view would be more appropriate
Independent Psychiatrists Panel Member

There is often no realistic discharge plan in place if an individual's order is revoked against the wishes of the treatment consultant. A contingency plan for this eventuality should be in place…several people have complained that if they are discharged to HSE hostel accommodation excessive restrictions on their liberty are still maintained. They do not feel always fully independent in their life choices…
Representative Body

PROCEDURES FOR INVOLUNTARY ADMISSION

The guidance template asked:
"In your experience of the operation of Part 2 of the Mental Health Act, 2001, are the procedures for involuntary admission of patients being correctly applied?"

Table 27 below provides a summary of responses.

Table 27 Procedures for Involuntary Admission

Response	Number	Percent %
Yes	152	63.9
No	58	24.4
Don't know, no reply	28	11.8
Total	238	100

Responses revealed an importance attached to standardised and predictable administrative procedures by all staff associated with an involuntary admission. Almost 64% of submissions considered that procedures were being correctly applied under Part 2 of the Act. General Practitioner's views that procedures were not being correctly applied figured strongly amongst those who answered no. Their views were frequently associated with concerns about assisted admissions and difficulties in applying to have patients admitted to approved centres.

ROLES IN THE OPERATION OF PART 2

The guidance template asked:
"In your view, are those who have a specific role in the operation of Part 2 of the Mental Health Act, 2001, fulfilling their role appropriately?"

Of those who replied more than half considered that roles were being fulfilled appropriately. This increases to 63% when "*Don't know, no answer*" responses are excluded. Table 28 below summarises the responses.

Table 28 Specific Roles in the Operation Of Part 2 of the 2001 Act: Fulfilling Their Role Appropriately

Response	Number	Percent %
Yes	131	55.0
No	77	32.4
Don't know, no answer	30	12.6
Total	238	100

Almost one in three submissions on this theme considered that some roles were not being fulfilled correctly. Some submissions, which were generally favourable, also went on to cite exceptions to the rule. Some recurring themes are described below.

Child and Adolescent Psychiatrists

Child and adolescent psychiatrists should be involved with anyone under 18 (child as per the act) regardless of availability of beds which are not the issue as assessment/clinical responsibility and report(s) to court (are) still (to) be provided by the appropriate specialist even should beds not be available

Community Mental Health Team

Removal of Persons to Approved Centres

To try and get a psychiatric escort is a day (or even two days) work. And this is after you have tracked down the appropriate psychiatrist and persuaded them of the necessity for admission!! Everyone seems to want to hide behind the Act and no one wants to take responsibility

General Practitioner

We would strongly suggest the formation of a working group inclusive of Garda representatives, MHC representatives and Nursing Staff representatives to monitor Assisted Admission/Involuntary Admission procedures on an ongoing basis, giving those involved an opportunity to share information which will ensure best practice in the interest of service users

Trade Union

Administration

...the recruitment and appointment of Grade V Mental Health Officers. This has been one of the outstanding successes of this project. It is vital that their time and general contractual conditions are protected to ensure their continuing dedicated role to the MHA. There is no doubt that their presence has been key in ensuring the smooth operation of the Act in approved centres

Representative Body

Training

Nurses have expressed positive views in relation to the support and training received by them in relation to the Mental Health Act. In particular the reference guide is positively received and the codes of practice are welcomed to support professional nursing practice. (we) *particularly wish*(es) *to endorse the trainers programme as a means of ensuring sustainability and the prudent use of resources*
Representative Body

THE OPERATION OF VARIOUS SECTIONS OF PART 2

The guidance template asked:
"Have you any other views on the operation of Part 2 of the Mental Health Act? Please specify the sections."

Many submissions commented on particular Sections of Part 2 of the Mental Health Act and commented on the provisions in terms of their adequacy, and consistency in operation. A number of submissions commented on several Sections of the Act which interact with Part 2, as well as making general comments on the Act as a whole. The Consultation received 508 comments on Part 2 of the Act. The definition of Mental Disorder in Section 3 of the Act was identified as problematic in some submissions which came from those in the profession of psychiatry. The test of severity of the illness of dementia or intellectual disability as a ground for involuntary admission was mentioned, and the absence of capacity in such patients to enter hospitals as voluntary patients. The exclusion of patients with a diagnosis of personality disorder from the definition of mental disorder was problematic for some practitioners, as was the exclusion of patients with alcoholism or substance addiction who were at a risk of immediate harm to themselves or others. *'The best interests of the person'* as the *'principal consideration'* in admission or treatment, as outlined in Section 4 of the Act was referred to as important by several submissions.

Table 29 below summarises the extent of references to specific sections of Part 2 in the submissions. Of the total of 238 valid responses, 172 submissions (72.3%) mentioned one or more sections of Part 2 of the Mental Health Act, 2001 as part of their submission.

Table 29 Number of Mentions; Sections 8 – 30 of Part 2

Sections of Part 2 of the Mental Health Act, 2001	No. mentions[69]	% of all mentions[70]
Section 8 – Criteria for involuntary admission to approved centres	21	4.1
Section 9 – Persons who may apply for an admission	42	8.3
Section 10 – Making a recommendation for involuntary admission	42	8.3
Section 11 – Disclosure of previous application for involuntary admission	4	0.8
Section 12 – Powers of Garda Síochána to take person believed to be suffering from mental disorder into custody	35	6.9
Section 13 – Removal to approval centres	60	11.8
Section 14 – Admission Order	15	3.0
Section 15 – Duration and renewal of Admission Orders	20	3.9
Section 16 – Information for Patients	17	3.3
Section 17 – Referral of admission order and renewal order to a (Mental Health) Tribunal	22	4.3
Section 18 – Review by a (Mental Health) Tribunal of admission orders and renewal orders	54	10.6
Section 19 – Appeal to a Circuit Court	11	2.2
Section 20 – Application for transfer of patient	3	0.6
Section 21 – Transfer of patient	13	2.6
Section 22 – Transfer of patient to hospital	4	0.8
Section 23 – Power to prevent voluntary patient from leaving approved centre	54	10.6
Section 24 – Power to detain voluntary patients	30	5.9
Section 25 – Involuntary admission of children	37	7.3
Section 26 – Absence with leave	8	1.6
Section 27 – Absence without leave	3	0.6
Section 28 – Discharge of patients	12	2.4
Section 29 – Voluntary admissions	1	0.2
Section 30 – Penalties under Part 2	0	0
Total	508	100

* *Respondents had the option of mentioning one or more sections of Part 2 of the Mental Health Act*

[69] *Number refers to the number of respondents, who mentioned that particular section.*

[70] *Percent refers to the percentage of the number of respondents mentioning a particular section out of the total number (508) of sections mentioned.*

Some examples are provided below.

