

GREEN PAPER  
ON MENTAL HEALTH

102095



# **GREEN PAPER ON MENTAL HEALTH**

**DEPARTMENT OF HEALTH  
JUNE 1992**

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*The cover photographs show patients and staff of the community oriented mental health service of County Wicklow.*

## FOREWORD

DR. JOHN O'CONNELL, T.D., MINISTER FOR  
HEALTH

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As a public representative and a medical practitioner I have been concerned for many years with the quality of the services we provide for persons suffering from a mental illness and the legal provisions which underpin these services. Consequently, I was very happy as Minister for Health to recommend to the Government that a Green Paper on Mental Health should be published.

I am pleased that the Government has decided to publish such a Paper to review the progress that is being made in developing a new psychiatric service as recommended in the Report of the Study Group on the Development of the Psychiatric Services, *Planning for the Future* and to identify issues which must be addressed in new mental treatment legislation.

The first part of the Green Paper highlights the unprecedented changes which have taken place in the psychiatric services since the mid 1980s. Our psychiatric services are well on the way towards the goal of a comprehensive, community oriented, integrated and sectorised service recommended in *Planning for the Future*. This approach to the organisation of psychiatric services has been endorsed by the World Health Organisation and by the World Federation of Mental Health. The Government reaffirms its commitment to complete the transformation of the services already begun. This commitment is given an added impetus by the Programme for Economic and Social Progress which identifies the following priorities for the psychiatric services to be achieved in the lifetime of the Programme:

- "the continued development of specialist assessment and rehabilitation units associated with the main acute general hospitals;
- additional places in day centres, workshops and supported hostels;
- the further development of child and adolescent psychiatric services;

- the development of community alcoholism programmes;
- the further development of alternative approaches to the delivery of psychiatric services; and
- the transfer of people with mental handicap inappropriately placed in psychiatric hospitals to the mental handicap services."

need and

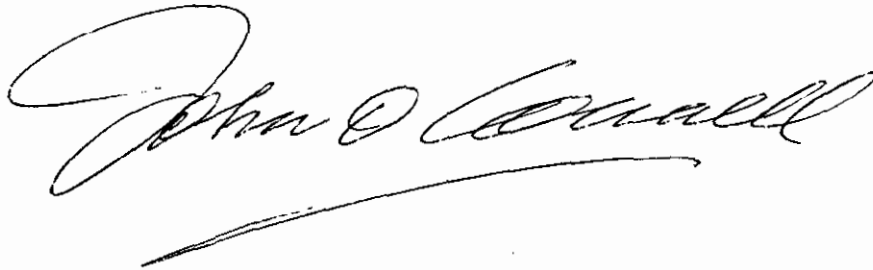
In response to the commitments of the Programme, the health boards have prepared plans to complete the reorganisation of the psychiatric services as recommended in *Planning for the Future*. These plans are currently being examined in my Department in the light of the issues identified in this Green Paper. The plans, as approved, will provide the basis for continued development of services, as resources permit.

The second part of the Green Paper is concerned with the content of new mental treatment legislation to replace the Mental Treatment Act, 1945. Many of the provisions of that Act have been overtaken by changes in psychiatry and developments in international law. The Government is committed to the principle of new mental treatment legislation which will meet our international commitments and provide a framework for the development of the psychiatric services into the next century. The Green Paper proposes how the issues which require attention might be addressed in new legislation and the Government invites submissions from interested parties on the proposals. It is the Government's intention, following extensive consultation, to announce its decisions in relation to the contents of a new Mental Treatment Bill.

The psychiatric services care for some of the most vulnerable people in our community. The contribution of the services to the quality of life of our community is not well understood. I believe that this Green Paper will inform the public of the major transformation that is underway in the psychiatric services thanks to the leadership and commitment of staff at all levels and lead to a consensus on the important issues to be addressed in new legislation.

I hope that the publication of this Green Paper will spark a debate on our psychiatric services generally and will bring the issue of mental illness into the public domain for consideration and discussion. I look forward to hearing the outcome of these discussions and, indeed, to taking part in the debate myself. I would like to assure those who wish to comment on the issues identified in this Green Paper, that

your views and opinions will be listened to and will contribute to the development of a more caring, effective and efficient mental health service.

A handwritten signature in cursive script, reading "John O. Connolly". The signature is written in black ink and features a long, sweeping horizontal line underneath the name.

Department of Health  
June 1992

# CONTENTS

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## **PART ONE — MENTAL HEALTH SERVICES**

Chapter 1	Planning for the Future — A Summary	11
Chapter 2	Towards a Comprehensive and Community Oriented Service	14
Chapter 3	Child and Adolescent Psychiatry	20
Chapter 4	Persons with Mental Handicap in Psychiatric Hospitals	22
Chapter 5	Alcohol Related Problems	25
Chapter 6	Disturbed Patients	29
Chapter 7	Forensic Psychiatry	31
Chapter 8	The Elderly Mentally Ill and Infirm	33
Chapter 9	Promoting Mental Health	37
Chapter 10	Towards a Sectorised and Integrated Service	40
Chapter 11	The Existing Psychiatric Hospitals	49
Chapter 12	The Psychiatric Service and the Consumer	51
Chapter 13	Private Psychiatric Hospitals	53
Chapter 14	Personnel Issues	55

## **PART TWO — MENTAL HEALTH LEGISLATION**

Chapter 15	Legislation and Mental Disorder	63
Chapter 16	Existing Legislation	66
Chapter 17	International Law and Principles in relation to Mental Disorder	71
Chapter 18	Criteria for Involuntary Admission	75
Chapter 19	Procedures for Involuntary Admission	80
Chapter 20	Duration of Detention	85
Chapter 21	Review of Detention Orders	88
Chapter 22	Consent to Treatment	94
Chapter 23	Mentally Disordered Offenders	98
Chapter 24	Supervision Orders	104
Chapter 25	Information, Representation and Legal Aid	108
Chapter 26	Protecting Mentally Disordered Patients	111
Chapter 27	Law and Administration	118
Chapter 28	The Next Steps	122
Appendix	International Law and Principles in Relation to Mental Disorder	125

PART ONE

# Mental Health Services



## CHAPTER 1

# Planning for the Future — A Summary

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1.1 The Study Group on the Development of the Psychiatric Services was appointed in October 1981. The terms of reference obliged the Group to

“assess existing services, to clarify their objectives and to draw up planning guidelines for future development of the service. . . .”

Early in the report, the Study Group identified the shortcomings of the psychiatric services as it found them:

“At present, the psychiatric hospital is the focal point of the psychiatric service in most parts of the country. Large numbers of patients reside permanently in these hospitals, many of them have lived there for years in conditions which in many cases are less than adequate because of overcrowding and capital underfunding. In addition, staff and public attitudes have tended to concentrate effort on hospital care as a result of which community facilities are relatively underdeveloped. The hospitals were designed to isolate the mentally ill from society and this isolation still persists.” (p xi)

1.2 In place of this hospitalised and isolated service, the Study Group proposed a service which was comprehensive, community oriented, sectorised and integrated. By “comprehensive” the Study Group meant a service which catered for the varying needs of people with psychiatric illness. The components of such a service include

- prevention and early identification
- assessment, diagnostic and treatment services
- in-patient care

- day care
- out-patient care
- community-based residences
- rehabilitation and training

1.3 The Study Group recommended that a comprehensive psychiatric service should be developed to serve the needs of a particular community and located within that community. The emphasis in such a service is on out-patient treatment and day care so that patients can continue to live in their own homes. As far as possible, there should be continuity of professional responsibility between the various services provided by the psychiatric team.

1.4 *Planning for the Future* introduced a new term to the debate on the reorganisation of psychiatric services — the sector. The provision of a comprehensive psychiatric service to a population within a geographic boundary was defined as a sectorised service. A multi-disciplinary psychiatric team would be based in each sector, with a recommended population of 25 — 30,000.

1.5 The Study Group recommended that psychiatric services should be integrated with general practitioner, community care and voluntary services. It recommended that in-patient treatment for all admissions should be provided in psychiatric units in general hospitals.

1.6 The Study Group warned that “psychiatric hospitals must not become forgotten places”. The Group emphasised the need for rehabilitation programmes for those who are not suitable for discharge to community accommodation.

1.7 It recommended a number of special services for the elderly, for children and adolescents and for persons with alcohol or drug related problems. It stressed the importance of leadership by doctors, nurses and managers to bring about the transformation of the psychiatric services. Finally, it recommended that each health board draw up a plan for the psychiatric services, with targets, objectives and timescales.

## **Implementation**

1.8 The Report of the Study Group was published in 1984. Its recommendations were accepted by Government and the Department

of Health began the process of implementation. Each health board was invited to prepare a plan to implement the recommendations of the Report. A development team was established for each health board area, involving officers of the board and officials of the Department of Health. The task of the development teams was to make progress towards the implementation of the health board plans.

1.9 In addition to the work of the development teams, there have been regular meetings between the Department and the health board officials responsible for the psychiatric services to discuss issues arising from the implementation of *Planning for the Future*. Regular meetings have also been held between the Department and representatives of the Irish Division of the Royal College of Psychiatrists, the Association of Administrative Psychiatric Nurses and the Irish Association of Social Workers to explore administrative issues relevant to the medical, nursing and social work professions in psychiatry.

1.10 In response to the commitments in the Programme for Economic and Social Progress, health boards have prepared plans to develop further their psychiatric services on the model recommended in *Planning for the Future*.

## CHAPTER 2

# Towards a Comprehensive and Community Oriented Service

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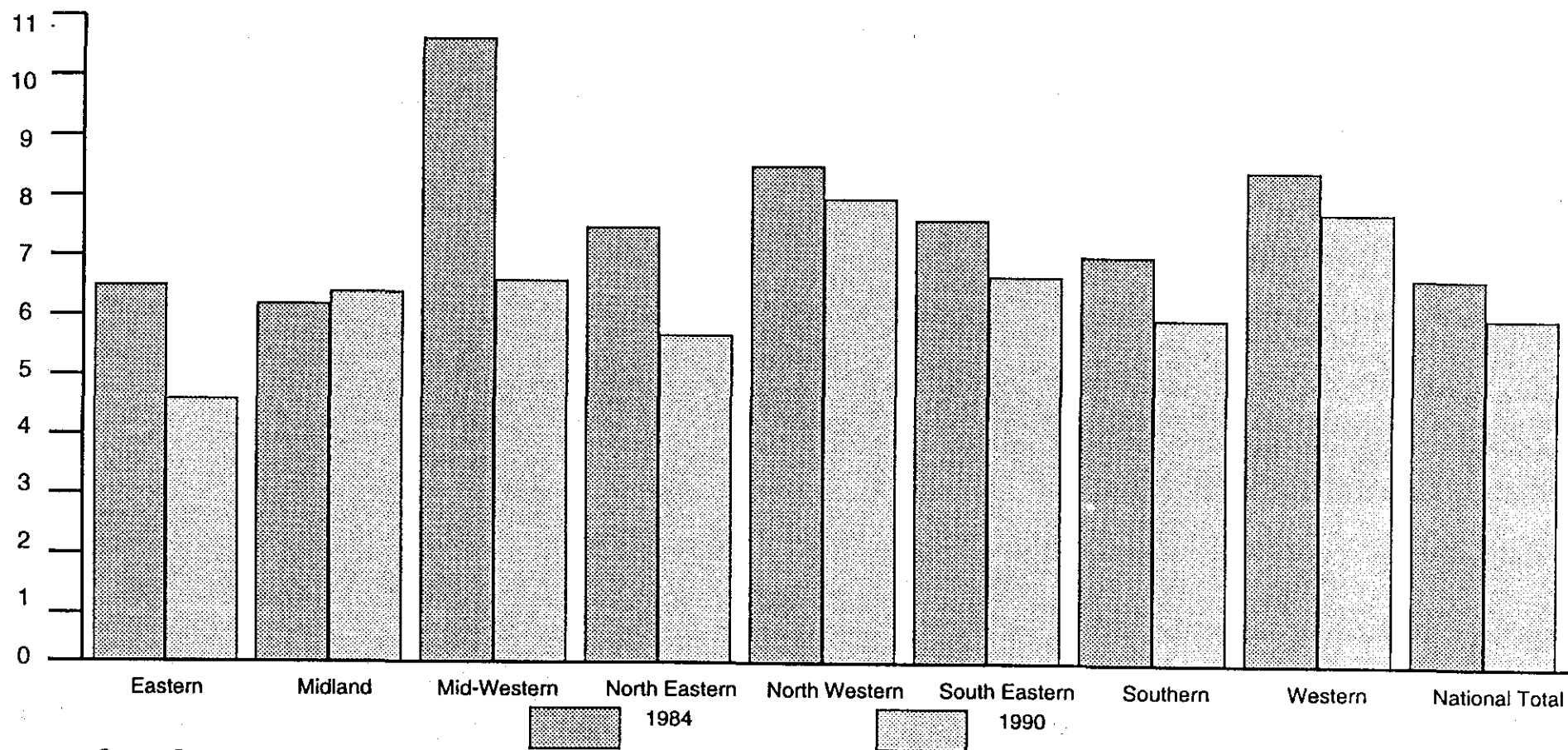
2.1 To what extent is a mentally ill person provided with a comprehensive psychiatric service that is locally based and community oriented? Is there an alternative in practice to admission to a psychiatric hospital for psychiatric treatment? In most health boards there are some psychiatric services which are comprehensive and community oriented as defined in *Planning for the Future* but such services are still not the norm.

2.2 Figures suggest that while facilities for the care of the mentally ill are increasingly to be found in the community, our services are still heavily reliant on hospital beds. The total number of admissions to public psychiatric hospitals and units in 1990 was 22,118 as compared to 28,330 admissions to the same hospitals in 1984. The rate of admission to hospital has declined in the same period from 6.2 to 5.2 per 1,000 population. Figure I compares rates in 1984 and 1990. The table highlights the reduction in admission rates and the variation between boards

2.3 The rate of hospitalisation of psychiatric patients has also decreased in recent years from 3.4 per 1,000 in 1984 to 2.0 in 1990 (see Figure 2) but our hospitalisation rates remain high by international standards. They are almost twice as high as those of France, Denmark, England and Wales. Data from the case registers maintained by the Health Research Board suggest that significantly fewer cases of mental illness are referred to the psychiatric services for specialist advice than in other countries but that once referred to the psychiatric network, patients tend to remain in its care for much longer.

2.4 On the credit side, there has been a significant increase in the number of day hospitals and day centres for the mentally ill. The function of a day hospital is to provide intensive treatment equivalent

**Figure 1**  
**ADMISSION RATES PER 1,000 POPULATION**  
**PUBLIC PSYCHIATRIC HOSPITALS AND UNITS BY HEALTH BOARD, 1984 AND 1990**



Source: Department of Health

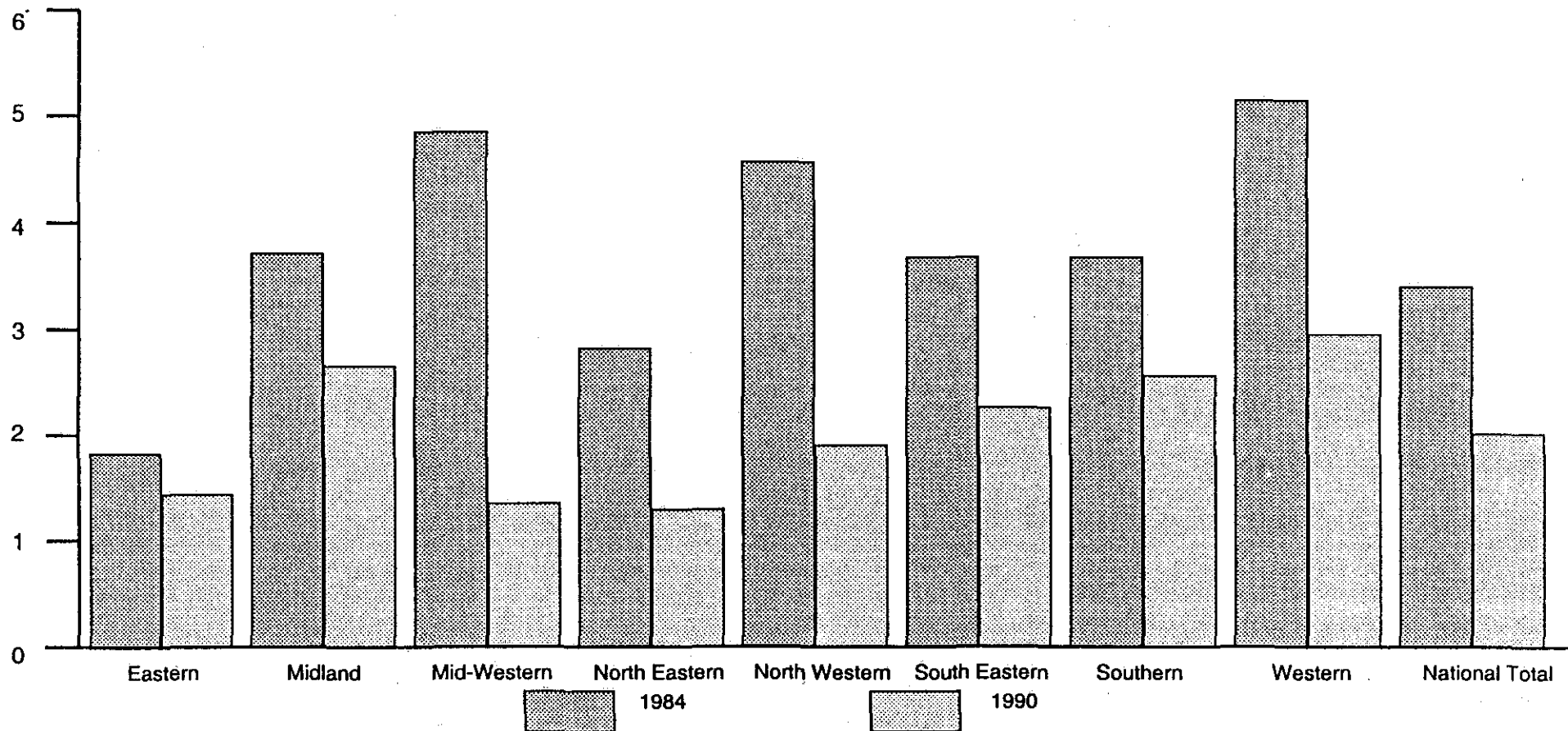
to that available in a hospital in-patient setting for acutely ill patients. Day centres provide social care (and possibly treatment) for patients who do not require the intensive services of a hospital but cannot manage fully at home. In 1984 there were 32 day hospitals and centres with 800 places. By the end of 1990, the number had increased to 97, providing 2,424 places. In some places mental health centres have been provided which incorporate a day hospital and day centre. In addition, the mental health centre may have crisis beds and facilities for out-patient consultations.

2.5 Hostels provide accommodation in the community for patients with a psychiatric condition. Patients may live a short time in a hostel or it may be their permanent home. Training hostels provide patients with an opportunity to prepare for a more independent life in the community. The number of hostels and training hostels has increased from 121 in 1984 to 292 in 1990. The number of places in these hostels has increased from just over 900 to 2,081 in the same period. The number of community residences has reached the norm of 60 per 100,000 population recommended by *Planning for the Future* for those catchment areas without an accumulation of long-stay patients.

2.6 The number of patients in public psychiatric hospitals and units at the end of December each year continues to fall. In December 1984, there were 11,613 patients in public psychiatric hospitals. The figure for December 1990 was 7,817. If the numbers of persons in psychiatric hospitals with mental handicap and those over 65 years of age are excluded from this total, the number of people in psychiatric hospitals whose primary problem is mental illness is about 3,300. The reduction in the numbers of long-stay patients — patients who have been in hospital continuously for longer than one year — has been brought about by the transfer of many patients from hospitals to the community either to independent living or to hostels, and by deaths. The level of such transfers and deaths has been greater than the number of new patients who have become long-stay in the same period.

2.7 The reduction in the number of new long-stay patients is considerable. In 1990, 333 people became new long stay patients in psychiatric hospitals compared with 541 in 1984. This change has come about because of the reduction in the average duration of stay of patients in psychiatric hospitals. For example, eighty six per cent of patients discharged in 1988 had spent under one month in the hospital.

**Figure 2**  
**HOSPITALISATION RATES PER 1,000 POPULATION**  
**PUBLIC PSYCHIATRIC HOSPITALS AND UNITS BY HEALTH BOARD, 1984 AND 1990**



Source: Department of Health

2.8 The picture which emerges from these figures is of a psychiatric service in which the psychiatric hospital still plays a major role but a role which is diminishing and changing. Day and community facilities are providing an alternative to long term care in psychiatric hospitals. Their effect can be seen in the continued fall in the number of patients in psychiatric hospitals and the reduction in the average duration of stay.

2.9 In terms of priorities for the future, it is clear that the momentum to provide additional community facilities must be maintained, particularly in areas which are still far from meeting the norms for community services recommended in *Planning for the Future*. The variation in admission rates to psychiatric hospitals suggests that there is an urgent need to review admission procedures in some in-patient facilities. Health boards have shown that it is possible to achieve an admission rate of 5 persons per 1,000 population. In the longer term it should be possible to achieve a rate of 3.5 persons per 1,000 population, provided sufficient community facilities are available. A rate of 5 per 1,000 would reduce admissions to about 17,000 a year; a rate of 3.5 would reduce admission to 13,000 a year. It is recognised that a number of factors, some of which are not well understood, will influence the speed at which these rates are achieved. For example, higher than average admission rates may occur following the discharge of long-stay patients from hospital to the community as such patients may experience difficulty in adjusting to a new environment. As the number of psychiatric units in general hospitals increases, the number of admissions may tend to rise because there is less stigma attached to such an admission. The expansion of community facilities may bring more cases of mental illness to light which may require hospital admission.

2.10 It is also necessary to ensure that as many existing long-stay patients as possible are transferred to alternative community settings. The psychiatric services must provide these patients with the social skills to cope with everyday life in the community. The availability of housing for hostels and group homes is also crucial to the successful transfer of long-stay patients from hospital. With the co-operation of some local authorities and the Mental Health Association, health boards have provided an impressive range of hostel accommodation for psychiatric patients. The continued co-operation of local authorities in what is essentially a housing function will be required if long-stay patients are to be given the opportunity of a new and better life in the community.



2.11 Chapters 3 to 9 which follow describe the service developments which are underway in relation to different client groups of the psychiatric services and the improvements which will be needed to make the services fully comprehensive and community oriented.

## CHAPTER 3

# Child and Adolescent Psychiatry

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3.1 Substantial progress has been made in the past year to develop psychiatric services for children and adolescents with additional funds made available under the Programme for Economic and Social Progress. Each health board now has or is in the process of establishing such a service. Increasing concern about the incidence of child sexual abuse and disturbed behaviour among adolescents contributed to the expansion of child and adolescent psychiatric services.

3.2 A child and adolescent psychiatric team usually consists of a consultant child and adolescent psychiatrist, a psychologist and a social worker with some administrative support. The vast majority of child and adolescent psychiatry is undertaken on an out-patient basis but there may be a need for a small number of in-patient places for acute cases. These should be located in a general hospital setting.

3.3 Children and adolescents with psychiatric problems have unique needs which cannot be appropriately met by the adult psychiatric service. Good communication is required, however, between the sector psychiatric team for adults and the child and adolescent psychiatric service in the interests of children and their parents. Because the emphasis in the treatment of child and adolescent disorders is on out-patient care and family involvement, child and adolescent psychiatry should be integrated with community care or paediatric services rather than with adult psychiatry. *Planning for the Future* recommended that the service should be firmly based in the community. A community location would also facilitate liaison between the child and adolescent psychiatric services and primary care services so that psychiatric problems in children and young people can be recognised at an early stage and appropriate treatment provided.

3.4 The early identification of potential problems will require the establishment of links between the child and adolescent psychiatric service and schools. A school psychological service in primary schools

has been commented upon in the Report of the Working Group on the Organisation of *Child and Adolescent Psychiatric Services in the Eastern Health Board Area* (1989). Such a service could in many instances intervene at an early stage in cases of learning difficulties to prevent the onset of subsequent emotional problems which would require the input of the child and adolescent psychiatric team. The Programme for Economic and Social Progress emphasises the need to identify at an early stage children suffering educational or social disadvantage, for positive intervention to support them by way of remedial teaching, guidance and counselling and the development of home/school links. The Department of Education has established a number of pilot projects to explore the contribution of a psychological service in schools which are being evaluated at present.

