Consultation on the Code of Practice on the Mental Health Act 2001

May 2010

Submission to the Mental Health Commission

Contents

Introduction

The Psychiatric Nurses' Association (PNA) as a professional organisation values the opportunity to contribute to the Consultation on the Code of Practice on the Mental Health Act 2001. This organisation (PNA) is committed to progressing the agenda of equality and integration for people with mental health problems and an intellectual disability and the delivery of high standards and good practices across all services.

In keeping with the review & recommendations of the Report on the Operation of Part 2 of the Mental Health Act 2001 [1]and the themes of The Quality Framework for Mental Health Services 2007[2], its associated standards and criteria with regard to a quality improvement culture in mental health services, the PNA endorses this process in drawing together the central issues which require guidance for all stakeholders under the 2001 Act.

It is not intended to comment on each area listed by the Mental Health Commission (MHC) but rather to comment on some of the main points to which the PNA wishes the Mental Health Commission to have regard in drafting the detail of the code of practice on the Act. Some of the comments are by way of highlighting what staff have requested in the provision of additional aids/ support structures and training with regard to the implementation of Part 2 of the Act -four years on and what they regard as necessary essential resources, tasks and activities that need to take place to increase effectiveness of the Act's implementation.

In order to consult and involve as broad a range of members as possible and to ensure that such developments take place in an informed and responsive way, we circulated the MHC consultation document to all PNA branches. The following is a summary of the findings generated and endorsed as a result of the stakeholder consultations. This composite document has drawn together the key interlinked themes arising from the consultation sent to PNA head office as part of this process. See Appendices 1 and 2 for actual submissions and transcriptions of consultation processes.

[1] Mental Health Commission (2008). Report on the Operation of Part 2 of the Mental health Act 2001 MHC, Dublin

[2] Mental Health Commission (2007). Quality Framework for Mental health Services in Ireland. MHC, Dublin.

Name: Aisling Culhane
Job Title (where relevant):Research & Development Advisor
Organisation (where relevant):Psychiatric Nurses Association (PNA)
Email address (optional):aculhane@pna.ie

Date of your comments (DD/MM/YYYY)

08 / 05 /2010

If this is a joint response by a group please specify the number of respondents this submission is made on behalf of:

Made on behalf of Seven Mental Health Services & One Intellectual Disability Service.

St Patrick's University Hospital Dublin
Waterford Mental Health Services
Kildare Wicklow Mental Health Services
Clare Mental health Services
East Galway Mental Health Services
Longford / Westmeath Mental Health Services
Dublin West Sth West Mental Health Services
Carriglea ID Services

The category of professionals or individuals it represents (e.g. 2 x Consultant Psychiatrists, 1 x Psychologist, 1 x Service User):

	All Nurses Number unavailable

Please specify the mental health service area, where relevant, that you are principally working in:

Child and Adolescent ☐

General Adult ☐

Forensic ☐

Later Life ☐

Intellectual Disability ☐

Other, please specify below ☐

This Submission is a collaboration of all individual submissions sent to PNA Head Office

Consultation Questions

Important: We would like to remind you before completing this section that the Mental Health Commission can only produce guidance on areas covered under the Mental Health Act (See appendix 2 for a list of these areas).

1. Do you think it would be **useful to have a code of practice** on the Mental Health Act? If no, please explain why.

Yes

2. Are there **areas mentioned** in Section 2 that you think it would be useful to have guidance on?

Case law since the Act went live
Assisted Admissions
Admission of Children
Information Provided to Patients & Issues of Capacity
Operation of Mental Health Tribunals
Holding Powers
Discharge with leave
Absence without leave
Change of legal status

3. Are there **other areas** under the Mental Health Act 2001 that you would like to see further guidance on which are not included in Section 2?

4. If you answered yes to question 1 or 2, please **explain why** guidance on this area/ areas would be useful so that we understand what **kind of guidance** you are looking for.