Section 9 – Persons who may apply for an admission

The functions of Authorised Officers mean that this group of staff deals with vulnerable people at times of particular and often very serious illnesses. The original intention was that the role of the Authorised Officer would be independent as proposed in the Green and White papers. Various professionals within the Mental Health service are carrying out this Authorised Officer function.
Public Sector Body

Section 10 – Making a recommendation for involuntary admission

I believe it would be preferable to have other professionals involved in the decision to admit a person under Part 2, Section 10. (It) could include a special grade of social worker here, an approved social worker...part of the decision making team; as in the UK
Lay Panel Member

Section 13 – Removal of persons to approved centres

As a GP in a rural setting, I have had great difficulty in obtaining Garda assistance for a violent patient and extreme difficulty in having her transferred to a safe environment.
General Practitioner

The National Assisted Admissions Service has worked well, as a Consultant Psychiatrist in an Approved Centre, we would have concerns if this changed as we know our service would not be in a position to provide staff to carry out this work.
Psychiatrist Group

Section 14 – Admission order

(We consider) *that mental health professionals who play a role in the decision to detain people with dual diagnosis must have completed appropriate training in relation to intellectual disability*
Voluntary Body Intellectual Disability

Section 16 – Information for Patients

Section 16 (2) Provision of information is problematic. Individuals complain that they have not received information to varying degrees. However, it is highly likely that poor retention of information and mental state at the time information is given are contributory factors. Lack of information on care, treatment and recovery plans has been documented by the Inspector of mental health facilities in her reports
Services User Voluntary Organisation

Section 18 – Review by a (Mental Health) Tribunal of admission orders and renewal orders

...Tribunals tend to be too adversarial and overly focused on medical issues without taking into account the service users' familial and social context/circumstances.
Service Users

Section 24 – Power to detain voluntary patients

A number of submissions considered this Section almost unworkable. This arose from the necessity to observe or hear the patient indicating a wish to leave, which was indicated as both improbable and unlikely where the service user is quite ill, cannot or does not wish to communicate, or is unable to judge the risk to their own health. The point was also made that the service user or patient has an actual right to treatment and this may be denied them by the Act.

Section 25 – Involuntary admission of children

There is an anomaly in the law regarding consent to treatment for children. Under the 1997 Non Fatal Offences Against the Persons Act, a 16 year old can consent to medical and surgical treatment without parental input. Current Mental Health legislation appears to assume that children are incapable of giving consent to psychiatric treatment
Mental Health Services

Children and adolescents are still struggling with an outdated, fragmented system, which causes children, their carers and staff, moral distress and anguish
Representative Body

INFORMATION ON PART 2 OF THE MENTAL HEALTH ACT

The guidance template presented three Likert statements to ascertain levels of satisfaction with information provided on the operation of Part 2. Responses to the three information questions are summarised below in Tables 30 to 32.

Table 30 "The information that has generally been provided on the operation of Part 2 of the Mental Health Act 2001 has been sufficient"

Response	Number	Percent %
Disagree	59	24.8
Don't know	6	2.5
Agree	150	63.0
Blank response	23	9.7
Total	238	100

Table 31 "The information that has generally been provided on the operation of Part 2 of the Mental Health Act 2001 has been accessible"

Response	Number	Percent %
Disagree	43	18.1
Don't know	12	5.0
Agree	161	67.6
Blank response	22	9.2
Total	**238**	**100**

Table 32 "The information that has generally been provided on the operation of Part 2 of the Mental Health Act 2001 has been easy to use"

Response	Number	Percent %
Disagree	69	29.0
Don't know	22	9.2
Agree	125	52.5
Blank response	22	9.2
Total	**238**	**100**

Tables 30 to 32 indicate that the majority of submissions judged that the information on Part 2 of the Act was sufficient (63%), accessible (67%) and easy to use (52%).

IMPACT AND QUALITY OF CARE

The guidance template presented one Likert statement on the possible beneficial impact of Part 2 and one final statement on quality of care for involuntary patients. Responses to these two questions are summarised below in Tables 33 and 34 below.

Table 33 "In general the impact of the operation of Part 2 of the Mental Health Act, 2001 on mental health services has to date been beneficial"

Response	Number	Percent %
Disagree	45	18.9
Don't know	36	15.1
Agree	136	57.1
Blank response	21	8.8
Total	**238**	**100**

Table 34 "In general the operation of Part 2 of the Mental Health Act, 2001 has improved the quality of care given to involuntary patients"

Response	Number	Percent %
Disagree	64	26.9
Don't know	65	27.3
Agree	86	36.1
Blank response	23	9.7
Total	**238**	**100**

More than half of all submission (57.1%) considered the impact of the Act had been positive for mental health services (Table 33). Of the remainder, almost 24% gave no reply or did not know. In terms of quality of care, just over one third of submissions (36%) agreed that the operation of Part 2 of the Act had improved the quality of care given to involuntary patients, (Table 34). However, 37% of submissions either did not know or gave no reply to this question.

8 CONCLUSIONS

The Mental Health Act 2001 brings Irish mental health law into compliance with international conventions. The commencement of the full provisions of the Act has been welcomed by the Mental Health Commission, service providers and service users. The Act has required major programmes of preparatory work by the Commission, the HSE, service providers & other statutory agencies. This has included the introduction of new practices for clinicians, new documentation associated with the revised statutory regime, data collection, training and the provision of information. A period of time has been required for services to adapt to the new procedures associated with the Act and this report, which has as its basis activity information on the first calendar year of commencement, provides timely feedback.

One of the most overt issues to emerge when comparing the operation of Part 2 of the Mental Health Act 2001 with that for previous years under the 1945 Mental Treatment Act is the significant decrease in the overall number of involuntary admissions, down 25% when compared with 2005, the most recent year suitable as a comparator. Comparable data shows the decrease in activity is accounted for by falls in the category Involuntary Admission Order for up to 21 days, Form 6, (-34%) as opposed to Certificate & Admission Order to Detain a Voluntary Patient (Adult,) Form 13, where the numbers have risen (+15%). Scotland, although not having directly comparable legislation, also had significant reductions in the number of involuntary admissions in the period immediately following their recent legislative change.