3.5 Child sexual abuse is a significant element in the workload of the child and adolescent psychiatric services. The number of confirmed cases of child sexual abuse has increased from 37 in 1982 to 568 in 1989. It is a difficult field which requires considerable expertise and understanding of families and children. A multi-disciplinary approach is essential due to the complex nature of cases of child sexual abuse. It is now widely accepted that, together with the community care services, the child and adolescent psychiatric team has a very important function in dealing with cases of child sexual abuse. The specialist training of the child and adolescent psychiatric team gives its members an understanding of aspects of the development of children, including the psychological factors involved which govern the child's behaviour and thinking.

3.6 It is the Government's intention to continue the strengthening of services for children and adolescents experiencing mental and emotional stress.

## CHAPTER 4

# Persons with Mental Handicap in Psychiatric Hospitals

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4.1 It has been accepted policy for some years not to admit persons with mental handicap to psychiatric hospitals unless they require psychiatric treatment. In 1981 there were 2,170 persons with mental handicap resident in these hospitals. By the end of 1990 this number had reduced to 1,432. A further 278 were accommodated in buildings on the campus of psychiatric hospitals but which are no longer part of the psychiatric service.

4.2 *Planning for the Future* referred to the inappropriateness of psychiatric hospitals for the care of persons with mental handicap, most of whom were not mentally ill. It also recognised their special and distinctive needs. The report recommended that their care should be separated from that of the mentally ill. At the end of 1990, 951 of the 1,432 persons with mental handicap in psychiatric hospitals were in separate accommodation. In some cases health boards, with the agreement of the Department, have separated the care of the mentally handicapped entirely from the rest of the hospital in separate or de-designated units and transferred responsibility for their care to the community care programme which is responsible for mental handicap services generally in the areas concerned. De-designation is planned in a number of other hospitals.

4.3 The Report of the Review Group on Mental Handicap, *Needs and Abilities — A Policy for the Intellectually Disabled* (1990) endorses this policy and recommends that the Department of Health, in consultation with the health boards and the regional mental handicap co-ordinating committees, should establish a planned programme for the transfer of people with mental handicap for whom it is appropriate from the psychiatric services to mental handicap centres. It is estimated that at least two thirds of the

mentally handicapped population in the psychiatric hospitals do not need full-time psychiatric care.

4.4 More needs to be done to improve the quality of care of people with mental handicap in the psychiatric hospitals. Standards of accommodation need to be improved. Personalised clothing and individual space should be provided for all patients. Activation programmes suited to the needs of each person should also be available. Staff responsible for patients with mental handicap should be offered training in modern skills of caring for such persons. Appropriate programmes need to be put in place to prepare those who are suitable for a transfer to services for the mentally handicapped.

4.5 Better liaison between the psychiatric team and the mental handicap service is required to improve services for people with mental handicap who are also mentally ill or have behaviour problems. Mental handicap centres will only be able to care for disturbed clients if they have sufficient staff trained to cope with mental illness and the assistance of the psychiatric team. Psychiatrists have an important consultation role when a person with mental handicap develops psychiatric illness or disturbed behaviour. Whether this consultation role can best be provided by the sector psychiatric team or by a psychiatrist in the mental handicap services is a matter for discussion and resolution, depending on the prevailing circumstances, in each health board area. What is essential is that arrangements exist in each area for the management of people with mental handicap who are disturbed, which ideally should take place in a mental handicap centre.

4.6 The transfer of a considerable proportion of persons with mental handicap currently in psychiatric hospitals to services for the mentally handicapped, preferably in the community, is referred to in the Programme for Economic and Social Progress. This transfer is necessary to improve services for the clients concerned and to maintain the momentum for change in the psychiatric services. As part of the planning process under the PESp, a programme is being prepared to improve services for this group of people to be implemented on a phased basis. A special adviser has been appointed to the Department of Health to assist health boards in the drawing up and implementation of this programme and to facilitate liaison with the mental handicap services.

4.7 It is intended that specific proposals in relation to persons with a mental handicap in psychiatric hospitals should be agreed by the end of 1992 and that real and sustained progress can then be made in putting these proposals into practice. In the meantime, improvements in facilities and placements continue as circumstances permit. About 70 persons with a mental handicap will transfer from a psychiatric to a mental handicap setting in 1992.

## CHAPTER 5

# Alcohol Related Problems

5.1 The proportion of admissions to psychiatric hospitals for the treatment of alcohol related problems continues to be a matter of concern. In 1982 there were 7,000 such admissions, accounting for 26 per cent of the total. In 1988 the number of admissions was lower, at 6,478 or 23 per cent of the total. Figure 3 illustrates the trend of admissions for alcoholic disorders from 1982 to 1988, which shows a decline between 1982 and 1987 and a levelling off of admissions in 1988. There would appear to be scope to reduce considerably the number of admissions to psychiatric hospitals for alcohol disorders. Table 5.1 illustrates the variation in the admission rates per 100,000 population for alcoholic disorders by health board. The variation between boards in admission rates and the extremely high rates in some boards may demonstrate the scope for reducing admissions for alcoholism and the consequential need to develop alternative treatment facilities in the community.

**Table 5.1**

**Admission Rates to Public Psychiatric Hospitals and Units for Alcoholic Disorders by Health Board, 1988**

Health Board	Rate per 100,000 population
Eastern	171.2
Midland	242.8
Mid-Western	238.7
North Eastern	131.4
North Western	238.2
South Eastern	209.3
Southern	120.1
Western	255.7
Average	188.1

Source: Health Research Board — Activities of Irish Psychiatric Hospitals and Units.

5.2 *Planning for the Future* emphasised the importance of preventive measures in reducing alcohol related problems, including taxation, law enforcement, and restrictions on advertising and the availability of alcohol. The Government is particularly concerned about the problem of alcohol abuse. There is a consensus that the most effective approach to the issue of alcohol use and abuse generally and by young people in particular is to implement a comprehensive national alcohol policy. Such a policy should address such issues as the economic, social, cultural, legislative, health and educational factors relevant to alcohol use and abuse. In pursuance of this strategy, the Government requested the Advisory Council on Health Promotion to develop such a comprehensive policy. The Council is well advanced with its task. It has prepared a number of research papers on the economic, cultural and social issues associated with alcohol abuse and has completed intensive consultations with relevant groups, including youth organisations.

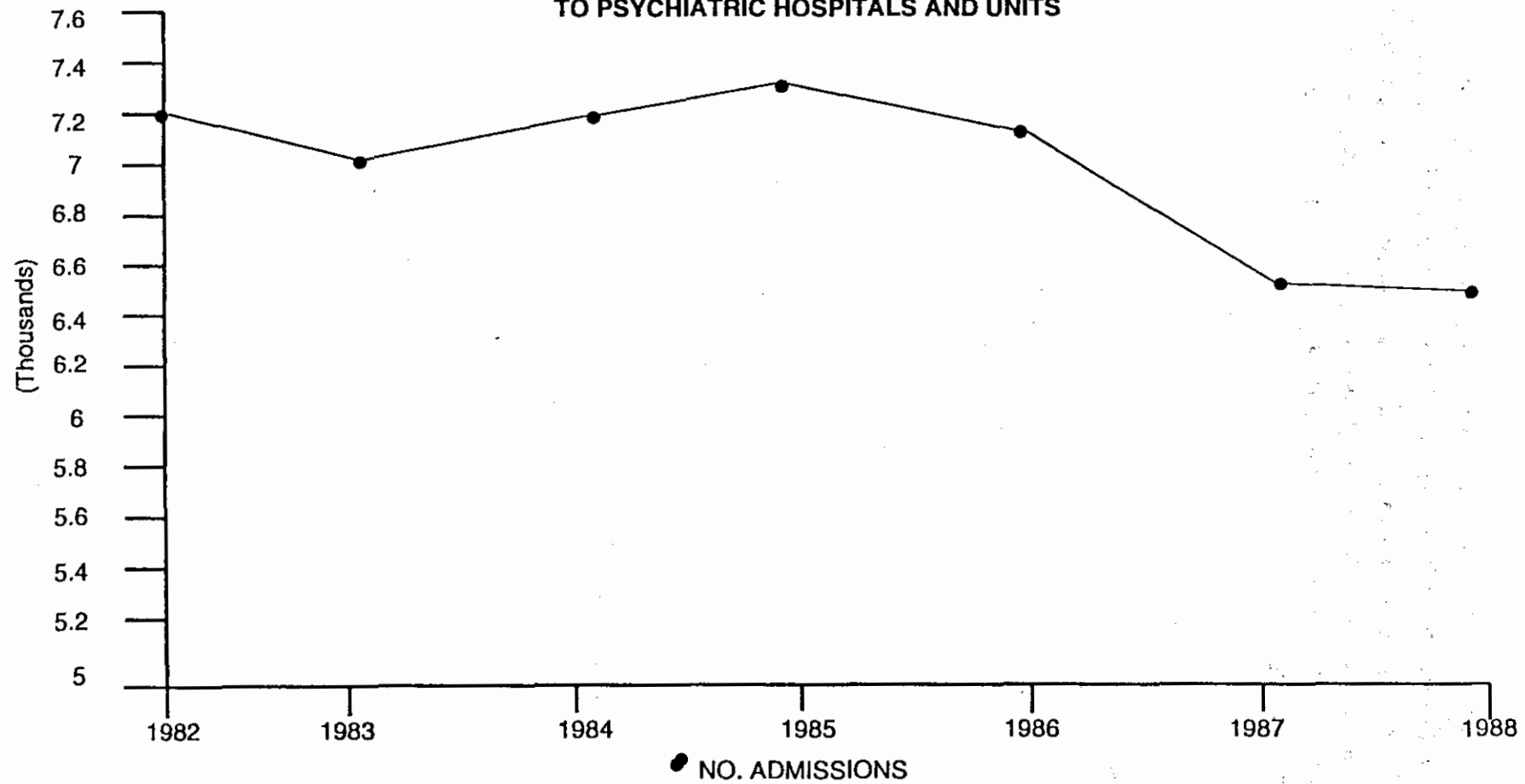
5.3 *Planning for the Future* recommended that the emphasis in the management of alcohol-related problems should be on community based intervention rather than on specialist in-patient treatment. In the intervening years, some health boards have developed local alcohol services and recruited alcohol counsellors. The available evidence suggests that these services are no less effective than hospital based programmes. There will, however, continue to be a need for detoxification facilities in hospitals and a small number of residential places for people who for social reasons, cannot benefit from day programmes.

5.4 The consultant psychiatrist has traditionally had the lead role in providing a treatment service for people with alcoholism problems within the psychiatric hospital. With the current emphasis on out-patient treatment and counselling, it is envisaged that the consultant psychiatrist will continue to have a significant function in the service but would spend more time in training other members of the multi-disciplinary team and in counselling and advising members of the primary care services. Nurses and social workers should have an important role in counselling people with alcohol related disorders.

5.5 The emerging community alcoholism service would appear to be developing separately from general practice. As with psychiatry in general, there is a need to define more clearly the role of the general practitioner and the alcoholism counsellor. The role of the specialist service should be to support the general practitioner in resolving



**Figure 3**  
**ADMISSIONS FOR ALCOHOLIC DISORDERS 1984-1988**  
**TO PSYCHIATRIC HOSPITALS AND UNITS**



SOURCE: HEALTH RESEARCH BOARD — ACTIVITIES OF IRISH PSYCHIATRIC HOSPITALS AND UNITS

problems in the context of the health of the individual and family as a whole.

5.6 As part of their plans for the further implementation of *Planning for the Future*, health boards which have not already developed a local alcoholism treatment service will be encouraged to make provision for such a service and to consider ways in which services provided by voluntary and private organisations can be integrated with health board services.

## CHAPTER 6

# Disturbed Patients

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6.1 *Planning for the Future* referred to the small number of patients who will, for a short time, require secure accommodation because of their aggressive behaviour. The number of persons for whom such provision is needed is small and the Report recommended secure units in a limited number of regional centres to meet their requirements.

6.2 Great emphasis is placed in *Planning for the Future* on individual patient assessment and active rehabilitation programmes geared to individual needs. These programmes play an essential part in restoring patients to a normal community environment and improving the quality of their lives. In the light of this approach, the Department of Health wrote to health boards in November 1987 requesting each board to review the level of locked ward accommodation within its psychiatric hospitals and to examine whether the patients currently being treated in these wards could be more appropriately managed in a more open environment.

6.3 The Department accepted, however, that there would be a continuing need for special facilities for patients with aggressive behaviour who are disruptive to the point where they are unmanageable in the acute in-patient unit or high support hostel. As an initial step in the process of providing special facilities for this category of patient, health boards were asked to investigate the possibility of designating a part of their accommodation as a special care unit to cater for such patients. A suggested bed norm of 5 beds per 100,000 population was put forward.

6.4 Health boards have adopted different approaches to the provision of secure facilities within their psychiatric service. In some areas, special care units have been set up in each catchment area which are specially designed to cope with disruptive and aggressive patients. Special training programmes have been provided for staff assigned to these units. It is the view of health board management

and the professional staff involved in these units that each catchment area should cater for its own disruptive patients. On the other hand, the designation of one special care unit in each region is the preferred option of other health boards. Some clinicians consider that the number of patients in this category is so small that a small number of properly designed, regional, secure units or one national unit should be sufficient for the whole country. There are also differences of opinion on the adequacy of the norm of 5 beds per 100,000 total population. On the basis of this norm a population of 500,000 would require a unit of 25 beds and 175 beds would be needed for the country as a whole. More research and discussion is required as to the most appropriate approach.

6.5 The Inspector of Mental Hospitals in the course of his visits to psychiatric hospitals has expressed concern about the admission criteria being applied in some instances where special care units have been established. Whatever arrangements individual health boards have in place for the management of disruptive patients, it is important that clear operational policies are worked out for these units based on:

- full integration with other psychiatric services in the area;
- strict admission criteria;
- active treatment and rehabilitation with a view to transferring patients as early as possible to more open settings.

6.6 These units should not be seen as providing long term care but rather as intensive treatment and rehabilitation units which will enable patients to be managed more successfully and which will, hopefully, lead to a reduction in the necessity for locked ward accommodation. Staff will need to be redeployed to provide the intensive staffing levels required in these units. Additional training will also be required.

## CHAPTER 7

# Forensic Psychiatry

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7.1 Forensic psychiatry is the term used to describe the specialist care of persons who are charged with or convicted of criminal offences and who are mentally ill. The Central Mental Hospital in Dundrum, Dublin provides a national forensic psychiatric service. Admission to the Central Mental Hospital is by way of:

- (a) referral from the prison service;
- (b) committal from the Courts of persons found to be guilty but insane who are detained at the pleasure of the Government;
- (c) committal from the Courts of persons found to be unfit to plead because of insanity;
- (d) transfer under Section 207 of the Mental Treatment Act 1945 from district mental hospitals.

The number of patients in the Central Mental Hospital under the above categories in March 1991 was as follows:

(a) referred from the prison service	43
(b) detained at the pleasure of the Government	11
(c) referred on court orders	14
(d) transferred under Section 207	16
Total	84

7.2 The Eastern Health Board is responsible for the administration of the Central Mental Hospital. The Board has adopted a development plan for the future operation of a national forensic service at the Central Mental Hospital. The main thrust of this plan is as follows:

- With the operation of an efficient admission and discharge policy in future, the Eastern Health Board can reduce the

number of places in the Central Mental Hospital from a current figure of 84 to about 70.

- A new 31 place secure unit on the site of the Central Mental Hospital, together with a further 40 places provided in a new extension, would form the nucleus of the service.
- The present staffing of the hospital, which comprises attendant grades mainly, will be reduced with the reduction in patient numbers and the remaining staff given training in psychiatric nursing. This process, which has already commenced, will improve the therapeutic environment of the hospital.

7.3 It will be seen, therefore, that it is the Board's intention to develop the Hospital as a properly equipped forensic psychiatric facility for persons referred from the courts and the prison service. It is also planned that the forensic service at Dundrum will develop its advisory role to all health boards in relation to the treatment and management of disturbed patients. Legal changes in the procedures for transfer of patients from psychiatric hospitals to the Hospital are proposed in the second part of this Green Paper.

7.4 There are a number of patients in the Central Mental Hospital, transferred from other psychiatric hospitals, who no longer require the specialist services of the hospital and who could more appropriately be cared for in the less restrictive environment of their local service. The Government favours the return of patients from the Central Mental Hospital to hospitals in their health board of origin where such a move is in the best interest of the patient.

7.5 The improvement of facilities at the Central Mental Hospital is essential to the future development of forensic psychiatric services in this country. A further issue arises, however, as to whether the law should be amended to give the courts discretion to refer defendants to a psychiatric hospital for assessment and/or treatment. Such a referral would arise if a defendant appeared to the court to require psychiatric care but was not pleading the defence of not guilty by virtue of insanity. The Third Interim Report of the Interdepartmental Committee on Mentally Ill and Maladjusted Persons (1978) recommended that the courts should have such powers. This issue is discussed in more detail in the second part of this Green Paper.

## CHAPTER 8

# The Elderly Mentally Ill and Infirm

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8.1 There are three distinct issues concerning the care of the elderly in the psychiatric services:

- the elderly in psychiatric hospitals
- the elderly mentally infirm
- the elderly mentally ill

### **The Elderly in Psychiatric Hospitals**

8.2 There are over 3,000 persons aged 65 years and over in psychiatric hospitals, the majority of whom have been there for a long time. Approximately 50 per cent of long-stay patients in psychiatric hospitals, that is those hospitalised continuously for one year or more, are over 65. Few of these elderly patients have an active psychiatric component to their illness but they remain heavily institutionalised. With appropriate rehabilitation, many could live in more appropriate accommodation in the community. Supervised hostels and sheltered accommodation would meet the needs of many.

8.3 An interim approach to this issue is the 'de-designation' of wards or buildings of psychiatric hospitals so that the elderly in such wards are technically no longer part of the psychiatric services. De-designation does, however, carry the risk that the elderly patients will become no one's responsibility. Before agreement is reached on a de-designation proposal, the Minister for Health must be satisfied that the change will lead to an improvement in the quality of life of the patients. It is recognised that de-designation is an interim arrangement and that the objective for these patients is to provide suitable accommodation in the community or in other facilities for the elderly.

8.4 There is a danger that as the focus of the psychiatric services moves from the hospital to the community that the elderly could be

left behind in deteriorating accommodation and that standards of care could fall. The elderly in our psychiatric hospitals must benefit from the general move to improve services for the elderly. The underlying principle of services for the elderly is to maintain people at home or in a home like environment wherever possible. The same principle must be applied to the elderly in psychiatric hospitals. Improved services for the elderly in psychiatric hospitals should be reflected in health boards' overall plans and management arrangements for the development of services for the elderly.

### **Elderly Mentally Infirm**

8.5 The elderly mentally infirm are persons suffering from dementia, of the alzheimer type or otherwise. The Working Party on services for the Elderly in its Report, *The Years Ahead — A Policy for the Elderly* (1988) drew attention to the urgent need to provide services for elderly people and their families affected by this disease. The majority of elderly people with dementia can be cared for at home with adequate home help, day care and respite facilities. The appointment of the first psychiatrists specialising in the psychiatry of old age in Dublin has emphasised the value of specialist advice and support to families, general practitioners and public health nurses.

8.6 Those whose behaviour is severely disturbed and who can no longer be managed at home require residential accommodation with varying degrees of support. These needs were traditionally met in psychiatric hospitals. The recommendation of *Planning for the Future* that the elderly with dementia should not routinely be admitted to psychiatric hospitals has been implemented by a number of health boards. However, alternative facilities need to be provided. A greater variety of accommodation for the elderly mentally infirm is needed, including facilities which provide a welfare service to those requiring constant nursing supervision.

8.7 If the recommendations of *Planning for the Future* and *The Years Ahead* concerning the elderly mentally infirm are to be implemented, psychiatrists with special expertise in the care of the elderly will have to be appointed, greater support for families provided and more specialised accommodation made available to care for people who are mentally infirm and behaviourally disturbed. Redeployment of existing posts of consultant psychiatrist will enable psychiatrists with a special expertise in the elderly to be appointed.



8.8 Comhairle na nOspidéal, the body with legal responsibility for approving consultant posts, recommended in 1985 that three posts of psychiatrist with responsibility for the elderly be appointed, two in Dublin and one in Cork. Two such appointments have been made in Dublin. The appointment of a third consultant in the Dublin area is under discussion, but no proposals have yet been received for an appointment in Cork. In view of the contribution of these specialists, there is an obvious need to make further appointments where they can be justified by the size of the elderly population. The precise number of specialist posts of consultant with a special interest in the psychiatry of old age and the size of the catchment area to be serviced by each consultant will need to be determined following a review of the operation of the specialist services recently established in Dublin. Where the population of elderly does not justify such appointments, one psychiatrist in each catchment area should be identified as the person with responsibility for providing specialist psychiatric services to the elderly mentally infirm. This psychiatrist will need to liaise with other sector psychiatrists and with general practitioners in the catchment area.

8.9 Greater support for families of the elderly with dementia is required through the home help service, home nursing, day care, including transport and respite care. The Director of Community Care or the person responsible for co-ordinating services for the elderly in each area has a critical role to play in co-ordinating these services.

8.10 Accommodation for the elderly mentally infirm could be purpose built, adapted or contracted from the voluntary or private sector. *The Years Ahead* recommended a norm of 3 beds per 1,000 elderly population for the severely mentally infirm and 6 beds per 1,000 elderly for welfare accommodation. Whether the psychiatric service or those responsible for services for the elderly take the lead role in the management of elderly mentally infirm with disturbed behaviour is a matter for each health board to decide, according to local circumstances.

### **Elderly Mentally III**

8.11 The third issue concerning the elderly is the care of those who develop psychiatric illness in old age. Between 20 and 25 per cent of the population aged over 65 years suffers from an identifiable psychiatric disability, compared with an estimated prevalence of 10 per cent in the population aged 18 to 64. The incidence of depressive disorders

tends to increase with age and the majority of the elderly with mental illness suffer from functional disorders. Over 16 per cent of persons admitted to psychiatric hospitals for the first time in 1988 were 65 years or over. Over 40 per cent of these patients were admitted with depressive disorders. There is general agreement that functional mental illness in the elderly should be managed in the same way as in younger people. The majority should be treated by their general practitioners with referral to the specialist psychiatric services when necessary. The appointment of consultants with a special interest in the psychiatry of old age will help to develop skills in the management of the elderly mentally ill. It is likely, however, that general psychiatrists will continue to deal with the majority of elderly referred to the psychiatric services for some time to come.

8.12 Elderly people developing psychiatric illness in their old age should be treated according to the principles outlined in *Planning for the Future* for the psychiatric services as a whole. It is even more important in the case of the elderly that unnecessary admissions to psychiatric hospitals are avoided and that their problems are treated with the minimum disruption to their lives.

## CHAPTER 9

# Promoting Mental Health

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9.1 Psychiatric services are primarily concerned at present with the treatment of mental illness. A comprehensive psychiatric service of the future must also promote mental health and prevent mental illness.

9.2 The causes of mental illness are not well understood but it appears that genetic and environmental factors play a major role. Developments in the biological sciences may in the future assist in the prevention of mental illness. In the short term, the control of environmental factors may offer the greatest opportunity to promote mental health and prevent illness.

9.3 Two significant environmental factors influencing mental health in this country are unemployment and poverty. In a study carried out by the Economic and Social Research Institute on unemployment, poverty and psychological distress (1991), the authors found that the unemployed were five times more likely than other people to exhibit symptoms of a non-psychotic psychiatric nature. The study found that a woman married to a man who is unemployed is also likely to experience a substantially increased level of psychological distress. The study confirmed that the enforced absence of necessities of a basic kind such as food, clothing and heat had a decisive impact on psychological distress. The authors concluded that social support played an important role in reducing the impact of deprivation by raising levels of self-esteem and reducing feelings of fatalism but it was not a panacea.

9.4 The ability of people to cope with life is a crucial factor influencing mental health. Unemployment and poverty may undermine this ability to cope for those affected, as outlined above. The ability to cope may also be affected by a range of other issues such as damaging experiences in childhood, inadequate preparation for the challenges of life and addiction to alcohol and drugs. Health boards

are already involved in a number of ways in promoting better coping skills through parenting programmes, pre-school playgroups, life-skills education in schools, alcohol and drug awareness programmes and social support for elderly people living alone. The Mental Health Association, in co-operation with health boards, is active in promoting mental health in local communities. Its annual public speaking competition for schools on a theme of mental health involves over 300 secondary schools in the country.