See following pages :

1. Cases since the Act went Live

Many contributors outlined the need / requirement for such a guide, since 2006 the Minister for Health and Children made an order bringing the substantial protections for patients contained in the Mental Health Act 2001 into law. At about the same time the Oireachtas passed the Criminal Law (Insanity) Act.

As a result of these Acts the rights of mentally ill patients, and indeed the obligations of psychiatric hospitals and nurses, changed dramatically. Legal changes such as these have lead to some initial confusion and difference in interpretation, many of which ultimately have to be clarified by the courts. Since 2006 a number of cases have come before the courts dealing with the application of both Acts to specific circumstances.

Whilst the MHC has produced a Summary of Judgments Delivered by the Superior Courts *on the Interpretation of the Mental Health Act 2001 (2009)*[3] outlining a summary of case law on inquiries pursuant to Article 40.4 and proceedings by way of judicial review it can be time consuming to go through these decisions. Therefore a comprehensive up to date account of recent court interpretations in a readable form to illustrate particular issues and advice as to the day to day operation of the Act would be welcomed by members of the PNA.

Comments included *"It would be useful to see what areas were the subject of case law in order to avoid pitfalls into the future. A short synopsis would suffice".*

2. Assisted Admissions

All submissions requested guidance on the above and clarification on a number of areas including

- Role of Nurses in Assisted Admissions
- Powers of Garda Síochána to take a person believed to be suffering from mental disorder into custody and removal of persons to approved centres.

Section 13(2) provides that the Clinical Director of an approved centre may arrange for the removal of a person to that approved centre by members of staff of the approved centre, where the applicant is unable to do so. This is known as the Assisted Admissions Service and an issue arose in relation to this in RL v Clinical Director of St Brendan's Hospital &

[3] Mental Health Commission (2009). Summary of Judgments Delivered by the Superior Courts on the Interpretation of the Mental Health Act 2001

Ors[4]. In this case the patient's legal team alleged that the patient was removed from her residence in breach of section 13(2) of the 2001 Act, as it was carried out by an independent contractor rather than a member of staff. Some members of this union PNA do not attend the removal of persons to approved centres under this section as part of ongoing industrial relations issues. In the Supreme Court, Mr Justice Hardiman in refusing the appeal and upholding the legality of the patient's detention stated that on its face, there was a breach of section 13(2). He commented that the inclusion of the words "members of staff" in the relevant section was extraordinary as the need to remove people may arise suddenly. Mr Justice Hardiman specifically stated that those responsible for the legislation should consult with those who implement the legislation to achieve a system where the statutory requirements are realistic.

E. F. v Clinical Director of St Ita's Hospital[5] was a judicial review concerning the independent contractors to effect a removal to an approved centre under s.13. The patient's counsel stated that the case was not made that the patient's detention was unlawful.[6].Instead, various declarations were sought e.g that the applicant was removed to St Ita's Hospital otherwise than in accordance with the provisions of the Mental Health Act 2001 and in particular s. 13 (2) and that the hospital's clinical director acted ultra vires those powers conferred on him by the Act in arranging for the applicant to be physically restrained and removed to St Ita's by persons not members of the hospital's staff. O' Keefe J. granted a declaration as requested in the case.[7] Section 63 of the Health (Miscellaneous Provisions) Act 2009 was enacted as a result of the *E. F.* case. It inserts a new s. 71A in the Mental Health Act 2001. The purpose of the amendment was to enable independent contractors to participate in removals or brining patients back to approved centres.

Whilst the above cases have clarified the position of contractors not members of staff of the approved centres some branches have outlined the additional difficulty of identification.
With regard to the matter of persons who are being involuntarily admitted and who are being provided with an escort by the National Assisted Admissions Service. This agency is not in a position to itself identify the person for admission. When an application is made, the responsibility falls to the Clinical Director of the relevant service to provide an escort, if a request has been made. In some reported instances the responsibility to identify the individual is being placed on members of this union. This is unacceptable in areas where

[4] .[2008] I.E.H.C.11: [2008] 3 I.R.296; High court, Feeney J., January 17,2008; Supreme Court (ex tempore), February 15, 2008

[5] [2009] I.E.H.C.253: High Court, O Keefe J., May 21 , 2009

[6] [2009] I.E.H.C.253, para.12.