It is important not to form any hasty conclusions on these figures, or to assume that reduced involuntary admissions are by themselves a positive development. Unlike the 1945 Act the provisions of the 2001 Act define mental disorder, section 3, and set out criteria for involuntary admission, section 8. The Commission's Mission is to ensure that the interests of those involuntarily admitted under the provisions of the Mental Health Act 2001 are protected and to foster and promote high standards in the delivery of mental health services. The Commission has captured a significant amount of information over the course of the 18 month period of commencement. This information provides useful measures against which to monitor these standards and protections. Additional feedback has also been gathered from the consultation exercise associated with the process of preparing this report.

Further detailed conclusions with regard to the main operational sections relating to Part 2 are provided below.

CRITERIA FOR INVOLUNTARY ADMISSION (SECTION 8)

The use by clinicians of the new criteria for involuntary admission is a major change associated with the Act. There has been jurisprudence relating to this section (MR v Sligo Mental Health Services). As a result the Commission has edited and re-issued the statutory forms and other associated documentation. A number of involuntary admission episodes have been coded as *Alcoholic Disorders, Other Drug Disorders,* and *Personality & Behavioural Disorders*. It is important to note that the 2001 Act states at subsection 8(2) that nothing in subsection 8(1) shall be construed as authorising the involuntary admission of a person to an approved centre by reason only of the fact that the person is

(a) suffering from a personality disorder, (b) is socially deviant, or (c) is addicted to drugs or intoxicants. Involuntary admissions are coded by diagnostic grouping at close of episode and this may differ from the patient's diagnosis on admission. Further research would be needed to determine if the patient's diagnosis on admission was the same as that at close of the episode of involuntary admission.

It is acknowledged that the criteria for involuntary admission do not address the issue of lack of capacity and that this may be particularly problematic in relation to individuals who have intellectual disability or dementia. Feedback from the consultation exercise confirms this. The introduction of capacity legislation is urgently needed to address these difficulties and to empower and protect vulnerable people who are not able to make their own decisions. This issue of lack of capacity has been raised in a number of the High Court cases since November 2006 and those involved in the cases, the patients /their families, the legal representatives, the approved centres, the tribunals and the Commission have identified this as a concern. Legislation is needed to make clear who can take decisions, in which situations, and how this should be done.

APPLICANTS (SECTIONS 9, 11 and 12)

The number of applications by HSE authorised officers appears very low (n = 102 : 7% of total) whereas those by members of the Garda Síochána are more than double that figure (n = 235 : 16% of total). Other countries have developed elaborate systems of emergency response for crisis situations that allow the patient's spouse or relative a choice as to whether or not to be the applicant. The above figures do not demonstrate a high degree of choice in this matter in Ireland, and indicate the matter develops into a policing rather than a health care issue in many situations. Research on applicants, by the Commission and the Health Research Board on pathways to involuntary admissions (MHC / HRB 2004) in 2002, showed 76% were performed by a relative, 7% by a health board official, 9% by members of the Garda, and 5% by others. The figures from 2007 represent a change in practice; the overall number of involuntary admissions has reduced combined with a percentage decrease in applications by Spouse/Relative that has been largely taken up by increases in the percentage of applications by members of the Garda. Submissions to the consultation exercise on the role of the Garda indicate there may be some lack of awareness of the procedures.

RECOMMENDATION FOR INVOLUNTARY ADMISSION (SECTION 10)

A substantial number of comments were made in the submissions regarding the operation of the procedures provided for under section 10 of the Act. Many of these submissions were from general practitioners who appear to have experienced problems arranging for the removal of patients to an approved centre, section 13 of the Act, with the role of the Garda in these situations and with access to available beds in approved centres. There were also a number of comments from other professionals on some general practitioners' lack of awareness of the new procedures. This appears to be linked to a need for an increased focus on the protection of the rights of patients, children and adults, in the pre-involuntary admission stage and the development of a greater range of community services that provide alternatives to detention. These appear to be issues requiring further co-ordination, targeted training and an information campaign directed at those sectors identified as having a deficient knowledge of practice under the 2001 Act.

REMOVAL OF PERSONS TO APPROVED CENTRES (SECTION 13)

There were substantial numbers of comments in the submissions regarding the operation of the procedures provided under this section of the Act. Many of these submissions were from general practitioners, the Garda, clinical directors and other staff groups. Section 13(2) provides that the Clinical Director of an approved centre may arrange for the removal of a person to that approved centre by members of staff of the approved centre, where the applicant is unable to do so. This is often performed by an Assisted Admissions service. A high degree of commentary in the submissions was in relation to practical difficulties associated with the operation of section 13. The HSE figures indicate that there are a substantial number of occasions where this type of service is required.

The Assisted Admissions service was an issue in the RL[71] case where the patient's legal team alleged that the patient was removed from her residence in breach of section 13(2) of the 2001 Act, as it was carried out by an independent contractor rather than a member of staff. In the Supreme Court, Mr Justice Hardiman in refusing the appeal and upholding the legality of the patient's detention stated that on its face, there was a breach of section 13(2). He commented that the inclusion of the words *"members of staff"* in the relevant section was extraordinary as the need to remove people may arise suddenly. Mr Justice Hardiman specifically stated that those responsible for the legislation should consult with those who implement the legislation to achieve a system where the statutory requirements are realistic.

DURATION OF INVOLUNTARY ADMISSION (SECTION 15)

Analysis of length of involuntary admission episodes shows that 53% of these in 2007 lasted less than 21 days, and only 1% lasted more than 1 year. This is a similar finding to research by the Commission and the Health Research Board on pathways to involuntary admissions (MHC/HRB 2004), and to statistics used in the White Paper on Mental Health (Department of Health & Children 1995). The duration of the initial detention periods in the 2001 Act are much shorter than those provided for in the 1945 Act. They have proved challenging but manageable from an operational perspective in terms of the admission orders for 21 days, and the renewal orders for 3 months, 6 months and 12 months. The review by a mental health tribunal of the second detention order, i.e. the 3 month renewal order, occurs within a short time interval of the first 21 day review, approximately 19 days in most cases. This can be confusing for the patient if they are very unwell and places a significant amount of administrative work on the approved centre within that time frame.

