

The Best is the Enemy of The Good: The Mental Health Act 2001

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§1 — INTRODUCTION

This article examines the *Mental Health Act 2001*, which is now the main piece of mental health legislation in the Republic of Ireland.² The new Mental Health Tribunal system came into force on 1 November 2006, and the Act is now fully in force.

The article is being published in two parts. This part deals with the new admission, detention, leave and transfer provisions. The second part, in the next issue of the *Journal*, examines the new safeguards: the Commission and the tribunals, and the consent to treatment procedures.

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² Referred to in this article as 'the Republic'. The key textbook is Anne-Marie O'Neill's *Irish Mental Health Law* (First Law Ltd, Dublin 2005, 873pp). This is an excellent piece of scholarship: well-researched, balanced, detailed, authoritative, readable. It is essential reading for academics and practitioners.

§2 — TERMINOLOGY

The 2001 Act is concerned only with civil admissions.³ The structure of the Act is distinctive. It does not contain schedules of the kind found in UK legislation and much is left to the discretion of practitioners and the courts.

Most of the terms in the statute will be familiar to practitioners from other jurisdictions. However, at the outset it is useful to know that an ‘approved centre for treatment’ is the name given to an institution that is approved to admit persons under the Act.

Section 67 provides that, subject to two exceptions, a person suffering from a mental disorder shall not be detained in any place other than an approved centre.

§3 — STATUTORY PRINCIPLES AND BEST INTERESTS

It has become fashionable for statutes to contain a set of principles and the 2001 Act is no exception. Section 4 states that:

4. – In making a decision under this Act concerning the care or treatment of a person (including a decision to make an admission order in relation to a person) –
- (a) the best interests of the person shall be the principal consideration with due regard being given to the interests of other persons who may be at risk of serious harm if the decision is not made.
 - (b) due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy.

A purposive and paternalistic approach

Mr Justice Neill said in *MR v Cathy Byrne & Others, Sligo Mental Health Services Respondent) and Mental Health Tribunal (Notice Party)* (2 March 2007) that a purposive approach is appropriate when interpreting this type of legislation. The underlying purpose is paternalistic.⁴

“It has been said and indeed it is common case that in approaching the construction of the Act, the purposive approach is to be adopted

In the case of *In Re Philip Clarke* [1950] I.R. 235 ... O’Byrne J, delivering the judgment of the court described the general aim the Act of 1945 as follows:

“The impugned legislation is of a paternal character, clearly intended for the care and custody of persons suspected to be suffering from mental infirmity and for the safety and wellbeing of the public generally. The existence of mental infirmity is too widespread to be overlooked, and was, no doubt present to the minds of the draftsman when it was proclaimed in Article 40.1 of the Constitution that though, all citizens, as human persons are to be held equal before the law, the State, may, nevertheless, in its enactments have due regard to differences of capacity, physical and moral, and social functions. We do

3 The provisions concerning mentally disordered offenders are mainly to be found in the Criminal Law (Insanity) Act 2006.

4 Unless a case referred to in this article has been given a formal citation, the case is unreported, in which case the

date of the judgment is given; any quotations and observations are based on the transcript of the judgment. Many of the transcripts have been published on the Mental Health Commission’s website (www.mhcirl.ie) and the website of the British and Irish Legal Information Institute (www.bailii.org).

not see how the common good would be promoted or the dignity and freedom of the individual assured by allowing persons, alleged to be suffering from such infirmity, to remain at large to the possible danger of themselves and others. The section is carefully drafted so as to ensure that the person alleged to be of unsound mind, shall be brought before, and examined by, responsible medical officers with the least possible delay. This seems to us to satisfy every reasonable requirement and we have not been satisfied, and do not consider that the Constitution requires, that there should be a judicial enquiry or determination before such a person can be placed and detained in a mental hospital. The section cannot, in our opinion be construed as an attack upon the personal rights of the citizen, on the contrary it seems to us to be designed for the protection of the citizen and for the promotion of the common good."

In my opinion having regard to the nature and purpose of the Act of 2001 as expressed in its preamble and indeed throughout its provisions, it is appropriate that it is regarded in the same way as the Mental Treatment Act of 1945, as of a paternal character, clearly intended for the care and custody of persons suffering from mental disorder."

According to Mr Justice O'Neill, section 4 gives statutory expression to the kind of paternalistic approach mandated in the case of *Philip Clarke*.

This proposition is difficult to accept when put in such a bald way. The learned judge himself noted in his judgment, "As is plainly obvious there are provisions included in the Act of 2001 which can be regarded as radical reforms of the *Mental Treatment Act 1945*."

The purpose of these radical reforms is an important part of the purpose of the Act. Such reforms were necessary because the old legislation fell short of internationally accepted standards and failed to protect adequately the interests of citizens, and in particular detained persons.

