

Psychiatric Nurses' Association PNA
Submission to the Mental Health Commission
Review of the Operation of Part 2 of the Mental
Health Act 2001



1. 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?

Introduction

The 1945 Mental Treatment Act, provided for admission and discharge procedures to psychiatric hospitals. Certain safeguards were built into the Act for the benefit of the patient. Among these were the appointment of visiting committees for hospitals the right of a relative or friends to appeal to the Minister for Health to have the patient examined by independent medical practitioners. Despite this Irish rates of involuntary admission have been deemed to be high by European standards (Walsh, 2002). In 2002 the Report of the Inspector of Mental Hospitals indicated that there were 23,234 admissions to psychiatric hospitals and acute hospital units. ¹Of these approximately 2,349 were involuntary admissions, representing about 10% of the total admissions². This figure represents one of the highest per capita rates of detention in Europe, for reasons that may be related to the lack of safeguards against involuntary admission and the lack of a review process for such detentions (Mills 2002). The old regime may have been a satisfactory way of operating a system of state sponsored and legitimise incarceration, it was perhaps less idyllic from the patients point of view. There were no structures such as a second psychiatric opinion prior to involuntary detention and there was no third party review of the continuation of detention. In today's society legal thinking gives increasing recognition to the rights of the individual as an essential ingredient of the government of a pluralist state, especially the right to liberty.

¹ O'Neill, A. (2005) Irish Mental Health Law, Dublin: First law Limited. (Pg 87)

² ibid

The human rights perspective on mental disability is a new way of thinking about the human difference of mental disability and the place of those who are different by way of being people with mental disability in our society.

“The human rights paradigm demands a new vision of the body politic – one that takes seriously the promise of equal citizenship and social solidarity”

Quinn (2005) pg Viii cited in O’Neill (2005)

Indeed the human rights perspective helped to inform a clear reform agenda in mental health issues. Article 5 of the Convention guarantees liberty a right that may be abridged or taken away only in accordance with the law. The Convention also calls for one extra element in any legal process that purports to deprive an individual of his liberty, namely the availability of a speedy system for the review of any detention that impinges on the right to liberty. The Conventions impact on Irish mental health legislation arose out of a case brought by a man who claimed that his involuntary detention under the Mental Treatment Act 1945 was in breach of his rights under the convention³. He had been involuntarily detained in a psychiatric hospital during 1994 and complained that the absence of an independent review of the legality of his detention violated the Convention. The case was not decided by the Court, but instead a “friendly settlement” was reached between the plaintiff and the Irish State before the Court had the opportunity to hear the case. The settlement contained an undertaking by the government to pass new mental health legislation that would provide the review procedure previously lacking.

The implementation of Part 2 of the Act whilst welcomed is a challenge for existing services, in that the essence of any service provision and care for this most vulnerable of care groups

³ Croke v Smith [1998] 1 IR 101

must combine the concepts of rights and responsibilities with a systematic transparent roll out of the necessary resources and structures so desperately needed for the mental health services in this jurisdiction. This submission by the Psychiatric Nurses Association PNA highlights some of the current difficulties within the system experienced both at the operational /frontline of service provision and from a strategic trade union perspective .in preparation for this submission members were consulted at a National Executive Council meeting the following is a synopsis of this consultation process and some of their experiences. The PNA continues to identify the urgent need to address the mental health care needs of individuals, families, and groups to improve their access to, and attainment of, quality mental health care in a variety of settings and environments.

Safeguards

The Psychiatric Nurses' Association (PNA) welcomes the operation of Part 2 of the Mental Health Act 2001 as the most significant legislative provision in mental health in 60 years and its introduction of fundamental protections and rights for those availing of mental health services

The Mental Health Review Tribunals guarantees an automatic and independent review of every admission order of persons involuntarily admitted to psychiatric centres and of any extensions of such orders. "The touchstone of the Mental Health Act 2001 is the protection, as far as possible of patient's personal rights."⁴ The watchwords of the new legislation are "second opinion" and "independent review". Under the Mental Health Act 2001 a patient cannot be involuntarily admitted or be subject to further involuntary detention or treatment without the activation of safeguard mechanisms designed to ensure that the rights of the patient are maximised. The main provisions of the Mental Health Act 2001 are:

⁴ Mills,S (2002) clinical Practice and the law, Dublin : Butterworths ,(pg.256)

- Establishment of Mental Health Commission.
 - Establish Mental Health Tribunal
 - Appoint Inspector of Mental Health Services
 - Develop Register of “Approved Centres”
- Monitor consent to treatment of ECT and psychosurgery
- Admission Criteria specified in the definition of mental disorder.
- Terminology

“Mental disorder” divided for the purposes of the Act into three categories.⁵
- Admission and treatment:
 - Involuntary admissions are to “Approved” Centres only.

The process of admission activates the review mechanism and puts in place certain safeguards such as shorter time limits, that may serve to encourage

⁵ (a) “mental illness”

A state of mind of a person which affects a person’s thinking perceiving emotion or judgement and which seriously impairs the mental function of the person to the extent that he or she requires care of medical treatment in his or her own interest or in the interest of other persons.

(b) “Severe dementia”

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

(c) “Significant Intellectual Disability”

arrested or incomplete development of the mind of a person, which includes significant impairment of intelligence and social functioning and abnormally aggressive or seriously irresponsible conduct on the part of the person.

The Act to apply, in addition to the presence of mental disorder, one of two conditions must be satisfied:

- (i) the mental disorder must give rise to a serious likelihood of harm to the person suffering from the condition or to a serious likelihood of harm to others or
- (ii) a failure to admit would result in a deterioration of the disorder or would prevent the administration of treatment that could only be given by such admission.

discharge rather than detention of those incorrectly or too precipitately admitted.