PROVISION OF INFORMATION (SECTION 16)

The majority of submissions to the consultation indicated that information on Part 2 of the Act was sufficient (63%), accessible (67%) and easy to use (52%). However more detailed reading of comments in the submissions indicates that further qualitative research into patient experiences in relation to all the new procedures would be useful and could be used to improve practice.

[71] *Unreported decision of Mr Justice Feeney dated 17.01.08 and unreported Supreme Court decision of Mr Justice Hardiman dated 15.02.08*

This is particularly so where only a small percentage of submissions were received from service users and their representative bodies. There appears to be a need for increased focus on the protection of the rights of patients, children and adults, at all stages but particularly in the pre-involuntary admission stage. This may include the need for more information to be provided to patients and ease of use. Findings could inform further targeted information campaigns relating to the human rights protections afforded by the 2001 Act.

MENTAL HEALTH TRIBUNALS (SECTIONS 17/18)

Reviews by mental health tribunals have raised some issues in relation to the interpretation of the legislation which have been clarified by case law. It can be seen that a relatively higher percentage of orders were revoked at hearing in the first six months of 2007 and for the remainder of the year the percentage reduced. The initial rise appears to be linked to a number of the transitional cases and decisions in a number of early High Court challenges that interpreted procedural aspects of the involuntary admission process.

There have been a number of submissions requesting that the Act be amended to allow a patient's legal representative to review the records relating to the patient at the approved centre, as is the case for the consultant psychiatrists who carry out independent medical examinations under section 17. It is argued that they can only fully represent the patient at the mental health tribunal if these records are made available to them from the outset.

The 2001 Act requires the mental health tribunal to review the detention of a patient not later than 21 days after the making of the order. The Commission is committed to arranging mental health tribunal hearings in accordance with fair procedure and all the provisions of the Act. Where these requirements are complied with the Commission can proceed to arrange the mental health tribunal hearing as early as possible in the involuntary admission.

APPEAL TO CIRCUIT COURT (SECTION 19)

There have been 39 Circuit Court appeal cases filed in the period since commencement to 31st December 2007. This number appears low (n= 2% of 2007 episodes). Only 10 cases went before the Court in the form of an interlocutory or full hearing. Additionally some of these cases have been withdrawn due to orders being revoked by the responsible consultant, patients not wishing to proceed or Article 40.4 proceedings. None of the appeals have resulted in an order being revoked. This may need to be explored further given this low uptake, the high percentage of withdrawals and the fact that none of the appeals have resulted in an order being revoked.

There have also been two Judicial Review cases launched in 2007 in relation to appeals under section 19. One resulted in a reserved judgment that is awaited and one is awaiting a date for hearing. These relate to the burden of proof, as the 2001 Act places this on the patient at the appeal stage. This issue may require further action depending on the judgment(s) received.

The Commission has feedback to date regarding the operation of the Circuit Court rules and a number of practical issues that have now become apparent could be reviewed with a view to making the appeals process more timely.

TRANSFER FROM ONE APPROVED CENTRE TO ANOTHER (SECTIONS 20/21)

Under the 2001 Act transfer to the Central Mental Hospital must first be proposed by the clinical director of the approved centre where the patient is being detained. The proposal goes before a mental health tribunal which can authorise or refuse to authorise the transfer and the patient can appeal the decision of the tribunal. There has been comment as to the length of time it takes to expedite these transfers. Concern has been expressed as to the care of patients while awaiting the appeal of the mental health tribunal's decision to authorise their transfer to the Central Mental Hospital. There has also been criticism arising from cases where a patient's detention in the Central Mental Hospital under the Criminal Law Insanity Act (2006) comes to an end and a complex procedure of admission to another approved centre, and the instigation of the procedures for a proposal to transfer the Central Mental Hospital, has to occur. The risks associated with the interaction between the 2001 Act and the Criminal Law Insanity Act (2006) are that delivery of the appropriate care to patients may be disrupted. It is clear that there is a need for further consideration of the interplay between the 2001 and 2006 Acts.

A number of transfers have been the subject of Article 40.4 cases; Mr Justice McMenamin in JB(2)[72], Mr Justice Sheehan in NB[73] and Mr Justice Peart in MM[74]. The issue in contention has principally been in relation to who is the responsible consultant psychiatrist, taking into account subsection 21(4) which states that *"the detention of a patient in another approved centre 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."* The courts have suggested that the subsection may need to be reviewed. An amendment may allow some flexibility to clinical staff where the patient remains in the other approved centre for an extended period of time. There will be situations where the patient will be eventually transferred back to their home service and ongoing input from that service will be desirable.

DETENTION OF A VOLUNTARY PATIENT (SECTIONS 23/24)

Analysis of data for the year 2007 shows there has been an increase in activity related to the detention of voluntary patients. Compared with 2005 the number of times this mechanism has been used has risen by 15%. There has been a substantial amount of material submitted to the consultation exercise in relation to the operation of section 23 and section 24. Some submissions suggested that the requirement for a person to indicate that he or she wishes to leave is too restrictive and that the consultant psychiatrist should be permitted to detain the person if the criteria for a mental disorder are met. A voluntary patient whose condition deteriorates to the extent that he or she would meet the criteria for a mental disorder cannot have their status changed unless they indicate a wish to leave the approved centre. Some submissions have suggested the removal of the reference to section 23 in

[72] *Unreported decision of Mr Justice McMenamin dated 15.06.07*

[73] *Extempore decision of Mr Justice Sheehan dated 05.11.07*

[74] *Unreported decision of Mr Justice Peart dated 01.02.08*

section 24. Another suggestion was to amend section 23 so that the grounds on which the person can be re-graded are not specified except for meeting the criteria for a mental disorder. Submissions have also suggested that the 24 hour timeframe provided for in section 23(1) should be extended to 48 hours to allow the same detention procedures as for people from outside an approved centre, i.e. under sections 9 and 10.

In an earlier review of the 2001 Act (Department of Health & Children 2007) the Minister at that time having considered the matter carefully, expressed a strong preference for the use of the normal involuntary admission procedures when a voluntary patient has a mental disorder and requires involuntary admission for treatment. The Minister expressed a wish to ensure that the status of patients should not lightly be changed from voluntary to involuntary, and that the rights of patients in this regard are to be fully safeguarded. He went on to state that the legal scope for using the normal admission procedures under sections 9 and 10 will be examined.