Why reform was necessary was explained by Mr Justice Clarke in *JH v Vincent Russel, Clinical Director of Cavan General Hospital, Health Service Executive (Respondent) and Mental Health Commission (Notice Parties)* (6 February 2007):

"Almost twelve years ago Costello P in giving judgment in *RT v. Director of Central Mental Hospital* [1995] 2 I.R. 65 said, at p. 81, the following:—

"These defects, not only mean that the section falls far short of internationally accepted standards but, in my opinion, render the section unconstitutional because they mean that the State has failed adequately to protect the right to liberty of temporary patients. The best is the enemy of the good.⁵ The 1981 reforms which would have remedied the defects were not brought into force because more thorough reforms were being considered (para. 16.13 of Green Paper)"

1.2 ... *The Mental Health Act, 2001* ... was the means adopted to address those difficulties. It is worthy of note that it was only in the last months of 2006 that some of the most important provisions of the 2001 Act came into force. Costello P spoke of the consequences of a fourteen year search for excellence"

Although no judge would likely argue otherwise, it must be emphasised that the main purpose of the 2001 legislation was patently not just to repeat the paternal character of the Act of 1945; nor was it intended simply to ensure the care and custody of people suffering from mental disorder. The 1945 Act promoted and secured those objectives. It did not, however, adequately protect citizens against unjustified

⁵ A quotation from Voltaire, meaning here that the search over many years for an 'excellent' scheme to replace the old legislation became the enemy of the 'good', because the delays required practitioners to operate for far too long a system which was manifestly not fit for the purpose.

infringements of liberty. The purpose of the 2001 Act was to address these deficiencies. It does so by prescribing more rigorous detention criteria, by a system of tribunal reviews, by second-opinion procedures, and through an independent Commission.

This is as it should be. Those we describe as ‘patients’ are individuals, no more and no less than any other individual; individuals who suffer, who will certain ends for themselves and their loved ones, who wish to develop, and be happy and fulfilled. They are members of the public – citizens – people whose needs and interests the Government exists to serve; brothers, sisters, mothers, fathers.

If this is accepted, the main purpose of the Act may be said to be to seek to ensure that members of the public are not unnecessarily detained, and also that they are protected from those members of the public who must necessarily be detained.

Ambiguities in the drafting

The drafting is not ideal. According to section 4, the best interests of the patient shall be the ‘principal consideration’ when deciding to make an order for their compulsory admission to hospital. However, it is clear that an ‘order for admission’ may only be made if the patient satisfies the statutory criteria for detention. This therefore is the principal consideration and, insofar as distinct, at best the patient’s best interests can only be a secondary consideration.

As an illustration of this principle, it would be unlawful to make an admission order in respect of a person on the sole ground that they are addicted to drugs or intoxicants, however much it might be in their best interests to receive treatment for substance misuse. Practitioners and tribunals must always act lawfully.

When interpreting the precise meaning of section 4, the first principle is therefore that the word ‘decision’ in section 4 means ‘lawful decision’ so that it should be read as beginning:

4.— In making a decision [that may lawfully be made] under this Act ... including a [lawful] decision to make an admission order in relation to a person ...

For the avoidance of doubt, a decision to admit or renew detention, or not to discharge, is lawful only if the person satisfies the statutory criteria for detention. As to breaches of procedural requirements, the detention of someone who satisfies the statutory criteria for detention is lawful unless non-compliance with prescribed procedures has affected the substance of the order or has caused an injustice.

Where risk to others is the main issue in a particular case — which quite often it is — then, provided the admission criteria are satisfied, in reality this is the ‘principal consideration’, not the best interests of the patient. Giving priority to the patient’s interests in such a case would require not having ‘due regard’ to the need to protect other persons from serious harm (One might argue that it is never in a patient’s best interests to harm someone but this is straining the language beyond breaking point. It is the legitimate interest of other members of the public in being protected from harm that is the reason why detention is necessary. The patient’s interests are secondary.)

When interpreting the precise meaning of section 4, the second principle is therefore that the best interests of the patient are not the principal consideration in cases where there is a serious likelihood of immediate and serious harm to other persons.

Solicitors and section 4

Section 4 has generated quite heated debate about the extent to which it requires solicitors to depart from their instructions or 'to turn a blind eye to' legal irregularities that may entitle their client to be discharged.

The Mental Health Commission, which administers the legal aid scheme, has made clear in its handbook and training materials its view that representatives must act in the 'best interests' of their clients.

Most solicitors have emphasised in training sessions their professional duty to follow their instructions, which includes seeking discharge and raising any issues about the order's legality, regardless of their own personal views as to the wisdom of discharge. A solicitor's professional duties are set out in *A Guide to Professional Conduct of Solicitors in Ireland* (2nd Edition, Law Society of Ireland, Dublin, October 2002):⁶

- Solicitors must serve the interests of justice as well as the rights and liberties of their clients. It is their duty not only to plead their client's cause but also to be their adviser.
- Solicitors should always retain their professional independence and their ability to advise their clients fearlessly and objectively. A solicitor should never permit his independence to be undermined by the wishes of a party who has introduced a client.
- A solicitor should take instructions directly from the client.
- A solicitor should present his client's case to his client's best advantage.
- It is the duty of the advocate to uphold fearlessly the proper interests of his client and to protect his client's liberty.

