editorial

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Ireland's Mental Health Act 2001: where are we now?

SUMMARY

Ireland's Mental Health Act 2001 was fully implemented in 2006 and aimed to bring Irish legislation more in line with international standards such as the European Convention on Human Rights and United Nations Principles for the Protection fo Persons with Mental Illness. The new legislation introduced several important reforms in relation to involuntary admission, independent reviews of involuntary detention, consent to treatment, and treatment of children and adolescents. Although the Mental Health Act 2001 focuses clearly on protecting the right to liberty, it also presents significant challenges in terms of service delivery and resources within Irish mental health services.

The Mental Health Act 2001[1] was passed by the Irish Houses of Oireachtas (parliament) on 8 July 2001 and implemented in a phased fashion over the following 5 years, culminating in full implementation on 1 November 2006. The Act was designed to update and replace the Mental Treatment Act 1945 and bring Irish legislation more in line with international standards, such as the European Convention on Human Rights and the United Nations Principles for the Protection of Persons with Mental Illness.[2] The central reforms in the Act included the establishment of a Mental Health Commission to oversee standards of care and the introduction of automatic review of involuntary admission orders by mental health tribunals.[3] The legislation required that a full review of the Act be performed after 5 years and the Department of Health and Children[4] completed such a review in May 2007.

In the first instance, it is important to note that the new legislation undoubtedly affords enhanced protections for certain rights for mental health service users, especially in relation to automatic reviews of involuntary admission orders. The establishment of the Mental Health Commission in April 2002 has also drawn welcome attention to important issues of policy and practice in relation to mental health services. Notwithstanding these benefits, the review by the Department of Health and Children[4] found that both mental health service users and providers reported a range of difficulties with the new legislation. That review, combined with accumulating clinical experience, have drawn attention to a number of specific concerns in relation to the new Act, including:

(a) the conduct of mental health tribunals;
(b) consent and capacity;
(c) children and adolescents;
(d) disruptions to mental health service delivery; and
(e) resources for mental health services.

Mental health tribunals

The majority of mental health tribunals are held in order to review involuntary admission orders. If the tribunal is satisfied that the patient is suffering from a mental disorder, as defined in the Act, and that appropriate procedure was followed on admission, the order is affirmed; if the tribunal is not so satisfied, the order is revoked and the patient is discharged. A mental health tribunal must be held within 21 days if the patient is still detained, whereas if the patient is no longer detained they may choose to have a tribunal at a later date.

On 1 November 2006, when the Mental Health Act 2001 was fully implemented, there were 388 patients still detained under the Mental Treatment Act 1945 and these detention orders remained in force during the period of transition. During the first 4 months following full implementation of the new Act (November 2006 to February 2007), 451 more patients were involuntarily admitted to approved centres. During this time, 505 orders were revoked by consultant psychiatrists prior to mental health tribunal hearings; 556 mental health tribunals were held; and 83 orders were revoked by mental health tribunals (i.e. 14.9% of those reviewed by mental health tribunals). Over the course of 2007, there were 2248 mental health tribunal hearings and 256 orders were revoked by mental health tribunals (i.e. 11.4% of those reviewed by mental health tribunals).

The review of the Mental Health Act 2001 performed by the Department of Health and Children[4] highlighted several difficulties with the conduct of tribunals, including adversarial approaches by some legal representatives, disruptions to activities at approved centres and administrative uncertainties. In addition, clinical experience suggests that at least some patients experience significant difficulty understanding the

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purpose and process of tribunals. One study at special hospitals in the UK, where tribunals have been in place for longer than in Ireland, found that only 9% of patients fully understood the powers of tribunals and 56% found the process too formal.[5]

The emergence of an adversarial approach at some tribunals may be attributable to a range of factors related to both process and setting: in many tribunals, the patient is seated opposite the tribunal psychiatrist, barrister and layperson (whom constitute the tribunal). The patient's treating psychiatrist is likely to undergo inquisitorial cross-examination by members of the tribunal and the patient's solicitor, in the presence of the patient. Regardless of the formal outcome of the tribunal, it is likely that this interchange will have significant, though variable, effects on the therapeutic alliance. The Department of Health and Children's commitment to further training for tribunal members is welcome but will not address the structural issue at the heart of this problem, i.e. the courtroom-style structure of the tribunal.

The timing of mental health tribunals has also raised concerns. The review of the Mental Treatment Act 2001 by the Department of Health and Children[4] indicated that it was the practice of the Mental Health Commission to establish tribunals later in the initial 21-day period in order to minimise costs. The review, by contrast, recommended that tribunals be established as early as possible in the 21-day period in order to minimise disruptions to approved centres and allow a greater proportion of detained patients to have tribunals. This would appear more consistent with the spirit of the Act.

Consent and capacity

The Mental Health Act 2001 outlines a series of requirements for consent to treatment by involuntary patients and details specific circumstances in which second opinions from independent psychiatrists or review by mental health tribunals are required (e.g. electroconvulsive therapy and psychosurgery respectively). The majority of these provisions apply only to involuntary patients, however, and a number of submissions to the review of the Act by the Department of Health and Children[4] concerned the treatment of voluntary patients. It is apparent, for example, that there is a significant deficit in the Act in relation to voluntary patients who do not wish to leave the approved centre but do not wish to receive treatment either; the Act permits a change to involuntary status only if the individual expresses a desire to leave.

The Mental Treatment Act 2001 also raises significant issues in terms of capacity to consent to admission and treatment. Under the Mental Health Act 2001, the term 'mental disorder' includes mental illness, severe dementia and significant intellectual disability. An individual can be detained under the Act if they fulfil the criteria for mental disorder, pose a risk or demonstrate substantially impaired judgement and refuse voluntary admission. There is significant concern, however, about the position of individuals who lack the capacity to consent to voluntary admission but do not fulfil criteria for involuntary admission.[4] The Irish Law Reform Commission, among others, has recommended the enactment of capacity legislation and, although such a move has broad support in principle, it is critical that capacity legislation takes account of the existing provision of both the Mental Health Act 2001 and the Criminal Law (Insanity) Act 2006.

Children and adolescents

The Mental Health Act 2001 defines a child as anyone under the age of 18 years, other than a person who is or has been married. The Act makes no distinction between children and adolescents. There are separate involuntary admission procedures for children centred on application to the district court by the Health Service Executive (Ireland's public healthcare provider), generally following expressions of concern by parents or guardians. In Ireland, many general adult psychiatry services have traditionally catered for the needs of adolescents aged 16 and 17 years, owing to profound deficits in psychiatry services for children and adolescents. Although the implementation of the Mental Treatment Act 2001 has, in theory, placed responsibility for 16 and 17 year olds firmly with child and adolescent psychiatrists, in practice many general adult psychiatry services have continued to cater for this group, pending the establishment of adequate child and adolescent psychiatry services.

This is a significant problem: in 2007, 193 children were admitted to adult psychiatry centres in Ireland, including children as young as 13 years.[6] In recognition of this reality, the Mental Health Commission has published a code of practice relating to the admission of children to approved centres designed for the treatment of adults. The legal implications of admitting children to approved centres for adults, however, have not yet been fully explored. It is to be hoped the clear definition of a 'child' in the Mental Health Act 2001 will expedite the provision of adequate psychiatry services for children and adolescents in the very near future.

Disruptions to mental health service delivery

The Mental Health Act 2001 places considerable additional clinical and administrative duties on many mental health service providers, including consultant psychiatrists. Additional responsibilities include filling out a large number of additional forms, preparing for and attending mental health tribunals, liaising with solicitors and psychiatrists providing second opinions, and teaching trainee doctors and others about the new legislation and codes of practice. There is particular concern about the quantity of additional work involved in preparing for and attending mental health tribunals, which can be unpredictable in timing, nature and duration.