CHILDREN – VOLUNTARY AND INVOLUNTARY ADMISSIONS (SECTION 25)

There were substantial numbers of comments in the submissions regarding the operation of the procedures provided for under this section of the Act. A theme that emerges is that there are perceptions that the Act provides a reduced level of human rights protections and safeguards for children when compared with the regime for adults. The fact that a separate regime is provided does itself, in the view of some respondents, cause confusion for those applying the procedures. Furthermore the application of these procedures is complicated by the lack of clarity on the interface of the provisions of the 2001 Act with those of the Non-Fatal Offences against the Person Act 1997, as mentioned by a number of submissions.

The activity information shows that there has been a small number of involuntary admissions of children (n=3). In each case these have been to adult units. There has been a large number of children (n=193) admitted on a voluntary basis to a large number of adult units (n=32). For example, in the HSE South region 60 voluntary admissions were made to 10 adult units. The provision of age appropriate approved centres for children and adolescents must be addressed as a matter of urgency. In some jurisdictions patients in hospitals where conditions are particularly bad have relied on Article 3 (inhuman or degrading treatment) or Article 8 of the Convention (right to respect for private and family life) to argue for improvements.

DISCHARGE OF PATIENTS (SECTION 28)

Analysis of orders revoked by the responsible consultant psychiatrist under the provisions of section 28 shows that there were 1,444 such instances in 2007. The patient may leave the centre at this stage or stay to receive treatment on a voluntary basis. The number of orders revoked by the responsible consultant psychiatrist under the provisions of section 28 has to be viewed in the context where patients may recover and no longer meet the criteria for mental disorder provided by the Act. Analysis of length of period of involuntary admission shows that 53% of episodes of involuntary admission in 2007 lasted less than 21 days, and only 1% lasted more than 1 year. This reflects the situation where

a patient's condition improves over time and the Act's requirement that the patient is detained pursuant to an admission order or a renewal order only for so long as is reasonably necessary for his or her proper care and treatment (s28(2)(b)).

The number of patients who requested a review by a mental health tribunal under section 28 has been very small (n=16) in 2007. There may be a number of reasons for this. Patients may not be aware of this right, may not be clear as to the purpose or outcome of such a review or they may be reluctant to revisit the matter of their involuntary admission. Subsection 28(5) requires that any review requested by a patient, who has been discharged, should be undertaken in accordance with Section 18 and that the provisions of Sections 17 to 19 shall apply with any necessary modifications. Section 18, however, provides that the mental health tribunal must decide as of the date of the review whether the patient is suffering from a mental disorder. If however, the patient's order has been revoked, the consultant psychiatrist has deemed that the patient is no longer suffering from a mental disorder within the meaning of the Act and therefore the mental health tribunal will not have any order to affirm or revoke. This would appear to be contrary to what is provided for in Section 18.

9 RECOMMENDATIONS

This final section of the report identifies the Commission's recommendations arising from the report and its conclusions. In the main these relate to issues relevant to particular sections of the 2001 Act however the first two recommendations relate to Part 2 in its entirety.

PART 2 (All sections) CODE OF PRACTICE FOR THE 2001 ACT

1. Arising from the detailed information in the report and its conclusions the Commission will commence a process of consultation with stakeholders to inform the preparation of a comprehensive code of practice for the 2001 Act for the guidance of all persons working in mental health services.

PART 2 (All sections) RESEARCH

2. Practitioners, policy makers, legislators and service providers need more detailed feedback from service users as to their experience of the process of involuntary admission and its effect on their lives. To provide this the Commission will coordinate a programme of experiential research to further examine service user experiences before, during and after the process of involuntary admission. A longitudinal study, with protected year on year funding, is envisaged with the aim of providing more detail as to patient experiences over time, assessing the Act's impact from a human rights perspective and monitoring the protection of patient's rights at all stages of involuntary admission.

BEST INTERESTS, etc., OF PERSON (Section 4)

3. As stated in the external commentary the fact that the 2001 Act does not define "best interests" is unfortunate as different approaches can be taken. This issue will also feature within future capacity legislation and will need a compatible approach. The preparation of a code of practice for the Act will provide an opportunity to discuss how best to approach "best interests" when applying procedures arising from the provisions of the Act.

CRITERIA FOR INVOLUNTARY ADMISSION (Section 8 which is linked to Section 3 "Mental Disorder")

4. The Commission is of the view that it may be prudent to consider the need to revisit section 3 to reflect the decision in the MR judgment.

5. A number of patients who have been subject to involuntary admission have had a diagnosis of Alcoholic Disorder, Other Drug Disorder, or Personality & Behavioural Disorder at close of episode. The Commission recommends that the research programme, detailed above, includes measures to examine if the criteria for involuntary admission at section 8 are always correctly applied.

6. It is acknowledged that the 2001 Act criteria for involuntary admission do not address the issue of lack of capacity and that this may be particularly problematic in relation to individuals who have intellectual disability or dementia. Feedback from the consultation exercise confirms this. It is recommended that the introduction of capacity legislation be prioritised by legislators to address these difficulties and to empower and protect vulnerable people who are not able to make their own decisions.

PERSONS WHO MAY APPLY FOR INVOLUNTARY ADMISSION (Sections 9, 11 and 12) & MAKING OF RECOMMENDATION FOR INVOLUNTARY ADMISSION (Section 10)

7. It is recommended that the HSE develop crisis response teams and an authorised officer service in line with best practice with the aim of improving patient and carer experiences in the application/recommendation stages. These services should be co-ordinated to form part of the wider development of community services outlined in Vision for Change.

8. In light of some submissions to the consultation regarding sections 9, 10, and 11 it is recommended that all services involved in involuntary admissions identify any shortfalls in their processes for staff training and information provision in connection with the procedures of the 2001 Act and take action to address these.

REMOVAL OF PERSONS TO APPROVED CENTRES (Section 13)

9. In light of the Supreme Court decision of Mr Justice Hardiman in the RL case it is recommended that consultation be initiated between the Department of Health & Children and the HSE as to the implications for the provision of the Assisted Admissions service.

