Five years after implementation: a review of the Irish Mental Health Act 2001

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This is the final version of this paper (10th July 2012)

Objectives:

The Mental Health Act 2001 (MHA 2001) was implemented in November 2006. Since that time, there has been considerable research into its impact, including the impact on service provision, use of coercive practices and the perceptions by key stakeholders. Our objective is to present a summary of research into the MHA 2001 since its implementation in the Irish state in the context of international standards and practice.

Methods:

We reviewed the literature presented on Medline and Google Scholar, directly assessed relevant journals and sought abstract information from the College of Psychiatry of Ireland.

Results:

There has been a small decrease in the rate of involuntary admission since implementation but there has been no change in the representativeness of diagnoses of individuals admitted involuntarily. Mental Health Tribunals were held for 57% of those admitted involuntarily and 46% of service users found that the Mental Health Tribunal made the involuntary admission easier to accept. One year after discharge, 60% of service users reflected that their involuntary admission had been necessary. Professional groups have expressed concerns regarding workload, training time for junior doctors and paperwork.

Conclusions:

The MHA 2001 has brought the practice of involuntary admission further into line with international standards. However, five years after the implementation of the Act international guidelines and practice have highlighted areas in need of further reform, including capacity legislation and consideration of advance directives and community treatment orders. Further research is also lacking on caregivers' or family members' perceptions of the MHA2001.

Keywords: Coercion; Involuntary admission; Mental Health Act; Human Rights; Legislation

1.0 Background:

The Mental Health Act 2001 (MHA 2001) was implemented in Ireland on 1st of November 2006 and stands as a key moment in the history of Irish psychiatry. This landmark legislation reformed the previous legal framework for psychiatric practice, the Mental Treatment Act 1945 (Ireland, 1946). The most significant measures included changes to the process of involuntary detention of persons with mental disorders, including a Mental Health Tribunal, an independent psychiatric assessment and free access to a solicitor. (Children, 2001) The MHA 2001 also led to the establishment of the Mental Health Commission, which is an independent statutory body whose functions are to promote high standards in the delivery of mental health services and to ensure the interests of individuals admitted involuntarily are protected. The MHA 2001 includes provisions for appeal of the result of a tribunal. It also places legal limits around the use of treatment without consent for involuntary patients. An underlying objective of the MHA 2001 was to bring the practice of involuntary admission into line with the European Convention for the Protection of Human Rights and Fundamental Freedoms (1950). (Council of Europe, 1951)

The period leading up to the implementation of the MHA 2001 involved much rich debate on the appropriate shape of the ethical and legal framework for the Irish mental healthcare system. This debate was informed by studies of existing practice in Ireland. For example, Rooney et al reviewed the practice of involuntary detention in an independent hospital in 1996. They found that patients were often unaware of their rights and details of their involuntary admission and a large proportion were not even aware that they had been admitted involuntarily. (Rooney, Murphy, Mulvaney, O'Callaghan, & Larkin, 1996)

The considerable international discussion and guidance on human rights of persons with mental disorders contributed to the context of the formulation and implementation of the MHA 2001. The human rights origins of mental health legislation can be traced to the United Nations (UN) Universal Declaration of Human Rights (UN, 1949) and the European Convention on Human Rights (ECHR) (Council of Europe, 1951). Over recent years, these principles have been further elaborated, for example in the WHO's 1996 Guidelines for the Promotion of Human Rights of Persons with Mental Disorders (WHO, 1996). These international standards have been accompanied by a rich literature, discussing and comparing international practice (Appelbaum, 1997; Zinkler & Priebe, 2002).

This review aims to provide an overview of research into various aspects of the MHA 2001, since its implementation in 2006. We will not discuss the functioning of the MHA 2001, as it has been described elsewhere by Kelly (2002). However, there are a few changes that we will specify to facilitate understanding of the articles included in the review. Firstly, under the MHA 2001 individuals with a sole diagnosis of a personality or substance use disorder cannot be admitted involuntarily (Ireland, 2001). Secondly, the MHA 2001 led to the provision of authorized officers, who are employees of the health service and are authorized to commence the first stage of the process of having an individual assessed for consideration for an involuntary admission. In this review, we aim to review the implementation of the MHA 2001 under key headings, including the rates of involuntary admission and the use of physical coercion, perceptions of the MHA 2001 by key stakeholders, amendments to the MHA 2001, possible future changes to the MHA 2001 and a comparison of the Irish legislation with international standards and recommendations.

