REPORT OF THE EXPERT GROUP ON THE REVIEW OF THE MENTAL HEALTH ACT 2001: WHAT DOES IT MEAN FOR SOCIAL WORKERS?

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Abstract

Involuntary psychiatric admission and treatment in Ireland is governed by the Mental Health Act 2001. In 2015, the *Report of the Expert Group on the Review of the Mental Health Act 2001* proposed 165 reforms which, if implemented, will bring substantial changes to psychiatric care in Ireland. The present article focuses on involuntary psychiatric admission and treatment, and outlines (a) current law governing this area; (b) general reforms proposed by the Report of the Expert Group on the Review of the Mental Health Act 2001; and (c) some of the proposed changes that specifically affect social workers, including developing the role of authorised officers, and enhancing requirements for multi-disciplinary input to certain decisions regarding involuntary admission and treatment. This period of reform offers valuable opportunities for social workers and others to help further protect and promote the rights of the mentally ill.

Key Words: Mental health, Psychiatry, Social work, Legislation, Human rights, Ireland.

Introduction

In March 2015, Minister of State for Mental Health Kathleen Lynch published the *Report of the Expert Group on the Review of the Mental Health Act 2001*. The report presents 165 recommendations which, if implemented, would bring radical changes to psychiatric care in Ireland. All mental health professionals, including mental health social workers, would be affected by the proposed changes. The present article focuses on involuntary psychiatric admission and treatment, and outlines (a) current law governing this area in Ireland; (b) general reforms proposed by the *Report of the Expert Group on the Review of the Mental Health Act 2001*; and (c) some of the proposed changes that specifically affect social workers.

(a) Involuntary Psychiatric Admission and Treatment in Ireland: The Current Position

In 2014, there were 17,797 psychiatric admissions in Ireland, of which the vast majority (88 per cent) were voluntary (Daly and Walsh, 2015:21). Far greater numbers were treated on an outpatient basis in primary care or by community mental health teams and voluntary organisations. Among the minority of mental health service-users who were involuntarily admitted, the most common diagnosis was schizophrenia (18.9 involuntary admissions per 100,000 population), followed by mania (8.7) and depressive disorders (4.5).

Involuntary admission and treatment is governed by the Mental Health Act 2001 which introduced important protections of human rights for detained persons, following full implementation in 2006. Key improvements included removing detention orders of indefinite duration; new involuntary admission procedures; automatic review of detention orders by tribunals; free legal representation and independent psychiatric opinions for detained patients; and establishment of the Mental Health Commission to oversee standards.

At present, the procedure for involuntary admission comprises a three key steps. It is first necessary that someone (e.g. a family member) apply for involuntary admission; this role can also be played by a Garda, member of the public or 'authorised officer', who is 'an officer of a health board who is of a prescribed rank or grade and who is authorised by the chief executive officer to exercise the powers conferred' by Section 9 of the Act (i.e. to make an application). A social worker may act as an authorised officer if appropriately trained for the role.

Next, a doctor (e.g. general practitioner) must examine the person and agree that involuntary admission is necessary (if appropriate). Following this, the person can be brought to the 'approved centre' (i.e. psychiatric unit or hospital). Within 24 hours of arrival, a consultant psychiatrist must examine the person and, if in agreement, sign a 21-day involuntary admission order. (A different procedure applies if the person is already a voluntary inpatient.)

Once involuntary admission occurs, the patient is assigned a solicitor under a free legal aid scheme and the Mental Health Commission sends an independent psychiatrist to examine the patient. A mental health tribunal then reviews the involuntary admission order within 21 days. The tribunal is independent of the hospital; has a lay (non-medical) majority; decides by majority voting; and has the power to discharge the patient. Patients are provided with further legal aid and funding for psychiatric opinions if they appeal to higher courts.

Once detained, a patient can receive medication without consent only if certain additional conditions are fulfilled. If he or she is deemed to require electro-convulsive therapy (ECT) and is either 'unable or unwilling' to consent, there is a further requirement for another examination and opinion. All of these provisions were either introduced or substantially revised by the 2001 Act with the intention of better protecting patient rights.

As a result, the 2001 Act clearly holds strong potential to protect specific rights (e.g. right to liberty), enhance

patient dignity, and promote the exercise of specific capabilities (especially in relation to reviews of involuntary detention). These potential benefits are, however, accompanied by significant caveats, with court cases often indicating strong paternalistic or welfare-based considerations in the years since full implementation.

Other human rights concerns relate to lack of clarity regarding the extent to which procedural aberrations are over-looked by tribunals; the absence of cumulative tribunal case-law; restrictions on grounds for civil proceedings in Circuit and High Courts; the fact that the burden of proof lies with the patient in the Circuit Court; and the notably paternalistic definition of voluntary patient, which does not require an person to possess mental capacity in order to become or remain a 'voluntary' patient.

Critically, there is also evidence of arguably excessive emphasis on paternalism and welfare-based concern in the interpretation of the 2001 Act in the Irish courts, and it is unclear whether or not this is proportionate to the strong paternalistic and welfare-based obligations outlined in the Irish Constitution. This is still a matter of debate. Notwithstanding these concerns, however, it is still readily apparent that the 2001 Act has helped significantly to protect the right to liberty for this group of patients, and Ireland's involuntary admission rate is now relatively low, at 45 per 100,000 population in 2014 (Daly and Walsh, 2015: 21), compared to approximately 54 in England (Expert Group on the Review of the Mental Health Act 2001, 2015:38).

(b) General Reforms Proposed by the Expert Group Review (2014)

In March 2015, the Expert Group on the Review of the Mental Health Act 2001 (of which I was a member) proposed a further series of reforms. One of the key proposals is the replacement of the principle of 'best interests' with a new set of guiding principles to govern decisions made under the Act. The proposed new principles are: (a) the enjoyment of the highest attainable standard of mental health, with the person's own understanding of his or her mental health being given due respect; (b) autonomy and self-determination; (c) dignity (there should be a presumption that the patient is the person best placed to determine what promotes or compromises his or her own dignity); (d) bodily integrity; and (e) least restrictive care.

The Expert Group also proposed several other substantial changes, including redefinitions of 'mental illness', 'treatment' and 'voluntary patient' (now to require mental capacity); a requirement that, for all detained patients, admission and treatment 'would be likely to benefit the condition of that person to a material extent'; additional protections for patients who are not detained but lack mental capacity; reduced burden on families and clearer access to medical care during the involuntary admission process; mandatory multidisciplinary input into detention and treatment decisions; earlier tribunals (to be renamed 'mental health review boards'); shorter renewal detention orders; various measures relating to children; inspection of community facilities; better access to information; and provisions to ensure that any detained patient who has capacity to refuse medication or ECT, and is unwilling to receive it, has that decision respected.

For detained patients who lack mental capacity but still need treatment, the report recommends additional protections in addition to those already in place (e.g. tribunals), ranging from an external review of medication after 21 days (as opposed to the current three months) and a legislative requirement for multidisciplinary input into certain decisions about involuntary treatment. It is also proposed to reverse the burden of proof in the Circuit Court.

The College of Psychiatrists of Ireland (of which I am a member) warmly welcomed the Expert Group report, noting that it 'will advance the rights of those patients with mental illness who are involuntarily detained' and 'recommends changes to protect those who lack capacity but who do not fulfil criteria for involuntary detention'. The College also, however, saw 'this as a missed opportunity to improve appropriate access to multifaceted assessment and intervention for the majority of people with mental health problems'.

More specifically, the review of the 2001 Act focused largely, as the Act itself does, on involuntary patients, who are an important but numerically small minority of persons who access mental health services. The majority are voluntary outpatients or voluntary inpatients, and while the Expert Group report makes some recommendations about the inspection process, it does not guarantee a minimum standard of multidisciplinary care for all. This is because the report focuses chiefly on the two areas that the Act itself focuses on: involuntary care and the roles of the Mental Health Commission and inspection process.

Notwithstanding these matters, it is clear the Expert Group report is a significant step forward in the continuous reform process that saw the number of psychiatry inpatients decline from the high levels of the 1960s to the relatively low levels today.

(c) Proposed Reforms with Particular Implications for Social Workers

With regard to social workers specifically, there are two key reforms of particular relevance proposed in the Expert Group report: further developing the role of authorised officers in the involuntary admission process, and enhancing requirements for multi-disciplinary input to certain decisions relating to involuntary admission and treatment.

With regard to authorised officers, the Expert Group recommended 'that there should be a more expanded and active role for authorised officers where involuntary admissions to an approved centre are being considered. This new role can lead to more appropriate and least restrictive treatment for individuals in community or other mental health settings and bring a greater focus on

involuntary admission being a treatment of last resort' (Expert Group on the Review of the Mental Health Act 2001, 2015:36).

More specifically, the Expert Group proposed that:

- The authorised officer must, after consultation with family/carers where possible and appropriate, make the decision on whether or not an application for involuntary admission of the person should be made.
- An authorised officer should be the person to sign all applications for involuntary admission to an approved centre. [This will include change of patient status in an approved centre from voluntary to involuntary, a process which currently requires just the opinions of two psychiatrists but under the new proposals would be essentially the same as the process of involuntary admission from the community.] This will have the effect of reducing the burden on families/carers in these difficult circumstances and reducing the involvement of Gardaí in the admission process.
- An application by an authorised officer to involuntarily admit a person to an approved centre shall remain in force for seven days from the time of the first application.
- The Group considers that the sequencing of whether the authorised officer or the registered medical practitioner sees the patient first is not relevant once they are undertaken independently. However, as regards completing and signing the appropriate documentation, the application for involuntary admission by the authorised officer must come first followed by the recommendation from the registered medical practitioner.
- Family/carers can request a second authorised officer to look at their case if they are not happy with the recommendations of the first authorised officer. If some time has elapsed since an authorised officer previously assessed a particular individual for involuntary detention, the same authorised officer can be asked to look again at the case (Expert Group on the Review of the Mental Health Act 2001, 2015:37).

The Expert Group expressed the view that authorised officers should be 'mental health specialists working in services other than staff of the approved centre' and 'should be aware of all treatment services available in a catchment area as well as the potential supports available within the person's social environment, and in weighing up both the individual's overall and immediate care and treatment needs along with the views and needs of family/carers, they can establish whether a suitable referral to an appropriate community or other mental health service, rather than go down the route of possible involuntary admission, would be more appropriate' (Expert Group on the Review of the Mental Health Act 2001, 2015:34).

As with the current, more limited authorised officer system, this expanded system would clearly include social workers among those who become authorised officers. The extent to which such a role would be taken up in practice would, of course, depend on the interest shown by various groups of mental health professionals, including social workers, were these proposals to be brought forward. At present, 28% of the 150 authorised officers delegated to undertake the role are mental health social workers, according to the HSE Mental Health Act Implementation Group.

The second area of proposed reform of particular relevance to social workers concerns enhanced requirements for multi-disciplinary input to certain decisions relating to involuntary admission and treatment. For example, the Expert Group recommends that an involuntary admission 'must be certified by a consultant psychiatrist after examination of the patient and following consultation with at least one other mental health professional of a different discipline that is and or will be involved in the treatment of the person in the approved centre. The opinion of that other mental health professional should be officially recorded' (Expert Group on the Review of the Mental Health Act 2001, 2015:39). Clearly, this 'other mental health professional' could be a mental health social worker who will be involved in the case.

Similar non-doctor opinions are to be required for emergency treatment prior to completion of the involuntary detention procedure, the independent psychiatric opinion prior to a tribunal, a renewal detention order, and treatment of a detained patient who lacks mental capacity. In addition, the Expert Group recommended that, for the 'mental health review board' (i.e. tribunal), a 'psychosocial report should also be carried out by a member of the multidisciplinary team from the approved centre who is registered with the appropriate professional regulatory body (i.e. CORU, Nursing and Midwifery Board or Medical Council) in the same timeframe as that recommended for the independent psychiatrist report. This report should concentrate on the nonmedical aspects of the patient's circumstances' (Expert Group on the Review of the Mental Health Act 2001, 2015: 49). This would, again, deepen multidisciplinary involvement and might well involve social work input to this report in many cases.

Other changes of possible relevance to social workers include the expanded definition of 'treatment' which, according to the Expert Group, should include 'a range of psychological and other remedies and where treatment is specifically mentioned in this report, it should be interpreted in its wider sense and not viewed simply as the administration of medication' (Expert Group on the Review of the Mental Health Act 2001, 2015:18). This revised definition of 'treatment' would, presumably, encompass social work inputs.

It is also proposed that 'wording of the [Mental Health Act 2001] should be amended to ensure that it is the multidisciplinary team that has responsibility for the clinical content of recovery plans rather than the proprietor' (Expert Group on the Review of the Mental

Health Act 2001, 2015:67). This would result in clear legal responsibility for 'recovery plans' (care plans) lying with the multi-disciplinary team, including social workers, who might then be called to explain the plans at 'mental health review boards'.

Conclusion

The proposals presented in the *Report of the Expert Group on the Review of the Mental Health Act 2001* aim to both broaden and deepen multi-disciplinary involvement in mental health care, and to build on the pre-existing roles played by social workers and others. If carried forward, these recommendations offer real opportunities for all stakeholders to better protect and promote the rights of the mentally ill, especially in the area of involuntary care.

Promoting such rights is, of course, rendered challenging by the fact that the mentally ill commonly face substantial problems in relation to a broad range of human rights, and not just rights to liberty and medical care (Kelly, 2015). The broader picture is that many people with mental disorder experience profound social and economic discrimination in their everyday lives. They are overrepresented in prisons and among homeless populations, and experience systematically higher levels of stigma, underemployment and social exclusion. These adverse social, economic and political factors greatly impair access to psychiatric and social services, and hugely amplify the effects of mental disorder in people's lives.

Mental health social workers and all other mental health professionals have unique opportunities to work with service-users, their families and carers to change this situation and achieve social justice. The *Report of the Expert Group on the Review of the Mental Health Act 2001* provides direction on this in relation to specific matters, especially concerning involuntary care, but there are also broader, societal dimensions to these issues that merit just as much attention and just as much reform.

Conflict of Interest

There is no conflict of interest to declare.

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