10. It is recommended that a summary of those submissions from the consultation exercise that refer to the involvement of the Garda in the involuntary admission process be considered by the joint Working Group on Police and Mental Health Services established by the Commission to determine what needs to be addressed as a priority.

11. It is recommended that approved centres examine their admission procedures to ensure no delays occur at the time of involuntary admission, particularly regarding involuntary admissions via emergency departments, and that they take measures to improve their liaison with the Garda & recommending doctors.

12. The Commission will examine issues connected with the implementation of section 13(2) and consider what standards or codes of practice are required to ensure patients' rights are safeguarded throughout the involuntary admission.

ADMISSION ORDER (Section 14)

13. The Commission considers it good practice that patients be given reasons for their detention at the time an order is made and that this should include the opinion of the consultant psychiatrist involved and the reasons for that opinion. The Commission will examine how best to put this into practice.

DURATION OF INVOLUNTARY ADMISSION (Section 15)

14. There has been some comment in the submissions on the duration of detention periods. The Commission's view is that the 2001 Act is compliant with the European Convention in this regard and it does not recommend that these periods be altered at this stage.

PROVISION OF INFORMATION (Section 16)

15. There appears to be a need for renewed focus on the protection of the rights of patients, children and adults, at all stages but particularly in the pre-involuntary admission stage. This includes the need for more meaningful information to be provided to patients. The Commission will ensure that a research programme, outlined above, will include qualitative measures of patient experiences in relation to the information they receive throughout their involuntary admission. Research findings will aim to inform further targeted information campaigns relating to the human rights protections afforded by the 2001 Act and improve practice.

MENTAL HEALTH TRIBUNALS (Sections 17/18)

16. The Commission remains fully committed to arranging the mental health tribunal hearing as early as possible in the involuntary admission and will continue to monitor its performance in this regard.

17. In response to concerns expressed that 12 month orders are an overly long period, for which there is only one review in each period, the Commission will monitor the extent of use of these orders as to date there have been a relatively small number. The Commission will further examine if it would be appropriate to recommend that the patient have a right to a further review within the 12 month period of the order, either automatically or by request.

18. The Commission recommends that the 2001 Act be amended to allow a patient's legal representative to review the records relating to the patient at the approved centre, as is the case for the consultant psychiatrists who carry out independent medical examinations under section 17.

The following recommendation relates to representations that the Commission introduce a system of appraisal for the work of mental health tribunal members and a suggestion in the external commentary that patients be allowed to apply for their mental health tribunal in public.

19. The Commission recommends that the Act be amended to allow the Commission to appoint external appropriately qualified observers/appraisers who would compile anonymised reports on selected mental health tribunals as part of a system of appraisal. It is further recommended that patients' views be canvassed on this, and on the option of requesting that a mental health tribunal be held in public, as part of the research programme referred to above.

APPEALS TO CIRCUIT COURT (Section 19)

20. The 2001 Act places the burden of proof on the patient at the appeal stage. As there are two Judicial Review cases in progress in relation to appeals under section 19 that deal in the main with the issue of burden of proof at the appeal it is recommended that the judgment(s) in these cases be awaited before any further action is taken.

TRANSFERS FROM ONE APPROVED CENTRE TO ANOTHER (Sections 20/21)

21. Concern has been expressed as to the care of patients while awaiting the appeal of the mental health tribunal's decision to authorise their transfer to the Central Mental Hospital. It is recommended that the Commission and the HSE examine how the welfare of the patient can be best protected in the period while they await the appeal to ensure their condition does not deteriorate or that they do not become a risk to themselves or others.

22. It is clear that there is a need for further consideration of the interplay between the 2001 Act and the Criminal Law Insanity Act (2006), in particular where a patient's detention in the Central Mental Hospital under the 2006 Act comes to an end. It is recommended that both Acts be reviewed with the aim of providing a seamless transfer from one form of detention to the other. The Commission recommends that the Department of Health and Children and the Department of Justice and Law Reform commence discussions to address the difficulties that arise in continuing a patient's treatment where they move from the jurisdiction of the Criminal Law (Insanity) Act (2006) to the 2001 Act.

23. Clarification is needed in relation to who is the responsible consultant psychiatrist when a patient is transferred under section 20 or section 21. The courts have suggested that the relevant subsections 20(4) and 21(4) may need to be reviewed. The Commission will examine these sections of the 2001 Act in light of relevant judgments to determine how greater clarity can be provided.

DETENTION OF A VOLUNATARY PATIENT (Sections 23 & 24)

24. The status of patients should not lightly be changed from voluntary to involuntary, and the rights of patients in this regard must be fully safeguarded. However a substantial number of submissions referred to difficulties in connection with the practical application of section 23 and section 24 in situations where a voluntary patient has a mental disorder and is not indicating a wish to leave the approved centre. To address this it is recommended that the legal scope for using the normal involuntary admission procedures under section 9 and section 10 be further examined by the Department of Health and Children so that clearer guidance can be issued to staff in approved centres.

CHILDREN – VOLUNTARY AND INVOLUNTARY ADMISSIONS (Section 25)

25. It is recommended that the provision of age appropriate approved centres for children and adolescents must be addressed as a matter of urgency by the HSE and that the level of service provision be increased as a priority in line with international comparators and best practice.

26. It is recommended that increased emphasis be given to the rights of children by making it mandatory that children detained under the 2001 Act be appointed a legal representative, be offered the services of an advocate, and for added emphasis that the best interests principles in section 4 of the Act be specifically restated within section 25.

27. It is recommended that the interface of the provisions of the 2001 Act with those of the Non-Fatal Offences Against the Person Act 1997 be clarified to provide practitioners with clearer guidance as to their powers and functions.

VOLUNTARY ADMISSION TO APPROVED CENTRES (Section 29)

28. This section promotes the principles of a least restrictive approach when considering the detention of a person suffering from mental disorder. This approach is recommended. It is hoped that capacity legislation, recommended above as a priority, will be implemented in such a way that it further supports the least restrictive principles and has a seamless interface with the 2001 Act.