The answer perhaps lies in the precise wording of section 4. It begins with the words, 'In making a decision under this Act ... including a decision to make an admission order in relation to a person ...'

Solicitors do not make decisions under the Act and therefore the section does not apply to them.

The legitimate needs and interests of patients, the tribunal and of society in general, are best promoted by ensuring that vulnerable citizens subject to compulsion have available to them a legal advocate, to test the strength of the evidence and to promote *their* case. It would be unethical for a legal representative to do otherwise, not simply in terms of their professional code but more generally.

When interpreting the precise meaning of section 4, the third principle is therefore that solicitors do not make decisions under the 2001 Act. Their duty is different. It is to advance their client's case in a manner consistent with their instructions. In exceptional circumstances, where an incapacitated person cannot give instructions, they must act in accordance with their own perception of their client's best interests. This generally involves testing the medical and other evidence said to support detention.

Effective representation assists the tribunal in reaching the right decision and therefore is consistent with section 4. A best interests approach to representation has to incorporate:

A requirement to always test the evidence.

A requirement to always request the best evidence available.

6 *A Guide to Professional Conduct of Solicitors in Ireland* (2nd Edition, Law Society of Ireland, Dublin, October 2002).

Representing the capable patient in accordance with their instructions as that course best protects the autonomy of the patient.

Representing the incapable patient by adopting clear principles, e.g. promoting the less restrictive alternative and a person's right to be unwise.

The current debate is interesting because it duplicates that in England and Wales following the introduction of legal representation at Mental Health Review Tribunals. As in the early days of the MHRT scheme in England and Wales, the debate is not one of substance, or even ethics in most cases, but an expression of the understandable anxieties of the medical profession about having to justify clinical decisions and being subject to regular judicial scrutiny.

§4 — VOLUNTARY ADMISSION

Section 29 provides that nothing in the Act shall be construed as preventing a person from being 'admitted voluntarily' to an approved centre for treatment or from remaining in such a centre after they have ceased to be liable to be detained.

In most jurisdictions, the term 'voluntary admission' denotes a patient who has capacity to consent, or 'volunteer', to go into hospital. In contrast, 'informal admission' means admission without legal formalities — the underlying idea being that a person may be admitted without the need for a legal order even if they lack capacity to consent to this.

What is the position here? The wording of sections 2 (*Interpretation*) and 29 (*Voluntary admission to approved centres*) suggests that in fact 'voluntary admission' means 'informal admission.'

Anecdotal evidence does suggest that many incapacitated people are being deprived of their liberty in institutions without there being any legal order authorising this. The implications of the *Bournemouth* judgment⁷ are therefore problematic.

§5 — THE DEFINITION OF MENTAL DISORDER

There are two main ways of defining mental disorder in statutes that deal with compulsory admission.

The first is to begin with a simple definition of mental disorder, and then to set out in separate sections the criteria for compulsory admission.

The alternative approach, seen in the 2001 Act, is to incorporate the criteria for detention within the very definition of mental disorder. Thus, the 2001 Act provides that a person may be involuntarily admitted on the ground that s/he is suffering from mental disorder. Here, the term 'mental disorder' equates to what used to be called 'certifiable mental disorder'; it is the modern version of the term 'lunatic'.

The simple definition approach has the advantage that it can be incorporated into other statutes; for example, legislation that imposes duties on NHS and other public authorities to provide services and after-care to anyone who suffers from mental disorder. Its generality also affords greater legal protection to police officers and other non-mental health professionals who apply the legislation. The alternative approach lacks these advantages but is more constitutionally sensitive. A person only comes within the ambit of the legislation at all if they have a serious mental disorder.

⁷ *HL v United Kingdom (Application 45508/99 (2004) 40 EHRR 761.*

The difference is perhaps best illustrated if one considers the application of powers of the kind found in sections 135 and 136 of the English and Welsh *Mental Health Act 1983*. A simple definition approach — such as, ‘mental disorder means any disorder or disability of mind’ — brings many more people within the ambit of these sections than does a definition which states that a person suffers from mental disorder only if they meet the criteria for civil admission to hospital.

§6 — THE CRITERIA FOR DETENTION

As just noted, the 2001 Act provides that a person may be admitted and detained if they are suffering from ‘mental disorder’. This term is defined as follows:

“mental disorder” means mental illness, severe dementia or significant intellectual disability where—

- (a) because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, or
- (b) (i) because of the severity of the illness, disability or dementia, the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission, and
(ii) the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent.