2.0 Methods:

We conducted a literature review, searching Medline and Google Scholar for all articles containing reference to the term “Mental Health Act 2001” since 2001. We excluded papers which did not contain original research into the Mental Health Act 2001, including discussion papers, government reports and papers which exclusively addressed speciality areas, namely learning disability, child and adolescent and forensic psychiatry. Searches of Google Scholar and Medline took place on 18th May 2012. These yielded 232 results from Google Scholar and 392 from Medline, of which thirteen fulfilled inclusion criteria from the former and four from the latter. All of these papers were included in the thirteen located through Google Scholar. In addition to these resources, we searched a number of other sources. The catalogues of the Irish Journal of Psychological Medicine and the Psychiatrist (previously Psychiatric Bulletin) were manually searched and one further paper was found by this method. Reference lists for papers were examined for any relevant research. We also contacted the College of Psychiatry of Ireland to enquire about any abstracts concerning the MHA 2001 that had been presented at conferences, yielding two poster abstracts. These methods located three further presentations and papers of interest in addition to the thirteen previously located, leading to a total of sixteen research papers, reviewed below. Themes for the review emerged from analysis of these sixteen papers and the international research into mental health legislation. The search method is illustrated in figure 1.

3.0 Results

3.1 Practice of involuntary admission:

3.11 Rates of involuntary admission

The national data from the Mental Health Commission on rates of involuntary admission indicates that there have been gradual changes. Since the initial implementation of the MHA 2001, the overall number of involuntary admissions, under both form 6 (admitted involuntarily) and form 13 (initially admitted voluntarily and then subsequently detained), has fallen from 50.14 per 100,000 in 2007 to 46.04 in 2010 (MHC, 2007, 2008, 2009a, 2010). A study undertaken in a community service in Dublin's south inner city found no significant difference in the overall number of involuntary admissions between 2006 and 2007 (Nwachukwu, Crumlish, Heron, & Gill, 2010). However the study did find that there was an increase in the proportion of admissions that were involuntary. Furthermore, the study found that there was no difference in the length of the involuntary admissions before and after the implementation of the MHA2001. Individuals who had previously been admitted involuntarily were found to have longer periods of voluntary status as part of their admissions following implementation. (Nwachukwu et al., 2010) Another study undertaken in County Galway also found that there was no change in the rate or duration of involuntary admissions before and after the implementation of the MHA2001. (Murray, Hallahan, & McDonald, 2009) In a private psychiatric hospital in Dublin there was an initial reduction in the total number of involuntary admissions however the admission rate returned to previous levels in the third year of implementation of the MHA 2001. (Clancy, Clarke, & Lane, 2008) Similarly, a decrease in the duration of the average involuntary admission was significant for the first two years after implementation, but not for the third year. (Clancy et al., 2008)

3.12 Demographic and Clinical Characteristics of Individuals admitted under the MHA2001

The Mental Health Commission reported that the diagnoses of those admitted involuntarily across Ireland have not changed significantly since implementation. Table 1 illustrates the number of patients detained according to ICD-10 diagnoses, as reported to the Mental Health Commission and presented in their annual reports. (MHC, 2007, 2008, 2009a, 2010) The broad diagnostic categories of those admitted have not changed significantly over the four years presented, the two most common being primary psychotic disorders and bipolar affective disorder/schizoaffective disorder, making up 73% of involuntary admissions in 2010. Interestingly, despite changes in the diagnostic criteria for involuntary admission under the MHA2001, individuals with a diagnosis of a personality disorder and substance use disorders continue to be admitted involuntarily, as displayed in Table 1, making up about 5% of involuntary admissions in 2010.

Studies examining rates of involuntary admission under the MHA 2001 did not find any change in the demographic and clinical characteristics of individuals admitted involuntarily under the MHA2001 as compared to the previous legislation. (Clancy et al., 2008; Murray et al., 2009; Nwachukwu et al., 2010) Specifically, there was no difference in gender, employment status, nationality, diagnosis or category for application for involuntary admission (i.e. risk to self or others and risk of deterioration in mental state). One study found that there had been an increase in the mean age of individuals admitted involuntarily since the implementation of the MHA2001. (Clancy et al., 2008) A recent study compared the clinical and demographic characteristics of patients detained involuntarily with those admitted voluntarily in a north-central Dublin centre. (Ng & Kelly, 2012) Their centre had a higher rate of involuntary admission (67.7 per 100,000) than the national average (38.5 per 100,000), consistent with its setting in a deprived urban area. Immigrants were more likely to

have involuntary status (34%) compared to those born in Ireland (12%). However, this was confounded by diagnosis in multivariate analysis.