APPENDICES

APPENDIX 1: SECTION 42(4) CONSULTATIVE GROUP MEMBERS

Dr. Mary Staines – Stewart's Hospital
Dr. Martina Kelly – General Practitioner
Dr. Fidelma Flynn – Chair Clinical Director's Group
Mr. Brian O'Donnell – National Federation of Voluntary Bodies
Mr. Seamus McNulty – Health Service Executive
Mr. Tony Leahy – Health Service Executive
Dr. Harry Kennedy – Irish College of Psychiatrists
Mr. Frank Browne – Irish Association of Social Workers, St. Loman's Hospital
Mr. Tony Kelly – National Service User Executive
Ms Christine Linscott – Association of Occupational Therapists Ireland
Dr. Michael Byrne – Psychological Society of Ireland
Chief Superintendent Gerry Blake – An Garda Siochana
Ms. Suzie Doheny – Schizophrenia Ireland
Mr. John Redican – Irish Advocacy Network
Dr. Conall Larkin – St. John of God
Dr. Jim Lucey – St. Patrick's Hospital
Mr. P.J. Lawlor – St. Fintan's Hospital
Dr. Amanda Burke – Irish College of Psychiatrists
Dr. Susan Finnerty – Mental Health Commission
Ms. Bríd Clarke – Mental Health Commission (Chair)
Dr. Gerry Cunningham – Mental Health Commission
Ms. Patricia Gilheaney – Mental Health Commission
Ms Rhona Jennings – Mental Health Commission
Ms. Rosemary Smyth – Mental Health Commission
Dr. Maria Frampton – Mental Health Commission
Dr. Fiona Keogh – Mental Health Commission
Ms Marina Duffy – Mental Health Commission
Mr. Simon Horne – Mental Health Commission (Secretary)

APPENDIX 2: THE REGISTER OF APPROVED CENTRES

HSE Dublin North East
Acute Psychiatric Unit, Cavan General Hospital
Acute Psychiatric Unit, St. Aloysius Ward, Mater Misericordiae Hospital, Dublin 7
Department of Psychiatry, Connolly Hospital, Blanchardstown, Dublin 15
Department of Psychiatry, Our Lady's Hospital, Navan, Co. Meath
St Brendan's Hospital, Rathdown Road, Dublin 7
St Brigid's Hospital, Ardee, Co. Louth
St Davnet's Hospital, Monaghan
St Ita's Hospital – Mental Health Services, Portrane, Donabate, Co. Dublin
St Joseph's Intellectual Disability Services, St. Ita's Hospital, Portrane, Donabate, Co. Dublin * *National Service*
St Vincent's Hospital, Fairview, Dublin 3
Sycamore Unit, Connolly Hospital, Blanchardstown, Dublin 15

HSE Dublin Mid-Leinster
Acute Psychiatric Unit AMNCH, Tallaght, Dublin 24
Central Mental Hospital, Dundrum, Dublin 14 * *National Service*
Department of Psychiatry, Midland Regional Hospital, Portlaoise, Co. Laois
Elm Mount Unit, St Vincent's University Hospital, Dublin 4
Jonathan Swift Clinic, St James's Hospital, Dublin 8
Lakeview Unit, Naas General Hospital, Naas, Co. Kildare
Newcastle Hospital, Greystones, Co. Wicklow
St Fintan's Hospital, Portloaise, Co. Laois
St Loman's Hospital, Mullingar, Co. Westmeath
St Loman's Hospital, Palmerstown, Dublin 20

HSE West
Acute Psychiatric Unit 5B, Midwestern Regional Hospital, Dooradoyle, Limerick
Acute Psychiatric Unit, Carnamuggagh, High Road, Letterkenny, Co. Donegal
Acute Psychiatric Unit, Midwestern Regional Hospital, Ennis, Co. Clare
Adult Mental Health Unit, Mayo General Hospital, Castlebar, Co. Mayo
An Coillín, Westport Road, Castlebar, Co. Mayo
Ballytivnan Sligo/Leitrim Mental Health Services, Ballytivnan, Sligo
Department of Psychiatry, County Hospital, Roscommon

Orchard Grove, Gort Road, Ennis, Co. Clare
Psychiatric Unit, University College Hospital Galway, Newcastle Road, Galway
St Brigid's Hospital, Ballinasloe, Co. Galway
St Conal's Hospital, Letterkenny, Co. Donegal
St Joseph's Hospital, Limerick
Teach Aisling, Westport Road, Castlebar, Co. Mayo
Unit 9A, Merlin Park University Hospital, Galway

HSE South
Acute Mental Health Admission Unit, Kerry General Hospital, Tralee, Co. Kerry
Acute Psychiatric Unit, Bantry General Hospital, Bantry, Co. Cork
Carraig Mór Centre, Shankiel, Cork
Department of Psychiatry, St Luke's Hospital, Kilkenny
Department of Psychiatry, Waterford Regional Hospital, Dunmore Road, Waterford
South Lee Adult Mental Health Unit, Cork University Hospital.
St Canice's Hospital, Dublin Road, Kilkenny
St Dympna's Hospital, Athy Road, Carlow
St Finan's Hospital, Killarney, Co Kerry
St Finbarr's Hospital, Douglas Road, Cork
St Luke's Hospital, Clonmel, Co. Tipperary
St Michael's Unit, Mercy Hospital, Cork
St Michael's Unit, South Tipperary General Hospital, Clonmel, Co. Tipperary
St Otteran's Hospital, Waterford
St Senan's Hospital, Enniscorthy, Co. Wexford
St Stephen's Hospital, Glanmire, Co Cork

Independent/Private and Private Charitable Institutions
Bloomfield Wing, Bloomfield Care Centre, Stocking Lane, Rathfarnham, Dublin 16
Hampstead Private Hospital, Hampstead, Glasnevin, Dublin 9
Highfield Private Hospital, Swords Road, Whitehall, Dublin 9
Kylemore Clinic, Church Road, Ballybrack, Co. Dublin
Palmerstown View, Stewart's Hospital, Palmerstown, Dublin 20
St Edmundsbury Hospital, Lucan, Co Dublin
St John of God Hospital, Stillorgan, Co. Dublin
St Patrick's Hospital, James's Street, Dublin 8

Child and Adolescent Services
St. Anne's Children's Centre, Taylor's Hill, Galway
Warrenstown Child & Adolescent In-patient Unit, Blanchardstown, Dublin 15

APPENDIX 3: LIST OF BODIES & ORGANISATIONS WHO MADE SUBMISSIONS – PUBLIC SECTOR BODIES, SERVICES, MENTAL HEALTH SERVICES, COMMUNITY AND VOLUNTARY ORGANISATIONS AND REPRESENTATIVE BODIES