Ground (a): Serious likelihood of serious and immediate harm

According to Mr Justice Neill, in *MR v Cathy Byrne & Others, Sligo Mental Health Services Respondent) and Mental Health Tribunal (Notice Party)* (2 March 2007):

- “The phrase ‘serious likelihood’ envisages ‘a standard of proof of a high level of probability. This is beyond the normal standard of proof in civil actions of “more likely to be true.” However, it falls short of the standard of proof required in a criminal prosecution, namely beyond a reasonable doubt: ‘What is required is proof to a standard of a high level of likelihood as distinct from simply being more likely to be true.’
- The harm apprehended must in the first instance be “immediate”. The critical factor which must be given dominant weight is the propensity or tendency of the person to do harm to themselves or others. If the clinicians are satisfied to the required standard of proof that that propensity or tendency is there then, having regard to the unpredictability of when the harm would be likely to occur, the likelihood of the harm occurring would have to be regarded as “immediate”.
- As to what constitutes ‘serious’ harm, the word ‘harm’ is a very general expression and its use is intended to encompass the broadest range of injury. Physical and mental injury are included. The term “serious” is more difficult to fully comprehend. It may very well be that a somewhat different standard would apply depending on whether the harm was inflicted on the person themselves or others. Clearly the infliction of any physical injury on another could only be regarded as “serious” harm, whereas the infliction of a minor physical injury on the person themselves could be regarded as not “serious”. Thus assaults directed at others, which had the potential to inflict physical injury could be considered to fall within the ambit of the term “serious”. Behaviours on the part of a person suffering from mental illness, dementia or disability, where there was a serious likelihood of these

behaviours resulting in serious actual physical injury to the person concerned, should rightly be regarded as “serious” harm. Where the likely end result of these behaviours was merely trivial injury, it would not or should not, normally be regarded as constituting “serious” harm for these purposes.”

Objection may be made to the meaning given to the word ‘immediate’. Some people who have been diagnosed as having a significant mental disorder certainly do have a propensity or tendency to seriously harm themselves or others. However, it is a long step from there to a finding that there is a serious likelihood of this occurring immediately. That judgment depends not just on the existence of a propensity or tendency to cause serious harm but on a whole range of other factors such as the person’s current mental state, the risk factors, their present situation, the level of security and supervision, their compliance with treatment, etc. If they are presently stable, the immediate risk may well be quite low, as in the case of many conditionally discharged restricted patients.

Mental illness, severe dementia, significant intellectual disability

The person must be suffering from mental illness, severe dementia or significant intellectual disability. The Act defines what these terms mean:

(2) In subsection (1)—

“mental illness” means a state of mind of a person which affects the person’s thinking, perceiving, emotion or judgment and which seriously impairs the mental function of the person to the extent that he or she requires care or medical treatment in his or her own interest or in the interest of other persons;

“severe dementia” means a deterioration of the brain of a person which significantly impairs the intellectual function of the person thereby affecting thought, comprehension and memory and which includes severe psychiatric or behavioural symptoms such as physical aggression;

“significant intellectual disability” means a state of arrested or incomplete development of mind of a person which includes significant impairment of intelligence and social functioning and abnormally aggressive or seriously irresponsible conduct on the part of the person.

It can be seen that:

- A person is only mentally ill if their state of mind seriously impairs their mental function to the extent that they require care or medical treatment;
- The definition of ‘severe dementia’ requires significant impairment affecting thought, comprehension and memory and severe psychiatric or behavioural symptoms, such as physical aggression; and
- The definition of ‘significant intellectual disability’ is essentially the same as that of ‘mental impairment’ in section 1(2) of the *Mental Health Act 1983*.

Exclusions

The 2001 Act provides that a person may not be involuntarily admitted ‘by reason only of the fact that s/he is suffering from personality disorder; is socially deviant; or is addicted to drugs or intoxicants.’⁸

These prohibitions are significantly wider than those in section 1(3) of the 1983 Act. They prevent citizens from being detained merely because they have a personality disorder or are socially deviant

8 *Mental Health Act 2001, s.8(2)*.

(which presumably includes the more specific English and Welsh exclusions of immorality, sexual deviancy and promiscuity).

The Northern Irish legislation has for some time excluded persons suffering from personality disorder. The research base is poor so that it is impossible to know the precise effect such exclusions have in practice. The author's impression — based on his time as a Commissioner in Northern Ireland and the operation of the *Mental Health Act 1959* in England and Wales — is that this exclusion is generally not determinative where a person poses a significant risk to others. If a similarly loose approach is taken in the Republic, it may be tempting for doctors to argue that such people are 'mentally ill' in a legal sense, because their state of mind affects their emotion or judgment, and this seriously impairs their mental function.

Implications in practice

The compulsory admission criteria provide the citizen with a fair measure of protection.

The admission and renewal procedures are explained later on. However, it is important to appreciate that the 2001 Act does not contain separate 28-day and six month admission orders equivalent to sections 2 and 3 MHA 1983. There are only 'admission orders,' which usually have an initial duration of 21 days and then may be renewed as necessary.

This is significant, as can be seen if one takes the case of someone with a learning disability. The definition of 'significant intellectual disability' in the 2001 Act is essentially the same as that of 'mental impairment' in the *Mental Health Act 1983*. Consequently, a person with a learning disability may only be detained under section 3 or an admission order if their disability is associated with abnormally aggressive or seriously irresponsible conduct. In the Republic the matter ends there because there is only one kind of admission order. Under the *Mental Health Act 1983*, there remains the option of admission for up to 28 days because section 2 does not require that the patient's learning disability is associated with a conduct disorder of the kind described.

The greater protection afforded to citizens under the 2001 Act emerges quite clearly if one considers what must be shown before an admission order may be made in a 'significant intellectual disability' case:

DETENTION OF PERSONS WITH A LEARNING DISABILITY			
REQUIREMENT		PROTECTION FOR CITIZENS	
1. The person must satisfy the definition of significant intellectual disability			
1		<i>A state of arrested or incomplete development of mind</i>	This requires that the person's mind (brain) never developed completely, or its development was arrested. It therefore excludes an adult whose brain is injured after developing fully, for example as a result of a road accident.
2	+	<i>Significant impairment of intelligence</i>	Conventionally, this requires an IQ of 70 or below.
3	+	<i>Significant impairment of social functioning</i>	Even if a person's intelligence is significantly impaired, an admission order may not be made unless their social functioning is also significantly impaired. Any significant impairment of social functioning present must be an aspect of their arrested or incomplete development of mind, and not caused, for example, by personality disorder.
4	+	<i>Abnormally aggressive or seriously irresponsible behaviour</i>	The person's learning disability must be associated with abnormally aggressive or seriously irresponsible conduct. Aggression is only abnormal in this sense where such an association exists.
2. The person must also meet the criteria in condition 2(a) or (b) below			
2a. Detention on the grounds of			
5a	+	<i>Serious likelihood of immediate and serious harm</i>	It is not enough that harm to the patient or others is possible.
6a	+		It is not enough that harm is 'likely'.
7a	+		It is not enough that harm is 'seriously likely' if this harm does not amount to 'serious harm'.
8a	+		Even if 'serious harm' is 'seriously likely', that harm must be 'seriously likely' to happen 'immediately'.
9a	+		If 'serious and immediate harm' is 'seriously likely', this identified risk of harm must arise 'because of' the individual's significant intellectual disability.

<i>2B. Detention on the grounds of</i>			
5b	+	<i>Likelihood of material benefit or alleviation</i>	The person's judgement must be impaired.
6b	+		If it is impaired, it must be impaired by reason of their disability.
7b	+		It is not enough that a failure to admit could lead to the condition deteriorating; 'serious deterioration' must be 'likely'.
8b	+		The proposed in-patient treatment must be 'appropriate treatment'.
9b	+		It may be that 'appropriate treatment' could be given as a voluntary patient, or as an out-patient, etc.
10b	+		Any benefit or alleviation of the patient's condition arising from forced 'reception, detention and treatment' must be of a 'material extent'.

§7 — APPLICATIONS AND ADMISSIONS

To anyone used to the *Mental Health Act 1983*, the application and admissions processes in the 2001 Act are distinctive.

As drafted, subject to very limited exceptions, 'any person' may make an application to a registered medical practitioner for a medical recommendation that any other person be involuntarily admitted to an approved centre.

A person may not make an application unless they have observed the person not more than 48 hours before the date of the making of the application.

The medical practitioner to whom such an application is made must not be a member of staff of the approved centre to which admission is sought, and often will be a general practitioner.

Unlike in England and Wales, the applicant is only applying for a medical recommendation to be given, not applying to a hospital for admission on the basis of completed medical recommendations.

Once such an application has been made, the Act provides that the medical practitioner 'shall' carry out an examination of the person within 24 hours. As drafted, there is no discretion; any person may apply to a doctor for any other person to be involuntarily admitted, and it is then mandatory for the doctor to examine the named person within 24 hours.

What if the named person refuses to be examined during the 24 hour period? The doctor is under a duty to examine the individual within 24 hours, but the named individual is under no duty to co-operate or to attend for examination. Nor is there any statutory power, equivalent to section 135 MHA 1983, which authorises a person's removal from private premises for the purposes of examining and assessing them.

A recommendation for admission is mandatory if the examining doctor is satisfied that the named person is suffering from mental disorder. The outcome will therefore be either that the doctor recommends admission or that the application is refused, and no recommendation is made.

If the application is refused, any future applicant must notify the doctor to whom they apply of any known previous applications which were refused. This has the advantage that the doctor knows that a professional colleague was not satisfied previously that the person was mentally disordered. On the other hand, as drafted, an examination within 24 hours is still mandatory for every application made.

Where a recommendation is given, it is given to the clinical director of the specified approved centre and remains in force for seven days.

The next task is how to get the patient to the designated approved centre. The Act provides that a copy of the recommendation shall be given to the applicant, who 'shall arrange' for the 'removal of the person' to the specified approved centre. If the applicant is unable to arrange this, the clinical director (or a consultant psychiatrist acting on their behalf) must arrange for the person's removal by staff of the centre, if the doctor who gave the recommendation requests this.

There is one further option in cases where there exists a serious likelihood of immediate and serious harm: The Garda can be required to assist staff with the person's removal to the centre, for which purpose members of the Garda can enter premises without a warrant and use any necessary detention or restraint.