[7] The exact nature of the declaration is not stated

staff have overwhelmingly balloted against being part of assisted admissions procedures and then subsequently being compromised both jeopardising the existing therapeutic relation they may have with the individual and placing them at risk. The Mental Health Commission must address this issue.

Two services requested guidance with regard to the role / power of An Gardaí in assisted admissions. Gardaí have the following powers.

- They may enter, if need be by force, any dwelling or other premises where they have reasonable cause to believe that the proposed patient may be, and
- They may take all reasonable measures necessary for the removal of the proposed patient to the approved centre including, where necessary, the detention or restraint of the proposed patient[8].

Garda assistance is being required more and more in the admission of involuntary patients of psychiatric facilities and it must be understood that nurses can never assure that role since nurses have no legal powers to arrest, forcible entry or detention except some limited right to detain a patient in an inpatient psychiatric facility pending examination by a psychiatrist but not outside of this either in public or in the persons own home nor do we seek those powers.

However Eldergill (2008)[9] suggests there may be a drafting omission within the 2001 Act with regard to the powers of An Gardaí.

"*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.*"

The question has been asked in one submission:

"When does the responsibility of the Gardaí end after entering the approved centre and what grade of staff should take over the responsibility of patients?"

[8] Section 13(4) of the Mental Health Act 2001.

[9] Eldergill (2008) "The Best Is the Enemy of the Good: The Mental Health Act 2001" J. Mental Health L.21,p32

Members have also expressed concern that individual patients are being accompanied onto the units not only by the assisted admissions teams but often by Gardaí who handcuff the individual, some of these patients are not considered violent by members of this union who are familiar with the patient over a period of time. This would seem a rather undignified response for the individual patient.

Other questions posed include:

"Should the NCHD always take charge of the patient from the Gardaí or should the Gardaí remain with the person until the initial assessment is complete? If the person is not deemed to meet the criteria and declines voluntary admission should the Gardaí take the person home?"

"Should the Gardaí check and remove all personal belongings from the patient prior to admission or remain present while nurses carry out task (recently a patient was found to be armed with a knife following being brought to unit by Gardaí who were no longer present). The current arrangement appears to be ad hoc and very much depends on each profession's interpretation of the Act."

Roles and responsibilities of members of the Garda Síochána and staff of the approved centres require further guidance and review.

It is an offence under s.67 to detain a person suffering from mental disorder in any place other than an approved centre [10].There are currently 65 centres on the register of approved centres. Approved centre status may either apply to an entire hospital (e.g. St Ita's Hospital or St Oterans Hospital) or to a clinic within a hospital (e.g Lakeview Unit in Naas General Hospital). If patients subject to Involuntary Admission Orders were accommodated outside the clinic or unit which has approved centre status, an offence would occur[11].

Clarification has been requested with regard to holding people in A& E departments' i.e. a place other than an approved centre prior to the arrival of assisted admission teams. An Instance has been reported whereby an admission was deemed unlawful as A& E is not an approved centre, indeed the patient was discharged and staff were asked to inform the Gardaí to subsequently identify the patient to Gardaí so they could arrest him and take him to begin the admission procedure again. This is hardly a dignified way to treat any individual and it would seem roles and responsibilities are clearly ad hoc in this regard. Quite rightly

[10] Mental health Act 2001,s 67. This expressly made subject to s.12 (power of a Garda to take a person believed to be suffering from a mental disorder into custody) and s.22 (transfer of patient to hospital, e.g. transfer of a patient to a surgical ward for surgery).

[11] ibid

the patient refused to be picked up by Gardaí as he was not a criminal and he subsequently presented that day for voluntary admission.

Points of clarification outlined in the submissions included:

"Should the reception area be separate from the ward i.e. in the hospital A & E department or a purposely designed area? This would enable assessment then transfer to ward only if the person meets the criteria for involuntary admission and in the absence of any significant medical concerns".