3.13 Applicants:

There has been a gradual change in the identity of applicants since 2007, with spouses and relatives having fallen from 69% to 61% of applications and Police ('Garda Siochana') having risen from 16% to 23%. The use of the authorised officer has remained constant at 7% since 2007. (MHC, 2007, 2008, 2009a, 2010) This is consistent with the study undertaken by Murray et al, who found the proportion of family applicants for involuntary admission to their service had fallen from 85% to 54% following implementation of the Act. (Murray et al., 2009) In a study undertaken in Dublin, approximately one quarter of individuals reported that their involuntary admission had a negative impact on their relationship with their family. However, this was not associated with the family being the applicants for the involuntary admission order. (B. O'Donoghue et al., 2009)

3.14 Incomplete Involuntary Admission Orders

The Mental Health Act 2001 has significantly changed the criteria for detention and documentation of the process. Under the MHA 2001, there are significant changes to the diagnostic criteria for involuntary admission and this could have led to the incorrect referral for involuntary admissions for individuals who were not eligible. In an audit of referrals for involuntary admission in the Longford and Westmeath catchment area there was no significant change in the percentage of involuntary admission orders that were not completed

(37%). (Rafiq & O'Hanlon, 2010) However, the audit found that involuntary admission orders were sometimes not completed due to incorrectly completed forms. (Rafiq & O'Hanlon, 2010) A further audit in a community mental health service in Dublin, found that approximately 30% of individuals referred for involuntary admission did not have their order completed. (Murphy, Smith, Barry, & Feeney, 2012)

3.15 Mental Health Tribunals:

The Mental Health Act 2001 makes provision for a Mental Health Tribunal within three weeks of admission. If an individual's legal status changes to voluntary within this time period the Mental Health Tribunal can proceed but only at the request of the service user. National statistics indicate that 57% (1,724/3,054) of individuals admitted involuntarily had a mental health tribunal, including those with involuntary admission orders, patients re-graded from voluntary to involuntary and renewal orders. (MHC, 2010)

In a mental health service in Galway, 68% of individuals had their status changed to voluntary within three weeks of admission and none of these individuals requested for their Mental Health Tribunal to proceed. (Murray et al., 2009) A study undertaken in Dublin also found a low rate of review by a tribunal among their Dublin sample, with only 42% having a Mental Health Tribunal. (Murphy et al., 2012) In another study undertaken in Dublin, it was found that 48% of individuals admitted involuntarily had a mental health tribunal and over half of individuals disagreed with the findings of the Mental Health Tribunal prior to discharge. (B. O'Donoghue et al., 2009) In a national survey, it was acknowledged by consultant psychiatrists that involuntary admission orders may be revoked early to avoid a Mental Health Tribunal. (B. O'Donoghue & Moran, 2009)

3.2 Use of physical coercion

3.21 National statistics for the use of seclusion, restraint and medication without consent

The Mental Health Commission routinely publishes data on the use of seclusion and restraint, most recently for the year 2009. There were 5,387 cases of physical coercion recorded with 47% of these being episodes of seclusion, 53% episodes of physical restraint and 0.3% episodes of mechanical restraint. (MHC, 2009b) The rates of physical coercion vary widely amongst catchment areas, for example rates of seclusion range from 2.8 per 100,000 in North Lee and North Cork to 112.0 per 100,000 in Dublin North Central and North West. The second highest rate was 75.5 per 100,000 in Waterford and Wexford. The duration of seclusion varies but nearly two thirds of episodes of seclusion last for an hour or less, with about 8% extending beyond 16 hours. However, the duration of seclusion varied from unit to unit, with all seclusion episodes lasting less than four hours in some centres, while 79% of episodes lasted longer than eight hours in the Central Mental Hospital. Physical restraint was also common with 2,855 episodes in 2009 and this form of physical coercion was used in all geographical areas. While the use of seclusion and physical restraint were common, mechanical restraint was only used in six approved centres (9%) in 2009 with a total of 15 episodes. This indicates a significant reduction from the 71 recorded in 2008. Prior to the MHA 2001, there was no formal method of measuring restraint or seclusion and therefore the use after implementation of the MHA 2001 cannot be compared to previous practice. It also should be noted that a number of approved centres do not have the facilities for seclusion and service users who required seclusion may be transferred to other approved centres, such as St

Brendans Hospital or the Central Mental Hospital. This practice could explain some of the variation in the use of restraint and seclusion between approved centres.

3.22 Local research on the use of physical coercion

The practice of seclusion was examined in a 29-bed unit in Leinster over a 12-month period. (Prinsloo & Noonan, 2010) During this time, there were 52 episodes of seclusions involving 26 service users over 28 admissions and 10% of these individuals had been in seclusion for over 72 hours. The study found that one third of service users who experienced seclusion had been admitted voluntarily initially. However all individuals except one had their legal status changed either at initiation of seclusion or during its practice. (Prinsloo & Noonan, 2010)

The use of physical coercion was examined in a cohort of 98 individuals admitted involuntarily in a Dublin mental health service. This found that 36% experienced restraint, 18% experienced seclusion and 38% were brought to hospital by either the assisted admissions team or the police. (B. O'Donoghue, Lyne, Hill, Larkin, et al., 2011) Overall, 56% of individuals experienced at least one of these coercive measures and the use of physical coercion was found to not be related to the perception of procedural justice, a measure of how fairly and respectfully a person feels they were treated. (B. O'Donoghue, Lyne, Hill, Larkin, et al., 2011)