Amnesty International Ireland
An Garda Síochána
Ballyfermot Child and Family Centre, Dublin
Barnardos
Brothers of Charity Services, Galway
Clare Mental Health Services, Clare
Dingle Day Centre, Kerry
Donegal Mental Health Services, Donegal
GROW in Ireland
Heads of Psychology Services of Ireland
Health Information and Quality Authority
Highfield Hospital, Dublin
HSE Dublin Mid-Leinster, Longford Westmeath Psychology Service
HSE Primary Community & Continuing Care Directorate
HSE Acting Mental Health Coordinator
HSE North East
HSE Newcastle Hospital, Wicklow
Irish College of Psychiatrists
Irish College of Psychiatrists Child and Adolescent Faculty
Irish College of General Practitioners
Irish Hospital Consultants Association
Irish Medical Organisation
Interim National Service Users Executive
Irish Advocacy Network
Irish Association of Emergency Medicine
Irish Association of Social Workers
Irish Association of Speech and Language Therapists
Kerry Network of People with Disabilities Ireland, Co Kerry
Kildare Mental Health Services, Kildare
Kildare Network of People with Disabilities Ireland, Co Kildare
Mater Child and Adolescent Mental Health Service, Dublin
Mental Health Commission Tribunal Panel Members
Mental Health Ireland
Mental Health Lawyers Association
Mental Health Nurse Managers Ireland
Mercy University Hospital Emergency Department, Cork
Mindfreedom
National Clinical Directors Group
National Council for the Professional Development of Nursing and Midwifery

National Disability Authority
National Federation of Voluntary Bodies Providing Services to People with Intellectual Disability
North Lee Mental Health Services, Cork
Northwest Dublin Mental Health Services
Pharmaceutical Society of Ireland
Principal Mental Health Social Workers
Psychiatric Nurses Association
Psychological Society of Ireland
Services, Industrial Professional and Technical Union SIPTU
South Lee Mental Health Services, Cork
St. Anne's Child and Adolescent Centre, Galway
St. Brendan's Hospital, Dublin
St. Brigid's Hospital, Galway (Clinical Director)
St. Davnet's Hospital, Monaghan (Professionals and Community Mental Health Team)
St. Frances Clinic, Children's University Hospital, Dublin
St. James's Hospital, Dublin (Consultant Psychiatrists/Clinical Directors)
St. John of God Hospital, Dublin
St. Patrick's Hospital, Dublin
St. Patrick's Hospital Consumer Council, Dublin
St. Vincent's University Hospital, Dublin 4 (Consultant Psychiatrist Group)
St. Vincent's Hospital, Fairview, Dublin 3 (Consultant Psychiatrist)
Stewart's Hospital, Dublin (Consultant Psychiatrist and Staff)
Teen Counselling, Mater Dei, Dublin

GLOSSARY

Admission order	The order authorising the reception, detention and treatment of the patient concerned and shall remain in force for a period of 21 days from the date of the making of the order in accordance with Section 15 of the Mental Health Act 2001;
Adult	Any person who is not included in the definition of a 'child' in the Mental Health Act 2001;
Approved centre	Means a hospital or other in-patient facility for the care and treatment of persons suffering from mental illness or mental disorder that is entered on the register of approved centres maintained by the Mental Health Commission;
Child	Means a person under the age of 18 years other than a person who is or has been married;
Clinical Director	Under the mental Health Act 2001, the governing body of each approved centre must appoint a consultant psychiatrist as clinical director.
Electroconvulsive therapy (ECT)	Electroconvulsive therapy (ECT) is a medical procedure in which cerebral seizures are induced by passing a small amount of carefully controlled electric currents across the brain for three to five seconds. The patient receives a muscle relaxant and is briefly anaesthetised during the procedure. Its purpose is to treat specific types of major mental illnesses
Episode of involuntary admission	An episode is a patient's unbroken period of involuntary admission
Hearing	a hearing is a sitting of a Mental Health Tribunal
Mental disorder	In the Mental Health Act 2001 "mental disorder" is defined in section 3
Mental health tribunal	Means the Mental Health Tribunal(s) provided for by the 2001 Act which the Commission shall from time to time appoint which or each of which shall be known as a Mental Health Tribunal to determine such a matter or matters as may be referred to it by the Commission
Patient	"patient" shall be construed in accordance with **section 14**; a person to whom an admission order relates is referred to in this Act as "a patient"
Person of Unsound Mind (pum)	Person of Unsound Mind. Such persons were a category of patient who may be admitted to and detained in a district mental hospital under section 162 of the Mental Treatment Act 1945.

Register	"The Register" means the Register of Approved Centres and cognate words shall be construed accordingly.
Regulations	Mean the regulations that the Minister shall make, after consultation with the Commission, for the purpose of ensuring proper standards in relation to Approved Centres, including adequate and suitable accommodation, food and care for residents while being maintained in centres, and the proper conduct of centres, make such regulations as he or she thinks appropriate pursuant to Section 66 of the Mental Health Act 2001;
Restraint: *Mechanical* *Manual*	 Any device which is attached or adjacent to a person's body which he or she cannot easily remove and that restricts freedom of movement or normal access to his or her body. The application of physical force without the use of any device for the purpose of restraining free movement of the patient's body.
Seclusion	Seclusion is the placing or leaving of a person in any room alone at any time, day or night, with the exit door locked or fastened or held in such a way as to prevent the person from leaving, MHC Rules R-S69(2)/02/2006
Spouse	In relation to the Mental Health Act 2001, means a husband or wife or a man or a woman who is cohabiting with a person of the opposite sex for a continuous period of not less than 3 years but is not married to that person; however for the purposes of Section 9 of the Mental Health Act 2001, "spouse" does not include a spouse of a person who is living separately and apart from the person or in respect of whom an application or order has been made under the Domestic Violence Act, 1996;
Temporary Reception Order	Under the 1945 Act a patient suffering from mental illness believed to require for his / her recovery not more than six months suitable treatment and is unfit on account of his / her mental state for treatment as a voluntary patient or who is an addict and is believed to require, for his / her recovery, at least six months preventive and curative treatment was detained on the legal authority of a Temporary Patient Reception Order.
Voluntary patient	Pursuant to the Mental Health Act 2001 means a person receiving care and treatment in an Approved Centre who is not the subject of an admission order or a renewal order;

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