"It is also a concern that a person's right to a comprehensive medical assessment is denied to them by virtue of them being the subject of an admission order. This situation had led to a number of incidents whereby patients health and well-being has been unnecessarily threatened it is therefore vital that the act makes a provision for a full medical assessment in A & E in accordance with best practice.
There needs to be a clear protocol between the approved center and A&E to facilitate the required medical assessment and/or treatment of an involuntary patient in A&E at the time of admission. In such cases the Gardaí should remain and convey the person to A&E and thereafter back to the approved center when the medical assessment is complete".

3. Admission of Children

The PNA and others including the Mental Health Commission have consistently highlighted the lack of sufficient child and adolescent in – patient and day hospital facilities. The admission of children to units in approved centres that primarily provide care and treatment to adults is undesirable.

According to the MHC's latest Annual Report[12], there were 392 admissions of children to approved centres in 2008. Some 63 per cent of admissions (247) were to adult units; 90 per cent of these (223) were 16 and 17 years of age and the remaining 10 per cent (24) were 15 years of age or under.
Just 37 per cent of admissions (145) were to child units; 62 per cent of these admissions (90) were 15 years of age or under and the remaining 38 per cent were 16 and 17 years of age.
Dr Patrick Devitt, Inspector of Mental Health Services, has described the practice of admitting children to adult centres as *'inexcusable, counter-therapeutic and almost purely*

[12] Mental Health Commission (2009) Mental Health Commission Annual Report 2008 including the Report of the Inspector of Mental Health Services, MHC, Dublin

custodial in that clinical supervision is provided by teams unqualified in child and adolescent psychiatry'.

If children are admitted of necessity to approved centres for adults the provisions of the Code of Practice Relating to Admission of Children[13] apply. In May 2009, the MHC approved an amendment to the Code of Practice Relating to Admission of Children under the Mental Health Act 2001 set out on page three of the amendment[14].

At this point it is worth referring to a previous issue raised by this union (PNA) with regard to the admission of children as part of the Review of the Operation of Part 2 of the Mental Health Act 2001 undertaken in 2008.

The Act defines a "child" as any person who is under the age of 18 other than a person who is or has been married.[15] This is in stark contrast with section 23 of the Non-Fatal Offences Against the Persons Act 1997, which states that for the purpose of medical treatment, an individual over the age of 16 has the capacity to consent[16]. Ultimately the 1997 Act and the 2001 Act are at odds. It is not clear what status the consent or refusal of consent, of a child between the ages of 16 and 18 years, to treatment for a mental disorder has.[17]

There is a question as to whether Section 23 NFOAP Act 1997 enables children aged 16 and 17 years to admit themselves voluntarily to an approved centre for treatment. The Mental Health Commission's legal advice is:

"That attempts to reconcile Section 23 NFOAP Act 1997 with the provisions of the Act give rise to significant difficulty. While it may be that the definition of medical treatment under the NFOAP Act 1997 would include psychiatric treatment, and one commentator has interpreted it to be so, the Act does not appear to contemplate the giving of consent to treatment by a "child", a term which, because of the way it is defined in the Act, includes Section 23 NFOAP Act 1997 minors". [18]

[13] Mental Health Commission (2006) Code of Practice Relating to the Admission of Children under the Mental Health Act 2001 MHC Dublin.

[14] Mental Health Commission (2009) Code of Practice Relating to the Admission of Children under the Mental Health Act 2001 Addendum Ref : COP- S33(3)/01/2006

[15] Mental Health Act 2001 s2

[16](Section 23 NFOAP Act 1997) which provides at Section 23(1) "the consent of a minor who has attained the age of 16 years to any surgical, medical or dental treatment which, in the absence of consent, would constitute a trespass to his or her person, shall be as effective as if it would be if he or she were of full age; and where a minor has by virtue of this Section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his or her parent(s) or guardian". Section 23(2) NFOAP Act 1997 provides that treatment includes any diagnostic procedure and any procedure ancillary to that treatment.