3.23 Administration of Electro-convulsive therapy (ECT) under the MHA 2001

The MHA 2001 governs the administration of ECT to those admitted involuntarily and who are either unable or unwilling to provide consent. A patient detained under the MHA 2001

can give consent in writing for ECT. In a case where an individual is unwilling or unable to provide consent, the programme of ECT must be approved by their consultant psychiatrist and by a second consultant psychiatrist. ECT can only be provided to involuntary patients under rules laid out by the MHC. (MHC, 2012) The most recent data from the MHC covering 2010 indicates that 16% of patients receiving ECT were admitted involuntarily. However, many of these patients provided consent and 10% of ECT programmes were administered to involuntary patients who were either unwilling or unable to consent to ECT. (MHC, 2012) There is significant regional variation in the use of ECT. (Dunne & McLoughlin, 2011) However, there are no statistics available on variation according to the legal status of the patient.

3.24 Amendments to the Mental Health Act 2001

The practice of involuntary detention has been reviewed by the Irish Courts since the implementation of the MHA 2001. The SM Judgment found that many detentions were illegal on the grounds that they did not specify a date for renewal or discharge. (Cummings & O'Connor, 2009) However, the effect of social issues, namely housing, in delaying discharge were not considered by the court, despite this being the basis for the review. Cummings and O'Connor (2009) discussed that while this judgment was reasonable, it did not address the concerns of SM or her consultant that her detention was continued due to the absence of suitable discharge accommodation. The practice of the Health Service Executive (HSE) in not addressing this concern regarding limiting her liberty and also the judgment were therefore at odds with government policy on maintaining patients in the "least restrictive environment" as outlined in A Vision for Change. (Group, 2006) An immediate result of the SM judgment was the passage of the Mental Health Act 2008 (MHA 2008), which was

passed to ensure that renewal orders under the MHA 2001 remained valid despite the SM judgment. Of note, it did not attempt to address issues around rights to suitable accommodation in continuing an involuntary admission.

3.30 Perceptions of the MHA 2001 by key stakeholders

3.31 Service Users Perspectives

In a study undertaken in Dublin, 72% of individuals admitted involuntarily stated prior to discharge that their involuntary admission had been necessary and a positive reflection was related to greater insight into illness. (B. O'Donoghue et al., 2009) In addition, 78% felt that the treatment they had received had been beneficial. However at one year follow-up, a proportion of people changed their perspectives and 60% reported that their involuntary admission had been necessary. (B. O'Donoghue, Lyne, Hill, O'Rourke, et al., 2011) During an involuntary admission, 86% of individuals were aware that they were admitted involuntarily under the MHA 2001, compared with 63% of patients from a study under the previous legal framework. (B. O'Donoghue et al., 2009; Rooney et al., 1996) Regarding mental health tribunals, over half (54%) could identify the three different background roles of those in the tribunal board and 57% felt that their case was adequately presented by their solicitor. In addition, the introduction of a review of the involuntary admission order by a mental health tribunal made the involuntary admission easier to accept for 46% of individuals. (B. O'Donoghue et al., 2009)

For many individuals, the involuntary admission had a negative impact on their relationship with their family and others, with 28% reporting a negative impact upon the relationship with

their family. There was a negative impact on the relationship with the consultant psychiatrist for 27% and a positive impact for 8%. Over one quarter of individuals admitted involuntarily reported that the involuntary admission resulted in negative consequences in their relationship with their family, their therapeutic relationship or their work prospects. (B. O'Donoghue et al., 2009)

3.32 Consultant Psychiatrists

The Mental Health Act 2001 aroused considerable debate in the psychiatric literature prior to its implementation and concerns were raised about the treatment of children, management of those with limited or diminished capacity, adequate resource provision for implementation, adequate training in the Act, the practice of tribunals and appropriate interaction with the police. (Ganter, Daly, & Owens, 2005)

A survey of consultant psychiatrists and trainees after implementation of the MHA 2001 highlighted serious concerns related to increased workload (69%), decreased time with service users (27%) and changes to the relationship with service users (41%). (Jabbar, Kelly, & Casey, 2010) Negative views were expressed about the adversarial nature of mental health tribunals, effects on therapeutic relationships and issues around the management of children. (Jabbar et al., 2010) Another survey of consultant psychiatrists found that most agreed that individuals should not be admitted involuntarily solely on the grounds that they suffer from a personality disorder (78%) or substance misuse, although 58% felt this led to a risk that such patients would not be admitted in situations where it was clinically necessary (B. O'Donoghue & Moran, 2009). While 73% believed that the rights of patients who had been admitted involuntarily had been respected following implementation and 32% felt that care of

these patients had improved, 48% stated that care of voluntary patients had deteriorated. 14% of consultant psychiatrists acknowledged that they had readmitted a patient involuntarily immediately after a tribunal had revoked the original order. Implementation appears to have had an adverse effect on many other areas of practice, including a reduction in junior doctor training by consultants (57%) and an increase in on-call workload (87%). Concerns specifically raised by respondents included the lack of provision in the Act around the treatment of voluntary patients who refuse treatment but are willing to remain in hospital (B. O'Donoghue & Moran, 2009).

3.33 General Practitioner (GP) Perspectives

The views of Irish GPs to the legislative changes have also been assessed and 53% of GPs were experiencing difficulties with the legislation, 85% reported an increase in workload and 63% reported that the legislation was not user-friendly. (Jabbar, Doherty, Aziz, & Kelly, 2011) The authors suggest that training may be helpful in addressing this and note that fewer GPs with training experienced difficulties (57%) compared to those without training (69%). (Jabbar et al., 2011) In another survey of a sample of 568 GPs, 75% had been involved in an involuntary admission and, among these, nearly one quarter reported that it takes seven or more hours to complete an admission. (M. Kelly, O'Sullivan, Finegan, Moran, & Bradley, 2011) Half of GPs stated that they felt sufficiently confident to complete the necessary paperwork. GPs voiced dissatisfaction with arrangements for transport of patients, particularly regarding a perceived delay during emergency situations. Furthermore, GPs voiced concern that those receiving patients were more concerned with correct paperwork than with patient wellbeing (M. Kelly et al., 2011).

3.34 Nursing perspectives:

In a survey of 317 nurses, 56% reported that their workload had increased and concerns were expressed regarding increased paperwork and a lack of legal clarity (Doherty, Jabbar, & Kelly, 2011). Similar to GPs, nursing staff conveyed a sense that there is excessive focus on legal technicalities. A majority noted the need for further training in the legislation.

4.0 Comparison of the Mental Health Act 2001 to international standards

The MHA2001 has been reviewed in the context of recent legislation in England and Wales and the World Health Organisation (WHO) Resource Book on Mental Health (B. D. Kelly, 2011). This Resource Book sets out 175 standards regarding human rights in mental health legislation and it was reported that the MHA 2001 complied just under half of the standards (48.2%) compared with just over half in England and Wales (54.2%). Areas of high compliance include definitions of a mental disorder, procedures for involuntary admission and treatment and clarity regarding offences and penalties. There is medium compliance around issues of competence, capacity and consent in all jurisdictions, though these areas are of more concern in Ireland than in England and Wales. Other areas of medium compliance are oversight and review and rules governing special treatments, seclusion and restraint. Areas of low compliance include promoting rights, voluntary patients rights, protection of vulnerable groups and emergency treatment, with the greatest deficit being in the area of economic and social rights.

Four key areas need rectification and clarification in England and Wales and Ireland in the context of the WHO guidelines (B. D. Kelly, 2011). Further measures are necessary to protect

and promote the rights of voluntary patients, especially regarding informed consent and the status of non-protesting patients. Furthermore, the situation in Ireland is especially poor with regard to issues around competence, capacity and consent. Thirdly, the relationship between common law and mental health law requires clarification, though this is more relevant to England and Wales than to Ireland. Finally and crucially, the active promotion of economic and social rights of those with mental illness requires consideration. There are no measures to reduce discrimination against people with mental disorders or to ensure housing, employment or social security. There is no specific promotion of community care, though the MHA 2001 does emphasise treatment in the least restrictive setting. It was suggested that these issues would be best addressed through changes to mental health legislation rather than through general legislation (B. D. Kelly, 2011).

The EUNOMIA study examined service users' perspectives of involuntary admission across eleven European countries and made suggestions for the best clinical practice in involuntary admissions (Fiorillo et al., 2011). These recommendations addressed a number of areas, including clinical conditions and legal pre-requisites for involuntary hospital admission, professional involved, relationships with the patient and their relatives, ethical issues, the use of a therapeutic plan and proposals to improve patients' health care.

The MHA 2001 is in accordance with these guidelines regarding clinical conditions and legal pre-requisites for involuntary admission. EUNOMIA proposes that the community mental health team should conduct the first comprehensive clinical examination leading to involuntary admission (Fiorillo et al., 2011). Under the MHA 2001, GPs perform this duty in Ireland and as previously discussed, GPs have stated that they find this duty time-consuming. EUNOMIA recommends clear police involvement in admission only when all alternatives

have been exhausted and only with written requests (Fiorillo et al., 2011). This is not the practice in Ireland under the MHA 2001. Legal practice in Ireland regarding the involvement of hospital teams and the conduct of hearings are in accordance with EUNOMIA guidelines. The MHA 2001 broadly agrees with EUNOMIA recommendations that patients should be fully informed on their admission of their legal status and rights. Practice in Ireland also follows the recommendation that contact be allowed outside of the ward with relatives and others. EUNOMIA recommends the use of the least restrictive practices, admission to the closest hospital, clear time limits on legal aspects of the detention procedure and the necessity of assessment by a psychiatrist (Fiorillo et al., 2011). These are both aspired to and broadly practiced in Ireland, except the absence of community treatment orders (CTOs) means that treatment in the least restrictive environment is not always provided. Therapeutic plans are not addressed under the MHA 2001 but the MHC has increasingly emphasised their necessity to appropriate practice in Ireland (MHC, 2010). EUNOMIA recommends that where patients lack capacity to consent to their treatment plan, their relatives should be involved (Fiorillo et al., 2011). The MHA 2001 does not address issues around involvement of relatives in terms of providing information and their formal involvement in treatment planning. However, this could be addressed within additional capacity legislation.

5.0 Potential changes to the MHA2001

5.1 Advance Directives

Advance directives are legal documents that allow patients to convey decisions about care ahead of time (Srebnik & La Fond, 1999). One means of achieving autonomy for patients is the suggestion to develop psychiatric advance directives. These would allow service users to

have a greater sense of control over their treatment in the context of an involuntary admission and could therefore play a role in maintaining service user engagement. There can be significant benefits to the introduction of advance directives: enhancement of patient autonomy and direct amelioration of some of the negative consequences of mental illness (Morrissey, 2010). Existing research indicates openness to the introduction of psychiatric advance directives in Ireland among patients, as 84% of service users would be interested in an advance directive in their treatment care plan (B. O'Donoghue et al., 2010). Legislative change around advance directives could take place in the context of much needed capacity legislation or through either standalone change or broader mental health reform.

5.2 Community Treatment Orders

Community treatment orders (CTOs) are a mechanism for providing involuntary treatment in a less restrictive manner and environment. These are established practice in a number of other jurisdictions, including the United Kingdom (Kisely, Campbell, & Preston, 2011). Government policy on mental health, outlined in A Vision for Change, advocates the provision of treatment and care in the community and specifies that home-based treatments should be the main method of treatment delivery (Group, 2006). In a survey on the location of treatment, 41% of patients who had been admitted involuntarily would have preferred to have been treated in their home (B. O'Donoghue et al., 2010). This preference was more marked among those with an affective disorder and those who had experienced their first admission. This would indicate that if psychiatrists were satisfied that the clinical presentation and risks could be appropriately and safely managed in the community, there would be a significant group of service users who would prefer this option.

5.3 Capacity legislation

The lack of capacity legislation has been raised as a key area in need of clarification in a number of recent reviews of legislation, most recently in a comparison of legislation in Britain and Ireland (Jabbar et al., 2011). The issue of capacity is connected to legal ambiguity around the status of voluntary patients who lack capacity to remain in hospital. This ambiguity can cause considerable difficulty in ensuring appropriate treatment. Currently, a voluntary patient can elect to stay in hospital but refuse all treatment. Similarly, there is uncertainty around the status of voluntary patients who do not desire to leave hospital but experience coercion, a situation that does arise (MHC, 2009b).

Voluntary patients may also lack many of the legal protections applied to involuntary patients, for example in the area of ECT. Currently, the law around the use of ECT for involuntary patients demands clear standards for such treatment. However, there is no provision for the use of ECT for voluntary patients whose mental state has deteriorated but who do not seek to leave hospital (Dunne & McLoughlin, 2011). The Wards of Court system is the only current legal recourse but this approach has been criticised by the Law Reform Commission (Dunne & McLoughlin, 2011). It is anomalous that MHC standards exist for involuntary patients but the same standards are not applied to voluntary patients, who may or may not maintain capacity. Capacity legislation would not answer all of these questions but it could help with some of these issues. Debate on capacity legislation would also allow discussion of the use of advance mental health directives, as previously discussed

6.0 Discussion

6.1 Practice of involuntary admission

There has been no significant change in the rate of detention since the implementation of the MHA 2001. Rates of involuntary admission vary considerably across jurisdictions (Zinkler & Priebe, 2002). Similarly, legal regulations for involuntary detention of mentally ill persons vary considerably (Dressing & Salize, 2004). For example, in the United States there has been a trend to replace the need for treatment as a defining criterion with dangerousness (Appelbaum, 1997). While the legislative change brought by the MHA 2001 has enhanced the human rights status of detained persons with mental disorders, it has not substantially changed the diagnostic criteria around detention criteria. It is therefore unsurprising that rates of detention have not substantially altered. Nonetheless, the findings presented highlight the importance of further research to clarify factors leading to changes in rates of involuntary detention both within jurisdictions and internationally. The finding that a higher proportion of non-Irish nationals admitted into mental health settings were admitted involuntarily can be explained by diagnostic factors, specifically diagnosis of schizophrenia. This finding warrants further investigation to determine whether immigrant groups in Ireland are more susceptible to serious mental illness, as has been found in other western countries (Singh, 2007).

6.2 Coercion under the MHA 2001:

Physical coercion, specifically restraint and seclusion, unfortunately remains common practice in mental health services in Ireland. This is particularly the case for seclusion and physical restraint, while mechanical restraint is a rare event. However, the prevalence of physically coercive practices vary considerably across the state. Recent international experience indicates that services can minimise the use of physical coercion in the context of

a move towards a recovery model (Ashcroft, Bloss, & Anthony, 2012). Given the variety of practice in Ireland, it would be interesting to see if a practice such as “No Force First”, as discussed by Ashcroft et al, could be replicated in Ireland and how this might affect other outcomes, including service engagement and patient acceptance of involuntary admission.

6.3 Perceptions of the MHA 2001:

Five years after implementation of the Mental Health Act 2001, significant changes to the process of involuntary admission have been introduced and have brought the practice more into line with human rights standards. For a practice that involves depriving individuals of their civil liberties to ensure they receive appropriate treatment for their mental health disorder, a majority of these individuals reflect that involuntary admission had been necessary and nearly half of individuals found the mental health tribunal beneficial. Healthcare professionals acknowledge that the care of individuals admitted involuntarily has improved, however they have expressed strong concerns about the lack of resources to implement these changes and that it may result in less time for voluntarily admitted service users and for training. It is unfortunate that to date there have been no published studies on caregiver and family perspectives of involuntary admission under the MHA 2001.

Much stakeholder feedback on the MHA 2001 has been negative and many of these criticisms are understandable. Enhanced transparency and legal oversight of involuntary detention has placed demands on primary care physicians, psychiatrists and nurses in terms of time and documentation. This experience provides lessons for future national and international mental health legislative reform regarding the need to consider the resource implications in terms of time and opportunity cost of enhanced human rights protections.

6.4 The MHA 2001 and international standards of human rights:

It must be remembered that the MHA2001 was introduced to ensure that the human rights of individuals admitted involuntarily are respected and that the practice adheres to the European Convention on Human Rights (ECHR) (Council of Europe, 1951). While most rights of the ECHR can be applied to mental health legislation, the specific rights most relevant to mental health are prohibition of torture (Article 3), the right to liberty and security (Article 5), no punishment without law (Article 7) and prohibition of discrimination (Article 14). Article 5 requires that a person can be detained during periods of “unsound mind” in the context of appropriate legal reviews. In addition, this Article requires that those detained must be informed of the reasons for their detention. The ECHR systematically defends these negative rights in mental health law but generally does not address positive rights, such as entitlement to specific services (Gostin, 2000). The rights outlined in the ECHR and in court rulings in relation to it have largely been implemented in the MHA 2001.

Since enactment of the MHA 2001, there have been further advances in terms of international standards of human rights. In 2005 the WHO published their Resource Book on Mental Health, Human Rights and Legislation (Freeman, Pathare, & World Health Organization., 2005). As we have seen, Irish adherence with these standards is mixed (B. D. Kelly, 2011). In 2006, the UN agreed the Convention on the Rights of Persons with Disabilities (CRPD) (UN, 2006). This outlines eight general principles regarding rights for persons with disabilities, including individual autonomy, non-discrimination and full and effective participation and inclusion in society. The CRPD has particular relevance regarding issues of capacity and consent in legislation (B. D. Kelly, 2011). While a full analysis of the relationship between

the MHA 2001 and human rights is beyond the scope of this review, previous literature addressing these questions will be discussed.

Irish legislative change has occurred in the context of considerable international legal reform of mental health law. Analysis of trends in mental health legislation across the Commonwealth of Nations indicates that more recent mental health legislation is associated with broader diagnostic criteria, use of capacity and treatability tests, treatment delivery in the interest of health rather than safety and regular reviews of treatment orders (Fistein, Holland, Clare, & Gunn, 2009). However, these trends are not universal. Of particular note to Ireland, legislation in England and Wales has diverged from this move toward increased patient autonomy (Fistein et al., 2009). Certain jurisdictions, such as Australian jurisdictions, have emphasised patient rights to a more limited extent, placing more emphasis on treatment (Gray, McSherry, O'Reilly, & Weller, 2010). The Irish MHA 2001 appears to have followed trends observed in Commonwealth nations, particularly with relatively broad diagnostic criteria, treatment mandated for health as well as safety and regular reviews of treatment orders. Furthermore, the MHA 2001 requires considerable need for treatment as well as incapacity due to the patient's condition in order to provide treatment.

However, the international literature highlights some ongoing issues in the accordance of the MHA 2001 with international human rights standards, particularly around the protection of voluntary patients and competence, capacity and consent. One particular area of concern from a human rights perspective is ECT, which may be given to involuntary patients in the presence of capacity where the patient is unwilling. There are further tensions arising in the legislation from the absence of an avenue to provide treatment in the "least restrictive" setting and the absence of provision for advance directives.