Application can be made by a spouse or relative of the person, an authorised officer or a member of the Garda Síochána. The medical practitioner to whom the application has been made must examine the patient within 24 hours of the application, and once their decision is made, a recommendation for admission remains valid for 7 days.⁶ The 2001 Act also provides for a system of independent review of the legality of involuntary detention of individuals.⁷

Voluntary patients may be admitted without the need for any formal application, recommendation or admission order under the 2001 Act.⁸ Unlike the 1945 Act, there is no need for an admission form. Under the new Act, a person may be admitted involuntarily to an approved centre on the grounds that he is suffering from a mental disorder, as defined by the Act.⁹

However it has been submitted to this organisation (PNA) in the absence of capacity legislation there is a difficulty with the 2001 Act with regard to the criteria for mental disorder both in terms of capacity to voluntary admission and capacity to consent to treatment. Some people do not have the capacity to consent to voluntary admission but do

⁶ Mills, S. (2002) *Clinical Practice and the Law*, Dublin: Butterworths, (Pg.260)

⁷ *Crooke V's Ireland* 21st December 2000 ECHR highlighted this deficiency in the Mental Treatment Act 1945, and ultimately was one of the factors that led to the Mental Health Act 2001.

⁸ Mental Health Act 2001, s.29

⁹ Mental Health Act 2001, s.3. This is in marked contrast to the provisions of the Mental Treatment Act 1945 where persons were involuntarily admitted because of unsoundness of mind or on the basis of being a temporary patient.

not fulfil the criteria for involuntary admission under the Act .This limits the scope for clinicians with regard to safeguarding the patient's welfare as in "the best interests of the patient "section 4 (1) they may be left with little alternative but to admit the individual involuntary. A further legal test, of "substantially diminished capacity" in the field of all health care including consent to psychiatric treatment, and the grounds upon which such health care may be given without consent should be added to the criteria governing all interventions under the Mental Health Act 2001. Indeed such problems have occurred with regard to individual patients residing on a unit of what was formerly a psychiatric hospital (but not an approved centre now) having to be admitted involuntarily as a result of them refusing medication thus incurring the whole process of an assisted admission GP etc.

The recommendations of the English Law Commission provide a useful guideline in this regard. ¹⁰As a matter of practice to ensure that accusations against bias in decision making can be refuted psychiatrists clinically disinterested in the relevant case and trained in assessment capacity should make the assessment of capacity of a person of mental disability (whether mental illness or intellectual disability) to consent to medical treatment.

On foot of these difficulties and in the absence of such safeguards, from a nursing and clinical perspective some comments have suggested that the operation of Part 2 of the Act is legally dominated and that there is less regard for individual clinician's judgement despite having the patient's "best interests" at heart.

Further whilst the Act lays down the criteria for mental disorder it fails to provide a definition for mental illness, it could be argued this is problematic due to many interpretations which can be taken to mean mental illness. The definition of "mental illness" in the Mental Health Act 2001 is circular and based on paternalistic welfare philosophy.

¹⁰ English Law Commission Report No. 231 on Mental Incapacity London: HMSO, February 28, 1995. Paras 3.2 to 3.22

Section 3 (2) of the Act indicates that *“mental illness”* is to be defined as a *“state of mind of a person which affects a person’s thinking, perceiving, emotion or judgement and which seriously impairs the mental function of the person to the extent that he or she requires care or medical treatment in his or her own interests or in the interests of other persons”*. The circularity of the definition lies in the notion that a person may be committed if he or she needs care or medical treatment because of a mental illness which seriously impairs his/her mental function to the extent that he or she needs care or medical treatment .¹¹

On a procedural point there have been reported difficulties with regard to episodes where a recommendation has been made by a registered medical practitioner following an examination of the person subject to the application, in some instances those individuals have been taken directly to the approved centre with the relevant documentation signed, and the admission order has been refused by the consultant psychiatrist. Whilst this is perfectly valid, it has been the case that those individuals have been subject to a whole assisted admissions procedure, removal from their home incorporating the assistance of Gardai, family etc. This is an unfortunate chain of events jeopardising therapeutic relationships the individual may have with the community team (Community Mental Health Nurse) and all stakeholders involved and therefore it is submitted by the PNA continued education is required with regard to procedure, definitions and mental state examinations for medical practitioners.

Of note with regard to procedures for making medical recommendations by a medical practitioner for the involuntary admission of an individual the definition of the term “examination” is a significant factor in the 2001 Act. An examination for the purposes of making a recommendation is defined as “a personal examination ...of the process and

¹¹ Indeed commitment based on vague standards such as “mentally ill” or “in need of treatment” has been held to be unconstitutional in the US. See *Goldy v. Beal* 429 F. Supp. 640 (M.D. Pa.1976).

content of thought, the mood and behaviour of the person concerned". The registered medical practitioner concerned must inform the person of the purpose of the examination unless in his or her view the provision of such information might be prejudicial to the person's mental health, well being or emotional condition.

The nature of the examination was not specified in the 1945 Act and was the subject of judicial consideration in *O' Reilly v. Moroney and the Mid Western Health Board*¹² where the Supreme court by a 2;1 majority ruled that the statements of the appellant's father that she had threatened to commit suicide and the observation of a registered general practitioner of the appellant's behaviour from a position of about 12 to 15 yards away from her house was sufficient to constitute an examination for the purposes of making a recommendation under the 1945 Act. In the light of the wide construction of the term " examination" in the 1945 Act the more precise definition in the 2001 Act is , from the perspective of protecting the rights of the patient is a welcomed addition.

Community Treatment Orders

It has been suggested that the inclusion of community treatment orders (CTO) may be a beneficial inclusion into the legislation.

Section 26(1) of the Mental health act 2001 provides that the consultant psychiatrist responsible for the care and treatment of a patient may grant permission in writing to the patient to be absent from the approved centre concerned for such period as he or she may specify in the permission being a period less than the unexpired period provided for in the relevant admission order, renewal order or order under section 25.

Section 26 (2) provides that where a patient is absent from an approved centre pursuant to subsection (1) , the consultant psychiatrist may, if he/ she is of the opinion that it is in the interest of the patient to do so, withdraw the permission granted under subsection (1) and direct the patient in writing to return to the approved centre.