[17] O'Neill, A. (2005) *Irish Mental Health Law*, Dublin: First Law Limited. (Pg. 90)

[18] Mental Health Commision (2006) Code of Practice Relating to Admission of Children under the Mental Health Act 2001(Pg 14)

The Commission's legal advice is:

"That while there are cogent arguments in favour of applying Section 23 NFOAP Act 1997 to the Act, the position is not so clear as to enable the Commission to proceed, or advise others to proceed, on that basis. The Commission has been advised that there is significant uncertainty as to whether Section 23 NFOAP Act 1997 has any application in relation to admission for and provision of treatment for mental illness. Medical and health professionals may need to obtain legal advice in relation to individual case."[19]

It appears that the Commission has been advised that there is significant uncertainty as to whether Section 23 NFOAP Act 1997 has any application in relation to admission for and provision of treatment for mental illness and advises *"Medical and health professionals may need to obtain legal advice in relation to individual cases.(Mental Health Commission 2006),it goes on to state "The present position, therefore, is that the Commission cannot advise mental health professionals to operate on the assumption that Section 23 NFOAP Act 1997 means that the consent of children aged 16 and 17 is effective to permit treatment under the Act"*[20].

The Mental Health Commission advises therefore that:

"…that irrespective of whether children aged 16 and 17 years are capable as a matter of law or fact of providing an effective consent to treatment, the views of 16 and 17 year olds as to their treatment should be sought as a matter of course. The Commission has also been advised that the existence of consent to treatment does not, of itself, impose an obligation to treat on a heath professional. Where there is disagreement as between child and parent(s), particularly in respect of some significant aspect of treatment, it is open to the professional involved to decline to give that treatment (where, for instance, the cooperation of the patient would be an important factor in whether the treatment is successful or not) or to seek guidance from the High Court as to how to proceed"[21].

It is laid down in the Act however that a voluntarily admitted *"child"* may not be afforded the same rights as an involuntarily admitted adult, such as their right to apply for the review of their confinement. They are purportedly present of their own free will and do not need the same protection as involuntarily admitted patients.

[19] ibid
[20] ibid
[21] ibid

But what of the children who are admitted voluntarily by virtue of their parent's consent, who are in dispute with their parents? The rationale here is strained. Having regard to the protection of civil liberties and to safeguard against possible abuses, this union (PNA) would argue that parents should not be able to "volunteer" their children for admission to mental hospitals without some additional check, such as an automatic review by a Mental Health Review Tribunal to safeguard against possible abuses. The process of admission under the 2001 Act activates the review mechanism and puts in place certain safeguards, such as shorter time limits, that they may serve to encourage discharge rather than detention of those incorrectly or too precipitately admitted for those over eighteen years. As outlined this is not the case for children and adolescents.

Following the first review of the Act, the Department of Health pointed out that both the detention under s.25 and the extension of the period of the detention require an order of the District Court. In addition, the provisions of the Child Care Act 1991, which includes the appointment of a guardian *ad litem (GAL)* if required, apply to proceedings under s.25. However the New Child Care (amendment) Bill 2009 proposes to limit the autonomy of GALs and their (GAL's) presently unfettered access to legal representation. It seeks to give the court statutory discretion as to whether a solicitor shall be appointed for a GAL and further , if the court does appoint a solicitor, then the "court may give directions as to the performance by the solicitor of his or her duties, which may include, if necessary , directions in relation to the instruction of counsel".

This amendment has serious implications for children and young people who rely on their GALs to bring to the court's attention, independently of HSE reports, an assessment of their needs, rights and interests. With regard to the Mental Health Act 2001 it clearly raises concerns particularly in incidences as described above whereby in effect a child in dispute with their parents is admitted "voluntarily" and in light of the amendment to the Code of Practice Relating to Admission of Children under the Mental Health Act 2001.

Not only are the lack of safeguards a concern, potential legal repercussions have been articulated by our members when it comes to the provision of treatment (i.e. medication) the use of seclusion or restraint with regard to this age group in unsuitable inappropriate facilities.