There is, it seems, a drafting omission here. The criteria for compulsory admission are (a) that there is a serious likelihood of the person causing immediate and serious harm to themselves or others, or (b) that failure to admit the person would be likely to lead to a serious deterioration of their condition, etc. As drafted, it is only if a person requires admission on the first of these grounds that the Garda can be required to assist and may enter premises without a warrant. If the recommendation has been given on the other ground, the Garda have no such powers. The named person may therefore prefer to remain indoors until the medical recommendation has expired.

Assuming the patient is admitted within the statutory seven-day period, s/he must be examined 'as soon as may be' by a consultant psychiatrist on the staff of the approved centre. A consultant psychiatrist, medical practitioner or registered nurse on the staff of the centre may take charge of the person and detain them for up to 24 hours, so that this examination can be carried out.

The examining psychiatrist must make an 'admission order' if s/he is satisfied that the person is suffering from mental disorder. S/he must refuse to make such an order where s/he is not satisfied that this is so.

§8 — DETENTION AND ADMISSION OF VOLUNTARY PATIENTS

The procedures just described are appropriate for admitting a person to an approved centre from the community.

What is the position where an admission order is required in respect of a 'voluntary patient' already at an approved centre?

Section 23 is concerned with the short-term detention of voluntary patients, and is broadly equivalent to section 5 of the *Mental Health Act 1983*.

Section 23(1) is triggered if an adult who is being treated in an approved centre as a voluntary patient indicates that they wish to leave. It enables a consultant psychiatrist, registered medical practitioner or

registered nurse on the staff of the centre to detain the person for up to 24 hours if of opinion that s/he is suffering from a mental disorder.

Where such a person is detained, section 24 provides that the consultant psychiatrist responsible for the patient must either discharge the patient or arrange for them to be examined by another consultant psychiatrist.

If a second consultant is asked to examine the patient, and is satisfied that they are suffering from a mental disorder, s/he must certify this opinion in writing. Once this is done, the patient's consultant must then make an admission order, authorising the individual's detention and treatment in the approved centre.

Where the second psychiatrist instead certifies that s/he is not satisfied that the patient is suffering from a mental disorder, the effect is that the person is discharged.

Case Law

There have been a number of cases on sections 23 and 24:

In *Q v St Patrick's Hospital (Respondent) and Mental Health Tribunal, Mental Health Commission (Notice Parties)* (21 December 2006), an admission order was made under section 24 in respect of a voluntary patient who had not indicated an intention to leave. Section 23 had therefore not been triggered and Mr Justice Higgins therefore held that the detention was unlawful; section 23 must be invoked before section 24 applies.

The wording of the sections is unambiguous and this is undoubtedly what they say. There is no problem if the ordinary admission procedure used for patients in the community can, where appropriate, also be used in respect of voluntary patients. If not then, without an expressed wish to leave, it would not always be possible to make an admission order where powers of detention and restraint are being used, or are required, in respect of a voluntary patient; where an incapacitated voluntary patient is effectively being detained on a best interests common law basis (the *Bournemouth* type scenario); or where it is desirable that a person without capacity receives the protective mechanisms afforded by the Act.

In *T O'D v Central Mental Hospital, HSE (Respondent) and Mental Health Commission (Notice Party)* (25 April 2007), the Central Mental Hospital had made a series of very basic errors in relation to the new detention provisions.⁹ On 6 December 2006, a renewal order was not made in time and the patient became a voluntary patient. He expressed an intention to leave and an admission order was made under section 24. For the second time, the hospital failed to renew an order in time, so the patient again became a voluntary patient. He again indicated a wish to leave, on 17 January 2007, and was detained. However, the admission order required by section 24 was not signed for a week, until 24 January. On review, the tribunal affirmed the admission order.

Mr Justice Charleton upheld the patient's detention, stating that a purposive approach to the legislation is required, that section 4 (best interests) infuses the entire legislation, and that the tribunal was entitled to take best interests into account. Indeed, had the tribunal not taken section 4 into account, that would be grounds for judicial review:

“26. ... I would hold that the purpose of s.18(1) [tribunal's jurisdiction and powers] is to enable the Mental Health Tribunal to consider afresh the detention of mental patients and to determine,

⁹ *The Central Mental Hospital was built in 1850 and is thought to be the oldest forensic mental health facility in Europe. It was originally the Republic's equivalent of Broadmoor Hospital but now provides high, medium and low secure places.*

notwithstanding that there may have been defects as to their detention, whether the order of admission or renewal before them should now be affirmed. In doing so, the Mental Health Tribunal looks at the substance of the order. This, in my judgment, means that they are concerned with whether the order made is technically valid, in terms of the statutory scheme set up by the Act or, if it is not, whether the substance of the order is sufficiently well justified by the condition of the patient ...

I would specifically hold that the purpose of s. 18(1) of the Act is to enable the Tribunal to affirm the lawfulness of a detention which has become flawed due to a failure to comply with relevant time limits.”

JH v Jonathan Swift Clinic, St James Hospital, Dublin (Respondents), Mental Health Tribunal (Notice Party) (25 June 2007) also concerned the application of sections 23 and 24. The admission order made in this case was made 20 minutes outside the permitted 24 hour period, and the consultant psychiatrist who made it was not the patient’s responsible consultant psychiatrist.

Mr Justice Peart held that a purposive approach should be adopted and that regard should be had to the best interest requirement in section 4(1). One had to balance the interest of a patient against failure to adhere strictly to time limits and procedures. Not every incident of non-compliance would render a detention unlawful. This could be inferred from the fact that tribunals could affirm orders in cases where procedural irregularities did not cause injustice or affect the substance of the order. A slavish adherence to the 24-hour time limit would militate against the very purpose of the legislative protection, which was to care for a vulnerable person. An admission order was mandatory once the second psychiatrist had certified that the patient met the criteria and the patient had therefore not been prejudiced. The moment the locum consultant psychiatrist came on duty, he became the consultant in charge of the patient’s care.

§9 —DURATION AND RENEWAL OF ADMISSION ORDERS

The Mental Health Commission must be sent a copy of any admission (or renewal) order within 24 hours. On receiving its copy, the Commission arranges for the patient’s case to be reviewed by a Mental Health Tribunal. The tribunal must conduct its review and make its decision within 21 days of the making of the order. It must affirm the order if it is satisfied that the patient is suffering from mental disorder and that any failure to comply with the statutory admission or renewal procedures has not caused injustice or affected the substance of the order.

An admission order lasts for 21 days unless it is extended by a tribunal for a further period.

The tribunal has a limited power to extend the usual duration of an admission order (or renewal order). Section 18(2) requires a tribunal to make its decision no later than 21 days after the making of the admission (or renewal) order. However, by sub-section (4), this period may be extended by a tribunal for a further period of 14 days, either on its own motion or at the patient’s request. It may then be further extended by the tribunal for a second period of 14 days, but in this case only on the patient’s application and only if the tribunal is satisfied that it is in the interest of the patient. Where an extension is given, the admission order (or renewal order) continues in force during the period of the extension.

The second part of this article contains a more detailed account of tribunal procedures.¹⁰

¹⁰ See the November 2008 issue of the *Journal of Mental Health Law*.

Renewal orders

The Act provides that an admission order may be extended by the consultant psychiatrist responsible for the patient's care and treatment. During the week before the renewal order is made, the consultant must both examine the patient and certify that they continue to suffer from mental disorder. Unless extended by a tribunal in accordance with the procedures described above, the statutory renewal periods are as follows:

- A first renewal order may be for up to three months;
- The second renewal order may be for up to six months;
- Subsequent renewal orders may be for up to 12 months.

As with the original admission order, the Commission must be sent a copy of each renewal order within 24 hours, at which point it refers the patient's case to the tribunal.

In *AMC v St Luke's Hospital Clonmel* (28 February 2007), a renewal order made on 4 December 2006 was to come into effect on 9 December upon the expiration of the previous order. Mr Justice Peart held that the tribunal had to hold its review within 21 days of the making of the renewal order, not within 21 days of the date the order came into effect. Section 18(2) was plain and unambiguous in this respect.

In *WQ v Mental Health Commission, Central Mental Hospital, Mental Health Tribunal (Respondents)* (15 May 2007), Mr Justice O'Neill said that the statutory scheme is based on short periods of detention each disconnected from each other. Consequently, an invalid previous renewal order does not render invalid a period of detention brought about by a subsequent valid renewal order. (The objection to this is that one cannot renew nothing. Once an admission order has expired for want of renewal, nothing then exists to be renewed subsequently.)

Renewal orders must be made by 'the consultant psychiatrist responsible for the care and treatment of the patient concerned.' In *JB(2) v Central Mental Hospital (Respondent) and Mental Health Commission, Mental Health Tribunal (Notice Parties)* (15 June 2007), the renewal order was made by a consultant psychiatrist at the approved centre from which the patient had been transferred to the Central Mental Hospital. Upholding the order, Mr Justice McMenamin said that this consultant had been involved in the patient's care and treatment since 2002; that the consultant who renewed an order must be truly engaged in the patient's care and treatment; and that more than one consultant could be involved in a patient's care and treatment. The court again emphasised the purposive nature of the legislation. (The objection is that, although more than one consultant may be involved in a patient's care and treatment, the use of the word 'the' indicates that only one of them is responsible for it, i.e. in charge of it.)

The case of *MD v St Brendan's Hospital, Mental Health Commission, Mental Health Tribunal (Respondents)* (24 May 2007) concerned the timing of renewal examinations and orders. An admission order for 21 days was made on 26 April 2007, which unless renewed would therefore expire at midnight on 15 May 2007. Renewal required an examination during the final week of this period of detention. This was done and a renewal report was issued, on 10 May 2007. On 15 May 2007, a tribunal reviewed the admission order that was due to expire at the end of that day. The patient's representative argued that a renewal order cannot be made until a tribunal has reviewed the prior admission order. Mr Justice Peart rejected this, stating that a renewal order only takes effect on the expiration of the previous order. If the previous order is revoked, the patient is free to leave. This decision was taken on appeal to the Supreme Court, which rejected the appeal, not surprisingly confirming that each new period of detention commences upon the expiry of the previous period.