9.5 Suicide is one measure by which one can judge the mental health of a country. The reported suicide rate, although low by European standards, has been increasing rapidly in recent years. In particular there has been an increase in suicide among younger age groups and among women, a trend which is common to most European countries. It is likely that the rising incidence of suicide and attempted suicide in younger people is influenced by the greater vulnerability of young people to the social conditions that accompany economic and cultural instability. A large proportion of suicides is associated with a recognisable mental disorder, most commonly a treatable depressive illness but also chronic alcoholism, and schizophrenia.

9.6 The World Health Organisation has recommended action to reverse the rising trend in suicide by the year 2,000. It highlights the importance of early detection and treatment of depression, alcoholism and schizophrenia. It suggests the need for improvements in the underlying societal factors that put a strain on the individual, such as unemployment, family stress, the social isolation of elderly people living alone and failure at school. It emphasises the need to develop the individual's ability to cope with events of life and provide a better network of social support. Since the risk of suicide is increased following an attempted suicide, it recommends that health and social service personnel be better trained to help potential suicide victims and be more attuned to the signs and circumstances of suicide risk.

9.7 Health boards are involved in promoting mental health in a number of ways as outlined above but there is no explicit obligation on boards to be active in this field. It is proposed in chapter 27 of this Green Paper that in any new mental treatment legislation, health boards would be obliged to promote mental health in association with voluntary and other statutory bodies.

9.8 It is the Government's intention that the promotion of mental health should form part of health promotion policies generally. We

are fortunate to have a number of voluntary groups active in this field and the co-operation that exists between them and the health boards will be encouraged and fostered.

## CHAPTER 10

# Towards a Sectorised and Integrated Service

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10.1 To what extent is our psychiatric service sectorised and integrated with the health services generally? The criteria for a sectorised service as defined in *Planning for the Future* are

- a population of known size of about 25-30,000 or larger in urban areas;
- clearly defined boundaries;
- served by a multi-disciplinary team, led by a consultant psychiatrist;
- the team responsible for all psychiatric services in the sector.

10.2 While considerable progress has been made towards sectorisation, the traditional hospital catchment boundaries still predominate in the organisation of the psychiatric services. The process of sectorisation in some areas is not complete. The sector boundaries chosen do not always correspond with those of other health services or with other administrative boundaries. In a few instances, teams have been assigned responsibility for a sector but their base is located elsewhere. Some sector teams do not have the range of facilities or the variety of professional staff to provide a comprehensive service. A sector team needs a mental health centre, hostels with varying degrees of support and a headquarters if it is to meet the needs of the population it serves. The professional skills required include those of medicine, nursing, psychology, occupational therapy and social work.

### **Integration with General Hospitals**

10.3 The mentally ill have traditionally been treated separately from patients with physical disorders. *Planning for the Future* envisaged an end to this isolation and the integration of psychiatry with acute

hospital and primary care services. Substantial progress has been made in providing psychiatric admission and treatment units in general hospitals. Such units are provided in St. James's, St. Vincent's Elm Park, Blanchardstown, Limerick Regional, Letterkenny, Ardkeen, Cork Regional, University College Hospital Galway, Cavan, Castlebar, Clonmel, Tralee, Naas and Roscommon Hospitals. It is expected that an acute unit will open in 1992 at the Mater hospital. Discussions concerning the opening of the unit at Beaumont Hospital have taken place. New units are incorporated in the plans for Mullingar, Navan and Kilkenny hospitals, the proposed hospital in Tallaght and the development of the Mercy hospital, Cork. The provision of an acute unit at several other general hospitals is under discussion. Proposals have also been put forward for the provision of free-standing units which would not be located at general hospitals. While there may be practical reasons why such units are being proposed, it is considered that the principle of integration with the general hospital service should be respected except in exceptional cases.

10.4 In 1990, 29 per cent of admissions to public psychiatric hospitals were to units in general hospitals. The opening of three acute units since 1990 should increase the proportion of such admissions to one third of all admissions. The effect of decisions by a number of boards to limit admissions to psychiatric hospitals and to channel all admissions through the acute units will also increase the proportion of admissions to units in general hospitals. However, the proportion is still low and admissions for acute psychiatry are still far from being integrated with general hospital services.

10.5 Considerable experience has been gained of the difficulties which have to be overcome in the integration of acute units in general hospitals and the possible limitations of such units in providing a comprehensive psychiatric service. Issues which have to be addressed before an acute unit can operate effectively include the relationship of the unit, on the one hand, to the general hospital and, on the other, to community services. Unlike other departments of the hospital, the psychiatric unit is part of a service much of which is based in the community and the reporting relationships of medical, nursing and other professional staff have to reflect the special characteristics of the service. The success of the acute unit also depends on the support facilities to care for patients requiring long term care and for the small number of disturbed patients who cannot be managed in a general hospital. In some cases the design of the acute units does not meet the requirements of patients with short term disturbance who could otherwise be managed in a general hospital setting.

10.6 Where acute psychiatric units attached to general hospitals and good community psychiatric services have been developed, it has been found that people with psychiatric problems who would never have presented at a psychiatric hospital because of the stigma attached to these institutions, are now seeking treatment at the new facilities. More patients admitted to the hospital for other reasons may be transferred to the psychiatric unit who might not have been transferred in the past to a psychiatric hospital. In addition, more patients in the rest of the hospital may be seen on a consultancy or liaison basis by staff from the psychiatric unit than previously. It is not clear whether new morbidity is the only reason for the higher admission rates to psychiatric units in general hospitals. It may be that the needs of many of these patients could be better met by day services. As well as providing alternative facilities for people discharged from psychiatric hospitals, health boards will have to take account of this additional service demand in acute units in planning their community facilities.

10.7 The experience of services with well developed community facilities and low admission rates is that the norm recommended in *Planning for the Future* for acute admission beds of 50 per 100,000 population may be somewhat higher than is required. On the other hand, the greater public acceptability of modern psychiatric facilities and increasing utilisation of the service suggests that it be too early to change the existing norm. If an admission rate falls below 5 per 1,000 population, as discussed in chapter 2, the norm for admission beds per 100,000 population will have to be reduced. The Department of Health intends to monitor admission rates and acute bed norms for psychiatric services closely in the next few years.

10.8 The provision of acute psychiatric units in general hospitals should ensure the integration of psychiatry with the other services on the hospital campus. It does not necessarily ensure that the criterion of comprehensiveness is met. Some acute units in general hospitals have developed separately from the community services in the catchment areas they serve. An acute unit, independent of community facilities cannot offer patients comprehensive psychiatric care. It is encouraging to note that an agreement between the Eastern Health Board, St. James's Hospital and St. Patrick's Hospital to provide a comprehensive service in the catchment area is working well. A similar arrangement between the Eastern Health Board, the Mater Hospital and St. Vincent's Hospital Fairview has been agreed. An



important element in such agreements is that the consultant psychiatrists treating patients in the acute unit also have sector responsibilities which involve them in the development and management of community facilities.

### **Liaison Psychiatry**

10.9 Liaison psychiatry is the term used to describe a psychiatric service to deal with the psychological aspects or psychiatric complications of physical disease. A patient with cardiovascular disease, cancer or diabetes may develop psychological or psychiatric complications and require the services of the psychiatric team. It is important that adequate arrangements are in place in general hospitals and in the community so that such persons in need of psychiatric assessment and/or treatment receive it promptly. The existence of acute psychiatric units in general hospitals greatly facilitates the provision of such a service.

### **Integration with other Community Services**

10.10 While a significant degree of integration between acute psychiatry and the general hospital services has taken place, the trend so far has been for community psychiatric services to develop to a large extent independently of other services. With the emphasis now being placed on the need to develop comprehensive community services to meet the health needs of vulnerable groups such as children, the mentally ill, the mentally handicapped and the elderly, there is a need to re-examine the manner in which community services are being developed. *Planning for the Future* did not provide detailed guidance on how to integrate psychiatry with other community services.

10.11 The Government has announced that a new structure for the health services in the present Eastern Health Board area will be put in place to facilitate the achievement of greater co-ordination in the delivery of health services. The new authority will deliver services on a geographic basis, rather than through the programme structure as at present. The special needs of the psychiatric service will be taken into account in this reorganisation and any which may follow in other health boards.

10.12 The organisation of psychiatric services in sectors, for which one consultant and his or her team is assigned responsibility, assumes that psychiatrists are trained to deal with a broad spectrum of psychiatric illness. There is evidence to suggest that psychiatry is developing

into sub-specialties, a practice which is the norm in many other medical specialties. Recognised sub-specialties of psychiatry in this country are child and adolescent psychiatry, the psychiatry of old age, forensic psychiatry and substance abuse. It has been suggested that sub-specialisation does not sit easily with the concept of the sector psychiatrist. The organisation of psychiatric services in larger catchment areas, it is argued, would allow a consultant team of sub-specialists share responsibility for a population while developing their special interests.

10.13 The Government is inclined to the view that even if further specialisation occurs in psychiatry, it would still favour the principle of one consultant being responsible for a sector. That consultant could call upon the expertise of the child and adolescent psychiatric team or the psychiatrist specialising in the care of the elderly if necessary. In some cases, the sector psychiatrist will have recognised expertise in a branch of psychiatry, such as substance abuse or the care of the elderly, which can be made available to the other sectors in a catchment area. The low density of the population over much of the country, the difficulty in ensuring that people have reasonable access to psychiatric services and the need to integrate psychiatry with other health services mean that the emphasis must continue to be on the provision of as general a psychiatric service as close to the people as possible.

### **Integration with General Practice**

10.14 The integration of psychiatry with primary care services is a major challenge for psychiatry. The traditionally low referral rate to the psychiatric services by comparison with other countries has already been remarked upon. This contrasts with a higher referral rate by general practitioners to medical and surgical specialists. The Irish psychiatric services also tend to hold onto patients for a longer period than in other countries. It has also been argued that some referrals to the psychiatric service could be more appropriately managed by general practitioners if there was better contact between the two services. These factors suggest a lack of communication and mutual confidence between general practitioners and psychiatric personnel. It is encouraging that the level of general practitioner referrals to the new community services is significant throughout the country.

10.15 Sectorisation in psychiatry was criticised by the Irish College of General Practitioners in a policy document, *The Future of General Practice in Ireland* (1988) because it did not automatically allow a

patient a choice of consultant in the same way as other specialties. It is accepted that sectorisation does limit a patient's choice of consultant but if a patient does not wish to be treated by the consultant responsible for his or her sector, the clinical director of the psychiatric services can assign another consultant to the patient. The experience to date of sectorisation has been positive and the benefits which have accrued to patients outweigh any perceived disadvantages. Sectorisation has brought psychiatric services closer to the people and has improved communication between general practitioners and the psychiatric team.

10.16 Developments in under-graduate and post-graduate medical education have increased general practitioners' confidence in dealing with psychiatric illness. The participation of general practice trainees in psychiatric placements supervised by the Irish College of General Practitioners has helped to increase the competence of general practitioners to deal with psychiatric illness. Nevertheless, there are two major shortcomings in the present arrangements. First, general practice trainees may be exposed to psychiatry too early in their three year programme. Second, the type of psychiatry they see, which is largely institutionally based, is not entirely relevant to their subsequent practice. A general practice trainee in a psychiatric hospital will see many persons suffering from schizophrenia whereas in general practice, he/she will, on average, encounter one new patient with schizophrenia every five years.

10.17 As the number of vocational training schemes in general practice increases, the Department of Health will encourage health boards to seek the accreditation of more psychiatric services. All general practice training posts in psychiatry should have a major involvement in community services.

10.18 A major advantage of sectorisation referred to in *Planning for the Future* is that the multi-disciplinary teams can establish good working relationships with the general practitioners, public health nurses and other professionals working in the sector. In addition useful contacts can be developed with voluntary organisations working in local communities, with members of the clergy and the Garda Síochána, community workers and others. In a sector with a population of 25-30,000, one would expect to find about 15 doctors and 8 to 10 public health nurses. There is evidence to suggest that, where sectorisation is in place, good working relationships have developed between the psychiatric team and other health professionals and community organisations. The absence of coterminous boundaries

between sectors and public health nursing districts makes good communication more difficult.

10.19 There is scope for improved communication between general practitioners and the psychiatric team. General practitioners' apparent reluctance to refer patients for specialist psychiatric advice in the past may have stemmed from the poor image of the psychiatric hospital and the reluctance of the psychiatric team to refer patients back to them once specialist advice had been given. If that is so, there is a responsibility on psychiatric personnel to convince the public that their service is a professional one which meets individual and family needs in the least restrictive way possible.

10.20 If general practitioners are to provide continuing care for patients with psychiatric illness, they need the support of the community psychiatric nurse and psychologist and other assistance which the psychiatric team can provide. Psychiatric teams need to think more about how they can help general practitioners look after psychiatric patients on a long term basis.

10.21 A feature of the psychiatric service as mentioned in paragraph 10.14 is the number of people who, once they have been referred to the specialist psychiatric service, continue to be treated by that service when they could more appropriately be managed by their general practitioner. A major disincentive to people being referred back to their general practitioner is the fact that while they can get their drugs in some instances free of charge at psychiatric out-patient clinics, they are not entitled, unless they are medical card holders, to have a prescription written by a general practitioner dispensed free of charge at their local pharmacy. It can be argued that psychiatric patients should be treated in the same way as patients with other conditions. Arrangements for the supply of drugs and medicines to persons in the community being treated for a psychiatric condition need to be reviewed and more appropriate arrangements made.

10.22 While the factors referred to in earlier paragraphs affect the development of a sectorised and integrated service, the variation in the rate of progress under these headings in different health boards requires further examination to identify the barriers which are impeding progress in some areas. One method of helping to overcome such barriers is to establish pilot projects which can be evaluated. The results of such evaluation could be used to encourage the development of a more integrated and sectorised service. Various models of

community based psychiatric services are being piloted at the moment and are being evaluated on behalf of the health boards involved.

### **Evaluation of Community Services**

10.23 With the significant progress achieved since the publication of *Planning for the Future* in the development of a range of psychiatric facilities in the community, there is now a need to establish mechanisms for evaluating the quality of community psychiatric services. If community psychiatry is to be successful, the health services must ensure that there is adequate support in the community for people discharged from psychiatric hospitals. Health boards must ensure that the standards of physical facilities and range of activation and rehabilitation provided within these facilities is sufficient to retain the confidence of people discharged from psychiatric hospitals, people who need to use the service for the first time and local communities generally. The Department of Health will develop guidelines on the standards to be achieved in these services to assist boards attain these standards in practice. As discussed in the second part of this Green Paper, it is the Government's intention to prepare a code of practice for psychiatric care and to retain a statutory inspectorate of psychiatric services. The functions of the inspectorate will be expanded to include inspection of community psychiatric facilities.

### **Voluntary Bodies**

10.24 Voluntary bodies are less numerous in services for the mentally ill than in services for the mentally handicapped, the physically disabled or the elderly. For this reason, the contribution of those voluntary bodies active on behalf of people with mental illness needs to be nurtured and supported by health boards. The Mental Health Association of Ireland, the Schizophrenia Association of Ireland, Grow, the Alzheimer Society, the St. Vincent de Paul Society and the Simon Community and other bodies have made a major contribution to supporting the mentally ill, to changing public attitudes to mental illness and infirmity and have prepared the way for the introduction of community psychiatric services. A number of health boards have, for example, seconded staff to the Mental Health Association to act as development officers, working with the public to develop a more enlightened attitude to mental illness and the mentally ill. Boards also support voluntary bodies in the field of mental illness by way of section 65 grants. If in the past, the isolated psychiatric hospital allowed little scope for voluntary activity, the integrated,

community based service of the future will allow many more opportunities for voluntary initiative and creativity. Health boards should encourage voluntary involvement wherever possible in the psychiatric services, in particular in changing public attitudes to mental illness, in establishing self-help groups for patients and their families, in befriending long-stay patients, in operating hostels and in monitoring client satisfaction with services.

### **Role of the Public**

10.25 In the initial stages of integrating psychiatric services in the community, resistance was experienced from the general public in some areas. For whatever reason, people felt threatened by the idea of persons under psychiatric care living in hostels locally or by proposals for community facilities for psychiatric patients. Happily such resistance is now rarely encountered and the public generally accepts that the presence of persons being treated for a psychiatric illness in the community poses no threat. In many cases, the support and friendship of the community for the persons transferred to community hostels has helped to overcome the stigma traditionally associated with psychiatric illness and psychiatric patients. The acceptance by the public that there is nothing to fear from people with mental illness and the awareness that a local community can contribute to the prevention and cure of mental illness are among the most positive developments which have taken place in the field of mental health in the past decade.

## CHAPTER 11

# The Existing Psychiatric Hospitals

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11.1 The main thrust of the service developments outlined in this document is towards the development of a comprehensive, integrated service with the emphasis on developments in the community. In the long term, the facilities traditionally provided by the large psychiatric hospitals for the majority of psychiatric patients will be replaced by services in general hospitals and in the community. As indicated in earlier chapters, this process is well underway. At the same time, one cannot forget that 22 of these large psychiatric hospitals remain. In December 1990, 5,799 of the residents in these hospitals were there for one year or more. The majority of these patients were elderly or had a mental handicap. A minority required secure care because of disturbed behaviour. In earlier chapters, policy developments have been outlined in relation to the elderly, people with mental handicap and disturbed patients in the psychiatric hospitals. While these developments are being put in place, these patients will continue to reside in the psychiatric hospitals, most of which were built in the last century. Many of these hospitals will be needed for several years to come and the standards of accommodation and care should provide as high a quality of life for patients as possible.

11.2 The role of the Inspector of Mental Hospitals in relation to standards in these hospitals is of great importance. The Inspector is required under the Mental Treatment Act, 1945 to visit each public psychiatric hospital once a year. A detailed report of each inspection is forwarded by the Department of Health to the Chief Executive Officer of the responsible health board, initially for verification of information in the report and secondly, for a response to the recommendations of the Inspector. In some cases, meetings are held between the Department, the Inspectorate and the health board to discuss improvements in the hospital and associated services. Very significant improvements in the quality of accommodation and care have taken place in the psychiatric hospitals in recent years as a result

of the Inspector's reports and subsequent discussions between the Department and the health boards.

11.3 The Inspector is obliged under the Act to submit an annual report on his inspections to the Minister for Health. During the mid-1980s, the practice of making annual reports lapsed due to the priority attached by the Department of Health to the implementation of *Planning for the Future*. The current Inspector, appointed in late 1987, has submitted a report to the Minister for the years 1988 and 1989 and the report for 1990 is expected shortly. The Minister is publishing these reports, and will do so annually hereafter. The Minister attaches great importance to achieving high standards of care in the psychiatric hospitals and will ensure that resources are made available to maintain an acceptable level of services in these hospitals.

11.4 The Inspector's annual reports emphasise the need to provide more rehabilitation for long-stay patients and for health boards to take a more active role in the management of the hospitals. Separate services for the elderly and people with mental handicap are recommended by the Inspector, on the model proposed earlier in this Green Paper.

11.5 In recognition of the vulnerability of long-stay patients in psychiatric hospitals and the need to maintain standards in the hospitals at the same time as services are moving to acute hospitals and the community, the Government intends to retain the present role of the Inspector in relation to the psychiatric hospitals. The Inspectorate will continue to provide an objective report on the standards of accommodation and care in the psychiatric hospitals and a means whereby the Department of Health and the public can be kept informed of the conditions in the hospitals and progress towards the rehabilitation of patients and their transfer to more appropriate services.



## CHAPTER 12

# The Psychiatric Service and the Consumer

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12.1 There has been an increasing emphasis on the importance of the consumer in the health services. The “consumer” in the psychiatric services is the patient and his or her family and friends. Just as the power of the consumer has made itself felt throughout the market economy, so is it being felt in the health services. *Planning for the Future* implicitly argued for a consumer oriented psychiatric service. It is perhaps time to make that concern explicit.

12.2 The central position of the patient in every aspect of the delivery of health care is recognised in the Programme for Economic and Social Progress. To this end, the Minister for Health will shortly be publishing a “Patients Charter” for hospital care which will recognise that every patient has a right

- of access to hospital services in accordance with need;
- to considerate and respectful care;
- to respect for religious and philosophical beliefs;
- to privacy in respect of his or her clinical condition;
- to information about treatment proposed, as well as the treatment options available;
- to confidentiality of medical records;
- to refuse to participate in the teaching of medical students and in research projects;
- to appropriate care on discharge; and
- to make a complaint.

12.3 In the application of the Charter to psychiatric hospitals, particular attention will be given to ensuring that patients have personal clothing and toiletries. The publication of the Charter and its focus on the rights of patients in hospitals will be of great benefit to psychiatric patients and their families. Patients and their families will have a yardstick by which to measure the services made available to them and a procedure whereby they can complain if these standards of care do not match those guaranteed in the Charter.

12.4 The need to examine services from the consumer's view point is critical in the psychiatric services because so many psychiatric patients are unable to express themselves and their families cannot always be relied upon to be advocates for their welfare. It is the Government's intention, discussed in more detail in chapter 26 of the Green Paper, to prepare a code of practice for the psychiatric services which will set out standards of good practice for these services. This code will emphasise that the objective of the psychiatric services is to provide a comprehensive and integrated service to patients and their families in the least restrictive environment possible.

12.5 The voluntary organisations active on behalf of the mentally ill and their relatives such as the Mental Health Association, the Schizophrenia Association and GROW, have first hand experience of services and can provide a consumer's perspective on local psychiatric services. The Department of Health will encourage health boards to meet with the voluntary bodies active on behalf of the mentally ill in their areas to get feedback on the way in which services for the mentally ill are provided and the priorities of patients and relatives for improvements. The Department will maintain its links with these organisations at national level as a source of information on the consumer's experience of the psychiatric services.

12.6 The poor image of the psychiatric services among the public has been referred to earlier. Public opinion is likely to lag behind service developments. Health boards may need to explore ways in which they can improve the image of their services, where these are provided in a comprehensive and individualised way.

## CHAPTER 13

# Private Psychiatric Hospitals

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13.1 There are 12 private psychiatric hospitals, providing about 1,000 beds. The three largest hospitals, St. Patrick's, St. John of God Stillorgan and St. Vincent's Fairview account for 540 of these beds. Under the Mental Treatment Act, 1945, each private psychiatric hospital must be registered by the Minister for Health and inspected twice a year by the Inspector of Mental Hospitals. The Inspector's reports indicate a high standard of care in these hospitals.

13.2 The three private hospitals referred to in paragraph 13.1 have entered into agreements with the Eastern Health Board to provide psychiatric services in their catchment areas for public patients and play an important role in the psychiatric services. Through their nurse training schools and involvement in senior registrar training, these hospitals also influence the quality of personnel in the psychiatric services generally.

13.3 Table 13.1 shows the relative numbers of admissions to and patients in public and private psychiatric hospitals and units in 1990. In addition, some of these hospitals have extensive out patient services. The figures indicate that 20 per cent of all admissions and 12 per cent of patients in hospital are catered for in private hospitals. A large proportion of admissions to private psychiatric hospitals are for the treatment of alcoholism. In 1988, 32 per cent of admissions to private hospitals were for the treatment of alcohol disorders, compared to 23 per cent in public hospitals.

**Table 13.1**  
**Admissions and Patients in Private and Public Psychiatric Hospitals and Units.**

	No. of Admissions 1990	No. of Patients 1990
Public Hospitals	22,118	7,817
Private Hospitals	5,554	1,048
Total	27,672	8,865

13.4 Private psychiatric hospitals make an important contribution to the care of the mentally ill in Ireland, either in association with health boards or in treating private patients. The Government respects the independence of the private hospitals and the freedom of patients with means to avail of their services. It is concerned, however, that the sizeable proportion of patients treated in these hospitals would benefit from the initiatives which are underway in relation to the development of a community psychiatric service. The private hospitals should be encouraged to develop further their out-patient and day-patient programmes in the treatment of psychiatric illness in general and alcohol addiction in particular. The Government would also welcome discussion on the scope for further co-operation between the private hospitals and the health boards in meeting specialised psychiatric needs arising from drug abuse, psychological disturbances associated with head injury, behavioural disturbance in children and AIDS related disorders.

## CHAPTER 14

# Personnel Issues

14.1 The quality of our psychiatric service depends on the quality of the people providing it. Over 8,400 people are directly involved in providing public psychiatric services. Table 14.1 shows the composition of this total:

**Table 14.1**

**Composition of Staff in Public Psychiatric Services (Dec 1991)**

Composition	Number
Medical Staff	305
Nursing and allied	5,008
Other professionals	219
Housekeeping/Catering	2,186
Clerical/administrative	410
Others (maintenance etc.)	288
Total	8,416

\*These figures do not include staff in acute units attached to general hospitals.