Children who require mental health interventions, services and supports are seriously out of step with need. There is limited availability of the appropriate range of services – those in primary care, community care, in-patient centres, day centres, rehabilitation services and outreach services to provide support in the home and school. Children and Adolescents are still struggling with an outdated, fragmented system which causes children their carers and staff, moral distress and anguish.

4. Information Provided to Patients and Issues Capacity

The PNA welcomes the publication of the Scheme of Mental Capacity Bill 2008[22]. The main purpose of which is to reform the existing wards of court system, insofar as it applies to adults and introduce a modern statutory framework governing decision making on behalf of persons who lack capacity. The Lunancy Regulation (Ireland) Act 1871 is the statutory provision governing wards of court. While recognizing that wardship may be necessary because the person is considered to be incapable of managing his (or her) person or property, this Act deals mainly with the power of the court over property issues. It does not deal specifically with the issue of withholding consent to medical treatment, choice of residence, and other matters relating to personal autonomy and self determination.

However at the time of writing the Mental Capacity Bill has not yet been published and the Scheme as presented does not deal with the glaring gap that currently exists, i.e. the issue of people who are being involuntarily detained within the terms of the Mental Health Act 2001 and lack capacity. If an application is made by such a person to a tribunal under the Mental Health Act 2001 and the tribunal determines that that person should not be involuntarily detained and do not fulfill the criteria for involuntary admission under the Act then a further application (if no determination has already been made as to capacity) to another court/ tribunal is necessary to deal with persons who need treatment under the Mental Health Act. Legislation is required to deal with persons who need treatment for mental illness but because of their lack of capacity are unable to consent to being admitted as a voluntary patient and / or consent to treatment.

This limits the scope for clinicians with regard to safeguarding the patient's welfare as in "the best interests of the patient "section 4 (1). A further legal test, of "substantially diminished capacity" in the field of all health care including consent to psychiatric treatment, and the grounds upon which such health care may be given without consent should be added to the criteria governing all interventions under the Mental Health Act 2001. Indeed such problems have occurred with regard to individual patients residing on a unit of what was formerly a psychiatric hospital (but not an approved centre now) having to be admitted involuntarily as a result of them refusing medication thus incurring the whole process of an assisted admission GP etc.

[22] Press Release of the Department of Justice, Equality and law Reform, "Minister Ahern Announces Proposals for a Mental Capacity Bill", (15 September 2008), available at www.justice.ie.

Other comments include:

"When a person admits himself voluntarily, becomes increasingly unwell mentally and physically and refuses all interventions such as medications and basic nursing care what do staff do. Under the act unless the person indicates that he wants to leave or attempts to leave he cannot be treated involuntarily. This has happened and has left nursing staff in a situation where they see a patient urgently in need of basic nursing care and medical intervention but are powerless to intervene. Guidance would be welcome".

"Under the MHA 2001, a person may only be treated without consent if they are an involuntary patient. However, there is no provision in the Act for treating voluntary inpatients whose mental state has deteriorated but who do not seek to leave hospital. Such people may lack capacity to make treatment decisions but be passively compliant. The Wards of Court system is currently the only legal recourse but is not a useful mechanism to pursue in persons best interests. Further guidance on the treatment of people lacking capacity to consent or withhold consent is required to protect and advance treatment. Capacity legislation may be on the way but in the interim treating teams are working within a legal vacuum. For treating teams (especially nurses who are in the treatment setting around the clock) a code of practice would provide guidance and assurance on best practice and best courses of action when faced with a dilemma".

It has also been commented that the 2001 Act should have contained a specific statutory scheme for the release of medical records to legal representatives. The case *E.J.W. v Waters and Mental Health Commission*[23] test case taken has improved the situation somewhat, it is no substitute for a proper statutory framework for the resolution of the complex issues of confidentiality which arise in such cases.[24]

The recommendations of the English Law Commission provide a useful guideline in this regard. [25]As a matter of practice to ensure that accusations against bias in decision making can be refuted, psychiatrists clinically disinterested in the relevant case and trained in assessment capacity should make the assessment of capacity of a person of mental disability (whether mental illness or intellectual disability) to consent to medical treatment.