§10 — LEAVE, TRANSFERS AND DISCHARGE

There are some interesting provisions concerning leave, transfer and discharge.

Leave of absence

Section 26 provides that a patient's consultant psychiatrist may grant the patient permission in writing to be absent from the approved centre. The period of leave granted must be less than the unexpired period of the relevant admission or renewal order. As in England and Wales, leave may be subject to conditions; and the consultant may later direct the patient in writing to return to the approved centre, if 'of opinion that it is in the interests of the patient to do so.'

The fact that a patient may not be granted leave of absence beyond the expiry date of the current order is sensible. However, it does raise the possibility of psychiatrists renewing the sections of recalled patients on the last day of their existing section and immediately sending them out on another period of extended leave.

There have been a number of cases in England and Wales concerning the creative use of leave in this way and the renewal of patients' sections in such circumstances.¹¹ The wording of the 2001 Act seems to give consultants in the Republic less leeway. Unless the serious likelihood ground is in play (see §6 above), the admission and renewal criteria refer to a 'failure to admit the person to an approved centre' and to the patient's reception, detention and treatment in such a centre. In other words, admission and renewal require that a person actually needs to be detained in an approved centre, rather than merely treated there periodically.

Absence without leave

Section 27 deals with absence without leave. It provides that the clinical director of an approved centre may arrange for members of staff to return to the centre a patient who is absent without leave, or who has failed to comply with any conditions attached to their leave.

The Garda must assist if requested to do so in cases where there is a serious likelihood of the person concerned causing immediate and serious harm to themselves or to others. A member of the Garda may then enter, if need be by force, any dwelling or other premises where s/he has reasonable cause to believe that the patient may be; and may take all reasonable measures necessary for the return of the patient to the approved centre, including the use of detention or restraint.

The Act does not make any provision at all for extending a patient's liability to detention where s/he is absent without leave at the time when renewal is due. All the Act states is that the patient's consultant must examine them during the week before the renewal order is made and certify that the patient continues to suffer from mental disorder.

On the face of it therefore, if the patient is absent for the whole of the renewal week, so that no examination can take place, the order simply expires at the end of that period.

¹¹ See e.g., *R (on the application of DR) v Mersey Health Care NHS Trust* [2002] EWHC Admin 1810; *R (on the application of CS) v MHRT and another* [2004] EWHC 2958 (Admin).

Transfers

Section 21 is concerned with transfers, other than transfers to the Central Mental Hospital. By section 21, the clinical director of an approved centre may arrange for a patient's transfer to another approved centre if of the opinion either that this would be for the patient's benefit or that it is necessary for the purpose of obtaining special treatment for such patient. Transfer requires the consent of the clinical director of the receiving centre.

Section 22 then deals with transfers to the Central Mental Hospital. The clinical director of the transferring approved centre must notify the Commission of the proposal, and the Commission must then refer the proposal to a tribunal.

The tribunal must review the proposal within 14 days. It must authorise the transfer 'if it is satisfied that it is in the best interest of the health of the patient' or, if it is not so satisfied, refuse to authorise it.

The tribunal's decision concerning a proposed transfer to the Central Mental Hospital may not be given effect until the time for appealing to the Circuit Court has expired or, where such an appeal is lodged, the appeal is determined or withdrawn.

This is an important protection for patients. The only weakness is that, once a patient is in the Central Mental Hospital, the tribunal has no similar power to review, direct or recommend the patient's transfer from the Central Mental Hospital to a local approved centre.

Discharge

Section 28 requires a patient's consultant psychiatrist to revoke an admission or renewal order if s/he 'becomes of opinion that the patient is no longer suffering from a mental disorder.'

What then happens is rather unusual. The discharging consultant must give the patient, or their legal representative, a notice stating that the patient is entitled to give notice during the following next 14 days that they wish to have the discharged order reviewed by a tribunal, or any tribunal review that is in progress completed.

Apparently, this right was incorporated because, when consulted, some patients in England and Wales indicated that they were dissatisfied about being discharged from section shortly before their tribunal took place. They felt that they had been denied their opportunity to question the doctor and to demonstrate to an independent tribunal the weakness of the case for their detention.

From the author's experience in practice, it is certainly true that some patients hope to obtain what might be called a certificate of sanity. The problem is that a tribunal must look at things as they are at the date of the tribunal hearing, not as they were when the order was made. A tribunal finding that a patient is not mentally disordered at the time of the hearing leaves entirely open the question of their mental state when they were sectioned.

Because the patient already possesses an order stating that they are not now mentally disordered, in the form of the consultant's discharge order, asking a tribunal to affirm this finding does not take matters much further. It does, however, carry a risk that the tribunal will find that, in their opinion, the person is mentally disordered, i.e. that the patient does meet the criteria for being sectioned. Such a decision would put the relevant professionals under pressure to arrange for a new admission order.