¹² Unreported, Supreme Court, November 16, 1993.

However, it should be noted that following the enactment of the European Convention on Human Rights Act 2003 the consultant's powers to withdraw the permission to be absent and to direct that patient to return to the approved centre must be exercised consistently with Article 5 (1) of the European Convention on Human Rights and following the decision of the European Court of Human Rights in *K v. UK*,¹³ except in emergency situations, a patient should not be recalled to an approved centre in the absence "of objective medical evidence" that s/ he remains mentally disordered.

It has been relayed to this organisation that in the absence of Community Treatment Orders (CTOs) and a situation whereby individual patients on prolonged periods of absence are not complying with their treatment regime (both in terms of drug therapy and attendance to community services i.e. day hospitals) patients have been recalled to the approved centre and admitted usually just before the mental health tribunal hearing whereby an admission renewal order is extended in the interest of the patient's own health or safety. However if there was a mechanism similar to the Community Treatment Order facility provided in the English legislation or that of New South Wales this would seem by some of our members (Community Psychiatric Nurses) a more robust and definitive mechanism for dealing with non compliance for those patients and their treatment and employ a more favourable measure for the early return of the person with mental illness to the Community.

In the English Courts in *R v. Hallstrom ex p. W*¹⁴, it was held that it was unlawful to use prolonged leave of absence as a means of ensuring that patients who did not need to be in hospital could be obliged to go on taking their medication outside. The court also ruled that it was unlawful to recall from leave a patient subject to section 3 solely in order to renew the authority to detain the patient if it was not appropriate and necessary for him to be detained in hospital for treatment. For the avoidance of doubt it is submitted that specific provision should be made by the Irish legislation for extension of leave to be granted without the necessity of a patient's returning to hospital. The inclusion of CTO's would allow clinicians to supervise patients to comply with their drug /medicines regime and return them to the approved centre if required for their therapeutic benefit. This would allow for a phased discharge for the individual with the proper safeguards in place for supervising the individual and a more appropriate mechanism for referral back to the centre in this regard

¹³ (1998) 40 B. M. L. R. 20

¹⁴ [1986] Q. B. 1090

than currently exists. Some of the literature has revealed CTO's have had significant therapeutic benefits for patients; greater compliance with outpatient treatment, especially medication; and reduced rates of hospital admissions. Some also reveal: better relations between families and patients, or enhanced social contacts; reduced levels of violence and self – harm and earlier identification of patients' relapse.(Dawson 2005)

Equally if the system of absence on trial is to work there is a need for a full community based support as proposed in government policy Vision for Change (2006) for the patient who through the process of absence on trail is preparing to leave hospital. The effects of lack of community support due to under resourcing, vacant posts and over stretched existing staff are not conducive to this process to be conducted in a safe and therapeutic manner. In this regard the PNA is critical of the recruitment moratorium late in 2007 and the continuing difficulties with regard to development and recruitment into posts, it's inevitable damage to the health service and its effects and delay on the expansion of services which ultimately compromise quality service delivery.

Children

In relation to the voluntary admission of children in the 2001 Act the Mental Health Commission in its Code of practice (2006) states "the majority of children will receive such care and treatment in an approved centre with the consent of their parent(s)"¹⁵.

It is noteworthy at this juncture that the Act defines a "child" as any person who is under the age of 18 other than a person who is or has been married.¹⁶ This is in stark contrast with section 23 of the Non-Fatal Offences Against the Persons Act 1997, which states that for the purpose of medical treatment, an individual over the age of 16 has the capacity to consent¹⁷. Ultimately the 1997 Act and the 2001 Act are at odds. It is not clear what status

¹⁵ Mental Health Commission (2006) Code of Practice Relating to Admission of Children under the Mental Health Act 2001(Pg 14)

¹⁶ Mental Health Act 2001 s2

¹⁷(Section 23 NFOAP Act 1997) which provides at Section 23(1) "the consent of a minor who has attained the age of 16 years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his or her person, shall be as effective as if it would be if he or she were of full age; and where a minor has by virtue of this Section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his or her parent(s) or guardian". Section 23(2) NFOAP Act 1997 provides that treatment includes any diagnostic procedure and any procedure ancillary to that treatment.

the consent or refusal of consent, of a child between the ages of 16 and 18 years, to treatment for a mental disorder has.¹⁸

There is a question as to whether Section 23 NFOAP Act 1997 enables children aged 16 and 17 years to admit themselves voluntarily to an approved centre for treatment. The Mental Health Commission's legal advice is:

"That attempts to reconcile Section 23 NFOAP Act 1997 with the provisions of the Act give rise to significant difficulty. While it may be that the definition of medical treatment under the NFOAP Act 1997 would include psychiatric treatment, and one commentator has interpreted it to be so, the Act does not appear to contemplate the giving of consent to treatment by a "child", a term which, because of the way it is defined in the Act, includes Section 23 NFOAP Act 1997 minors". 19

The Commission's legal advice is:

*"That while there are cogent arguments in favour of applying Section 23 NFOAP Act 1997 to the Act, the position is not so clear as to enable the Commission to proceed, or advise others to proceed, on that basis. The Commission has been advised that there is significant uncertainty as to whether Section 23 NFOAP Act 1997 has any application in relation to admission for and provision of treatment for mental illness. Medical and health professionals may need to obtain legal advice in relation to individual case"*²⁰

It appears that the Commission has been advised that there is significant uncertainty as to whether Section 23 NFOAP Act 1997 has any application in relation to admission for and provision of treatment for mental illness and advises *"Medical and health professionals may need to obtain legal advice in relation to individual cases.*(Mental Health Commission 2006),it goes on to state *"The present position, therefore, is that the Commission cannot advise mental health professionals to*

¹⁸ O'Neill, A. (2005) *Irish Mental Health Law*, Dublin: First Law Limited. (Pg. 90)

¹⁹ Mental Health Commission (2006) Code of Practice Relating to Admission of Children under the Mental Health Act 2001(Pg 14)

²⁰ *ibid*

operate on the assumption that Section 23 NFOAP Act 1997 means that the consent of children aged 16 and 17 is effective to permit treatment under the Act”²¹.

The Mental Health Commission advises therefore that:

“...that irrespective of whether children aged 16 and 17 years are capable as a matter of law or fact of providing an effective consent to treatment, the views of 16 and 17 year olds as to their treatment should be sought as a matter of course. The Commission has also been advised that the existence of consent to treatment does not, of itself, impose an obligation to treat on a health professional. Where there is disagreement as between child and parent(s), particularly in respect of some significant aspect of treatment, it is open to the professional involved to decline to give that treatment (where, for instance, the cooperation of the patient would be an important factor in whether the treatment is successful or not) or to seek guidance from the High Court as to how to proceed”²².

It is laid down in the Act however that a voluntarily admitted “child” may not be afforded the same rights as an involuntarily admitted adult, such as their right to apply for the review of their confinement. They are purportedly present of their own free will and do not need the same protection as involuntarily admitted patients.

But what of the children who are admitted voluntarily by virtue of their parent’s consent, who are in dispute with their parents? The rationale here is strained. Having regard to the protection of civil liberties and to safeguard against possible abuses, this union (PNA) would argue that parents should not be able to “volunteer” their children for admission to mental

²¹ ibid

²² ibid

hospitals without some additional check, such as an automatic review by a Mental Health Review Tribunal to safeguard against possible abuses. The process of admission under the 2001 Act activates the review mechanism and puts in place certain safeguards, such as shorter time limits, that they may serve to encourage discharge rather than detention of those incorrectly or too precipitately admitted for those over eighteen years. As outlined this is not the case for children and adolescents. The 2001 Act changes the age of consent to psychiatric treatment from 16 to 18 years. For those in this age group, safeguards and rights that were afforded to them under the 1945 Mental Treatment Act have been removed under the new legislation.

Not only are the lack of safeguards a concern, potential legal repercussions have been articulated by our members when it comes to the provision of treatment (i.e. medication) the use of seclusion or restraint with regard to this age group in unsuitable inappropriate facilities.

Children who require mental health interventions, services and supports are seriously out of step with need. There is limited availability of the appropriate range of services – those in primary care, community care, in-patient centres, day centres, rehabilitation services and outreach services to provide support in the home and school. Children and Adolescents are still struggling with an outdated, fragmented system which causes children their carers and staff, moral distress and anguish.

Other points of concern expressed to this union (PNA) relate to

- When an individual is taken to an approved centre by Gardai and the assisted admissions team they have to remain on the unit as an involuntary patient until seen by the consultant psychiatrist inside 24 hours. They do not have the option of staying as a voluntary patient an alternative afforded to them under the 1945 Mental

Treatment Act. This lack of flexibility contrasts with the ethos of the *protection, as far as possible of patient's personal rights.*

- In the case of having to take an individual directly to an approved centre it means that the individual is not physically / medically assessed prior to psychiatric assessment. We know often symptoms of an acute mental disorder can be a symptom of an underlying physical condition that may be missed.
- As a union we have had mixed reports with regard to the process of the Mental Health Tribunal - in that some patients appear to have unrealistic expectations and false hope with regard to their plan of future care and the possibility of the tribunal overturning their involuntary status. This causes an atmosphere of anger and resentment thereafter not conducive to a recovery process.
- On some occasions the relevant documentation is not in order, this may mean the patient may be free to leave if they do not agree to stay voluntarily. This is often a situation not deemed to be in the best interest of the patient and Section 23 (1) of the act is implemented often by registered psychiatric nurses. However this can have negative repercussions on staff in that they are at increased risk of being assaulted if the individual has a violent disposition and is unwilling to co operate.

2. 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?

Human Rights

Mental illness diagnosis involves subjective judgement about rationality and behaviour it inevitably raises questions about civil rights, which relate to its misuse for political ends or as a result of ethical bias. The nature of mental health legislation and the need for it reflects these two aspects of mental illness. Firstly the nature of mental illness – the fact that it often involves decreased rationality and responsibility and that the sufferer may have little or no insight into her condition – has resulted in the power to decide to accept or reject treatment being removed in some cases from the mentally ill person and given to other authorised people instead. Secondly the element of subjectivity involved in the definition of mental illness, the fact that its diagnosis is based on behaviour and is therefore open to being abused and the fact that the treatment sometimes results in the sufferers autonomy being restricted, result in a need for the rights of the sufferer to be protected.

Mental health legislation has the difficult role of protecting the right of patients to autonomy, the rights of others who may be advisably affected or even injured by the mentally ill person, and the rights of the mentally ill themselves to be protected from their own irrationality. Legislation therefore must balance the interests of the individual with the protection of society.

The 2001 Act emanates from a Human Rights perspective which informed a clear reform agenda in mental health legislation in this jurisdiction. The Mental Health Act 2001 born out of Ireland's signatory of the European Convention of Human Rights and its impact on Irish mental health legislation substantially overhauls the legislation governing involuntary detention.

However there have been some difficulties since the commencement of Part 2 of the 2001 Act there have been 30 Article 40.4 cases filed. Of these 15 have resulted in written judgements 1 of which is a Supreme Court decision.

Members of this union (PNA) report 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 chained unless they indicate a wish to leave the approved centre. Examples have been raised in this regard whereby individual's detention was deemed unlawful by the Tribunal due to the fact that they didn't attempt to leave the unit and as such was not covered by a section 23 detention. In such instances the case has been referred to the High Court whereby the verdict has been given to discharge the patient and go through the whole admission procedure again.

This is farcical in the extreme it belittles the patient adds further stress on the family and makes a nonsense of the nurse /clinician's judgement. The provisions of the Mental health Act dealing with holding powers seem to deviate from the terms of the White Paper which proposed that nurse be given holding powers to detain a patient in an approved centre for up to six hours within which time the person must be examined by a medical practitioner and a consultant psychiatrist may hold such a patient for a period of 48 hours within which time procedures for detention must be completed.²³

²³ See para.3.34.

Section 25 Admission of Children

Good mental health legislation is the guardian of civil liberties. Under the *Mental Health Act 2001*, there are many protections afforded to adults, which children are denied due to their voluntary status, to the detriment of their civil liberties. The right to apply for a review of their confinement to an independent Mental Health Tribunal is one that is afforded to involuntary adult patients under the *Mental Health Act 2001*.²⁴ A mature minor, who is admitted to psychiatric hospital as a voluntary patient due to consent given by their parents, is denied this right.²⁵ The logic behind this denial is that because voluntary patients are present of their own accord, they are free to leave if they decide to and thus do not need the same protection as involuntary patients. In the case of mature minors who are detained voluntarily and desire to leave, it is their parents who apply for such a release;²⁶ the mature minor is never free to leave of their own accord. All of the aforementioned safeguards against unfair admissions, such as access to legal representation, are not afforded to those detained voluntarily, based on this rationale.²⁷

The 1991 UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, also known as the MI Principles,²⁸ elaborate the basic rights and freedoms of people with mental illness under the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights.²⁹ They state that “*special care should be given...to protect the rights of minors*”³⁰

²⁴ Mental Health Act 2001, s.17

²⁵ O’Neill, A. (2005) *Irish Mental Health Law*, Dublin: First Law Limited. (Pg. 248)

²⁶ Mental Health Act 2001 s 23(2)

²⁷ O’Neill, A. (2005) *Irish Mental Health Law*, Dublin: First Law Limited. (Pg. 248)

²⁸ General Assembly Resolution No. 46/119 of 17 December 1991

²⁹ Crowley, F. (2003) *Mental Illness – The Neglected Quarter*, Dublin: Amnesty International (Pg11); both of these Conventions have been ratified by Ireland.

³⁰ MI Principle 2

Admission as an Involuntary Patient – Section 25

In the Mental Health Act, other than where the HSE is involved, the voluntary admission of children appears to lie solely with parents, or a person acting in *loco parentis*. It therefore seems possible for children to be admitted and detained against their will, despite being competent to make their own decisions.

It also appears that children are denied the protection afforded to adults under the 2001 Act. Section 25 of the *Mental Health Act 2001* provides for the circumstances where a Health Service Executive may make an application to the District Court, for an order to refer a child to an in-patient facility.³¹ Under section 25(3) and (4) there is provision for children to be admitted on the application of the HSE to an approved centre by order of the Court without any examination by a Consultant Psychiatrist, where the parents or guardians refuse consent to such examination or cannot be found. It is only after admission that the Health Service Executive may be directed, by the District Court, to have an examination performed by a Consultant Psychiatrist, to ascertain if the child is actually suffering from a mental disorder.³² The Irish College of Psychiatrists, in its views published on the new mental health legislation in 2001, stated that they found this to be a possible serious infringement of children's civil liberties.

"We view this as a possible serious infringement of children's civil liberties. In these circumstances, the provisions of the Child Care Act 1991, Section 13, subsection 7,³³ should be invoked in the first instance rather than the Mental Health legislation, where there has been no medical examination".³⁴

³¹ Mental Health Act 2001, s.25(1)

³² Mental Health Act 2001, s.25(4)

³³ Child Care Act 1991, s.13(7)(a)(iii): where a justice makes an emergency care order, he may, of his own motion or on the application of any person, give such directions (if any) as he thinks proper, with respect to the medical or psychiatric examination, treatment or assessment of the child.

³⁴ Irish Collage of Psychiatrists (2001) *Comments on the Mental Health Act 2001* [online], available: <http://www.irishpsychiatry.com/comments.html> [accessed 1st of March 2006]

Article 25 of the CRC provides *“the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement”*. While a court order under section 25(1) will be for a period of 21 days and may be renewed by the court, review of the detention by Mental Health Review Tribunals established under the Act will not be available to children; neither is the right to change to voluntary status following a period of involuntary admission.

Consent Under Section 61 – Involuntarily Admitted Children

Section 61 of the *Mental Health Act 2001* refers to the continuance of the administration of medicine to children that have been involuntarily detained under section 25 of the Act. In stark contrast to involuntarily admitted adults, no consent is necessary from involuntarily held children for the further administration of such drugs.³⁵

The UN *Convention on the Rights of the Child 1989* provides that:

*“States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.”*³⁶

Ireland ratified this convention on September 28th 1992. The provisions of the *Mental Health Act 2001* which potentially deny the right of a child under the age of 18 to express their views in matters

³⁵ Mental Health Act 2001 s. 61

³⁶ UN Convention on the Rights of the Child 1989, Art. 12.1

of admission to a psychiatric hospital and to consent to further treatment, in effect, breach the provisions of Article 12.1.³⁷

The ideal would be if a mature minor could also be afforded the opportunity to consent to psychiatric treatment (including the continuance of the administration of medicine) especially where the anomaly exists that if they were married, they would be afforded the privilege however raising the age of consent from 16 years of age to 18 years of age would appear to preclude this age group from access to Mental Health Tribunals.³⁸

The 2001 Act is deficient in not providing an effective complaints procedure. Building an efficient advocacy and complaints process into the legislation is important to ensure that the individual children and individual children's concerns and issues are not neglected.³⁹

MI Principle 21 provides for the right of every child with mental illness or being treated within the mental health services "to make a complaint through procedures as specified by domestic law." Ireland is obliged to ensure that the appropriate mechanisms are in force for the "submission, investigation and resolution of complaints."⁴⁰ A child should also have access to an independent advocate when admitted to a mental facility, when a family member is unavailable, as the MI Principles reinforce.

"Special care should be given within the purposes of these Principles and within the context of domestic law relating to the protection of minors to protect the rights of minors, including if necessary, the appointment of a personal representative other than a family member."⁴¹ "If and for so long as a patient is unable to understand such information, the rights of the patient shall be communicated to the personal representative, if any and if

³⁷ O'Neill, A. (2005) *Irish Mental Health Law*, Dublin: First Law Limited. (Pg.93)

³⁸ A 17 year old can consent to medical / surgical treatment cannot consent to psychiatric treatment. Another major issue is the lack of appropriate treatment facilities for this age group.

³⁹ Crowley, F. (2003) *Mental Illness – The Neglected Quarter*, Dublin: Amnesty International (Pg.45)

⁴⁰ MI Principle 22

⁴¹ MI Principle 2

appropriate, and to the person or persons best able to represent the patient's interests and willing to do so." 42 "A patient who has the necessary capacity has the right to nominate a person who should be informed on his or her behalf, as well as a person to represent his or her interests to the authorities of the facility." 43

It is apparent the 2001 Act is deficient in not establishing an effective complaints procedure with respect to services provided under the Act, as well as mental health service provision generally. Building an advocacy and complaints process into legislation is important to ensure that individual children and children's issues and concerns are not neglected, particularly during the process of implementing the Act. It is our understanding that the HSE has held some discussions with Barnardo's with regard to the establishment and provision of an Advocacy service, however as such we regard it a missed opportunity not to have written into the Act the building of an advocacy and complaints process into the legislation.

Human Rights and the treatment of people within proper therapeutic mental health facilities

The rights and freedoms that are guaranteed in the International Covenant on Civil and Political Rights (ICCPR), International Covenant on Economic, Social and Cultural Rights (ICESCR), and the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR), extend to everyone without discrimination, including those with mental ill health. Article 12 of the ICESCR enshrines the right to the highest attainable standard of mental health for all.

⁴² MI Principle 12(2)

⁴³ MI Principle 12(3)

The UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (the MI Principles) were adopted in 1991⁴⁴, and elaborate the basic rights and freedoms of people with mental illness that must be secured if states are to be in full compliance with the ICESCR⁴⁵. The right to *“the best available mental health care”* is enshrined in MI Principle 1(1), which *“includes analysis and diagnosis of a person’s mental condition, and treatment, care and rehabilitation for a mental illness or suspected mental illness”*. MI Principle 1(2) lays down the basic foundation upon which states’ obligations are built: that *“all persons with a mental illness, or who are being treated as such persons, shall be treated with humanity and respect for the inherent dignity of the human person”*.

In complying with the ICESCR, Ireland is also obliged to secure for all its people *“the provision of a sufficient number of hospitals, clinics and other health-related facilities, and the promotion and support of the establishment of institutions providing counselling and mental health services, with due regard to equitable distribution throughout the country”*⁴⁶.

The entitlements under Article 12 *“include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health”*⁴⁷.

⁴⁴ Adopted by General Assembly Resolution 46/119, 46 U.N. GAOR Supp. (No. 49) Annex at 188-192, U.N. Doc. A/46/49 (1991). The MI Principles apply to all persons with mental illness, whether or not in in-patient psychiatric care, and to all persons admitted to psychiatric facilities, whether or not they are diagnosed as having a mental illness.

⁴⁵ Although the MI Principles are a General Assembly Resolution and therefore not legally binding, General Comment No. 5, ‘Persons with Disabilities’, was adopted by the UN CESCR on 9 December 1994 to outline the application of the ICESCR to people with mental and physical disabilities, and recognised the MI Principles as one of the instruments to ensure respect for the full range of human rights for persons with disabilities.

⁴⁶ CESCR, General Comment No 14 ‘The right to the highest attainable standard of health’, UN ESCOR, 2000, UN Doc No E/C, 12/2000/4.

⁶ Ibid

3. In your view has the operation of Part 2 of the Mental Health Act, 2001, had any unintended consequences, positive or negative?

Unwanted Consequences

Some members of this union report that some patients do not wish to have a Mental Health Tribunal that they find the whole process intimidating and heightens their levels of anxiety. Indeed some patients have stated that the choice to proceed with a Tribunal should be left with the patient. Again if the necessary capacity legislation were in place this would perhaps enable this option.

The question of medication and seclusion was also raised, with some members recounting that on foot of the tribunal procedures and in some instances the adversarial method the admitting consultant was treated at the tribunal by members of the legal profession, they have found that dosages of prescribed medication are being reduced - whilst this might appear to be a positive consequence, our members report on the contrary that issues have arisen whereby the therapeutic dosage for ameliorating the effects of the illness are not being prescribed due to the inquisitional methods of tribunals on clinicians re high dosages of medication. In addition our members also report the decrease of seclusion for similar reasons which in their opinion are not serving the best interests of the distressed patient on some occasions.

The transfer to the Central Mental Hospital cannot take place until (a) a Mental Health Tribunal has determined that such a transfer would be in the best interest of the health of the patient concerned and (b) until the period of time for the bringing of an appeal to the Circuit Court has expired. If an appeal is made the transfer cannot take place until after the appeal is either determined or

withdrawn. In the absence of the regional intensive care rehabilitation units laid down as government policy in *Vision for Change* The time period required by the Act before a patient may be transferred to the Central Mental Hospital is causing difficulties in the approved centres. These approved centres very often do not have suitable facilities for the detention of a patient who requires treatment in the Central Mental Hospital pending his or her transfer. Containing an individual with aggressive tendencies in unsuitable environments is non therapeutic for the individual and places staff and other patients at risk, whilst all resources are directed towards containing that particular individual.

An issue also arises when patients in the Central Mental Hospital detained under the Criminal Law (Insanity) Act 2001 reach the end of their sentence but continue to require treatment in the Central Mental Hospital due to their mental disorder. Currently, such patients are transferred to local mental health services, and detained under the Mental Health Act 2001, again in the absence of the appropriate therapeutic facilities and safeguard these individuals this is placing extra burdens on all staff within these units and not conducive to international standards of best practice.

Other difficulties mentioned as discussed previously include, scheduling of Mental Health Tribunals; claims of an adversarial approach by some legal representatives; disruptions caused by visits to centres by legal representatives and second opinion consultants; access to independent second opinion assessment reports prior to the Mental Health Tribunal occurring; and uncertainty over who is responsible for sending forms to the Commission. It is also suggested that procedures for informing patients and service providers of Mental Health Tribunal decisions are unclear.

4. 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?

Procedures

There is also some concern expressed re the high level of revoked admission orders that do not progress to a Mental Health Tribunal. Sometimes this leads to an earlier discharge than is warranted. Also there is considerable disruption in day to day running of services which can arise from the late notification of Mental Health Tribunal hearings replacement of staff etc.

Mental Health Tribunal hearings should take place at the earliest possible opportunity and that all necessary arrangements should be made to facilitate this.

The provision of a Mental Health Tribunal hearing as soon as possible after an involuntary admission is made will reduce the number of admission orders that are revoked prior to the tribunal hearing, facilitate better spacing of any second Mental Health Tribunal, alleviate difficulties experienced by both patients and service providers and minimise disruption to services. The Mental Health Commission and service providers should work together, on an ongoing basis, to ensure optimal collaboration in relation to the Mental Health Tribunal process. It is also considered necessary that patients and their legal advisors have earlier (than the 14 day time period) access to the second opinion reports prior to hearings

It was also suggested that the 21 day timeframe for the reviewing of renewal orders is creating operational difficulties and distress associated with the anticipation of Mental Health Tribunal hearings. A patient admitted will have their admission order (which is valid for 21 days) reviewed by a Mental Health Tribunal within 21 days. If the patient is then the subject of a renewal order (valid for three months), a second Mental Health Tribunal must take place within 21 days of the renewal order being made.

5. 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?

Roles

We have had some concerns regarding the clarification of the role of the R.P.N. at Mental health Tribunals, in some instances staff have referred to their perceived role by some Tribunal members as that of a custodial one. This is unacceptable and jeopardises the therapeutic relationship between the nurse and service user

Removal of persons to an approved centre (Section 13)

With regard to the matter of persons who are being involuntarily admitted and who are being provided with an escort by the National Assisted Admissions Service. This agency is not in a position to itself identify the person for admission. When an application is made, the responsibility falls to the Clinical Director of the relevant service to provide an escort, if a request has been made. In some reported instances the responsibility to identify the individual is being placed on members of this union. This is unacceptable in areas where staff have overwhelmingly balloted against being part of assisted admissions procedures and then subsequently being compromised both jeopardising the existing therapeutic relation they may have with the individual and placing them at risk. The Mental Health Commission must address this issue.

Clarification has been requested with regard to holding people in A& E departments' i.e. a place other than an approved centre prior to the arrival of assisted admission teams. An Instance has been reported whereby an admission was deemed unlawful as A& E is not an approved centre, indeed the patient was discharged and staff were asked to inform the

Gardai to subsequently identify the patient to Gardai so they could arrest him and take him to begin the admission procedure again. This is hardly a dignified way to treat any individual and it would seem roles and responsibilities are clearly ad hoc in this regard. Quite rightly the patient refused to be picked up by Gardai as he was not a criminal and he subsequently presented that day for voluntary admission.

Members have also expressed concern that individuals are being accompanied onto the units not only by the assisted admissions teams but often by Gardai who handcuff the individual, some of these patients are not considered violent by members of this union who are familiar with the patient over a period of time. This would seem excessive manpower and lack of communication amongst the individuals involved at the very least not to mention the undignified response for the individual. Roles and responsibilities of members of the Garda Síochána and staff of the approved centres require further review.

Roles and responsibilities in relation to resources and their impact on the legislative framework

The Psychiatric Nurses Association continues to identify the urgent need to address the mental health care needs of individuals, families, and groups to improve their access to, and attainment of, quality mental health care in a variety of settings and environments. The essence of any service provision and care for this most vulnerable of care groups must combine the concepts of rights and responsibilities with a systematic transparent roll out of the necessary resources and structures so desperately needed for the mental health services in this jurisdiction. No amount of legislation is going to be better than having the right amount of people with the right training and the right skills to engage people who are suffering from severe mental illnesses.

The 2001 WHO annual report recommended *“the comprehensive and widespread availability of “a full range of therapies considered essential to modern psychiatric care: psychotherapy, psychosocial*

rehabilitation, and vocational rehabilitation and employment.” The Irish College of Psychiatrists (2003) agreed: *“Psychotherapy and psychological treatments are not alternative therapies but should be available as part of a comprehensive mental health service.”* Yet, in primary, community and in-patient care, there is widespread over reliance on medication alone as therapy, because the range of other therapies and therapists is not available. It has been observed that *“gaps in the range of services and professionals providing these services, has resulted in uneven and restricted availability of psychotherapy and other interventions”*. Keogh (2003)

The Commencement of the Health Act 2004 in January 2005⁴⁸ introduced major changes to the management and organisation of the publicly funded health services, including mental health services. There is now one single organisational structure for health services - Health Service Executive (HSE) and services are delivered locally through the local health office (32). Public health services are now administered by 32 local health managers located within HSE West, HSE South, HSE Dublin Mid-Leinster and HSE Dublin North East. This is in contrast to the previous administration of 10 health boards, with one CEO for each health board. Each catchment now has a local health manager (LHM) who is responsible for all health services, including mental health. Each region has lead LHMs with strategic responsibility for adult mental health, disability services and child and adolescent mental health services.

However this new structure is not without its criticisms with regard to management and governance not least again by the Inspectorate of Mental Health Services in 2006

..... “mental health occupies only a small fraction of all health services and must compete for attention and resources along with all other health services. Without strong senior management and leadership at catchment level the needs of the mental health services are not represented. Each LHM area seemed to operate in isolation from its neighbours, even where resources should be shared in order to provide equality of access.” Mental Health Commission (2007).

⁴⁸ Health Act 2004, s6: Health Act 2004 (Establishment Day) Order 2004 (S.I. No. 885 of 2004).

It seems the Inspectorate encountered difficulties with decisions regarding funding, allocation of resources and staffing, which were made, at times, without reference to needs identified by senior management teams. Very few services had any five-year plan; most were operating from a yearly business plan from which they had little expectation of any results. In some areas, the Inspectorate had difficulties in obtaining information on sector size and staffing of community mental health teams, with information still incomplete at the time of the report. There was no evidence of a devolved budget to the services with each team responsible for the service that they provide. Many community mental health teams and sub-speciality teams were unaware of the cost of delivering their service. While there is a commitment to increase funding to the services; clearly problems pertain with regard to management and allocation of monies particularly in specialty areas

There is still a requirement to train/ recruit large numbers of health specialists and personnel to meet the staffing resource required to implement the recommendations of International and National policy.

The absence of fully developed Community Mental Health Teams CMHTs increases the likelihood of an individual's mental health deteriorating to such an extent that s/he needs in-patient admission.

It is vital that adequate budget contingency should run parallel with policy and legislation.

Resources Children

The UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care set out standards of care to be observed in psychiatric hospitals – underfunding heretofore has brought the standards of facilities in **all** Irish mental health services across the spectrum into question. Moreover funding has not been distributed effectively or according to need. This applies in particular to child & adolescent mental health services.

Ireland ratified the UN Convention on the Rights of the Child (CRC) in 1992, and made a commitment to respect the rights of children less than 18 years of age provided therein. The CRC represents binding minimum standards, not aspirations or high ideals, and requires special endeavours from

Government to prioritise the rights of children. A holistic approach to the development of the child is central to the CRC, and its rights provide a framework within which Government policies and laws can be judged, with the best interests of the child placed centrally. Ireland is therefore obliged under the CRC to provide a comprehensive regime to promote mental well being, and identify, treat and protect children with or at risk of mental ill health. In addition under the CRC, children should be treated in a manner that takes into account the needs of persons of their age, and should not be detained in adult facilities unless it is considered in their best interests to do so. Article 24(1) obliges Ireland to provide *“facilities for the treatment of illness and rehabilitation of health”* and *“strive to ensure that no child is deprived of his or her right of access to such health care services”*.

The *UN Principles for the protection of persons with Mental Illness and for the Improvement of Mental Health Care* states that *“all persons with a mental illness, or who are being treated as such persons , shall be treated with humanity and respect for the inherent dignity of the human person”* (Office of The United Nations , 1991; Principle1)” Prior to that, the United Nations International Covenant of Economic, Social and Cultural Rights (1966; Article 12) articulated *“the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”*. .This PNA poses the question: *“How can the treatment of children in institutional settings designed for adults constitute inherent dignity of the human or be considered as contributing to attaining the highest standard of mental health?”*

The Code of Practice relating to Admission of Children under the Mental Health Act 2001 was issued by the Mental Health Commission on 1st November, 2006 The code of practice emphasises that the best interests of the child shall be the principal and overarching consideration, in light of the present facilities one year after the operation of part 2 of the Act this clearly is not the case and still the roles and responsibilities of the relevant authorities under the Act i.e. Health Service Executive and the Department of Health & Children are not being adhered to .

The Mental Health Act is only one step in a process of the reform and modernisation of mental health care in our society. There is a requirement for a commitment to properly funded resources to

adequately provide for the reality behind the paradigm of human rights in the Mental Health Act 2001.

“There is an urgent need to provide the resources and structures needed to implement the new Act..... Certainly, there is little point in having an elegant legislative framework if the resources are not in place to provide high quality mental health care to all”. Kelly (2002)

6. Have you any other views on the operation of any sections of Part 2 of the Mental Health Act, 2001? Please specify the sections.

Other Views

Non specific sections. Members have asked the question - given the lack of resources and underfunding of mental health services

- **Where is the funding coming from in relation to costs of tribunals coming from?**
- **Is that spending been taken from the overall mental health budget spend?**

To Conclude

We as a professional organisation value the opportunity to contribute to the Mental Health Commission Review of the Operation of Part 2 of the Mental Health Act 2001 and are committed to progressing the agenda of equality and integration for people with mental health problems going forward. This submission takes an experiential approach pulling together a conglomeration of experiences related by our members who have direct contact with service users, and evidence from legislation outside this jurisdiction. The establishment of the Mental Health Commission and its publications and information strategies are welcomed at a time when the level of general knowledge about mental illness is meagre often referred to as “mental health literacy”. As a union we are committed to professional based interventions designed to help service users and professionals collaborate in the treatment of mental illness. However as discussed we urge the Mental Health Commission to lobby for a law that makes provisions for people who lack capacity

By raising the age of the child from 16 under the Mental Treatment Act 1945 to 18 under the Mental Health Act 2001 seems to preclude mature minors from the decision making process (although this remains to be tested). It is possible that work practices are being shaped by this untested legal grey area and that professionals are reluctant to treat mature minors certainly as inpatients because of this. The Mental Health Act 2001 challenges both law and policy developed to recognise the person with mental illness as an essential ingredient of the ethical carer / service user relation. However problems pertain with regard inclusivity of children and adolescents. Effective and tailored support mechanisms are required to encourage meaningful participation of children and adolescents in the planning, delivery and evaluation of mental health services.

The proper management of resources and a sound financial standing enables mental health services to provide sustainable, effective quality mental health care. We call on the Mental Health Commission to fix a responsibility with government to respond to the 2001 Act and mental health

policy Vision for Change by committing the necessary resources required. This organisation has already posed the question to the Minister for Health *“who is responsible for the development of our services in accordance with “Vision for Change” and who is accountable for ensuring that the additional resources promised by Government are utilised for the benefit of people some of whom are the most marginalised and at risk in our society”?*

The HSE have a statutory responsibility to ensure that the services, care and treatment facilities for some of the most vulnerable in our society are adequate and a responsibility to ensure that the monies allocated to Mental Health are being spent and where there are deficits, many of which were identified in the Vision Document, that they are rectified. There appears to be a genuine frustration and disillusionment from staff delivering the service at their lack of information and participation in planning. It is of vital importance that meaningful information is provided to staff and regular open communication to assist planning. We call on the Mental Health Commission to put the necessary pressure on the HSE and Government to fulfil its commitments to our mental health services.