14.2 Staff in the psychiatric services have experienced a period of change unprecedented in the Irish psychiatric services. The implementation of *Planning for the Future* initiated major reorganisation of services and reappraisal of the role of staff. The immense contribution made by staff in the psychiatric service to bringing about improvements in the service is fully acknowledged. Both medical and nursing management have played an important part in leading the way towards a new psychiatric service. It is a tribute to commitment and professionalism of staff that they have achieved so much in a relatively short period of time. It is not surprising that a number of issues affecting staff need to be addressed as the new psychiatric service emerges.

## **Role of the Resident Medical Superintendent**

14.3 Under the Mental Treatment Act, 1945 there is an obligation on health boards to appoint a chief medical officer to each psychiatric hospital who is referred to as the resident medical superintendent (RMS). The RMS was given considerable powers and responsibilities in relation to the management of psychiatric hospitals and the welfare of patients, including detained patients. Traditionally he or she was seen as the person who made all important decisions regarding the day to day operation of the hospital. The implementation of the recommendations of *Planning for the Future* for a new kind of psychiatric service has changed the nature of the RMS's role. These changes, and the development of the common contract for consultants which emphasises the autonomy of individual clinicians, have given rise to the suggestion that the RMS post as defined in the 1945 Act is no longer relevant to modern psychiatric services.

14.4 There is, however, a case to be made for one consultant psychiatrist having overall responsibility for the clinical administration of a psychiatric service in a catchment area. The post of RMS could therefore be replaced by the post of clinical director which would be held by a consultant psychiatrist. His or her responsibilities would reflect the community orientation of the new psychiatric services and the need for integration with other services.

14.5 It is recognised that the extent to which the clinical director would have authority over the other consultant psychiatrists and the relationship between the clinical director and other mental health professionals is one which needs careful consideration. Because of the unique organisation of the psychiatric services and because questions of individual liberty arise in the treatment of detained psychiatric patients, it can be argued that overall professional responsibility for the service should rest with the clinical director who would have a direct reporting relationship with health board management. It could be argued therefore that the clinical director should have authority over other consultant psychiatrists and other disciplines in the catchment area. However, it is recognised that each consultant psychiatrist will have clinical autonomy for the care of his or her patients within broad guidelines established by the clinical director. Models for the role of the clinical director already exist in the public psychiatric services and in the private psychiatric hospitals.

14.6 The Government would welcome views on the following issues:

- the nature of the post of clinical director in the new psychiatric service;
- the conditions of service of the post. For example, the post might be filled in a permanent capacity or on a short term contract by one of the consultant team; and
- the extent of clinical director's authority over other consultant psychiatrists and other professional staff.

### **Senior Registrar Training**

14.7 There are 19 senior registrar posts in this country for doctors preparing for consultant posts in psychiatry. The Postgraduate Medical and Dental Board and the Irish Division of the Royal College of Psychiatrists established a working group to examine the number and structure of such posts. This group recommended that the current independent training programmes in psychiatry organised within individual employing agencies should be replaced by a unified, national, higher training programme in psychiatry and that the number of senior registrar posts should be increased to 54. It would be important that, within these arrangements, rotations include a substantial element of community psychiatry, rehabilitation techniques and management skills. The expansion of senior registrar posts to the level recommended can only be achieved on a phased basis. Agencies should create senior registrar posts from within the existing staffing complement when opportunities arise. The experience of other specialties suggests that such posts contribute greatly to service development and to ensuring that some of the best young specialists remain in our services.

### **Nurse Training**

14.8 Nurses are by far the largest professional group in the psychiatric services, accounting for nearly 60 per cent of all staff. Their numbers have, however, fallen significantly from 7,000 in the late 1970s to about 5,000 at present. The voluntary redundancy scheme, the embargo on the filling of vacancies and emigration have contributed in recent years to the fall in numbers. In addition there has been a significant reduction in the recruitment of student psychiatric nurses since 1987.

14.9 Important changes have taken place in the structure of nursing since the publication of *Planning for the Future*. The application of employment equality legislation to the psychiatric services required a

new method of selection and promotion of staff and a new grading structure. The integration of male and female nurses on the same wards was a consequence of these changes, a process which is not yet complete.

14.10 Nurses have played a pivotal role in bringing about the changes to a more community oriented psychiatric service. The changes have radically altered the working lives of many nurses and placed demands on them with which they were ill equipped by their training to deal. It is a natural consequence of the changes which have taken place in the profession and the services, that some should have questioned the role of psychiatric nurses and their relevance to the new kind of psychiatric service.

14.11 While the role of the nurse in community psychiatric services may differ from that of the nurse in the traditional hospital service, it is clear that psychiatric nurses will continue to play an essential part in services for the mentally ill. The person who will spend most time with the patient helping him or her to recovery is the psychiatric nurse. The involvement of psychiatric nurses as members of the same multi-disciplinary team responsible for the patient in the hospital and in the community is one of the strengths of our services. It helps to ensure a continuity of care throughout the period of treatment and care of the patient. There is a need, however, to ensure that nurses moving to a community setting have the skills to provide a therapeutic milieu. Work in the community puts less emphasis on the physical aspects of care than in the hospital. It requires greater skill in assessment, counselling and behavioural and family therapy. The Government is aware of the need to provide staff trained to work in hospital settings with the skills required to work successfully in the community. Health boards have been requested to assign responsibility for post-qualification training for psychiatric nurses to one person in each catchment area. This person is responsible for assessing the training needs of staff and for ensuring that these needs are met in a planned way.

14.12 Because of the continuing importance of psychiatric nurses to the future psychiatric services, it is essential that able young people are recruited to the profession. Approval has been given to a number of boards to recruit student nurses. Each nursing school must satisfy the requirements of An Bord Altranais for accreditation. The new syllabus for student psychiatric nurses is generally considered to be an excellent one. Regional schools of psychiatric nurse training are



now emerging with students rotated through a variety of facilities during their under-graduate years.

14.13 The reduction in the recruitment of student nurses in recent years and the general financial difficulties of the health services appear to have had a negative influence on school leavers as they consider their career options. Those boards who have advertised for student psychiatric nurses have found it difficult to fill all the places available in spite of the poor employment prospects in the economy during this period. An Bord Altranais has been asked to inform career guidance teachers that recruitment of student nurses has resumed and that psychiatric nurses will play an essential role in the future health services. There will need to be obvious career opportunities for psychiatric nurses in the new service in order to attract students of a high calibre.

### **The Multi-Disciplinary Team**

14.14 The relatively small numbers of staff in the psychiatric service with a background in psychology, social work and occupational therapy is a cause for concern. Social workers, psychologists and occupational therapists have a distinctive contribution to make to the care of the mentally ill. These professions should have a greater involvement in the psychiatric service of the future.

### **Services and Legislation**

14.15 This part of the Green Paper has discussed the progress which has been made in providing a psychiatric service as recommended in *Planning for the Future* and the policy and personnel issues which will need to be addressed if further progress is to be made. The second part of the Green Paper, which follows, discusses the role of legislation in relation to people with mental illness and mental disorder and outlines the options for a new legal framework to replace the mental Treatment Act, 1945.

PART TWO

# Mental Health Legislation

## CHAPTER 15

# Legislation and Mental Disorder

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15.1 It is sometimes asked why it is necessary to have specific legislation for people with mental disorder. Why, if the policy as outlined in the first part of this Green Paper is to integrate services for people with mental illness, mental handicap and mental infirmity with other health services and to provide those services as far as possible in the community, should one discriminate against such people by having specific legal provisions governing their care? To answer this question one must first refer to the characteristics of certain forms of mental disorder and to the historical experience of people with mental disorder.

15.2 A mental disorder, unlike most physical disorders, affects a person's thought process and interferes with his or her ability to make judgements. In a minority of cases, the disorder may lead to violent behaviour, sometimes self directed, sometimes directed at others. A few may neglect themselves to the extent that their lives may be in danger. Because of the mental disorder, he or she may not be capable of understanding that he or she requires treatment for recovery or at least protection from the consequences of his or her actions. Since the early nineteenth century, the State has exercised its powers to protect such people against the consequences of their behaviour and against abuse and exploitation in society. In many western countries the intervention of the State to regulate the conditions under which people with mental disorder could be detained and to prescribe safeguards in law to protect their rights contributed to a remarkable improvement in the standard of care such people received. In this country in the last century, as detailed by Dr J A Robins in *"Fools and Mad" — A History of the Insane in Ireland* (1986), the mentally disordered were gradually removed from prisons, workhouses and other inappropriate places to specialised institutions which were, by the standards of the day, managed in a humane way. Although there have been dramatic improvements in the treatment and management of many mental disorders in this half of the twentieth century, the

problem still remains of how the relatively small number of people with mental disorder who refuse or who are incapable of seeking treatment or protection in their own interest or that of others, should be managed. It is widely accepted that such persons should benefit from the rule of law and that a society which values the rule of law should define and safeguard the rights of such people.

15.3 The recent historical experience of people with mental disorder emphasises the need to make explicit legal provisions for their treatment and welfare. The exploitation of people with mental illness and mental handicap and the abuse of psychiatry for political purposes in some countries are well known. The rights of the mentally disordered have received particular attention in the evolution of international law concerning human rights in recognition of the vulnerability of such people and the need to prevent abuses by authoritarian states. The evolution of international law on these issues is far from complete but already it has had a significant impact on legal developments in a number of countries. The implications of international legal developments in respect of people with mental disorder are discussed in detail in chapter 17 of the Green Paper.

15.4 This part of the Green Paper is primarily concerned with the rules for the involuntary admission, detention and treatment of people with mental disorder. It is important to emphasise, however, that these legislative provisions will affect only a small minority of admissions to psychiatric hospitals. In 1990, there were 27,672 admissions to public and private psychiatric hospitals and units, of which 3,300 or 12 per cent were involuntary. Most of these patients were discharged within six months. In the 11 years from 1980 to the end of 1990, only 10 per cent of detained patients had their detention extended beyond six months. Of the 8,000 patients in psychiatric hospitals in 1990, 1,468 or 18 per cent were detained. The legislative changes discussed in this Green Paper should further reduce the number of patients who are admitted involuntarily or who are detained for long periods of time. The care of detained patients will continue to be just one of the responsibilities of the psychiatric services. The vast majority of patients will be admitted and treated on a voluntary basis. The Government proposes to remove the remaining legal formalities that distinguish an admission of a patient voluntarily seeking treatment for a mental illness from a patient seeking treatment for a physical illness. It envisages that in future, patients will be referred for specialist psychiatric care by their general practitioners, in the same way as patients are referred to other specialists.

15.5 The Government is of the view that new legislation should encompass more than the procedures for detention and the safeguarding of the rights of detained patients. It believes that it should also define the role of health boards in relation to providing services for people who are mentally ill. In particular, new legislation offers an opportunity to provide a statutory framework for the development of psychiatric services as recommended in *Planning for the Future* and to integrate further the psychiatric services with health services in general.

## CHAPTER 16

# Existing Legislation

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### **The Mental Treatment Act, 1945**

16.1 The Mental Treatment Act, 1945 (No. 19 of 1945), as amended by subsequent Acts, provides the statutory framework for the detention of people with mental disorder and for the administration of the psychiatric services. The Act was an innovative piece of legislation in the mid 1940s and its principles have been described as “admirably enlightened” (J.A. Robins op. cit. p. 196). It enabled patients to be admitted voluntarily to psychiatric hospitals and changed the admission procedures for involuntary patients. The Act repealed the procedure inherited from the nineteenth century whereby most patients were committed to psychiatric hospitals on the order of two peace commissioners. The Act provided for a review of each detention order by the Minister, a provision which was repealed by the Mental Treatment Act, 1961 (No. 7 of 1961).

16.2 The 1945 Act sets out the procedures for the admission of voluntary patients and involuntary patients but excludes mentally disordered persons charged with criminal offences and wards of court. The following paragraphs describe the procedures for the admission of a voluntary and involuntary patient under the Act.

### **Voluntary Patients**

16.3 Voluntary patients enter hospital and receive treatment of their own free will and are admitted with the minimum of formality. If the psychiatrist of the hospital agrees that treatment is required, the patient completes a simple written application. The procedure varies slightly in the case of a person under 16 years. An application for admission of a child is made by the parent or guardian and must be accompanied by a recommendation from a registered medical practitioner stating that he or she has examined the patient on a specified date not more than seven days before the date of the

application and that, in his or her opinion, the patient will benefit by the proposed admission.

16.4 A voluntary patient may give notice that he or she wishes to leave the hospital, and must be allowed to do so on or after the expiration of 72 hours. If the patient is under 16 years, the notice must be given by the parent or guardian, who is then entitled to remove the patient.

### **Involuntary Patients**

16.5 A person may be admitted to a psychiatric hospital or unit and detained without his or her consent as a temporary patient or as a person of unsound mind. A temporary patient is either a person who requires to be detained for treatment and who is believed to require not more than six months suitable treatment for recovery, or an addict who, by reason of addiction to drugs, intoxicants or perverted behaviour is either dangerous or in serious danger of mental disorder.

16.6 An application for admission is normally made by a near relative, or in certain circumstances by a community welfare officer, or any interested person such as a Garda Síochána. The application must be accompanied by a medical certificate to the effect that the patient is suffering from mental illness, or is an addict, and requires treatment. In the case of a private patient, this certificate must be signed by two doctors. The medical officer of the psychiatric hospital may make a reception order for the involuntary admission of the patient on the basis of the application form presented and the medical certificate. The order gives authority to convey the patient to the hospital. If the patient is brought to the hospital before the order is made, he or she may be detained for a period of 12 hours while a decision is being taken whether or not to make a reception order.

16.7 A temporary patient may not be detained for longer than six months in the first instance, but this period may be extended by further periods of six months, subject to a maximum of two years in total. A temporary patient may, if he or she recovers, be discharged sooner than the six months permitted by the order or may choose to become a voluntary patient during the period of detention.

16.8 The term "person of unsound mind" is defined broadly in the 1945 Act. In general he or she is a person who requires detention for care and protection and who is unlikely to recover within six months. The admission procedure followed is similar to that for temporary

patients. The medical officer of the psychiatric hospital must, however, examine every person to whom an application for admission as a person of unsound mind refers before signing the reception order. A person of unsound mind may be detained for an indefinite period. As with temporary patients, he or she may be discharged at any time following recovery or may decide to become a voluntary patient.

16.9 A detained patient who is not dangerous to himself or herself or others may, with the approval of the resident medical superintendent of the hospital, be allowed absence on parole for a period not exceeding 48 hours or absence on trial for periods of up to 90 days. Absence on parole is to enable detained patients to attend to family and other obligations. Absence on trial is a stepping stone to discharge. A temporary patient or a person of unsound mind who leaves the hospital without permission may be apprehended and returned to the hospital within 28 days. If it is found necessary to have a person who is absent without leave beyond this period readmitted as a detained patient, a fresh application must be made and the procedures outlined above for involuntary admission must be repeated.

### **Safeguards against Improper Detention**

16.10 The principal remedies against detention of patients under existing legislation are:—

- (a) A person or someone acting on his or her behalf may apply to the courts for a judicial review of the decision to detain under the habeas corpus provisions of Article 40.4.2° of Bunreacht na hÉireann. The patient, or someone acting on his or her behalf, may apply to the High Court for an habeas corpus order that he or she be released on the grounds that he or she is being unlawfully detained.
- (b) Any person may apply to the Minister for Health for an order under section 222 of the 1945 Act for the examination of a detained patient by two medical practitioners, and the Minister on consideration of their report, if he or she thinks fit, may direct the discharge of the patient.
- (c) Section 12 of the 1945 Act provides for the appointment of an Inspector of Mental Hospitals who is a registered medical practitioner and who is normally a psychiatrist. The Inspector must visit all public mental hospitals at least once a year and private hospitals, once every six months. He has a duty to give special attention to the state of mind of any patient



detained where he has reason to doubt the propriety of the detention, or when he is requested to by the patient, or by any other person. The Inspector must also ascertain whether the periods of detention of any temporary patients have been extended since his or her previous visit. If so, he or she must give particular attention to the patients concerned. The Inspector may report to the Minister on the propriety of any detention, and the Minister, acting on that report, may order the discharge of the patient.

- (d) Any relative or friend of a person detained may make application to the resident medical superintendent under section 220 of the 1945 Act for the discharge of a patient to his or her care. The application must be granted unless the medical superintendent is of the view that the person will not be properly taken care of or certifies that the patient is dangerous or otherwise unfit for discharge, in which event an appeal against refusal of the application lies to the Minister.
- (e) Section 189 of the 1945 Act obliges the resident medical superintendent of a hospital, when he or she extends the period of detention of a temporary patient, to advise the patient and the person who applied for the original reception order that either of them may make their objections known to the Inspector of Mental Hospitals. On receipt of an objection, the Inspector must take such steps as he or she deems necessary to satisfy himself or herself of the propriety or otherwise of the continued detention of the patient.
- (f) Every patient has the right under section 266 of the 1945 Act to have a letter forwarded, unopened, to the Minister for Health, the President of the High Court, the relevant health board, the Inspector of Mental Hospitals or if the patient is a ward of court, to the Registrar of Wards of Court. The Inspector may report to the Minister on the propriety of the detention of a patient and the Minister may direct his or her discharge. The President of the High Court may require the Inspector to visit and examine any patient detained as a person of unsound mind and to make a report.

16.11 While these are important safeguards for detained patients, they have been overtaken by those required by international law, as discussed in the next chapter. The main shortcomings of the 1945 Act, as amended, are the wide grounds on which a person may be detained, the indefinite detention of persons of unsound mind and

the absence of an independent review of the decision to detain or of an automatic review of long term detention.

16.12 The 1945 Act, as amended, also provides the legal framework for the administration of the psychiatric services. It places an obligation on health boards to provide psychiatric hospitals and to appoint resident medical superintendents to these hospitals. It enables health boards to board out patients detained in psychiatric hospitals. It imposes penalties for the ill-treatment or neglect of patients by staff of psychiatric hospitals and limits the use of mechanical means of bodily restraint. The Act provides for the registration by the Minister of private psychiatric hospitals and details the duties of the Inspector of Mental Hospitals. Part VIII of the Act deals with the conditions of employment of staff in the psychiatric hospitals.

### **Health (Mental Services) Act 1981**

16.13 In 1981, the Health (Mental Services) Act was passed by the Oireachtas. The Act was intended to give patients greater protection against unnecessary detention in psychiatric hospitals. It provided for a limitation of the criteria for involuntary admission, changed the procedures for involuntary admission and detention of patients and provided for an appeal against detention and an automatic review of long term detention by a specialised tribunal. This Act has not been brought into force for a number of reasons. Its provisions have been overtaken by developments in international law which require different safeguards against improper detention than those provided in the 1981 Act. Secondly, the general thrust of the Act has been superseded by developments in the psychiatric services, particularly since the publication of the Report, *Planning for the Future* in 1984 and its adoption as policy by successive Governments. One of the main drawbacks of the 1981 Act is that it does not provide a legal framework for the developing community psychiatric services. Notwithstanding its shortcomings, there are many useful provisions in the 1981 Act which it is proposed to repeat in new legislation.

## CHAPTER 17

# International Law and Principles in relation to Mental Disorder

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17.1 In framing new mental health legislation, regard must be had to this country's obligations under international conventions. There have been important developments since the mid 1970s in relation to the criteria for and procedures surrounding the detention of people with mental disorder and their right to appeal and to an independent review of such decisions. The principal vehicle for these developments has been the *European Convention for the Protection of Human Rights and Fundamental Freedoms* which came into force in 1953. The Convention is not a part of Irish domestic law, but citizens can sue the State through the Commission of Human Rights and the Court of Human Rights in Strasbourg. It is a serious breach of the State's international obligations if a violation of the Convention is established. Decisions of the Court of Human Rights on cases concerning detained psychiatric patients under the Convention since the mid 1970s have defined member states' obligations in relation to such patients. In 1983 the Committee of Ministers of the Council of Europe issued a *Recommendation for the Legal Protection of Persons Suffering from Mental Disorders Placed as Involuntary Patients* which complements the provisions of the European Convention.

17.2 As a member of the United Nations, the State has ratified the *International Covenant on Civil and Political Rights* and Optional Protocol. The Covenant is not part of Irish domestic law but it provides a complaints procedure to the Human Rights Committee of the United Nations and a procedure whereby the State must report on its legislative and other measures to give effect to the rights recognised by the Covenant. In addition, the General Assembly in December 1991 agreed *Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care* prepared by the Human Rights Committee. Although not binding in law,

the *Principles* are likely to have considerable moral force as a yardstick against which member states' legislation will be judged in future.

17.3 The appendix to the Green Paper gives details of the obligations imposed by the *European Convention* and the *UN Covenant* in relation to people with mental disorder. The text of the Council of Europe *Recommendation* and of the *UN Principles* is also included.

### **Council of Europe Convention**

17.4 The *European Convention* sets out safeguards for persons who are detained. It specifies that no one can be detained except by a procedure defined by law and that a person must be informed of the reasons for the detention and must be able to appeal against the lawfulness of the detention. The body of case law under the Convention which has been built up by the European Commission and Court of Human Rights from cases involving detained psychiatric patients has established the following principles:

- (a) that national legal provisions must conform with the *European Convention*;
- (b) that mental disorder may be interpreted widely for the purposes of detention, and may include personality disorders but not social nonconformity;
- (c) that the patient must be reliably shown by objective medical experts to have a mental disorder;
- (d) that the nature or degree of the mental disorder must be such as to justify the deprivation of liberty and continued detention is only valid so long as the disorder persists;
- (e) that the detention must be in accordance with domestic law;
- (f) that a greater discretion may be allowed to national authorities in the detention in emergencies of persons capable of presenting a danger to others;
- (g) that the detention must take place in a hospital, clinic or a special institution for the mentally disordered;
- (h) that the detained person (or his or her family or other representatives) must be informed of the fact of and reasons for the detention;
- (i) that if the decision to detain is taken by an administrative body the patient is entitled to have the lawfulness of his or

her detention reviewed "judicially", but if the decision is taken at the close of judicial proceedings, the review is considered to be part of the proceedings. The review must take place promptly;

- (j) that the patient has the right to be heard and represented in proceedings involving his or her detention;
- (k) that the patient has the right to have his or her detention reviewed at reasonable intervals.

17.5 The Council of Europe *Recommendation* of 1983 (referred to subsequently as the *Recommendation*) and the *UN Principles for the Protection of Persons with Mental Illness*, (subsequently referred to as the *UN Principles*) incorporate the safeguards established in case law under the *European Convention* and go further in recommending protection for detained patients. Frequent reference will be made to the *Recommendation* and the *Principles* in the subsequent chapters of this Green Paper.

17.6 In discussing the need for new mental treatment legislation in this country and the scope of such legislation, it is interesting to note the number of countries in which mental treatment legislation has been reviewed in the recent past to take on board developments at international level in respect of the rights of mentally disordered people. The *European Convention* and the *UN Covenant* have influenced new legislation in Switzerland (1980), England and Wales (1983), Scotland (1984), Northern Ireland (1986), Japan (1987), India (1987), the former USSR (1988), Denmark (1989), Belgium (1990) and France (1990). New legislation is being considered at present in the Netherlands, Poland, Canada and Bulgaria.

17.7 Current law in the 1945 Act and also the scheme set out in the 1981 Act are not entirely in accordance with the State's international obligations. The main deficiency in current legislation is the absence of review of the decision to detain by a body independent of the person taking the decision and of the executive. Some countries in reviewing their laws in relation to detention of people with mental disorder have interpreted international obligations as requiring the sanction of a court to the involuntary detention of a person in a psychiatric hospital. Other countries have interpreted these obligations as requiring the review of detention orders by an independent body which is not a court in the traditional sense. The Government is inclined to the view that a review of decisions to detain by an independent body which is not a court in the strict sense would best

meet the circumstances of this country and puts forward suggestions to this end in chapter 21. The Government recognises that the provision of an independent review of the decision to detain is one of a number of substantial changes required in the legal framework governing the detention of people with mental disorders. Changes are suggested in the following chapters to the criteria for the detention of people with mental disorder, the duration of detention and the safeguards for the protection of detained patients which would adapt Irish law to the requirement of international law. The Government invites the views of interested parties on the proposals outlined.

## CHAPTER 18

# Criteria for Involuntary Admission

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18.1 One of the important functions of legislation in relation to the mentally ill is to define the criteria by which a mentally ill person may be detained involuntarily in a mental health facility. Under the 1945 Act, a person may be detained if he or she

- (a) is suffering from mental illness, is believed to require not more than six months for recovery and is unsuitable for treatment as a voluntary patient, or
- (b) is an addict, and is believed to require for recovery at least six months preventive and curative treatment, or
- (c) is or is believed to be a person of unsound mind
  - (i) in need of care and treatment and unlikely to recover within six months, or
  - (ii) is not under proper care and control or neglected or cruelly treated,
  - (iii) and for public safety or the safety of the person him/herself, it is necessary for the person to be placed under care and control.