6.5 Potential changes to the MHA 2001:

The existing research highlights a considerable discrepancy between the theory and practice of mental health measures in Ireland. The MHA 2001 considerably improved the consistency of Irish mental health law with human rights standards. A Vision for Change recommendations built on this foundation by outlining how services should be developed in the community setting with the service user working with a multidisciplinary team in planning their treatment. While there has been progress in implementing A Vision for Change, the emphasis on community based treatment has not translated into legislative reforms aimed at minimising involuntary inpatient treatment.

CTOs have been used internationally over many years as an alternative to involuntary admission or to reduce the length of admission. However, a Cochrane review found that their success in minimising involuntary admission remains unclear (Kisely et al., 2011). A clinician survey in four Commonwealth countries indicates more confidence regarding their success in specific situations (O'Reilly, Dawson, & Burns, 2012). There would be considerable support for the use of CTOs among certain patient groups in Ireland, most notably among those with affective disorders, a group that would benefit less in the views of many clinicians (O'Reilly et al., 2012). To date, clinician views appear to be mixed, with a discussion paper on whether CTOs should be introduced in Ireland concluding that there is currently limited evidence on their effectiveness and suggesting a 'wait and see' approach would be most appropriate over coming years as evidence gathers from neighbouring jurisdictions (Walsh, 2010). However, during any review of current mental health law, it may be appropriate to review international evidence regarding the application of CTOs in Ireland.

Experience with the MHA 2001 indicates that while legislative change would significantly improve community alternatives to involuntary detention, non-legislative changes in practice could also enhance community treatment options. The most important experience in this regard is around the SM Judgment and the MHA 2008. This case highlighted the lack of provision for economic and social rights for a vulnerable group of people and deficiencies in the promotion of community treatment. The case resulted in the rapid passage of the MHA 2008, necessary given that the SM Judgment indicated that a considerable number of renewal orders for involuntary admissions would otherwise be invalid. However, questions raised by the case did not lead to legislative reform around economic and social rights or resource allocation to support existing rights.

A further related issue is the discrepancy in current legal protections and human rights standards for involuntary and voluntary patients. While the MHA 2008 was passed rapidly to address an immediate legal issue, capacity legislation to clarify the legal situation for voluntary patients who lack capacity to consent to remain in hospital or accept treatment has been delayed considerably. Such capacity legislation could also address patient advance directives.

In addition to ensuring that each country's mental health legislation adheres to human rights doctrines, mental health services should also provide interventions that have been shown to reduce involuntary admissions. One promising development in achieving this is the use of a Joint Crisis Plan, which is currently under study in the UK after a pilot study showed a reduction in compulsory treatment with its use (Thornicroft et al., 2010). There is also some evidence to suggest that treatment adherence therapy may reduce involuntary admissions

(Staring et al., 2010). As is the case with improved legal checks on the involuntary process, measures that reduce the need for compulsory detention and treatment have the potential to improve the acceptability of the process when and after it occurs.

7.0 Conclusion:

The MHA 2001 has considerably improved the human rights framework for individuals affected by mental illness who are admitted involuntarily in Ireland. There is evidence that many measures within the legislation, particularly the Mental Health Tribunal, have improved satisfaction with the process of involuntary admission and treatment. The research presented in this review highlights this improvement but also areas of potential reform, such as measures to reduce involuntary admission, human rights issues for voluntary patients and a need for more training for mental health professionals in mental health law and its human rights underpinnings.

Table 1: Diagnoses of individuals admitted involuntarily between 2007 to 2010 (Mental Health Commission, 2007; Mental Health Commission, 2008; Mental Health Commission, 2009a; Mental Health Commission, 2010)

	Number of episodes (%)			
Diagnoses	2007	2008	2009	2010
Schizophrenia, Schizotypal and Delusional Disorders	800 (38)	838 (52)	811 (48)	563 (49)
Bipolar Affective Disorder/ Schizoaffective disorder – Mania	437 (21)	395 (24)	435 (26)	273 (24)
Major Depressive Disorders	158 (7)	153 (9)	152 (9.0)	90 (8)
Organic Disorders	102 (5)	99 (6)	115 (7)	81 (7)
Substance Use Disorders	43 (2)	34 (2)	57 (3)	51 (4)
Alcohol Use Disorders	39 (2)	29 (2)	32 (2)	30 (3)
Anxiety Disorders	31 (2)	38 (2)	30 (2)	21 (2)
Personality and Behavioural Disorders	16 (0.8)	18 (1)	29 (2)	21 (2)
Eating Disorders	6 (0.3)	8 (1)	3 (<1)	1 (<1)
Intellectual Disability	9 (0.4)	4 (<1)	10 (1)	7 (1)
Developmental Disorders	0 (0)	0 (0)	3 (<1)	0 (0)
Other Diagnoses	10 (1)	9 (1)	5 (<1)	7 (1)
Unrecorded	475 (22)	0 (0)	0 (0)	0 (0)
Total	2,126 (100.00)	1,625 (100.00)	1,682 (100.00)	1,145 (100.00)

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