It is clear that mental health tribunals play a crucial role in delivering key benefits of the new legislation, especially in relation to the protection of the right to freedom for involuntary patients. It would be regrettable,

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however, if this were to occur at the expense of voluntary in-patients and out-patients and if, owing to preoccupation with the administrative demands of mental health tribunals, there was a diminution of consultant psychiatrist attendance at out-patient clinics, team reviews, family meetings, supervision sessions and educational activities. Increased delegation of these activities to trainee doctors, combined with reduced time for supervision, would result in a significant diminution of both quality and quantity of services provided to patients who voluntarily engage with services. This was a key issue for psychiatrists prior to full implementation of the Act[7] and it remains a matter of significant concern.

In comparative terms, it is instructive to examine the experience in Scotland, where, following the introduction of the Mental Health (Care and Treatment) (Scotland) Act 2003, fewer patients were involuntarily detained but those that were detained were more likely to progress to longer-term detentions.[8] In addition, 65% of psychiatrists in Scotland felt that care for voluntary patients had suffered as a result of the new legislation; 52% did not consider the tribunals to be better than the pre-existing court system; and 59% felt that their own out-of-hours workload had increased as a result of the new legislation.[9] The disruption to care for voluntary patients in Scotland was also highlighted by patient groups[9] and is likely to present similar cause for concern in Ireland.

A further factor contributing to disruption of mental health service delivery following the introduction of the Mental Health Act 2001 in Ireland is the necessity for psychiatrists to attend High Court appeals in relation to the Act. In the first year following full implementation, there were 30 relevant cases filed under Article 40.4 of the Irish constitution, which empowers the High Court to examine whether an individual is being detained in accordance with the law; 15 such cases resulted in written judgments, of which one was a Supreme Court decision. Details of these and other challenges are available on the Mental Health Commission website (www.mhcirl.ie). Again, although it is readily apparent that such appeals form a crucially important part of the legislative structure of the Act, it is also important to note that they are likely to result in considerable absences from clinical duties for psychiatrists.

Resources for mental health services

The Mental Health Act 2001 undoubtedly represents an important improvement in the protection of the right to freedom for involuntary patients. Notwithstanding these benefits, the issues outlined above reflect significant concerns that have emerged since the Act was implemented. Many of these concerns had been expressed prior to full implementation, especially in relation to effects on the therapeutic alliance, increased administrative activity and implications for service delivery.[7,10] In addition to these central concerns, however, the review by the Department of Health and Children[4] also highlighted a broad range of other issues, including the availability of 'authorised officers' to instigate involuntary admissions, the role of the police in involuntary admissions, transfers between hospitals, management of patients who require forensic admission and the composition of the Mental Health Commission.[4] The majority of these issues are likely to prove soluble within the provisions of the Act or with slight amendments. The development of solutions to the more substantive issues raised by the Act (e.g. impact on service delivery), however, is likely to be severely hampered by the overall level of resources available to mental health services in Ireland.

It has been apparent for many years that Irish mental health services are inequitably resourced and, in many areas, substantially underdeveloped.[11–14] Particular concerns have focused on services for children and adolescents, and facilities for adults with serious mental illness and difficult to manage behaviours. The need to provide psychiatric intensive care units for the latter group was recognised in 1984 in a policy document entitled *The Psychiatric Services – Planning for the Future*,[15] but these were never built. An urgent need for 'intensive care rehabilitation units' was emphasised again in 2006 in *A Vision for Change*[16] and is now clearly established in both the professional[17] and public media.[18]

It would be regrettable if the implementation of the Mental Health Act 2001 were to further delay these much-needed developments by disproportionately diverting attention and funding away from service development and into administrative costs for the new Act. In 2006, the non-capital allocation to the Mental Health Commission was €12 million (£8.95 million)[14] and the cost of mental health tribunals from November 2006 to June 2007 was estimated at €2.56 million (£1.91 million), with an estimated cost of €3377 (£2520) per tribunal.[19] Although there is an undeniable need for adequate funding for both the Mental Health Commission and mental health tribunals, there is an equally urgent need to match this level of funding in the delivery of mental health services. The right to freedom is certainly critical, but so is the right to treatment.

Declaration of interest

None.

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