18.2 For the purposes of the 1945 Act, an addict is defined as a person who

- (a) by reason of addiction to drugs or intoxicants is either dangerous to himself or herself or others or incapable of managing his or her affairs or of ordinary proper conduct, or
- (b) by reasons of his or her addiction to drugs, intoxicants or perverted conduct, is in serious danger of mental disorder.

18.3 There are difficulties with these criteria in the light of the modern understanding of mental disorder, the case law of the *European Convention* and the guidelines of the *Recommendation* and of

the *UN Principles*. While European law allows a wide interpretation of mental disorder as justification for detention, it excludes social nonconformity. The definition of addiction in the 1945 Act includes behaviour which would amount to social nonconformity. Furthermore, *The Recommendation* limits detention to a person who "by reason of his mental disorder, represents a serious danger to himself or to other persons or who, because of the serious nature of his mental disorder, the absence of placement would lead to a serious deterioration of his disorder or prevent appropriate treatment being given to him". The criteria for detention in the *UN Principles* are similar. The 1945 Act does not refer to "dangerousness" as a criterion for detention of a person who is mentally ill and the grounds on which a person may be detained as a person of unsound mind do not include the prevention of a deterioration of the condition by treatment.

18.4 The criteria for detention in the 1981 Act represented an advance on those in the 1945 Act. The 1981 Act provided that before a person could be detained he or she would have to be

- suffering from mental disorder of such a degree that detention and treatment in a psychiatric centre are necessary in the interests of the person's health or safety or for the protection of other persons or property, and
- that the person is not prepared to accept or is not suitable for treatment otherwise than as a detained patient.

18.5 These criteria are closer to the requirements of European case law but the reference to the "protection of property" might cause problems. The inference that a person must be treatable before he or she could be detained might also give rise to difficulties in the application of the Act. For these reasons, some rewording of the criteria for detention in the 1981 Act are necessary in the new legislation. The following, based on the *UN Principles* is suggested:

A person may be involuntarily admitted to a mental health facility if he or she is suffering from a mental disorder and

- (a) because of that mental disorder, there is a serious likelihood of immediate harm to that person or to other persons; or
- (b) that in the case of a person whose mental disorder is severe and whose judgement is impaired, failure to admit or detain that person is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate



treatment that can only be given by admission to a psychiatric centre.

## **Defining Mental Disorder**

18.6 The 1945 and 1981 Acts use the term "mental disorder" but do not define it. It is important to be clear on what is covered by the term. "Mental disorder" is a legal, not a clinical term. It encompasses broad clinical diagnoses such as mental illness, mental handicap, mental infirmity and personality disorders. To what extent should persons with these diagnoses come within the law governing involuntary admission to mental health facilities? The *UN Principles*, which are concerned with the care of the mentally ill, refer only to detention of persons suffering from mental illness. European law, on the other hand, interprets mental disorder broadly, including personality disorders.

18.7 The argument for confining detention to people who are mentally ill rests mainly on the issue of treatability. If a person has a condition which is not treatable in a psychiatric hospital, how can one justify his or her detention? The argument for a broad interpretation rests on the issue of dangerousness. If a person, by reason of a manifestation of mental disorder is a danger to himself or herself or to others, the state has a responsibility to protect that person and society. It has been suggested that detention under mental treatment legislation should only be permitted on the criterion of treatability or dangerousness. However, the European Convention permits treatability and dangerousness to be used as criteria in assessing whether a person needs to be detained.

18.8 It would not be desirable to allow mental handicap alone to be a criterion for detention. However, there are people with mental handicap who exhibit abnormally aggressive behaviour and who are a danger to themselves and others, who require to be confined for their own good or for the good of others. It is preferable to have such detention made according to legal procedures and with safeguards under law rather than exclude such people from the law and allow de facto detention without procedures and safeguards. It is proposed that such detention should in future take place in centres which specialise in the care of people with mental handicap.

18.9 Mental infirmity raises a similar issue. Mental infirmity per se should not constitute a reason for detaining a person but it may be

necessary to detain someone who is mentally infirm and exhibiting abnormally aggressive behaviour for his or her own good or for the good of others.

18.10 The inclusion of personality disorder under the term mental disorder is the most controversial issue as regards the definition of mental disorder. English and Welsh law limits detention under this heading to persons with a "psychopathic disorder" defined as "a persistent disorder or disability of mind (whether or not including significant impairment of intelligence) which results in abnormally aggressive or seriously irresponsible conduct on the part of the person concerned". This approach is an option for new legislation in this country.

### **Defining "Mental Health Centre"**

18.11 The 1945 Act confines involuntary admission to a psychiatric hospital managed by a health board or an approved institution under the Act. Approved institutions are private psychiatric hospitals registered by the Minister. The 1981 Act made a similar provision for detention in "district psychiatric centres" and "registered psychiatric centres". The situation has become a little more complex than envisaged at the time of the 1945 Act with the opening of acute psychiatric departments attached to general hospitals. These departments have been designated by the Minister under the Act for the involuntary admission and detention of patients. It is proposed in new legislation to limit detention of people with mental disorder to mental health centres and to define a mental health centre as a psychiatric hospital managed by a health board, a psychiatric department of a health board or voluntary general hospital, a registered psychiatric hospital or a mental handicap centre specialising in the care of people with mental handicap who are abnormally aggressive or who are a danger to themselves or others. Whether, in addition to the above, patients should be admitted to and detained in high support hostels, is an issue on which the Government would welcome views.

### **Defining "Person" in Relation to Detention**

18.12 Under the 1945 Act it is not possible to detain a person who is under 16 years of age in a psychiatric hospital. Provision is made only for the voluntary admission of children on the application of their parents. The 1981 Act made no change in relation to children. The question arises as to whether existing provisions are adequate to meet the needs of a child of, say, 12 years or more who may require

treatment for his or her welfare and who may have no contact with his or her parents or who may have no parent who is prepared to apply for his or her admission to hospital. Existing and proposed procedures for protecting children who are neglected or abused by taking them into the care of health boards cannot be used for the purpose of involuntary admission as the care order does not permit a health board to detain a child against his or her will. The Government would welcome views on whether special provisions are needed for the small number of children who are mentally disordered and in need of treatment and who cannot be treated as voluntary patients.

18.13 The Child Care Act, 1991 defines a child as a person under the age of 18 years, unless the person is or has been married. New mental treatment legislation should, if it is to be consistent, use the same definition. If in new mental treatment legislation the age of a child is raised from 16 to 18 years, the issue of whether there should be special procedures to enable young people to be detained for treatment arises directly. Although not common, there are occasions when persons between 16 and 18 years are detained under existing legislation for treatment or protection. It might be unwise to remove this option in the case of a young person without replacing it with a procedure which would ensure that a young person received the treatment that he or she requires.

### **Issues for Discussion**

18.14 The following are the main issues concerning the criteria for detention on which the Government would welcome views:

- the wording of the criteria;
- the definition of mental disorder;
- the places where people with mental disorder may be detained;
- should there be provision in new legislation for the compulsory admission for treatment in limited circumstances of children without their parent's consent?
- should new mental treatment legislation define a child as a person under 18 years of age?

## CHAPTER 19

# Procedures for Involuntary Admission

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19.1 In addition to the criteria for involuntary admission, legislation must also lay down the procedures which must be followed before someone can be detained in a mental health centre. The 1945 Act prescribes in detail the steps which must be followed before someone can be involuntarily admitted and detained. The first stage is the making of an application for a person to be received as an involuntary patient. Such applications are normally to be made by a spouse or relative, but the Act provides that in certain circumstances other persons, such as community welfare officers or a Garda Síochána can make such applications. An applicant must be 21 years of age.

19.2 The application must be made to the person in charge of the hospital and be accompanied by a recommendation or certificate from a registered medical practitioner that, following examination, in his or her opinion, the person meets the criteria for involuntary admission as a person of unsound mind or as a temporary patient. The recommendation is usually made and the certificate signed by a general practitioner. In the case of a person who is the subject of an application for involuntary admission as a private temporary patient, two medical practitioners must certify, following separate examinations, that the person meets the criteria for detention as a temporary patient.

19.3 The person to whom the application refers may be detained only in a health board psychiatric hospital or an approved institution under the Act. The decision to make a detention order, on the basis of the application and accompanying certificate from one or two medical practitioners, is the responsibility of a medical officer in the hospital or institution. It is considered good practice by the Department of Health, although not required by law, that a detention order be signed by a consultant psychiatrist.

19.4 The 1981 Act simplified the procedures for involuntary admission but provided that each application for detention be accompanied by the recommendations, following examination, of two medical practitioners. It enabled a person to be detained in a psychiatric centre for examination and assessment for a period not exceeding 48 hours, following which a reception order could be made.

19.5 European case law obliges the detention of any person to be in accordance with domestic law. The patient must be "reliably shown" by "objective medical experts" to have a mental disorder and the detention must take place in a hospital, clinic or a special institution for the mentally disordered. Existing procedures for involuntary admission meet these criteria. The *UN Principles* recommend that where the person is considered to be in need of treatment, as distinct from a danger to himself or herself or others, the agreement of a second mental health practitioner, independent of the first, should be required. Procedures in this country specify that a person cannot be detained without the recommendation of at least one medical practitioner and without an order signed by another medical practitioner.

19.6 The *European Convention* requires that a person who is detained be informed promptly, in a language which he or she understands, of the reasons for his or her arrest and any charges against him or her. This requirement has been elaborated in European law which has established that a detained person, or his or her family or other representatives, must be informed of the fact of and reasons for the detention. While it is considered good practice in the psychiatric services that a person who is about to be detained be so informed, there is no explicit requirement in our legislation. The 1981 Act included a requirement that the medical officer in charge of a psychiatric centre should give every detained patient a copy of the detention order and a statement in writing of his or her entitlements and rights under the Act. New legislation will have to ensure that the patient and his or her family or representative is fully informed about the facts of and reasons for the detention in a more expanded way than in the 1981 Act. Who should be responsible for ensuring that the patient and his or her family are fully informed is discussed in more detail in chapter 25.

### **Who should make the Application?**

19.7 While it is not proposed to make major changes in the procedures for involuntary admission, with the exception of the right to

information, there are issues which require further discussion. The first concerns the person who should make the application to have a person detained in hospital.

19.8 Considerable public concern has been expressed that current procedures, which emphasise the role of the spouse and relatives in initiating an application for detention, may encourage applications which have more to do with marital and family disharmony than with mental disorder. In Northern Ireland, an application for involuntary admission may be made by the nearest relative or a social worker approved under the Mental Health (Northern Ireland) Order 1986. If an application is made by the nearest relative, the responsible health and social service board is required to arrange for a social worker to interview the patient and provide the medical officer of the centre to which the patient has been admitted with a report on his or her social circumstances as early as possible following admission. The social worker's report deals with such matters as the past history of the patient's mental disorder, his or her present condition and the social and familial factors bearing on it, the wishes of the patient and those of his or her relatives. The social worker is also expected to consider other options for giving the patient the care and treatment required, such as guardianship, voluntary admission, day care, community support and support from friends, relatives and voluntary organisations.

19.9 Social workers are one professional group who are trained to assess the social situation of the person and the dynamics of families. Psychologists and some nurses are also trained in these skills. The involvement of a social worker, psychologist or nurse in initiating applications or assessing the social dimension of applications for involuntary admissions would recognise that social factors play an important role in the need for a person to be involuntarily admitted. Clearly if such a function was assigned to professional staff, they would have to work independently of the psychiatric services as otherwise they might be subject to a conflict of interests. The Government would welcome views on the issue of who should initiate applications for detention and which is the most appropriate professional training for such a role. It is recognised that the Garda Síochána should retain a residual role to act in clearly defined circumstances, such as in emergencies when there is no relative or appropriate professional staff available to initiate an application.

19.10 It may also be necessary to disqualify a relative from making an application for the detention of a spouse where, for example, a

couple have separated or are in the process of separating or where a court order has been sought under the Family Law (Protection of Spouses and Children) Act, 1981. The views of interested parties on the disqualification of relatives in these circumstances would be welcome.

### **Medical Recommendation**

19.11 The number of medical practitioners who should recommend or certify that a person should be detained in a mental health centre is a second issue concerning procedures for detention on which the Government would welcome views. The 1981 Act provided that recommendations of two medical practitioners would be required. The Minister reserved the right to designate an area or prescribe the circumstances by regulations in which one recommendation would be sufficient. As mentioned above, two recommendations are required at present under the 1945 Act for the detention of a private patient as a temporary patient.

19.12 The argument in favour of the recommendation of a second medical practitioner is that it provides a safeguard to all patients which is currently available to private patients only. The arguments against are based on the difficulty in obtaining a second opinion in certain circumstances and that a second medical opinion has to be given in any event by the medical officer of the hospital before he or she can detain the person to whom the application refers. It could also be argued that with the independent review of detention orders proposed in chapter 21 of this Green Paper, that a second medical recommendation will not be necessary to protect the interests of the patient. The question as to whether medical practitioners making such recommendations should have formal training in psychiatry also needs to be considered.

19.13 The Government would welcome the views of interested parties on the issue of a second medical recommendation for public and for private patients in the light of the new safeguards for patients proposed in this Green Paper and on the qualification of medical practitioners making such recommendations.

### **Discharge of Voluntary Patients**

19.14 The 1945 Act obliges a voluntary patient to give 72 hours notice of his or her intention to leave the hospital. This requirement is to provide for situations in which a voluntary patient wishes to

discharge himself or herself against medical and nursing advice. The person may be suffering from a mental disorder to such a degree that it would justify his or her detention. The 72 hour requirement allows the staff of the hospital time to notify the patient's family and to arrange for the detention of the patient, if necessary. The 1981 Act reduced the period of notice to 48 hours. The Government recognises that the formal requirement to give notice of one's intention to leave the hospital distinguishes a voluntary patient in a psychiatric hospital or unit from a patient receiving treatment for a physical disorder. However, it is aware that because of the impaired judgement of some voluntary patients receiving psychiatric care, special measures may be required to discourage such patients from discharging themselves against professional advice. An alternative approach would be to give nurses the legal authority to detain a voluntary in-patient for up to six hours, within which time the person must be examined by a doctor who may detain the person for up to 48 hours. The decision to detain a voluntary in-patient, as with all decisions to detain, would be subject to review by an independent body. The Government would welcome views on which would be the best approach to handling this issue.

### **Issues for Discussion**

19.15 The following are the main issues concerning procedures for detention on which the Government would welcome views:

- who should initiate the application for involuntary admission and what is the most appropriate professional training for this role?
- should a relative be disqualified from making an application for the detention of a spouse where certain legal proceedings have been taken or are in train?
- should there be one or two medical recommendations accompanying an application for involuntary admission of a patient and should recommending doctors have formal training in psychiatry?
- should special provision be made to detain voluntary patients in hospital under certain circumstances?



## CHAPTER 20

# Duration of Detention

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20.1 Under the 1945 Act, a person who is the subject of an application for a temporary patient reception order may be detained for 12 hours in hospital while a decision is being taken by the medical officer whether or not to make a reception order. The duration of any order detaining a person as a temporary patient is six months, although a person may be discharged sooner. Detention may be further extended, in the case of an addict, by periods up to six months and for other temporary patients by periods not exceeding six months, the aggregate of which may not exceed eighteen months. There is no limit specified for the duration of an order detaining a person as a person of unsound mind.

20.2 The *Recommendation* establishes the principle that detention should be for a limited period or, if there is no limit, that the necessity for detention should be examined at regular intervals. The *UN Principles* recommend that involuntary admission initially be for a short period pending an independent review of the decision to detain and that a review body should review the cases of involuntary patients at reasonable intervals. The absence of a fixed limit on the detention of persons of unsound mind or of procedures to review indefinite detention mean that the 1945 Act does not meet the standards of the *Recommendation*. Although the 1945 Act permits an initial detention for a short period of twelve hours duration, it is not for the purpose of facilitating an independent review of the detention. Nor does this preliminary detention apply to patients admitted as persons of unsound mind.

20.3 The 1981 Act provided for an initial period of detention for examination and assessment not exceeding 48 hours. A further order detaining the patient could then be made for 28 days from the date of admission. Detention beyond this time required an order signed by two consultant psychiatrists, for a period not exceeding three months from the date of admission in the case of a first extension and

in subsequent extensions, for periods of one year. The procedures of the 1981 Act on the length of detention orders and for review of long term detention orders at regular intervals would appear to meet European standards and the *UN Principles*.

20.4 The Government would welcome the views of interested parties on whether the new legislation should, as the 1981 Act did, distinguish between detention for a short period for examination and assessment and detention for a longer period for treatment and if it should, what should be the length of the initial period. The purpose of detention for assessment is to resolve as many difficulties as possible for the person concerned and to reduce to a minimum the number of people who need to be detained for longer periods. During detention for assessment, a person may be helped to overcome the most disturbing symptoms of his or her illness and may opt to continue treatment as a voluntary patient. In Northern Ireland, the law has gone one step further and allows detention for assessment to be disregarded for certain purposes. A legal or contractual obligation to disclose information to any person does not apply to such periods. The main argument against detention for assessment is that it could result in an increase in the overall number of persons involuntarily admitted to psychiatric centres. Medical practitioners might be more inclined to recommend admission and to detain people for observation and assessment if the consequences of the order are limited.

20.5 An alternative approach would avoid distinguishing between the purpose of the initial and subsequent periods of detention by having one kind of detention order, a treatment order, which would initially be for seven days, extendable to 28 days. Such an approach might avoid the risk of too many patients being committed for "assessment" yet it would allow a short, initial period of treatment in which many of the patient's problems might be resolved.

20.6 If there is not agreement on the value of an initial detention order for, say seven days, a decision must be taken on how long the initial period of detention for treatment should be. The *UN Principles* recommend that it be "short". Scottish law limits the initial period of detention to 28 days. Such a period would appear to satisfy the criterion of "short" in the *UN Principles*.

20.7 A further decision has to be reached on the maximum length of any subsequent detention order. The 1981 Act provided for a 28 day treatment order, extendable to three months from the date of admission and to 12 month periods thereafter. In Northern Ireland,

England and Wales and Scotland such orders are limited to two periods of six months and then to periods of one year.

### **Issues for Discussion**

20.8 The Government would welcome views on the following issues:

- whether new legislation should provide for an initial period for examination and assessment of detained patients of 48 hours as provided on the 1981 Act or whether there should be one kind of treatment order, for an initial period of seven days, extendable to 28 days;
- the length of subsequent periods of detention.

## CHAPTER 21

# Review of Detention Orders

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### **Review of Initial Detention Order**

21.1 Prior to the 1945 Act, most people were committed to a psychiatric hospital on the order of two peace commissioners acting on a certificate from a dispensary doctor as to the person's dangerous condition. The 1945 Act removed the role of lawyers in the detention of a person, replacing them by a decision of a medical officer of a psychiatric hospital acting on a medical recommendation. As originally enacted, the 1945 Act provided that the Minister for Health would review each decision to detain a patient under the Act. The Act provided that a copy of each detention order be sent to the Minister within three days of the person's admission. The Minister was obliged to keep a register of all detained patients. The Minister could amend a detention order and direct the discharge of a patient detained on a detention order and ministerial sanction was required to the extension of any temporary reception order.

21.2 These powers of the Minister to review detention orders were repealed by the Mental Treatment Act, 1961, although the Minister still retains a power to direct the discharge of any person who is improperly detained. While it is understandable why the power of the executive in the review of individual decisions to detain should have been restricted, the Minister's function of review under the Act as enacted was not transferred to an independent body. Under current legislation there is no independent review of a decision to detain a person in a psychiatric centre or any subsequent decision to extend detention.

21.3 The *European Convention* obliges signatory states to provide a review by a "judicial" body of the lawfulness of a detention order, unless the decision to detain is taken at the close of judicial proceedings. A "judicial" body does not necessarily mean a court. It may be an administrative body but it must be independent from

that which originally requested involuntary admission or decided the detention. The *UN Principles* recommend that the review body be a judicial or other independent and impartial body established by domestic law and envisage a review of every decision to detain. In formulating its decisions, the review body should have the assistance of one or more qualified and independent mental health practitioners. Its review of a decision to admit a person as an involuntary patient should take place as soon as possible after that decision and should be conducted in accordance with simple procedures as specified by law. Under European law, the review body must have power to discharge a person if it considers that the criteria and procedures for detention have not been met in any particular case and its decisions must not be overruled by an executive body.

21.4 As outlined in chapter 16 of this Green Paper, a detained patient can challenge the lawfulness of his or her detention in the courts. Under article 40.4.2° of Bunreacht na hÉireann a person may seek an order of habeas corpus on the grounds that the detention is unlawful. He or she may also apply to the courts for an order of habeas corpus under common law. However, the European Court of Human Rights has deemed that habeas corpus relief under common law is an inadequate appeal against detention. It is not clear whether the Court would view the habeas corpus relief provided under the Constitution as an adequate protection for detained patients.

21.5 The 1981 Act provided for the establishment of a review board or boards to review involuntary admissions. However, the 1981 Act did not envisage that the boards would review decisions to detain in the sense of an independent confirmation that the criteria for detention and the proper procedures were followed in every case. Under the Act the board/s could only review a decision to detain on the basis of an application from the person detained, a spouse, certain relatives and other persons. The grounds on which the board could examine the detention were not specified. It could not discharge a detained patient, however, unless it was satisfied that detention and treatment in the centre were no longer necessary in the interests of the person's health or safety or for the protection of other persons or property. Because of the onus placed on the patient to show that his or her detention was no longer necessary, the review board as envisaged in the 1981 Act would not have provided for a review of the *decision* to detain. Furthermore, the Act permitted an appeal to the Minister for Health against a decision of the board which meant that its decisions could have been overturned by the executive, contrary to the criterion of the European Convention.

21.6 New legislation will have to provide for either involvement by the courts in the decision to detain a person or for review by an independent body of the decision to detain. In most European countries, the decision to detain is taken following judicial proceedings on the basis of a medical recommendation. There is a case for assigning this function to the courts in this country. It would ensure due regard for the procedural propriety of detention and the openness of decision making and avoid the necessity of establishing a new body. The courts have an established role in a similar field, that of confirming a decision to take children who are abused or neglected into the care of a health board.

21.7 On the other hand it can be argued that our courts are not well suited to the investigatory process needed to confirm the legality of a detention. In the Netherlands, for example, judges often visit the psychiatric hospital to interview the patient to establish at first hand his or her situation. In view of the volume of initial detention orders, 3,300 in 1990 and the number of centres in which people may be detained, about 30, the introduction of a judicial confirmation would involve a substantial additional workload for the courts.

21.8 On balance, the Government would favour a continuation of the present procedure whereby the decision to detain is taken by medical practitioners but with an independent review of the decision to detain. This independent review could be carried out by a body which might be called the Mental Health Review Board, which would be established by law and would have the necessary degree of independence to carry out its functions in an impartial way. The Board would review every decision to detain, as recommended in the *UN Principles*, by checking that the proper procedures were followed and that the grounds specified on the detention order conformed with the criteria for detention under the Act. The Board would be notified of every decision to detain a person and would review the legality of each detention within say, a week of the admission. The review of the decision to detain would only involve a hearing if the detained person or a person representing him or her, objected to the detention. The Board would have the power to declare the detention invalid if it was not in accordance with the proper procedures or if, following a hearing, the board found that (a) there was no likelihood of immediate harm to the person or to other persons because of his/her mental disorder or (b) detention was not necessary for the giving of appropriate treatment to the person for his/her mental disorder. The Board would have a panel of medical practitioners, lawyers and informed lay people who would hold hearings when requested. The

Board itself might consist of a small number of part-time members with medical, legal, nursing, and other relevant backgrounds, supported by a full-time secretariat. An appeal would lie to the High Court against a decision of the Board.

21.9 Alternatively the role of the Board might be confined to reviewing the decision to detain on application from the person detained or another interested party. In this case, alternative arrangements would have to be made to have an administrative review of the decision to detain by a person or persons independent of the consultant who signed the detention order.

### **Review of Long-Term Detention**

21.10 Under the European Convention, a detained patient has the right to have his or her detention reviewed at reasonable intervals. The *Recommendation* specifies that a patient should be able to request a judicial authority to consider the need for continued detention at reasonable intervals and the *UN Principles* recommend that this function be carried out by an independent review body. The 1981 Act provided that a review board would review automatically the detention of a person who was detained for a period of two years and whose detention had not been reviewed during the preceding six months. A review board could order the discharge of a patient if it was satisfied that detention and treatment in the centre were no longer necessary in the interest of the person's health or safety or for the protection of other persons or property. An appeal against a decision of a board could be made to the Minister who could overturn it.

21.11 The function of reviewing long-term detention orders could be assigned to the courts. Alternatively, given that similar difficulties would arise for the courts in carrying out such reviews as in reviewing initial detention orders, responsibility for the review of detention orders subsequent to the initial order might be assigned to the proposed Mental Health Review Board. The Board would be sent a copy of each subsequent detention order and it would check that the proper procedures were followed in making the order. It would hold a hearing if the patient or an interested party requested and a hearing had not been held in the previous say, six months. In addition, the Board would hold a hearing automatically to review the detention of any person detained for one or possibly two years. As in the 1981 Act, an obligation would rest with the medical officer in charge of the centre to notify the Board of any patient who had been detained for the specified period and who was entitled to have his or her detention

reviewed by hearing. The Board could order the discharge or conditional discharge of a patient if it was satisfied that a) there was no longer a likelihood of immediate harm to the person or to other persons because of his/her mental disorder or b) detention was no longer necessary for the giving of appropriate treatment to the person for his/her mental disorder. Instead of an appeal to the Minister as provided in the 1981 Act, an appeal would lie to the High Court, as in the case of the initial review of detention. How often such automatic review hearing should take place, is an issue on which the Government would welcome views.

21.12 The Government is aware that there may be constitutional implications to establishing a board with powers in relation to personal liberty. Because the suggested powers and functions of the Board, which might be described as judicial, are of a strictly limited nature in a specialised field, it is felt that the proposed arrangements would be permissible under the Constitution.

21.13 It is proposed that in the period between the making of the detention order and the review of the order by the Mental Health Review Board, a person would continue to have recourse to the courts for relief under the habeas corpus provisions of Article 40.4.2° of Bunreacht na nÉireann. If the proposals in this chapter are acceptable, the constitutional safeguards of habeas corpus would be supplemented by a more expeditious review procedure for detained patients which would fully meet the standards of European law.

### **Issues for Discussion**

21.14 The Government would welcome views on the following issues:

- whether the review of the decision to detain a person should be a function of the courts or of an independent Mental Health Review Board;
- if a Mental Health Review Board is established, whether it should review all decisions to detain or whether it should only review decisions on application;
- if the role of the Mental Health Review Board is confined to a review of the decision to detain on application, who should be assigned the function of reviewing every decision to detain to ensure that proper procedures were followed?



- the criteria and procedures for the review of initial detention orders;
- whether the review of subsequent detention orders and automatic hearing for persons detained on a long-term basis should be assigned to the courts or to the proposed Mental Health Review Board;
- the frequency of automatic review hearings of long-term detention.

## CHAPTER 22

# Consent to Treatment

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22.1 Under common law, the administration of medical treatment to a person without his or her consent is unlawful unless the treatment is urgently necessary. Consent may be given expressly or implied by conduct. Valid consent implies that the person has been told about the nature and purpose of the treatment, is able to understand its nature and purpose and consent must be given without coercion or unreasonable influence.

22.2 It has been widely assumed that if a person was involuntarily detained in a psychiatric hospital for treatment, he or she was not competent to decide whether or not he or she should be given medical treatment and that treatment could be given without consent. That assumption has been challenged in a number of countries with the increasing recognition of the rights of detained patients. Procedures will be required in new legislation to ensure that a detained patient gives informed consent to medical treatment whenever possible or, if he or she cannot give consent or refuses to give consent, to specify the conditions under which such treatment may be administered.

22.3 The *Recommendation* requires that a detained patient be treated under the same ethical conditions as any other sick person. It recommends that a treatment which is not yet generally recognised by medical science or presents a serious risk of causing permanent brain damage or adversely altering the personality of the patient may be given only if the doctor considers it indispensable and if the patient, after being informed, has given informed consent. If the patient is not capable of understanding the nature of the treatment, the doctor should submit the matter for decision to an independent authority prescribed by law which should consult the patient's legal representatives, if any.

22.4 The *UN Principles* recommend that a proposed plan of treatment may be given to a patient without informed consent only if all the following conditions are satisfied:

- (a) the patient is an involuntary patient;
- (b) an independent authority is satisfied that the patient lacks the capacity to give or withhold informed consent,
- (c) the independent authority is satisfied that the proposed plan of treatment is in the best interest of the patient's health.

These conditions would not apply to a patient with a personal representative empowered by law to consent to treatment for the patient. They would not cover treatment of detained patients by psychosurgery and other intrusive and irreversible treatments for mental illness. The *UN Principles* recommend that such treatments should only be carried out where the patient has given informed consent *and* an independent body is satisfied that there is genuine informed consent and that the treatment best serves the health needs of the patient.

22.5 In view of the guidelines of the *Recommendation* and the *UN Principles*, new legislation should specify the conditions under which detained patients may be treated without consent and the conditions which any mentally disordered person may be treated by psychosurgery or other treatment which presents a serious risk of causing permanent brain damage or adversely altering the personality of the patient. Treatment for physical disorders and treatment of voluntary psychiatric patients would still be governed by the common law.

22.6 The 1981 Act provided that the Medical Council, the governing body of the medical profession, could make rules in regard to the application to any person of a therapeutic procedure for the treatment of mental illness, and specify the conditions to be complied with and the precautions to be taken to safeguard the rights and well-being of patients to whom the procedure was applied. The Act makes it unlawful for a person "to apply any procedure" specified in the rules unless a person has given consent as provided for in the rules.

22.7 There are problems with the provisions of the Act in the light of the subsequent *Recommendation* and the *UN Principles*. No provision was made in the Act for overseeing the application of the rules about consent by an independent body. The section applied to all psychiatric patients, not just detained patients. The application of the section could therefore allow the treatment of voluntary patients without consent. If it is necessary to treat a voluntary patient without his or her consent, the patient should be detained to ensure adequate safeguards. The Act did not make explicit provision for the treatment of a detained patient who refuses to give consent and no reference is

made to special procedures for psychosurgery or other forms of irreversible treatment which adversely affect the personality of the patient. Nor is there provision for appeal against a decision to treat without consent.

22.8 It is proposed to incorporate safeguards based on the *UN Principles* in new legislation. It will be necessary to distinguish between two main categories of medical treatment for mental disorder:

- (i) treatment requiring the patient's consent *and* a second medical opinion. Such treatment could not be given if a patient does not give consent and the safeguard would apply to all psychiatric patients. Such procedures would include psychosurgery and the surgical implantation of hormones. Such procedures could only be carried out if two independent people, one of whom must be a medical practitioner, certified that the patient understood the treatment and had consented to it. The independent people might be appointed by the Mental Health Review Board.
- (ii) treatment requiring consent *or* a second medical opinion. This provision would apply only to detained patients. Treatment could be given without consent provided there was a second medical opinion. The person providing the second medical opinion would have to be satisfied that the patient lacked the capacity to give or withhold informed consent or that having regard to the patient's own safety or the safety of others, the patient was unreasonably withholding such consent. He or she would also have to be satisfied that the treatment was in the best interest of the patient's health. Two forms of treatment might come within this category: the administration of medicine for mental disorder after a specified period of medication and electroconvulsive therapy (ECT). The second medical opinion might be provided by a medical practitioner appointed by the Mental Health Review Board.

22.9 New legislation could also provide for the appointment of a personal representative to give consent to treatment on behalf of a detained patient. Treatments in paragraph (ii) above could be given to such patients without informed consent if the personal representative, having been fully informed, consents on the patient's behalf. The Mental Health Review Board might be required to approve the appointment of personal representatives. New legislation could also

permit a person or his or her personal representative to appeal to the High Court against a decision to treat, on the grounds that the proper procedures to seek consent or to dispense with consent were not followed or that treatment without consent was not justified.

22.10 The above procedures should ensure that the necessary safeguards are included in our legislation to protect the welfare of detained patients who are incapable of giving consent to treatment or who refuse to give consent and to protect all psychiatric patients against unnecessary surgical operations for mental disorder.

### **Issues for Discussion**

22.11 The Government would welcome views on whether the scheme outlined in this chapter to deal with the consent to treatment of patients with mental disorder provides an adequate safeguard for patients and a workable scheme for practitioners.

## CHAPTER 23

# Mentally Disordered Offenders

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23.1 The removal of people who were mentally ill from the prisons was a major goal of policy towards the mentally ill in the last century and a major impetus behind much of the reforming legislation of that century. It could be argued that the process of defining the role of the psychiatric services in relation to offenders who are mentally ill is not yet complete and that new legislation should address the outstanding issues.

23.2 These issues were addressed by the Interdepartmental Committee on Mentally Ill and Maladjusted Persons, better known as the Henchy Committee, after its chairman, Mr Justice Henchy. In its Third Interim Report (1978), the Committee commented that

“many persons are dealt with by the Courts as “normal” offenders who are either not responsible (or not fully responsible) for the conduct charged against them or who, even if fully responsible for such conduct, are in need of psychiatric or other special treatments. The inability or restricted ability of the courts to order that convicted persons receive appropriate psychiatric treatment is a grave defect in the present state of the criminal law”.

23.3 At present a judge has no power to remand an accused person to a psychiatric hospital for assessment or treatment. A judge cannot order that a convicted person be sent direct to a psychiatric institution for treatment. The judge may only annex a recommendation for psychiatric treatment to a sentence of imprisonment. He or she may also suspend sentence if the convicted person seeks treatment on a voluntary basis. Specialist psychiatric treatment is provided to prisoners by psychiatrists who visit the prisons on request or, where the illness is severe, by transfer to the Central Mental Hospital, Dundrum. The advantage of this system to the health services is that a service is provided locally to the prisons with a specialist service in Dundrum

with minimal demands on the psychiatric service. Unlike most European countries, prisoners are not admitted to the psychiatric hospitals. The need for secure ward or units in the hospitals thereby is reduced.

23.4 International thinking on the care of mentally ill offenders emphasises their right to treatment and to safeguards similar to those of other detained persons. It may be significant that of the 31 cases concerning the status of psychiatric cases heard by the European Commission of Human Rights up to 1989, 21 concerned mentally ill offenders or persons referred by a court for a report on their mental state. It was decisions of the Court of Human Rights on many of these cases that have interpreted the application of the *European Convention* in signatory states. The *Recommendation* recognises the right of the mentally ill offender to be treated under the same ethical and scientific conditions as other people with mental illness. In particular, the mentally ill offender has the right to receive appropriate treatment and care. The *UN Principles* encompass people serving prison sentences or who are otherwise detained in the course of criminal proceedings or investigations and who are found to have or are believed to be suffering from a mental illness. Under the *UN Principles*, such persons are entitled to receive the best available mental health care and should be treated according to the *UN Principles* "with only such limited modifications and exceptions as are necessary in the circumstances". The *UN Principles* envisage that domestic law may authorise a court or other competent authority, acting on medical advice, to order that such persons be admitted to a mental health facility.

23.5 In some jurisdictions which provide for referral by the courts of mentally ill or impaired persons to psychiatric hospitals, the courts have the following powers:

- (a) remand the accused person to hospital for a report on his or her mental condition;
- (b) remand the accused person to hospital for treatment;
- (c) make an interim hospital order committing an offender to a psychiatric hospital for assessment, for a maximum of six months;
- (d) make a hospital order committing an offender to a psychiatric hospital for treatment;
- (e) make a restriction order (where a hospital order has been made) which requires the agreement of the appropriate

Government Minister to the prisoner's transfer to another hospital, leave of absence or discharge. Restriction orders may be made on the grounds of the nature of the offence and the likelihood of the person committing further offences;

- (f) make a probation order, with a condition of psychiatric treatment.

23.6 In such cases, the courts hear evidence from medical practitioners as to the presence of mental illness or mental impairment in the accused or convicted person and give an opportunity to the appropriate health authority to make representations about the remand or order to one of its hospitals.

23.7 Difficulties for the psychiatric services of giving courts greater powers to refer mentally ill offenders to psychiatric hospitals include

- (a) the introduction of a new category of detained patients to psychiatric hospitals which would increase the number of detained patients;
- (b) the possible creation of tension in psychiatric hospitals at a time when the emphasis on security is being reduced;
- (c) the stigma of involuntary admission and detention for other patients in a psychiatric hospital might be increased;
- (d) the provision of more secure accommodation attached to psychiatric hospitals would probably be required.

23.8 The experience of Northern Ireland where mentally ill offenders or persons before the courts are admitted to all psychiatric hospitals would not suggest that these difficulties are insurmountable. The right of health and social services boards to be heard before a court decides to refer a defendant or offender to a psychiatric hospital, a right which did not exist before the Mental Health (Northern Ireland) Order 1986, has helped to improve co-ordination between the courts and the psychiatric hospitals. There is no special psychiatric hospital in Northern Ireland equivalent to the Central Mental Hospital, Dundrum. The most dangerous and difficult patients are referred to special psychiatric hospitals in Britain. The arrangement means that the psychiatric hospitals do not have to accept all referrals, regardless of their ability to cope with an individual patient. The numbers referred by the courts are not large. In the two year period from 1 April 1988 to 31 March 1990, only 50 people in Northern Ireland were referred by the courts to psychiatric hospitals.



23.9 The advantages of providing courts with wider powers in respect of mentally ill or impaired offenders as recommended by the Henchy Committee include providing a more humane option to the courts in dealing with mentally ill or disordered defendants or convicted persons. It would also bring Irish law as regards mentally ill offenders closer to the European norm.

23.10 The Government is inclined to the view that the balance of advantage lies in providing the courts with a wider range of options in dealing with mentally ill offenders, including the referral of mentally ill defendants and offenders to psychiatric hospitals. It would be the intention that before a court could refer a defendant or a convicted person to a psychiatric hospital for assessment and/or treatment, that it should have an independent report on the mental state of the person and provide the responsible health board with an opportunity of advising on the suitability of a referral to a particular hospital. Provision would also be made for the automatic review of persons detained for long periods on court orders by the Mental Health Review Board, which could have the power to discharge a patient or be obliged to recommend to the court whether continued detention or discharge was justified.

### **Other Issues in relation to Criminal Insanity**

23.11 As regards other recommendations of the Henchy Committee, the Minister for Justice has announced his intention to introduce legislation to amend the law in relation to criminal insanity. Issues to be covered in the Minister for Justice's legislation include procedures for determining the release of guilty but insane persons, provisions about fitness to plead at a criminal trial, a possible change in the verdict of guilty but insane, the introduction of a right of appeal against such verdicts, the definition of insanity and the possibility of introducing the verdict of guilty but with diminished responsibility. As these matters will be dealt with in the Minister for Justice's legislation, they are not covered by this Green Paper.

### **Transfer from Psychiatric Hospitals to the Central Mental Hospital**

23.12 Under Section 207 of the 1945 Act, a detained patient in a psychiatric hospital who is believed to have committed an indictable offence may be transferred to the Central Mental Hospital, Dundrum. The transfer may take place following a special sitting of the District Court in the psychiatric hospital. The justice must be satisfied on

prima facie evidence that the person has committed the offence and if placed on trial, would be unfit to plead and must certify that the patient is suitable to be sent to Dundrum. The certificate is sent to the Minister for Health, who, on the advice of the Inspector of Mental Hospitals, approves or does not approve the transfer. The Minister must also approve the return of a patient from Dundrum to his or her original hospital.

23.13 This procedure is seriously defective for the following reasons:

- (a) the person does not have a proper trial for the offence or on the question of his or her fitness to plead;
- (b) the judge, if satisfied that there is prima facie evidence that the person has committed the offence, has no option but to grant the certificate;
- (c) no criteria are set out for the Minister's decision;
- (d) there is no limit to the length of the person's detention in the Central Mental Hospital;
- (e) it is not clear whether the charge goes into abeyance once the certificate is signed or whether it can later be revived.

23.14 The Government considers that section 207 should be replaced in new legislation by more appropriate procedures for transfers between psychiatric centres and the Central Mental Hospital. The transfer of a patient might in future require the signature of two consultant psychiatrists, one of whom would be the consultant in clinical charge of the patient, and another being a consultant psychiatrist attached to the forensic psychiatric service at the Central Mental Hospital. The decision to transfer might also be reviewed by the Mental Health Review Board, with an appeal to the High Court. The transfer should be for a limited period of say, six months at a time. The Board might automatically review the continued detention in Dundrum of any person who has been transferred from another hospital and who is there two years or more.

23.15 The Central Mental Hospital, Dundrum will continue to be the hospital to which the most difficult and dangerous persons would be referred from the courts and the prisons. The legal status of the hospital will be changed to that of a special psychiatric centre. This change in status, together with the development of forensic psychiatric services outlined in the first part of this Green Paper, will enhance the therapeutic role of the hospital.

## **Issues for Discussion**

23.16 The Government would welcome views on the best way of ensuring that the interests of justice, the mentally ill defendant or offender and the psychiatric services are met in a balanced way in new legislation. In particular it would welcome views on the following issues:

- should the courts be given powers to refer persons to psychiatric hospitals for assessment and/or treatment?
- if they should, what measures should be included in new legislation to govern such referrals?
- if they should not, how should the needs of persons with mental disorder coming before the courts and requiring treatment be met?
- what procedures should govern the transfer of patients from psychiatric hospitals to the special psychiatric centre, Dundrum?

## CHAPTER 24

# Supervision Orders

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24.1 The care of people with mental disorder should be provided on the principle of the least restrictive alternative. Care and treatment should be provided to people with mental disorder in an environment which restricts their freedom to the minimum necessary to ensure their welfare. There are situations where a supervision order may provide the least restrictive alternative to detention in a psychiatric hospital. People with a mental illness or a severe mental handicap may need supervision if they are to take medication or to look after themselves. Traditionally this supervision has been provided within the psychiatric hospital. Professionals have faced a dilemma if they wished to transfer a detained patient to a hostel in the community as part of a programme of rehabilitation. The 1945 Act provides that a detained patient may only be "absent on trial" or "absent on parole" for a maximum of 90 days or 48 hours respectively. These provisions are inadequate to ensure the continuing care of patients in the community who are not sufficiently well to be formally discharged.

24.2 A supervision order would provide another option in the care of mentally disordered people who no longer need to be detained in a psychiatric centre for their well being or the safety of others. It might also provide an alternative to detention in a centre for a small number of people whose primary need is for supervision to encourage them to take medication or to look after themselves.

### **Care and Protection**

24.3 A supervision order for adults with mental disorder may have a wider value in addition to its role as a alternative to detention in a psychiatric centre. Cases have come to light of the abuse, exploitation and neglect of elderly people who are mentally infirm or people with mental handicap. The National Association for the Mentally Handicapped of Ireland has proposed that legislation be introduced

to protect adults with mental handicap from abuse, neglect or exploitation. Mr Justice Finlay, in a Supreme Court judgement (306/87) involving wardship of a woman with mental handicap, commented on the need for legislation to be enacted to provide for the protection of persons with mental handicap.

24.4 There are two options under current legislation for protecting the welfare of adults with mental disorder who are being neglected, abused or exploited. (Children up to 18 years will be protected under the child care legislation when implemented). Under the 1945 Act, adults aged 16 years and over could be classified as persons of unsound mind who are not receiving proper care and attention and be detained indefinitely in a psychiatric hospital. These provisions of the Act help to explain why there are so many people with mental handicap and elderly mentally infirm in the psychiatric hospitals. The second option is to make the person a ward of court. This procedure was originally designed to protect the property and affairs of wealthy people with mental disorder, and was not primarily concerned with their care and welfare. In recent times however, wardship procedures have been used to protect people with very small means. The procedure is, however, cumbersome and expensive and, as mentioned above, Mr Justice Finlay has commented on the need for legislation to protect people with mental handicap.

24.5 It is not proposed in new legislation to allow for the detention in a psychiatric centre of people who are mentally disordered and who are not receiving proper care and attention as the 1945 Act provides. The question to be addressed is whether the new legislation should include a provision for supervision orders in circumstances similar to those now covered by the 1945 Act. There is clearly a need to provide a legal means of protecting these people in the least restrictive manner possible and the new legislation offers an opportunity to do so in a comprehensive way.

24.6 It could be argued that it is inappropriate to use mental treatment legislation to protect people with mental handicap and that such protection should be provided as part of a general health Act or other general legislation. The Government recognises the genuine concern of those representing people with mental handicap on this issue. However, as explained in chapter 18, the new legislation will deal with mental disorder, which is a legal term encompassing mental illness, severe mental handicap, severe personality disorder and severe mental infirmity. People with such forms of mental disorder

may require to be admitted involuntarily for assessment and/or treatment or be the subject of a supervision order for their own safety or well-being or the safety of others. It is appropriate that the same rules should apply to their detention and supervision as to all persons with mental disorder and that they should enjoy similar safeguards of review and appeal.

### **Procedures for Supervision Orders**

24.7 An application to place a person under a supervision order might be made on the grounds that a person is suffering from mental illness, or severe mental handicap or severe mental infirmity to such an extent that it warrants placing him/her under a supervision order and that such an order is necessary for the welfare of the person. An application might be accompanied by a medical recommendation to establish the medical grounds and a recommendation by a qualified social worker to establish the welfare grounds.

24.8 The person responsible for supervision might be a relative, an officer of a health board or an employee of a mental handicap centre. Under the order, the supervisor might have three powers. He or she could require the person to live at a specified place. The intention behind this power would be to discourage the person subject to supervision from living with people who abuse or exploit him or her or to ensure that he or she resides in a particular hostel or other facility. The second power would enable the supervisor to require the patient to attend specified places at specified hours for medical treatment, occupation, education or training. This power would not include a power to administer treatment against the wishes of the person. A person who refuses to take treatment which his or her doctor considers is necessary for his or her welfare should be admitted as an involuntary patient and the procedures concerning consent to treatment outlined in chapter 22 should apply. The third power would enable the guardian to require access to the patient at the place where the patient lives by any doctor, nurse, social worker, or other professional specified by the supervisor. The intention behind this power is to ensure that the patient does not neglect himself or herself.

24.9 The procedures for an application to have a person placed under a supervision order would be similar to those for the involuntary admission of a person to hospital. An application might be made to a health board by a relative, social worker or other professional, or an interested party such as an employee of a mental handicap centre. The application would be accompanied by the medical and social work

recommendations referred to in paragraph 24.7. If the application is accepted by a board, it would take effect immediately. The initial period of supervision would be for six months. It might be renewed for a further six months and then extended for consecutive periods of one year. Each order would be subject to review by the Mental Health Review Board and the person subject to the order or the nearest relative could appeal to the High Court against the order or its renewal. It is suggested that a person would be 18 years or over before he or she could be placed under a supervision order to avoid confusion with procedures under the Health (Child Care) Act, 1991.

### **Issues for Discussion**

24.10 The Government would welcome views on the following issues:—

- the value of supervision orders;
- the categories of people with mental disorder which such orders might cover;
- the procedures for making supervision orders which might be included in new legislation.

## CHAPTER 25

# Information, Representation and Legal Aid

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### Information

25.1 The *European Convention* requires that a person being detained is informed of the fact of and the reasons for his or her detention. The *Recommendation* advises that patients should be assisted to decide whether or not to appeal by a person designated by an appropriate authority. At the time the *Recommendation* was agreed, this country entered a reservation in relation to this provision on the grounds that it was inappropriate and unnecessary in Irish circumstances. It was the view of the Government at the time that the article of the *Recommendation* assumed a degree of judicial intervention in the detention process which was at variance with the Irish system of detention which was based solely on medical certification. New mental treatment legislation provides an opportunity to remove this reservation if there is general agreement on the value of such advice. The *UN Principles* recommend that the grounds for detention be communicated to the patient without delay and to the review body, to the patient's personal representative if any, and, unless the patient objects, to his or her family.

25.2 A key question is who should be responsible for informing patients and their representatives of the reason for their detention and of their right to appeal to the courts under the Constitution or to request a hearing from the Mental Health Review Board. Should a member of the staff of the hospital or an independent person be designated for that purpose?

25.3 In the Netherlands in the early 1980s the difference between formulating the rights of psychiatric patients and the practical application of these rights was recognised. To bridge the gap between theory and practice, an independent Foundation of Patient Advocates was created in 1981, with the support of the Dutch Government. The



patient advocate's main task is to assist patients in safeguarding their legal rights, finding solutions to patients' complaints, giving advice about their legal position and, if necessary, by offering legal advice. The work of the patient advocate is made possible through an agreement between each hospital and the Foundation. This agreement gives the patient advocate the right to visit all the wards and to talk to all patients who also have the right to contact the advocate. In 1990 the Foundation employed 36 patients' advocates, working in 47 hospitals. The work of the Foundation is financed by the Dutch government.

25.4 An effective and inexpensive system to inform detained patients could be developed in this country if health boards or the Mental Health Review Board entered into agreement with voluntary bodies active in the field of mental health to organise volunteers to provide this service to detained patients. Alternatively, the function could be assigned to a member of the staff of the hospital, such as a social worker. The views of interested parties on how detained patients could be informed of their rights are invited.

### **Representation and Legal Aid**

25.5 Under the European Convention, a patient has the right to be heard and represented in proceedings involving his or her detention. The *Recommendation* advises that a patient be informed of his or her right to appeal against the decision ordering or confirming detention and, if he or she requests it or the person hearing the appeal considers that it would be appropriate, have the benefit of the assistance of a lawyer or of another person. The State entered a second reservation to this article of the *Recommendation* on the same grounds as the reservation referred to in paragraph 25.1 above. It would appear that developments in European law have overtaken this view and that explicit provision will have to be made for legal representation for detained patients seeking a review of their detention. In practical terms this would mean recognising the right of detained patients to be represented during an appeal to the courts or a hearing by the Mental Health Review Board and providing assistance towards legal costs for those without the means to pay for them. The UN *Principles* recommend that a patient should be entitled to the services of a legal or other professional representatives of his or her choice without payment should the patient lack the means.

25.6 At present a person challenging his or her detention under the 1945 Act in the courts can seek free legal aid and assistance under

the Civil Legal Aid scheme. The scheme is subject to a means test and to approval by the Legal Aid Board. The scheme does not at present, however, provide for representation before a tribunal, such as the hearings of the Mental Health Review Board proposed in this Green Paper. The scheme would have to be amended to include legal aid and assistance to detained persons involved in such hearings.

25.7 Alternatively, detained persons might be included under the provisions of the Criminal Justice (Legal Aid) Act 1962. It could be argued that the deprivation of a patient's liberty entitles that patient to the same right to legal aid as an accused person under criminal law. On that argument, a scheme closer to that for accused persons under the 1962 Act should be provided for detained persons. On the other hand, it could be argued that detained patients should be dealt with as far as possible by civil rather than criminal procedures. A third option would be to oblige the health boards to pay the legal costs of a person challenging his or her detention without the means to pay.

25.8 The Government is committed to the principle of providing legal aid and assistance to detained patients seeking a review of the legality of their detention. This assistance would be provided to patients with inadequate means to cover the work done by a solicitor in preparing the case, including payment for an independent medical report, where necessary. Such patients would also be provided with legal representation at any hearing or appeal.

### **Issues for Discussion**

25.9 The Government would welcome views on the following issues:—

- whether procedures should be put in place to inform detained patients of their rights;
- if so, what is the most appropriate way to provide this information;
- the manner in which legal aid and assistance should be provided for detained patients with inadequate means in hearings or appeals involving their detention.

## CHAPTER 26

# Protecting Mentally Disordered Patients

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### **Inspector of Mental Hospitals**

26.1 The 1945 Act assigns significant powers to the Inspector of Mental Hospitals to protect patients in psychiatric hospitals. He or she is obliged to visit and inspect every health board psychiatric hospital or unit once a year and every registered psychiatric hospital and the Central Mental Hospital, twice a year. The Inspector must see every patient whom he or she has been requested to examine or the propriety of whose detention he or she has reason to doubt, inspect every part of the institution and ascertain the adequacy of the accommodation, the standard of care and treatment and the staffing arrangements. The Inspector may recommend to the Minister that a detained patient should be discharged. He or she must furnish a report to the Minister on each inspection of a psychiatric hospital and an annual report to the Minister. The Inspector may visit any psychiatric hospital at any time of the day or night and may examine any person on oath for the purpose of carrying out his or her duties. Any patient in a psychiatric hospital may send an unopened letter to the Inspector in which he or she may make a complaint and the Inspector may investigate the complaint.

26.2 The Inspector must be a medical practitioner. The 1945 Act also provides for the appointment of registered medical practitioners as Assistant Inspectors, who have all the powers of the Inspector. At present the Inspector is assisted by one Assistant Inspector and a Psychiatric Nursing Adviser.

26.3 For the reasons outlined in chapter 11, the Government has decided to retain a national inspectorate of mental health services. The role and functions of the future inspectorate need to be examined.

26.4 The 1981 Act took a minimalist approach to the role of the inspectorate. It provided for the annual inspection of psychiatric centres by a designated medical officer of the Minister and for visits and inspections by "any officer" of the Minister. The Act did not specify any other responsibilities of the medical officer or officials and gave no rights to patients to make complaints to them.

26.5 The Government is inclined to the view that a more positive inspectorate should be provided for in new legislation than envisaged in the 1981 Act. The Inspector should be a consultant psychiatrist with a distinguished record in his or her profession. The Inspector should be assisted by a small number of assistant inspectors, who should include consultant psychiatrists, a nurse, social worker and psychologist. The focus of the inspectorate in future legislation could be similar to that at present, although it could be argued that its responsibilities in relation to detained patients may in future become the responsibility of the Mental Health Review Board. Alternatively, the primary focus of the inspectorate might be the standard of accommodation and the quality of care and treatment of psychiatric patients. The Inspector would be entitled to visit every place in which mentally ill patients were cared for, including hostels and day centres and the special centres proposed in chapter 18 where people with mental handicap with severe behavioural disorders may be detained. Patients should be able to make complaints to the Inspector who should be obliged to investigate them. It is not envisaged that the remit of the inspectorate would extend to mental handicap centres, except those centres which may be registered to detain patients. The inspectorate would publish an annual report on the mental health services.

### **Code of Practice**

26.6 The Government believes that a code of practice for the care of the mentally disordered would help to ensure high standards of care throughout the service. It proposes that new legislation would oblige the Minister for Health to prepare, publish and from time to time revise, a code of practice. The code might provide guidance in relation to the admission of patients with mental disorder to hospital or their placement under supervision orders and good practice in the treatment of patients suffering from mental disorder. The Minister would consult interested parties in the preparation and alteration of the code. The code would not have the force of law but it could be used in court cases to establish what is recognised as good practice in the psychiatric services.

## **Patients who Cannot Manage their own Affairs**

26.7 Article 9 of the *Recommendation* states that detention, by itself, cannot constitute a reason for the restriction of the legal capacity of a patient. It advises that the authority responsible for detaining a person should see, if necessary, that adequate measures are taken in order to protect the material interests of the patient. At the time the *Recommendation* was signed, this country entered a reservation to this provision on the grounds that it would be undesirable to impose an obligation on a consultant psychiatrist to take measures to safeguard the material interests of his or her patients. The proposed changes in this Green Paper would enable the principle of safeguarding the material interest of the patient to be met without placing an undue burden on the consultant psychiatrist. The function of ensuring that the material interests of the patient are protected could be the function of the clinical director or a social worker in the hospital or of the Mental Health Review Board.

## **Wards of Court**

26.8 The *UN Principles* recommend that any decision that a person, by reason of mental illness, lacks legal capacity, should only be made after a hearing by an independent and impartial tribunal established by domestic law. Under Irish law, a mentally disordered person who is incapable of managing his or her own affairs and who has property may be made a ward of court. It is accepted that the courts operate the provisions in relation to wards of court flexibly and in the best interests of the patient and that clinicians are given considerable scope by the courts in the management of such patients.

26.9 There are some difficulties between the jurisdiction of the courts over wards and the scope of mental treatment legislation. In the absence of any legislative provision to the contrary, the courts would probably take the view that their power over the body of ward is superior to the powers of detention under the Mental Health Acts. Section 283 of the 1945 Mental Treatment Act states that "no power, restriction or prohibition contained in the Act shall apply in relation to a person of unsound mind under the care of a Judge of the High Court or of a Judge of the Circuit Court". This provision was included in mental treatment legislation to avoid interference with the courts' powers in relation to the care and protection of persons and the estates of persons who were found to be of unsound mind under the Lunacy Regulation (Ireland) Act, 1871.

26.10 The Commission of Inquiry on Mental Illness which reported in 1966 felt that the law in relation to wards of court should be amended. The Commission was concerned that a ward of court could not be admitted to a psychiatric hospital under the provisions of the Mental Treatment Act, 1945 and that an application for the admission to a psychiatric hospital of a person whose past history was unknown to the applicant might have resulted in an illegal detention. The Commission considered that the law needed to be amended so as to make it lawful for a ward of court to be admitted to a mental hospital either under a court order or under the statutory provisions applicable to persons who are not wards of court. The Commission also felt that the law relating to wards of court was unduly restrictive as hospital authorities had no power to discharge such persons or allow them leave of absence without the leave of the court. It recommended changes to the law so as to allow mental hospital authorities as much freedom as possible in dealing with patients who were wards of court, subject only to such control as the court considered necessary.

26.11 Section 47 of the 1981 Act, provides that "nothing in this Act shall affect any jurisdiction exercised immediately before the commencement of this section by a judge of the High Court or a judge of the Circuit Court in connection with the care and protection of persons and the estates of persons found to be mentally disordered". By not re-enacting the specific exemption of wards from the provision of mental treatment legislation, the 1981 Act probably permitted emergency action to be taken in relation to a ward under the Act. For the protection of people acting under mental treatment legislation, the legal position of wards under mental treatment legislation should be spelt out more clearly.

### **Enduring Power of Attorney**

26.12 The procedure to make a person a ward of court can be slow, complicated and expensive. The Law Reform Commission has recommended that a system of enduring power of attorney be introduced to this country in addition to the ward of court procedures. An enduring power of attorney is a power of attorney which, subject to safeguards, continues in force after the person who granted the power becomes mentally incapable of handling his or her affairs. The person granting the power of attorney appoints a person to act either generally or in a manner specified on behalf of the person granting the power. This procedure is particularly well suited to assisting people with progressive brain disease, such as alzheimer disease, or

recurring mental illness, to manage their affairs by a relatively simple procedure. The Government would welcome views on the value of a system of enduring powers of attorney to meet the needs of the mentally infirm and chronically mentally ill.

### **Correspondence and Communication**

26.13 Under section 266 of the Mental Treatment Act, 1945 a patient in a psychiatric hospital is entitled to send an unopened letter to the Minister for Health, the President of the High Court, the Registrar of Wards of Court, the health board or the Inspector of Mental Hospitals. Article 7 of the Mental Treatment Regulations, 1961 permits the resident medical superintendent or person in charge of a psychiatric hospital to examine correspondence to and from a patient, if he or she thinks fit, other than letters under section 266 referred to above. It may be necessary to provide greater safeguards for patients' correspondence in new legislation.

26.14 The *Recommendation* advises that restrictions on personal freedom of the patient should be limited only to those which are necessary because of his or her state of health and for the success of treatment. A patient's right to communicate with a lawyer, with the detaining authorities, with the person designated to advise the patient on his or her rights and to send any letter unopened, should not be restricted. It is recognised, however, that the right to correspond or communicate may have to be curtailed if the correspondence or communication poses a threat to the health or well-being of the person to whom it is directed. It is proposed in new legislation that the only grounds on which the right of a patient to correspond or communicate could be limited would be where such a threat was established to the satisfaction of the clinical director.

### **Seclusion and Restraint**

26.15 The seclusion and restraint of patients in psychiatric hospitals is permitted under the 1945 Act. Seclusion of a patient is defined in the 1961 Regulations under the Act as "the placing of a patient in any room alone and with the door of exit locked or fastened or held in such a way as to prevent the egress of the patient". Bodily restraint is defined in the same Regulations as "the application of clothing or other material whereby the movements of the body or any part of the limbs of a patient are restrained or impeded". The Act excludes bodily restraint unless "the restraint is necessary for the purposes of

medical or surgical treatment or to prevent the person of unsound mind injuring himself or others". The Regulations prohibit seclusion or bodily restraint except "where it is essential for the safety of the patient, or the safety of others, and is certified as so essential by a medical officer". The Regulations oblige the hospital authorities to enter a record of every case of seclusion or bodily restraint in a register and provide detailed guidance on what does and does not constitute seclusion and bodily restraint. The Inspector of Mental Hospitals is obliged to pay particular attention to any system of coercion, restraint or seclusion when inspecting a psychiatric hospital.

26.16 It is recognised that seclusion and bodily restraint will continue to be features of the care of a minority of mentally disordered patients and that new legislation should define the grounds which justify such practices and the procedures which must be followed to protect patients' welfare. In addition, the proposed code of practice would advise on good practice in relation to the use of restraint and seclusion.

### **Clinical Trials**

26.17 Section 9 of the Clinical Trials Act, 1987 specifies the conditions which must be fulfilled before a person may participate in clinical trials of substances or preparations. The Act permits participation by patients who are not capable of giving consent, under certain conditions. The Government would welcome views on the adequacy of the provisions of the Act to safeguard mentally disordered patients.

### **Civil Proceedings**

26.18 Section 260 of the Mental Treatment Act 1945 places an obligation on the person who wishes to take civil proceedings in respect of an act purporting to have been done in pursuance of the Act to satisfy the High Court before the proceedings are instituted that there are substantial grounds for contending that the person against whom the proceedings are to be brought acted in bad faith or without reasonable care. The question as to whether such limitations should continue to apply needs to be considered.



## **Other Issues**

26.19 The Government would welcome the views of interested parties on other issues concerning the protection of mentally disordered patients which would be appropriate to mental treatment legislation.

## **Issues for Discussion**

26.20 The Government would welcome views on the following issues:

- the role and functions of the inspectorate of mental health services;
- the value of a code of practice for the care of the mentally disordered and the contents of any such code;
- the best way of protecting the material interests of mentally disordered patients;
- whether the legal position of wards of court in new mental treatment legislation should be changed;
- whether there should be an enduring power of attorney for people with mental disorder;
- the extent to which the right of mentally disordered persons to correspond and communicate should be limited;
- the rules which should govern the future use of seclusion and bodily restraint;
- whether the provisions of the Clinical Trials Act, 1987 are sufficient to safeguard the interests of mentally disordered patients;
- other issues concerning the protection of mentally disordered patients which would be appropriate to mental treatment legislation.

## CHAPTER 27

# Law and Administration

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27.1 Significant legal changes in the administration of services for people with mental disorder will be required to provide a framework for the changes proposed in both parts of this Green Paper. The changes proposed in this chapter attempt to strike a balance between integrating the administration of services to people with mental disorder as closely as possible with the administration of the health services generally, while ensuring at the same time that the rights and welfare of people with mental disorder are protected.

### **Mental Health Review Board**

27.2 As outlined in chapter 21 of this Green Paper, it may be necessary in new legislation to establish an independent body, a Mental Health Review Board, to review decisions to detain a person suffering from mental disorder and to review automatically long term detentions. Other functions have been proposed in this Green Paper as appropriate to the Board, such as a decision to place a person under a supervision order, the provision of a second opinion in relation to consent to treatment, the review of decisions to transfer patients to the Central Mental Hospital, Dundrum and responsibilities in relation to informing patients and their legal representation. The Board would have to maintain a register of detained patients to carry out these functions.

27.3 The Mental Health Review Board would be established by law, with statutory responsibility for the functions assigned to it. The members of the Board would be appointed by the Minister and could only be removed by a decision of Government. The chairman might be a judge or lawyer of high standing in his or her profession. Other members of the Board would include psychiatrists, a general practitioner, a nurse, a psychologist, a social worker, representatives of voluntary organisations active on behalf of people with mental disorder, and lay people. The Board members would be part-time

and would be supported by a small secretariat. The Board would appoint a panel of medical practitioners, lawyers and other people who would assist it to carry out its functions in relation to the review of detention, consent to treatment, and transfers to the Central Mental Hospital. The Board would have the power to declare a detention or supervision order invalid and its decisions could only be overruled by the High Court. It would be responsible for confirming that the detained patient, or where appropriate the family or guardian, is aware of the patient's rights and informed of what is taking place in proceedings relating to detention, supervision orders, consent to treatment, transfers or complaints and of the patient's entitlement to a hearing as part of such proceedings. The Board would also be empowered to insist upon and obtain legal representation for a detained patient with inadequate means, even where it is not sought. The Board should be entitled to refer any proceedings to the High Court and a patient should be able to appeal against a decision of the Board to the High Court. The Board would report on its activities periodically to the Oireachtas.

### **Inspectorate**

27.4 As discussed in chapter 26, the Government intends to provide for a national inspectorate of mental health services in new mental treatment legislation. This is a function which the proposed Review Board might be assigned in addition to those already mentioned. There are arguments for and against associating the inspectorate with the proposed Board. The argument in favour of such an association is that an inspectorate under the Board might have a greater degree of independence than one reporting to a Minister. On the other hand, the active inspectorate of recent years has demonstrated the benefit of a close link between inspection and the policy making functions of the Department of Health. The Government has an open mind on the issue of how best to organise the inspectorate and would welcome the views of interested parties.

### **Role of Health Boards**

27.5 The legal framework of the mental health services reflects the hospital orientation of the service in the 1940s. The health boards are obliged under the 1945 Act, as amended, to manage psychiatric hospitals and to provide in-patient services for people with mental illness. The absence of a legal framework which reflects a community based, comprehensive, integrated and sectorised service as recommended in *Planning for the Future* has not prevented health boards

from developing services in this direction, as outlined in the first part of this Green Paper. However, a legal framework which reflected the new psychiatric service would give the service a secure foundation and assist with further development.

27.6 Under new legislation health boards will continue to play the key role in the management and delivery of services to people with mental illness. It is proposed that a general obligation would be placed on each health board to provide a comprehensive psychiatric service to its population, a service that is community oriented and integrated as far as possible with other health services and organised in catchment areas and sectors. Specifically, boards would have a statutory obligation to co-ordinate the efforts of statutory and voluntary agencies to achieve effective action in the promotion of mental health, the prevention of mental illness and the treatment and after care of people who are mentally ill. Health boards would be obliged in new legislation:

- to provide in-patient facilities for the treatment of people with mental illness in each catchment area, including mental health centres for the involuntary admission of persons with mental disorder;
- to provide in each region or in association with another health board, a secure mental health centre for the most difficult detained patients;
- to provide out-patient facilities, day hospitals, day centres, hostels and workshops for the treatment, rehabilitation, training and after care of persons with mental illness;
- to organise the provision of services to people with mental illness in sectors, which correspond as far as possible with the districts/sectors used for the organisation of other health services.
- to prepare every five years, or more frequently if requested by the Minister, a plan for the development of psychiatric services in the functional area of the health board.
- to support voluntary organisations active on behalf of the mentally ill.

### **Resident Medical Superintendents**

27.7 The future role of the resident medical superintendent was discussed in chapter 14 of this Green Paper. The Government proposes to change the role of the resident medical superintendent to

that of clinical director for mental health services. The issue which arises here is whether the clinical director should have a statutory basis in new legislation. The Government would welcome views on the issue.

## **Personnel**

27.8 The conditions of service of staff in the psychiatric service are specified in detail in the 1945 Act. It is proposed that new legislation would protect the rights of existing staff, as provided for in the 1981 Act. Following the commencement of new legislation, new staff joining the psychiatric services would enjoy the same conditions of service as staff in the health services generally.

## **Other Issues**

27.9 There may be other issues which are not discussed in this Green Paper concerning the administration of the services which should be covered by new mental treatment legislation. The Government would welcome views on any such issues.

## **Issues for Discussion**

27.10 The Government would welcome views on the following:

- the structure and composition of the proposed Mental Health Review Board;
- whether the inspectorate of psychiatric services should be attached to the Department of Health or the proposed Mental Health Review Board;
- the responsibility of health boards in relation to services for people with mental illness;
- whether the post of clinical director for mental health services should have a statutory basis;
- protecting the rights of psychiatric staff;
- any other issues which concern the administration of the services which should be covered by new mental treatment legislation.

## CHAPTER 28

# The Next Steps

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28.1 The Government has published this Green Paper to review changes in services for people with mental illness and to initiate discussion on the issues which should be dealt with in new mental treatment legislation. Interested parties wishing to make their views known on the issues raised in this Green Paper are invited to make submissions to the Minister for Health. Following consideration of these submissions and consultation with the parties making submissions, the Government will announce its intentions in relation to the contents of new mental treatment legislation.

28.2 Submissions on the Green Paper should be addressed to the Secretary, Department of Health, Hawkins House, Dublin 2. Interested parties in making submissions are requested to follow the sequence of issues as set out in the Green Paper. Submissions should be made before the 1st October 1992.

# Appendix

# International Legislation and Principles in Relation to Mental Disorder

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## **The European Convention on Human Rights — Summary**

1. The provisions of the *European Convention for the Protection of Human Rights* (1953) which are of relevance to patients with mental disorder are as follows:

- *Article 3* which states that  
“No one shall be subjected to torture or to inhuman or degrading treatment or punishment.”
- *Article 5.1*  
This Article guarantees the “right to liberty and security of the person” but defines a certain number of exceptions “in accordance with a procedure defined by law” of which Article 5.1(e) includes the lawful detention of “persons of unsound mind”.
- *Article 5.2* states that  
“Everyone who is arrested shall be informed promptly, in a language which he understands, of the reasons for his arrest and any charges against him”. This is interpreted to cover detained psychiatric patients as well as accused persons.
- *Article 5.4* states that  
“Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.”

2. To date the law developed by the Commission and Court of Human Rights has dealt with procedural safeguards. It may well be that the next area of attention for these bodies will be the conditions of confinement and the right to treatment and therapeutic standards. This may be done in the context of Article 3 which outlaws inhuman and degrading treatment.

3. In this context the provisions of the *European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment* (1987) should be noted. This is a Council of Europe convention which establishes a Committee which may visit places of detention to investigate the treatment of detainees. The Committee reports to the Council's Committee of Ministers. The convention came into force in 1989, and the State is now



obliged to provide facilities and information to the visiting Committee in relation to all places of detention, including psychiatric hospitals.

### **United Nations Covenant — Summary**

4. The *UN Covenant on Civil and Political Rights* provides at Article 9 that:

- “(i) Everyone has the right to liberty and security of person. No one shall be deprived of his liberty except on such grounds and in accordance with such procedures as are established by law.
- (ii) Anyone who is arrested shall be informed, at the time of arrest, of the reasons for his arrest and shall be promptly informed of any charges against him....
- (iii) Anyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings before a court, in order that the court may decide without delay on the lawfulness of his detention and order his release if the detention is not lawful.”

5. These rights are almost conterminous with those under the *European Convention* except that the right to information is “at the time of arrest”. Article 7 of the Covenant provides that,

“no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, now one shall be subjected without his free consent to medical or scientific experimentation”.

*Article 10.1* provides that,

“all persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person”.

6. The Human Rights Committee set up under this Covenant has been very active in protecting the rights of mentally ill patients internationally and has made it clear that Articles 7 and 10.1 apply to them.

7. The text of the Council of Europe *Recommendation on the Legal Protection of Persons Suffering from Mental Disorders* and of the UN *Principles for the Protection of Persons with Mental Illness*, follows.

# Council of Europe Recommendation

Recommendation No. R (83) 2 of the Committee of Ministers to member states concerning the legal protection of persons suffering from mental disorders placed as involuntary patients.<sup>1</sup> Adopted by the Committee of Ministers on 22 February 1983.

The Committee of Ministers, under the terms of Article 15.b of the Statute of the Council of Europe

Considering that the aim of the Council of Europe is to achieve a greater unity between its members, in particular through harmonising the laws on matters of common interest;

Having regard to the Convention for the Protection of Human Rights and Fundamental Freedoms and to its application by the organs established under that convention;

Having regard to Recommendation 818 (1977) of the Consultative Assembly of the Council of Europe on the situation of the mentally ill;

Considering that common action at European level will promote the desired better protection of persons suffering from mental disorder;

Recommends that the governments of the member states should adapt their laws to the rules annexed to this recommendation or adopt provisions in accordance with those rules when introducing new legislation.

## RULES

### *Article 1*

1. These rules concern the involuntary placement of persons suffering from mental disorder. Placement decided pursuant to criminal proceedings is not

<sup>1</sup> When this recommendation was adopted and in application of Article 10.2.c. of the Rules of Procedure for the meetings of the Ministers' Deputies, the Representatives of the following member states reserved the right of their governments to comply or not with the provisions indicated below of the rules appended hereto:

- The Federal Republic of Germany: Articles 3.a and 6.b;
- Ireland: Articles 4.2 last sentence and 3 last sentence, and 9.2;
- Liechtenstein: Articles 4.2 last sentence and 3 first sentence, and 6.b;
- The Netherlands: Articles 3.a, 4.4 and 6;
- Sweden: Article 6.b;
- Switzerland: Articles 4.1 last sentence, final phrase, and 2 last sentence, and 6.b;
- The United Kingdom: Articles 4.2 last sentence and 3 last sentence, and 6.b.

covered by these rules; however, Rules 5, 9, 10 and 11 apply to such a placement.

2. Involuntary placement (hereinafter referred to as "placement") means the admission and detention for treatment of a person suffering from mental disorder (hereinafter referred to as "patient") in a hospital, other medical establishment or appropriate place (hereinafter referred to as "establishment"), the placement not being at his own request.

3. The admission of a patient to an establishment for treatment at his own request does not fall within the field of application of these rules. However, these rules apply to cases where a patient who has originally been admitted at his own request is to be detained in an establishment in spite of his wish to be discharged.

#### *Article 2*

Psychiatrists and other doctors, in determining whether a person is suffering from a mental disorder and requires placement, should do so in accordance with medical science. Difficulty in adapting to moral, social, political or other values, in itself, should not be considered a mental disorder.

#### *Article 3*

In the absence of any other means of giving the appropriate treatment:

- a. a patient may be placed in an establishment only when, by reason of his mental disorder, he represents a serious danger to himself or to other persons;
- b. states may, however, provide that a patient may also be placed when, because of the serious nature of his mental disorder, the absence of placement would lead to a deterioration of his disorder or prevent the appropriate treatment being given to him.

#### *Article 4*

1. A decision for placement should be taken by a judicial or any other appropriate authority prescribed by law. In an emergency, a patient may be admitted and retained at once in an establishment on the decision of a doctor who should thereupon immediately inform the competent judicial or other authority which should make its decision. Any decision of the competent judicial or other authority mentioned in this paragraph should be taken on medical advice and under a simple and speedy procedure.

2. Where a decision for placement is taken by a non-judicial body or person, that body or person should be different from that which originally requested or recommended placement. The patient should immediately be informed of his rights and should have the right of appeal to a court which should decide under a simple and speedy procedure. Moreover, a person whose duty it is

to assist the patient to decide whether to appeal should be designated by an appropriate authority, without prejudice to the right of appeal of any other interested person.

3. When the decision is taken by a judicial authority or when an appeal is made before a judicial authority against the decision of placement by an administrative body, the patient should be informed of his rights and should have the effective opportunity to be heard personally by a judge except where the judge, having regard to the patient's state of health, decides to hear him through sole form of representation. He should be informed of his right to appeal against the decision ordering or confirming the placement and, if he requests it or the judge considers that it would be appropriate, have the benefit of the assistance of a counsel or of another person.

4. The judicial decision referred to in paragraph 3 should be open to appeal.

#### *Article 5*

1. A patient put under placement has a right to be treated under the same ethical and scientific conditions as any other sick person and under comparable environmental conditions. In particular, he has the right to receive appropriate treatment and care.

2. A treatment which is not yet generally recognised by medical science or presents a serious risk of causing permanent brain damage or adversely altering the personality of the patient may be given only if the doctor considers it indispensable and if the patient, after being informed, has given his express consent. If the patient is not capable of understanding the nature of the treatment, the doctor should submit the matter for decision to an appropriate independent authority prescribed by law which should consult the patient's legal representative, if any.

3. Clinical trials of products and therapies not having a psychiatric therapeutic purpose on persons suffering from mental disorder, subject to placement, should be forbidden. Clinical trials having a psychiatric therapeutic purpose are a matter for national legal provisions.

#### *Article 6*

The restrictions on personal freedom of the patient should be limited only to those which are necessary because of his state of health and for the success of the treatment; however, the right of a patient:

- a. to communicate with any appropriate authority, the person mentioned in Article 4 and a lawyer, and
- b. to send any letter unopened,

should not be restricted.

*Article 7*

A patient should not be transferred from one establishment to another unless his therapeutical interest and, as far as possible, his wishes are taken into account.

*Article 8*

1. A placement should be for a limited period or, at least, the necessity for placement should be examined at regular intervals. The patient can request that the necessity for placement should be considered by a judicial authority at reasonable intervals. The rules in Article 4, paragraph 3, apply.

2. The placement may be terminated at any moment on the decision:

- a. of a doctor, or
- b. of a competent authority,

acting on his own initiative or at the request of the patient or any other interested person.

3. The termination of the placement does not necessarily imply the end of treatment which may continue on a voluntary basis.

*Article 9*

1. The placement, by itself, cannot constitute, by operation of law, a reason for the restriction of the legal capacity of the patient.

2. However, the authority deciding a placement should see, if necessary, that adequate measures are taken in order to protect the material interests of the patient.

*Article 10*

In all circumstances, the patient's dignity should be respected and adequate measures to protect his health taken.

*Article 11*

These rules do not limit the possibility for a member state to adopt provisions granting a wider measure of legal protection to persons suffering from mental disorder subject to placement.

# UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care

(Adopted by the General Assembly 17 December 1991)

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## *Application*

These Principles shall be applied without discrimination of any kind such as on grounds of disability, race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, legal or social status, age, property or birth.

## *Definitions*

In these Principles:

“Counsel” means a legal or other qualified representative;

“Independent authority” means a competent and independent authority prescribed by domestic law;

“Mental health care” includes analysis and diagnosis of a person’s mental condition and treatment, care and rehabilitation for a mental illness or suspected mental illness;

“Mental health facility” means any establishment, or any unit of an establishment, which as its primary function provides mental health care;

“Mental health practitioner” means a medical doctor, clinical psychologist, nurse, social worker or other appropriately trained and qualified person with specific skills relevant to mental health care;

“Patient” means a person receiving mental health care and includes all persons who are admitted to a mental health facility;

“Personal representative” means a person charged by law with the duty of representing a patient’s interests in any specified respect or of exercising specified rights on the patient’s behalf, and includes the parent or legal guardian of a minor unless otherwise provided by domestic law;

“The review body” means the body established in accordance with Principle 17 to review the involuntary admission or retention of a patient in a mental health facility.

#### *General Limitation Clause*

The exercise of the rights set forth in these Principles may be subject only to such limitations as are prescribed by law and are necessary to protect the health or safety of the person concerned or of others, or otherwise to protect public safety, order, health or morals or the fundamental rights and freedoms of others.

#### *Principle 1*

##### *Fundamental Freedoms and Basic Rights*

1. All persons have the right to the best available mental health care, which shall be part of the health and social care system.
2. 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.
3. All persons with a mental illness, or who are being treated as such persons, have the right to protection from economic, sexual and other forms of exploitation, physical or other abuse and degrading treatment.
4. There shall be no discrimination on the grounds of mental illness. “Discrimination” means any distinction, exclusion or preference that has the effect of nullifying or impairing equal enjoyment of rights. Special measures solely to protect the rights, or secure the advancement, of persons with mental illness shall not be deemed to be discriminatory. Discrimination does not include any distinction, exclusion or preference undertaken in accordance with the provisions of these Principles and necessary to protect the human rights of a person with a mental illness or of other individuals.
5. Every person with a mental illness shall have the right to exercise all civil, political, economic, social and cultural rights as recognised in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights and in other relevant instruments, such as the Declaration on the Rights of Disabled Persons and the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment.
6. Any decision that, by reason of his or her mental illness, a person lacks legal capacity, and any decision that, in consequence of such incapacity, a personal representative shall be appointed, shall be made only after a fair hearing by an independent and impartial tribunal established by domestic law. The person whose capacity is in issue shall be entitled to be represented by a counsel. If the person whose capacity is at issue does not himself or

herself secure such representation, it shall be made available without payment by that person to the extent that he or she does not have sufficient means to pay for it. The counsel shall not in the same proceedings represent a mental health facility or its personnel and shall not also represent a member of the family of the person whose capacity is at issue unless the tribunal is satisfied that there is no conflict of interest. Decisions regarding capacity and the need for a personal representative shall be reviewed at reasonable intervals prescribed by domestic law. The person whose capacity is at issue, his or her personal representative, if any, and any other interested person shall have the right to appeal to a higher court against any such decision.

7. Where a court or other competent tribunal finds that a person with mental illness is unable to manage his or her own affairs, measures shall be taken, so far as is necessary and appropriate to that person's condition, to ensure the protection of his or her interests.

## *Principle 2*

### *Protection of Minors*

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.

## *Principle 3*

### *Life in the Community*

Every person with a mental illness shall have the right to live and work, as far as possible, in the community.

## *Principle 4*

### *Determination of Mental Illness*

1. A determination that a person has a mental illness shall be made in accordance with internationally accepted medical standards.
2. A determination of mental illness shall never be made on the basis of political, economic or social status, or membership of a cultural, racial or religious group, or any other reason not directly relevant to mental health status.
3. Family or professional conflict, or non-conformity with moral, social, cultural or political values or religious beliefs prevailing in a person's community, shall never be a determining factor in diagnosing mental illness.
4. A background of past treatment or hospitalisation as a patient shall not of itself justify any present or future determination of mental illness.



5. No person or authority shall classify a person as having, or otherwise indicate that a person has, a mental illness except for purposes directly relating to mental illness or the consequences of mental illness.

#### *Principle 5*

##### *Medical Examination*

No person shall be compelled to undergo medical examination with a view to determining whether or not he or she has a mental illness except in accordance with a procedure authorised by domestic law.

#### *Principle 6*

##### *Confidentiality*

The right of confidentiality of information concerning all persons to whom these Principles apply shall be respected.

#### *Principle 7*

##### *Role of Community and Culture*

1. Every patient shall have the right to be treated and cared for, as far as possible, in the community in which he or she lives.
2. Where treatment takes place in a mental health facility, a patient shall have the right, whenever possible, to be treated near his or her home or the home of his or her relatives or friends and shall have the right to return to the community as soon as possible.
3. Every patient shall have the right to treatment suited to his or her cultural background.

#### *Principle 8*

##### *Standards of Care*

1. Every patient shall have the right to receive such health and social care as is appropriate to his or her health needs, and is entitled to care and treatment in accordance with the same standards as other ill persons.
2. Every patient shall be protected from harm, including unjustified medication, abuse by other patients, staff or others or other acts causing mental distress or physical discomfort.

#### *Principle 9*

##### *Treatment*

1. Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others.

2. The treatment and care of every patient shall be based on an individually prescribed plan, discussed with the patient, reviewed regularly, revised as necessary and provided by qualified professional staff.

3. Mental health care shall always be provided in accordance with applicable standards of ethics for mental health practitioners, including internationally accepted standards such as the Principles of Medical Ethics adopted by the United Nations General Assembly. Mental health knowledge and skills shall never be abused.

4. The treatment of every patient shall be directed towards preserving and enhancing personal autonomy.

#### *Principle 10*

##### *Medication*

1. Medication shall meet the best health needs of the patient, shall be given to a patient only for therapeutic or diagnostic purposes and shall never be administered as a punishment or for the convenience of others. Subject to the provisions of paragraph 15 of Principle 11, mental health practitioners shall only administer medication of known or demonstrated efficacy.

2. All medication shall be prescribed by a mental health practitioner authorised by law and shall be recorded in the patient's records.

#### *Principle 11*

##### *Consent to Treatment*

1. No treatment shall be given to a patient without his or her informed consent, except as provided for in paragraphs 6, 7, 8, 13 and 15 below.

2. Informed consent is consent obtained freely, without threats or improper inducements, after appropriate disclosure to the patient of adequate and understandable information in a form and language understood by the patient on:

- (a) The diagnostic assessment;
- (b) The purpose, method, likely duration and expected benefit of the proposed treatment;
- (c) Alternative modes of treatment, including those less intrusive; and
- (d) Possible pain or discomfort, risks and side-effects of the proposed treatment.

3. A patient may request the presence of a person or persons of the patient's choosing during the procedure for granting consent.

4. A patient has the right to refuse or stop treatment, except as provided for in paragraphs 6, 7, 8, 13 and 15 below. The consequences of refusing or stopping treatment must be explained to the patient.

5. A patient shall never be invited or induced to waive the right to informed consent. If the patient should seek to do so, it shall be explained to the patient that the treatment cannot be given without informed consent.

6. Except as provided in paragraphs 7, 8, 12, 13, 14 and 15 below, a proposed plan of treatment may be given to a patient without a patient's informed consent if the following conditions are satisfied:

- (a) The patient is, at the relevant time, held as an involuntary patient;
- (b) An independent authority, having in its possession all relevant information, including the information specified in paragraph 2 above, is satisfied that, at the relevant time, the patient lacks the capacity to give or withhold informed consent to the proposed plan of treatment or, if domestic legislation so provides, that, having regard to the patient's own safety or the safety of others, the patient unreasonably withholds such consent; and
- (c) The independent authority is satisfied that the proposed plan of treatment is in the best interest of the patient's health needs.

7. Paragraphs 6 above does not apply to a patient with a personal representative empowered by law to consent to treatment for the patient; but, except as provided in paragraphs 12, 13, 14 and 15 below, treatment may be given to such a patient without his or her informed consent if the personal representative, having been given the information described in paragraph 2 above, consents on the patient's behalf.

8. Except as provided in paragraphs 12, 13, 14 and 15 below, treatment may also be given to any patient without the patient's informed consent if a qualified mental health practitioner authorised by law determines that it is urgently necessary in order to prevent immediate or imminent harm to the patient or to other persons. Such treatment shall not be prolonged beyond the period that is strictly necessary for this purpose.

9. Where any treatment is authorised without the patient's informed consent, every effort shall nevertheless be made to inform the patient about the nature of the treatment and any possible alternatives and to involve the patient as far as practicable in the development of the treatment plan.

10. All treatment shall be immediately recorded in the patient's medical records, with an indication of whether involuntary or voluntary.

11. Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient's medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient.

12. Sterilisation shall never be carried out as a treatment for mental illness.

13. A major medical or surgical procedure may be carried out on a person with mental illness only where it is permitted by domestic law, where it is considered that it would best serve the health needs of the patient and where the patient gives informed consent, except that, where the patient is unable to give informed consent, the procedure shall be authorised only after independent review.

14. Psychosurgery and other intrusive and irreversible treatments for mental illness shall never be carried out on a patient who is an involuntary patient in a mental health facility and, to the extent that domestic law permits them to be carried out, they may be carried out on any other patient only where the patient has given informed consent and an independent external body has satisfied itself that there is genuine informed consent and that the treatment best serves the health needs of the patient.

15. Clinical trials and experimental treatment shall never be carried out on any patient without informed consent, except that a patient who is unable to give informed consent may be admitted to a clinical trial or given experimental treatment, but only with the approval of a competent, independent review body specifically constituted for this purpose.

16. In the cases specified in paragraphs 6, 7, 8, 13, 14 and 15 above, the patient or his or her personal representative, or any interested person, shall have the right to appeal to a judicial or other independent authority concerning any treatment given to him or her.

### *Principle 12*

#### *Notice of Rights*

1. A patient in a mental health facility shall be informed as soon as possible after admission, in a form and a language which the patient understands, of all his or her rights in accordance with these Principles and under domestic

law, which information shall include an explanation of those rights and how to exercise them.

2. 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 appropriate, and to the person or persons best able to represent the patient's interests and willing to do so.

3. 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.

### *Principle 13*

#### *Rights and Conditions in Mental Health Facilities*

1. Every patient in a mental health facility shall, in particular, have the right to full respect of his or her:

- (a) Recognition everywhere as a person before the law;
- (b) Privacy;
- (c) Freedom of communication, which includes freedom to communicate with other persons in the facility; freedom to send and receive uncensored private communications; freedom to receive, in private, visits from a counsel or personal representative and, at all reasonable times, from other visitors; and freedom of access to postal and telephone services and to newspapers, radio and television;
- (d) Freedom of religion or belief.

2. The environment and living conditions in mental health facilities shall be as close as possible to those of the normal life of persons of similar age and in particular shall include:

- (a) Facilities for recreational and leisure activities;
- (b) Facilities for education;
- (c) Facilities to purchase or receive items for daily living, recreation and communication;
- (d) Facilities, and encouragement to use such facilities, for a patient's engagement in active occupation suited to his or her social and cultural background, and for appropriate vocational rehabilitation measures to promote reintegration in the community. These measures should include vocational guidance, vocational training and placement services to enable patients to secure or retain employment in the community.

3. In no circumstances shall a patient be subject to forced labour. Within the limits compatible with the needs of the patient and with the requirements of institutional administration, a patient shall be able to choose the type of work he or she wishes to perform.

4. The labour of a patient in a mental health facility shall not be exploited. Every such patient shall have the right to receive the same remuneration for any work which he or she does as would, according to domestic law or custom, be paid for such work to a non-patient. Every such patient shall, in any event, have the right to receive a fair share of any remuneration which is paid to the mental health facility for his or her work.

#### *Principle 14*

##### *Resources for Mental Health Facilities*

1. A mental health facility shall have access to the same level of resources as any other health establishment, and in particular:

- (a) Qualified medical and other appropriate professional staff in sufficient numbers and with adequate space to provide each patient with privacy and a programme of appropriate and active therapy;
- (b) Diagnostic and therapeutic equipment for the patient;
- (c) Appropriate professional care; and
- (d) Adequate, regular and comprehensive treatment, including supplies of medication.

2. Every mental health facility shall be inspected by the competent authorities with sufficient frequency to ensure that the conditions, treatment and care of patients comply with these Principles.

#### *Principle 15*

##### *Admission Principles*

1. Where a person needs treatment in a mental health facility, every effort shall be made to avoid involuntary admission.

2. Access to a mental health facility shall be administered in the same way as access to any other facility for any other illness.

3. Every patient not admitted involuntarily shall have the right to leave the mental health facility at any time unless the criteria for his or her retention as an involuntary patient, as set forth in Principle 16, apply, and he or she shall be informed of that right.

#### *Principle 16*

##### *Involuntary Admission*

1. A person may (a) be admitted involuntarily to a mental health facility as a patient; or (b) having already been admitted voluntarily as a patient, be

retained as an involuntary patient in the mental health facility if, and only if, a qualified mental health practitioner authorised by law for that purpose determines, in accordance with Principle 4, that that person has a mental illness and considers:

- (a) That, because of that mental illness, there is a serious likelihood of immediate or imminent harm to that person or to other persons; or
- (b) That, in the case of a person whose mental illness is severe and whose judgement is impaired, failure to admit or retain that person is likely to lead to a serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission to a mental health facility in accordance with the principle of the least restrictive alternative.

In the case referred to in subparagraph (b), a second such mental health practitioner, independent of the first, should be consulted where possible. If such consultation takes place, the involuntary admission or retention may not take place unless the second mental health practitioner concurs.

2. Involuntary admission or retention shall initially be for a short period as specified by domestic law for observation and preliminary treatment pending review of the admission or retention by the review body. The grounds of the admission shall be communicated to the patient without delay and the fact of the admission and the grounds for it shall also be communicated promptly and in detail to the review body, to the patient's personal representative, if any, and, unless the patient objects, to the patient's family.

3. A mental health facility may receive involuntarily admitted patients only if the facility has been designated to do so by a competent authority prescribed by domestic law.

### *Principle 17*

#### *Review Body*

1. The review body shall be a judicial or other independent and impartial body established by domestic law and functioning in accordance with procedures laid down by domestic law. It shall, in formulating its decisions, have the assistance of one or more qualified and independent mental health practitioners and take their advice into account.

2. The review body's initial review, as required by paragraph 2 of Principle 16, of a decision to admit or retain a person as an involuntary patient shall take place as soon as possible after that decision and shall be conducted in accordance with simple and expeditious procedures as specified by domestic law.

3. The review body shall periodically review the cases of involuntary patients at reasonable intervals as specified by domestic law.

4. An involuntary patient may apply to the review body for release or voluntary status, at reasonable intervals as specified by domestic law.
5. At each review, the review body shall consider whether the criteria for involuntary admission set out in paragraph 1 of Principle 16 are still satisfied, and, if not, the patient shall be discharged as an involuntary patient.
6. If at any time the mental health practitioner responsible for the case is satisfied that the conditions for the retention of a person as an involuntary patient are no longer satisfied, he or she shall order the discharge of that person as such a patient.
7. A patient or his personal representative or any interested person shall have the right to appeal to a higher court against a decision that the patient be admitted to, or be retained in, a mental health facility.

### *Principle 18*

#### *Procedural Safeguards*

1. The patient shall be entitled to choose and appoint a counsel to represent the patient as such, including representation in any complaint procedure or appeal. If the patient does not secure such services, a counsel shall be made available without payment by the patient to the extent that the patient lacks sufficient means to pay.
2. The patient shall also be entitled to the assistance, if necessary, of the services of an interpreter. Where such services are necessary and the patient does not secure them, they shall be made available without payment by the patient to the extent that the patient lacks sufficient means to pay.
3. The patient and the patient's counsel may request and produce at any hearing an independent mental health report and any other reports and oral, written and other evidence that are relevant and admissible.
4. Copies of the patient's records and any reports and documents to be submitted shall be given to the patient and to the patient's counsel, except in special cases where it is determined that a specific disclosure to the patient would cause serious harm to the patient's health or put at risk the safety of others. As domestic law may provide, any document not given to the patient should, when this can be done in confidence, be given to the patient's personal representative and counsel. When any part of a document is withheld from a patient, the patient or the patient's counsel, if any, shall receive notice of the withholding and the reasons for it and shall be subject to judicial review.
5. The patient and the patient's personal representative and counsel shall be entitled to attend, participate and be heard personally in any hearing.



6. If the patient or the patient's personal representative or counsel requests that a particular person be present at a hearing, that person shall be admitted unless it is determined that the person's presence could cause serious harm to the patient's health or put at risk the safety of others.

7. Any decision, whether the hearing or any part of it shall be in public or in private and may be publicly reported, shall give full consideration to the patient's own wishes, to the need to respect the privacy of the patient and of other persons and to the need to prevent serious harm to the patient's health or to avoid putting at risk the safety of others.

8. The decision arising out of the hearing and the reasons for it shall be expressed in writing. Copies shall be given to the patient and his or her personal representative and counsel. In deciding whether the decision shall be published in whole or in part, full consideration shall be given to the patient's own wishes, to the need to respect his or her privacy and that of other persons, to the public interest in the open administration of justice and to the need to prevent serious harm to the patient's health or to avoid putting at risk the safety of others.

### *Principle 19*

#### *Access to Information*

1. A patient (which term in this Principle includes a former patient) shall be entitled to have access to the information concerning the patient in his or her health and personal records maintained by a mental health facility. This right may be subject to restrictions in order to prevent serious harm to the patient's health and avoid putting at risk the safety of others. As domestic law may provide, any such information not given to the patient should, when this can be done in confidence, be given to the patient's personal representative and counsel. When any of the information is withheld from a patient, the patient or the patient's counsel, if any, shall receive notice of the withholding and the reasons for it and it shall be subject to judicial review.

2. Any written comments by the patient or the patient's personal representative or counsel shall, on request, be inserted in the patient's file.

### *Principle 20*

#### *Criminal Offenders*

1. This Principle applies to persons serving sentences of imprisonment for criminal offences, or who are otherwise detained in the course of criminal proceedings or investigations against them, and who are determined to have a mental illness or who it is believed may have such an illness.

2. All such persons should receive the best available mental health care as provided in Principle 1. These Principles shall apply to them to the fullest extent possible, with only such limited modifications and exceptions as are

necessary in the circumstances. No such modifications and exceptions shall prejudice the persons' rights under the instruments noted in paragraph 5 of Principle 1.

3. Domestic law may authorise a court or other competent authority, acting on the basis of competent and independent medical advice, to order that such persons be admitted to a mental health facility.

4. Treatment of persons determined to have a mental illness shall in all circumstances be consistent with Principle 11.

#### *Principle 21*

##### *Complaints*

Every patient and former patient shall have the right to make a complaint through procedures as specified by domestic law.

#### *Principle 22*

##### *Monitoring and Remedies*

States shall ensure that appropriate mechanisms are in force to promote compliance with these Principles, for the inspection of mental health facilities, for the submission, investigation and resolution of complaints and for the institution of appropriate disciplinary or judicial proceedings for professional misconduct or violation of the rights of a patient.

#### *Principle 23*

##### *Implementation*

1. States should implement these Principles through appropriate legislative, judicial, administrative, educational and other measures, which they shall review periodically.

2. States shall make these Principles widely known by appropriate and active means.

#### *Principle 24*

##### *Scope of Principles Relating to Mental Health Facilities*

These Principles apply to all persons who are admitted to a mental health facility.

#### *Principle 25*

##### *Saving of Existing Rights*

There shall be no restriction upon or derogation from any existing rights of patients, including rights recognised in applicable international or domestic law, on the pretext that these Principles do not recognise such rights or that they recognise them to a lesser extent.