[23] Unapproved, High Court, Peart J., November 25,2008

[24] See Whelan D, (2009) *Mental Health Law and Practice*, Roundhall Thomson Reuters Dublin pg 246 & 247 for full details

[25] English Law Commission Report No. 231 on Mental Incapacity London: HMSO, February 28, 1995. Paras 3.2 to 3.22

On foot of these difficulties and in the absence of such safeguards, from a nursing and clinical perspective some comments have suggested that the operation of Part 2 of the Act is legally dominated and that there is less regard for individual clinician's judgment despite having the patient's "best interests" at heart.

Other comments made with regard to Information Provided to Patients include :

"As a nurse on the ground in a busy acute unit a quick reference guide with regard to time would be invaluable. What I mean by this is e.g. the applicant for an admission order must have seen the patient within last 48 hours, GP must have seen patient within 24 hours, admission order is valid for 7 days etc. When a patient is being admitted involuntarily to an acute unit checking forms can take time particularly as increasingly there are agency and bank nurses on duty who, because they don't regularly work in acute Psychiatry need to look up act to ensure admission is legal. A quick guide would be of great assistance."

Another submission referred to guidance on the provision of information for patients with regard to the *"Absence without Leave"* procedure and *"Holding Powers".*

Another Comment stated
"A code of practice for involuntary administration of medication, a copy of which would be given to the patient, would make this practice more transparent and help reduce the potential conflict that arises".

5. Operation of Mental Health Tribunals

We have had some concerns regarding the clarification of the role of the R.P.N. at Mental Health Tribunals, in some instances staff have referred to their perceived role by some Tribunal members as that of a custodial one. This is unacceptable and jeopardises the therapeutic relationship between the nurse and service user.

Writing an opinion piece from the perspective of the psychiatric profession, Obomanu and Kennedy[26] pull no punches in their critique of the adversarial tactics employed by lawyers at tribunals. They suggested that four principles should be written into the new English Mental

26

Health Bill, including a principle that nothing should be said or done to undermine an existing or future therapeutic relationship.[27]

Some members of this union report that some patients do not wish to have a Mental Health Tribunal that they find the whole process intimidating and heightens their levels of anxiety. Indeed some patients have stated that the choice to proceed with a Tribunal should be left with the patient. Again if the necessary capacity legislation were in place this would perhaps enable this option.

There is also some concern expressed re the high level of revoked admission orders that do not progress to a Mental Health Tribunal. Sometimes this leads to an earlier discharge than is warranted.
Also there is considerable disruption in day to day running of services which can arise from the late notification of Mental Health Tribunal hearings replacement of staff etc.
Mental Health Tribunal hearings should take place at the earliest possible opportunity and that all necessary arrangements should be made to facilitate this. The provision of a Mental Health Tribunal hearing as soon as possible after an involuntary admission is made will reduce the number of admission orders that are revoked prior to the tribunal hearing, facilitate better spacing of any second Mental Health Tribunal, alleviate difficulties experienced by both patients and service providers and minimise disruption to services. The Mental Health Commission and service providers should work together, on an ongoing basis, to ensure optimal collaboration in relation to the Mental Health Tribunal process. It is also considered necessary that patients and their legal advisors have earlier (than the 14 day time period) access to the second opinion reports prior to hearings

It was also suggested that the 21 day timeframe for the reviewing of renewal orders is creating operational difficulties and distress associated with the anticipation of Mental Health Tribunal hearings. A patient admitted will have their admission order (which is valid for 21 days) reviewed by a Mental Health Tribunal within 21 days. If the patient is then the subject of a renewal order (valid for three months), a second Mental Health Tribunal must take place within 21 days of the renewal order being made.

Other difficulties mentioned as discussed previously include, scheduling of Mental Health Tribunals; claims of an adversarial approach by some legal representatives; disruptions

[27] W. Obomanu and H. Kennedy, " