

Mental Health Law

Expert Group Review of the Mental Health Act 2001

– Potential Implications

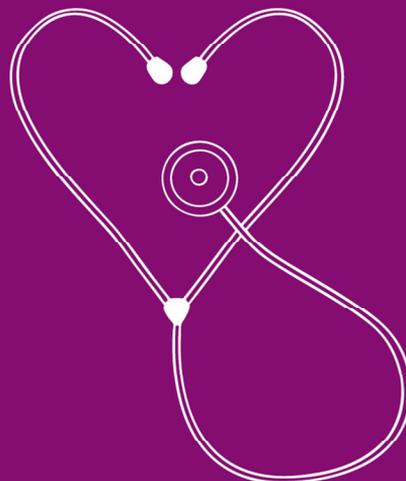
On 5 March 2015, Minister Kathleen Lynch published the Expert Group Review of the Mental Health Act 2001 and indicated that her department would draft a general scheme of a bill to reflect the Group's proposed changes to the legislation.

The recommendations are extensive and the result of a detailed and thorough review of the Act and of practice. Many embrace the rights based approach to mental health and should be, and have been welcomed, by mental health practitioners ("MHPs") and other stakeholders.

This e-zine focuses on some of the potential legal consequences of the recommendations. It deliberately seeks to challenge and test some of those recommendations.

Not to be contrarian for the sake of it, but to ensure that any legislative proposals have been well thought out and have been '*put through their paces*' before being enacted. When these proposals are made law, service users and MHPs will together have to work with them, and clinical decisions made under the Act are subject to review in the courts (whether by habeas corpus, judicial review or statutory appeal). Frequently, the key matter before the court is the legal minutiae of the interpretation of a legislative provision. MHPs and institutions are not lawyers, and they have to operate the procedures laid down in legislation on a day to day basis without a lawyer at the bedside. It is crucial therefore that any provisions that are potentially unclear, or that may present significant clinical challenges, are debated well in

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advance of any draft legislation, so that all stakeholders, including service users and MHPs, can have confidence in any new legislation.

Removal of Best Interests as a guiding principle (section 2.1)

The Group recommends the removal of the best interests of the patient as a guiding principle. The 2001 Act includes best interests as the principal consideration. The motivation for this change is the perhaps well founded concern that the concept of best interests has been interpreted by the courts in an overly paternalistic manner. The ill that the Group seeks to cure is not the concept of 'best interests' per se; it is the interpretation of same in a paternalistic and heavily objective manner.

The reformulation of the guiding principles, in particular the promotion of patient autonomy is very welcome. However, the relegation of 'best interests' from principal consideration to complete omission is a very significant step, and may have unforeseen and unwelcome legal results. Consideration should be given to better defining the term 'best interests' (as per the Mental Health Commission's ("MHC") conclusion in their 2008 Report on the Operation of the Mental Health Act 2001 [p. 86]) and including it as a guiding principle, though not as the principal one (as per the suggestion of College of Psychiatrists of Ireland).

Definition of Mental Illness (section 2.2)

The Group recommends the following definition of mental illness (which will be separated from the criteria required for admission):

"Mental illness means a complex and changeable condition where the state of mind of a person affects the person's thinking, perceiving, emotion or judgment and seriously impairs the mental function of the person to the extent that he or she requires treatment."

The Group recognises that mental health is 'increasingly recognised as a complex and changeable condition'. While undoubtedly true, reflecting this in a technical piece of

legislation, particularly a definition at the heart of it, may give rise to difficulties. Legislation is first interpreted literally, and the inclusion of the words 'complex and changeable' risks a cohort of patients being excluded from the operation of the legislation. If **all** mental illness is 'complex and changeable', then the words are legally superfluous. If not, there is a significant risk that a service user with a non-complex or static/stable illness will unintentionally fall outside the legislation.

Criteria for Detention (section 2.4)

The Group recommends significant changes to the criteria for detention. The existing grounds under sections 3(1)(a) ("the risk ground") and 3(1)(b) ("the therapeutic ground"), which were previously distinct (although a service user could fall within both grounds) are now effectively amalgamated. Service users must fulfill all three criteria to warrant detention:

- a. the individual is suffering from mental illness of a nature or degree of severity which makes it necessary for him or her to receive treatment in an approved centre which cannot be given in the community; and*
- b. it is immediately necessary for the protection of life of the person, for protection from a serious and imminent threat to the health of the person, or for the protection of other persons that he or she should receive such treatment and it cannot be provided unless he or she is detained in an approved centre under the Act; and*
- c. the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit the condition of that person to a material extent.*

The proposed changes may have significant consequences:

1. The Group accepted that where a service user *with capacity* refuses every treatment option offered, (c) no longer applies as they are not receiving any treatment (the Group also recommends that refuge alone cannot constitute treatment) and they must be released. The Group accepts that this poses a serious dilemma for MHPs although no proposals are offered as to how this dilemma should be resolved. If this recommendation were enacted, a competent service user detained on the basis that they pose a serious and immediate threat to themselves or others need only refuse all treatment options, in which case they will not be detainable regardless of circumstances and risk to self/others. Serious consideration must be given to whether this is in the interests of the service user or the MHPs. Consideration should also be given to the interaction between this recommendation and the other duties of MHPs, such as the duty to the patient, to others and to wider society in circumstances where such a risk exists. In particular:
 - Can the MHP simply discharge the service user with no further action?;
 - Will legislation exclude the MHPs legal liability (to the patient or others) in such circumstances?;
 - Will the MHP be obliged to inform An Garda Síochána, and what role can AGS legitimately have in such circumstances?;
 - Will the MHP be obliged to inform family members or those who may be at risk from such a service user?
2. What remains of the old 'therapeutic ground' will require that there is a *serious and imminent threat* to the service user's health (rather than the existing provision where detention can occur if a failure to admit *is likely to lead to a serious deterioration in their condition*). This change of emphasis from proactive and preventative to

reactive practice is potentially significant. There is a risk that the therapeutic advantage of early intervention, and the chance to provide *effective* treatment, may be lost to a form of clinical and legal brinksmanship where MHPs will be required to wait until the 11th hour before providing treatment to the potential detriment of service user's short term and perhaps long term health.

Capacity Assessments (section 2.6)

The Group recommends that where a MHP is of the view that a service user may lack capacity to give informed consent to the proposed admission, they must refer the service user for a formal assessment of capacity to be completed within 24 hours. The outcome of this assessment has a significant impact on how the admission proceeds thereafter, and the service user will have a right of appeal from the assessment. While the focus and centrality on an individual's capacity is to be welcomed, consideration should be given to how this may work in practice:

1. It is envisaged that the formal assessment is by a MHP with the '*required competencies*' accredited by professional bodies; if the admitting MHP has such competencies, it is not clear what the basis is for a second assessment, which may only add unnecessary duplication. The service user still retains the independent review of their detention by a consultant psychiatrist (who could also assess their capacity) together with a right of an appeal from the initial capacity assessment.
2. If it is envisaged that the capacity assessment must be performed by an external MHP (from outside the admitting institution), the requirement to do so within 24 hours may give rise to clinical dangers. Hedigan J (in CC v Clinical Director of St Patrick's Hospital (No. 2) [20009] IEHC 47), commenting on the section 23/24 re-grading procedure, stated that a requirement that the 2nd psychiatrist be independent of the admitting

institution was '*extremely impractical and even dangerous in many of the more urgent cases*'.

3. Even if performed by an MHP from the same institution, *completion* of the assessment within 24 hours will be an unnecessarily tight window in some cases. Assessments of capacity are not always straightforward as capacity can fluctuate over time, and change with various interventions.

Voluntary Patients (section 2.7 – 2.8)

Very significant changes are proposed in relation to voluntary patients to address the fact that they are currently defined in the negative (ie. a patient who is not the subject of a detaining order) and have limited or no protection or procedural safeguards in existing legislation. The Group recommends distinguishing between service users who have capacity to consent to admission, and those who do not. They recommend a variety of measures:

1. All voluntary service users (with capacity) must be provided with significant information (including their right to refuse treatment/leave the approved centre at any time).
2. The creation of a new category of service user, an '*Intermediate Patient*' who lacks capacity but does not fulfil the criteria for involuntary detention, whose admission proceeds down a different procedural pathway.
3. An '*Intermediate admission or renewal order*' must be completed in respect of Intermediate Patients' (and the MHC informed).
4. A Mental Health Tribunal (to be renamed Mental Health Review Boards – MHRBs) will review the admission (within the same period as for involuntarily detained service users) but will focus on the question of capacity and that correct procedures were followed.
5. Where an Intermediate Patient has in place a Decision-Making Representative (a circuit court

appointed representative under the yet-to-be-enacted capacity legislation), that representative may refuse treatment (including admission) on behalf of the service user. This is subject to one exception where the consultant psychiatrist may over-rule such a refusal in '*emergency circumstances where treatment is deemed necessary and the person's actual behaviour is injurious to self or others and no other safe option is available*'. Any such over-ruling would prompt a MHRB review within 3 days.

The proposed changes have some significant potential consequences:

1. The Group does not indicate whether the independent consultant psychiatrist has a role in the review of the detention of the '*Intermediate Patient*'. If the MHRB review is to be a genuine and robust review of a clinical decision, it should be informed by the views of an independent psychiatrist, who has the opportunity to assess the service user, and to comment on the assessment of capacity, which is ultimately a clinical assessment.
2. While not directly addressed by the Group, the ability (under existing section 18) of the MHRB to '*cure*' procedural defects where it does not affect the substance of the order should equally apply to the review of Intermediate admission or renewal orders
3. The definition of emergency circumstances (where the refusal of an Intermediate Patient's Decision-Making Representative can be over-ruled) should be considered. The requirement that a service user's '*actual behaviour*' be injurious to self or others is problematic for two reasons:
 - It is a higher standard than the corresponding '*risk ground*' for involuntarily detained service users, which has no apparent justification.

- Its meaning needs clarification; as currently drafted, it suggests that the service user's present behaviour must be *actively and actually* injurious and that an imminent threat of injury would not be sufficient, which would potentially pose a serious risk to patients and others. It should also be clarified whether 'injurious' applies to physical injury only.
4. For similar reasons to those given above, the MHRB review of the overruling of a Decision-Making Representative should be informed by the views of an independent psychiatrist. From a practical perspective, the 3 day window within which the MHRB must sit would be very difficult to achieve (even if an independent psychiatrist is not part of the process). For instance, such a decision taken on the Friday of a bank holiday weekend could not practically be reviewed within 3 days.

Authorised Officers (section 2.9)

Perhaps the most sweeping changes proposed relate to the role of Authorised Officers. Under existing legislation, they have a very limited role, being one of those eligible to apply for involuntary admission under section 9. In practice, they are responsible for only 8% of all Applications (a figure that has remained low since enactment of the 2001 Act). The Group proposes to radically expand their role to include the following:

1. The AO will make ***all*** Applications for involuntary admission (***including*** those made by AGS via section 12);
2. The AO will make ***all*** applications for involuntary admission after section 23 has been invoked (section 23/24 change of status from voluntary to involuntary);
3. Family/carers will be entitled to ask that a 2nd AO review the 1st AO's assessment;
4. The AO can ask for the opinion of a 2nd medical practitioner if they are not happy with the Recommendation of

the 1st medical practitioner (or lack of it).

5. The 'new' AOs will be '*experienced Mental Health Professionals*'.

The Group recognises that a detailed costing of the proposal would need to be drawn up and envisages the new legislation being rolled out incrementally to allow the new service to develop. The extent of the proposed expansion of this role will need careful consideration and planning. In particular, the following will need to be considered:

1. The interaction of the AO with others in the process leading to involuntary detention, for instance:
 - It is envisaged that the AO can refuse the request of a family/carer to make an application (subject to a 2nd opinion). This seems to insert an unnecessary additional step within an already detailed process. Under current legislation, an additional intermediate step already exists between the Application and Admission Order, namely the Recommendation of a registered medical practitioner. The Group doesn't clearly explain what value is added by the involvement of the AO at this stage.

While an AO brings mental health experience, mental health experience is provided by the registered medical practitioner who makes the Recommendation (to a degree), by the MHPs at the section 14 Admission Order stage, by the independent psychiatrist review stage and by the MHRB review stage. On the other hand, an AO is unlikely to have any background knowledge of a service user and their prior mental health, unlike the family/carer and in most instances, the registered medical practitioner (who will

usually be the service user's own GP).

GPs, psychiatrists and mental health nurses are)?

- Is the 2nd opinion facility only available from a decision of an AO not to make an Application, or can a family member/carer who is not in agreement seek a 2nd opinion of a positive decision?
- It appears that in the case where the AOs differ in their assessment, the 2nd AO's view is to be preferred. However, there appears to be no basis for such preferment.
- The Group proposes that once section 23 is invoked (the temporary detention of a voluntary patient), the AO will, within 24 hours, make the decision to proceed (or not) with the section 23/24 re-grading procedure. This raises the prospect of an AO, who is unlikely to have any prior clinical relationship with a service user, being in a position to effectively veto the views of a service user's consultant psychiatrist (or other MHP), which seems inappropriate and unsafe. As completion of the existing section 23/24 process already requires a second consultant psychiatrist (followed by MHRB review), it is uncertain what added value the AO will bring to this stage of the process.

2. Given the proposed extensive and critical role of the AO, its legal position will need to be considered, and appropriate measures put in place. For instance:

- Are the decisions of the AO judicially reviewable?
- How will the AO be indemnified?
- Will the AO be professionally regulated (in the manner that others in the chain such as

Involvement of multidisciplinary team in involuntary admissions (section 2.10)

The Group recommends that at the time of making an involuntary admission the consultant psychiatrist must consult with at least one other mental health professional of a *different discipline*, which must be recorded. However, ultimate decision making authority will rest with the consultant. It is to be assumed that is a reference to another practitioner such as a mental health nurse, or psychologist, or an occupational health practitioner (or other professional), which is welcome and likely reflects what occurs in day-to-day practice.

Patients first requiring medical treatment (section 2.11)

Of particular reference to acute (non-psychiatric) Hospitals, the Group recommends certain safeguards where a service user requires (physical) medical treatment prior to admission at an Approved Centre:

1. This can only occur where sanctioned by the registered medical practitioner (who made the Recommendation), the Clinical Director or the Consultant Psychiatrist acting on the CD's behalf. As an emergency measure, its use should be widened to include any MHP (or at least a psychiatric Registrar) to ensure that in circumstances where a medical emergency becomes apparent on arrival to an approved centre perhaps overnight, no delay is experienced waiting for the Clinical Director or the Consultant Psychiatrist before ensuring access to appropriate emergency medical intervention.
2. In such circumstances, the Admission Order must be completed within the same timeframes (ie. within 24 hours of arrival to Hospital).
3. Responsibility for the care of the service user remains with the CD of the Approved Centre.

Mental Health Tribunals (section 2.13)

The Group recommends a variety of measures with regard to MHTs (including their renaming as Mental Health Review Boards). Of particular note:

1. The 21 day period from Admission Order to MHRB review should be shortened to 14 days (subject to further extension by the MHRB where necessary).
2. The independent psychiatrist must (a) review the service user (and consult with the consultant psychiatrist and another MHP of a different discipline) in the 5-7 days prior to the MHRB sitting and (b) provide their report in the 24 hours prior to the MHRB sitting.

Before any such tightening of timeframes is legislated for, it is important to ensure that adequate resources are in place, particularly where it is envisaged that MHRBs (and independent psychiatrists) are to take on additional roles.

3. The 'lay member' or 'community member' on the MHRB must not and must never have been a psychiatrist, lawyer or MHP; while the intention is that the 3rd member of the MHRB 'bring something different' to the MHRB, the consequences of losing ex-MHPs as lay members should be carefully considered, particularly whether this may have an impact on those willing to act as lay members and the possible consequences of the loss of mental health experience and knowledge these members bring.

Appeals to the Circuit Court (section 2.16)

The Group recommends that:

1. The sole basis of appeal remains whether the service user has a mental disorder (at the time of the appeal);
2. The onus of proof switches to the Approved Centre itself (rather than

the service user, as is the case now)

3. The Approved Centre, as the detaining authority, should be the legal Respondent in such cases (while the Mental Health Commission/Tribunal should be a Notice Party)

From a practical perspective, this change would have a number of potential consequences:

1. The switching of the onus of proof places a higher responsibility on MHPs to establish that the service user suffers from a mental disorder;
2. If the Approved Centre is the legal Respondent, the current situation whereby the MHC and their lawyers 'present' the case and consult with practitioners prior to their evidence is unlikely to continue. The Approved Centre will be required to arrange their own legal representation (if desired);
3. The Approved Centre, as legal Respondent, is more likely to have an award of legal costs made against them if the service user is successful in their appeal.

Section 23/24 re-grading procedure (voluntary to involuntary patient) (section 2.17)

In addition to the involvement of the AO in this process (as discussed above), the Group also recommends that:

1. It should no longer be a requirement that a service user indicate a wish to leave the centre (reflecting the judgment of Hogan J., in *KC v Clinical Director of St Loman's Hospital*);
2. After section 23 has been invoked by a MHP, and an AO has made an application for an involuntary admission within 24 hours thereof, a *registered medical practitioner* (who is not the owner/agent/employee of the centre) should assess the service user within 24 hours of the AO's application and determine whether

a Recommendation should be made. Thus, the proposed changes effectively results in all of the section 9, 10, 11 and 14 procedures being applied to the section 23/24 re-grading procedure. It is not clear whether the second stage (whereby the consultant psychiatrist responsible for care and treatment either discharges or arranges for examination by another consultant psychiatrist) and third stage (assessment by another psychiatrist) of the current section 23/24 procedure will still be required, or whether the final stage simply involves an admission order by one consultant psychiatrist. This latter point will need to be clarified.

On the face of it, affording voluntary inpatients the same procedural safeguards as persons in the community seems logical but it may have some unintended negative consequences:

1. As there is no requirement for this *registered medical practitioner (RMP)* to have any psychiatric background (or knowledge of the service user), it is difficult to see how it will add value, particularly if it replaces the role of the second consultant psychiatrist.
2. The requirement that the RMP – who must assess the service user within 24 hours of the AO's application – must not be an employee/agent of the relevant approved centre is potentially dangerous and is in apparent conflict with existing High Court jurisprudence. Hedigan J. has described section 23/24 as '*emergency provisions*' and described any requirement that the second psychiatrist involved in the section 23/24 process be independent of the approved centre as '*extremely impractical and even dangerous in many of the more urgent cases*' (CC v Clinical Director of St Patrick's Hospital (No. 2) [20009] IEHC 47).

Electro-Convulsive Therapy (section 2.19)

The Group recommends that ECT cannot be administered to a competent service user in the absence of consent. While most of the recommendations of the Group will be considered as part of a wider review of mental health legislation, and will not be expected to become law for perhaps years, the Minister has indicated that this proposal will be the subject of urgent legislation this year.

ECT may still be administered where a person lacks capacity, subject to certain safeguards:

- Where a substitute decision-maker appointed under the proposed Assisted Decision-Making (Capacity) Bill authorises such treatment.

Where the decision-making representative does not give consent, ECT may only take place where it is required as a life-saving treatment, for a patient where there is a threat to the lives of others or where the condition is otherwise treatment resistant, and such ECT may then only be administered subject to approval by a Mental Health Review Board which must convene within 3 days of the decision being taken.

Conclusion

In the preface to the Group's Report, the Chair expresses his belief that the recommendations "*provide a practical and realistic way forward which can ensure that the safeguards necessary for mental health legislation are robust and fully compliant with international best practice as well as ensuring that those vulnerable people who need care and treatment get it when required*". Many of the recommendations made will receive a unanimous welcome and are long overdue. However, others need more clarity, and debate, to ensure that any new legislation secures the support of all stakeholders, is practically achievable and most importantly acts to protect vulnerable patients who need care.

Legislation of this nature, particularly involving detailed procedural requirements, will inevitably end up before the courts (as was, and continues to be the case, in respect of the 2001 Act).

Therefore, the implications of these recommendations need to be considered in some detail, particularly where they need further clarity or where there is a risk of unwelcome consequences for service users and practitioners. Proceeding cautiously is particularly important when one notes (as the Group does) that the rate of involuntary admissions in Ireland under the existing legislation compares very favourably with other jurisdictions (including England). Only 11% of the over 18000 admissions to Irish psychiatric units in 2013 were involuntary.

While many of the recommendations are to be welcomed, it is important that changes to this complex area are thoroughly examined and considered before they are enacted.

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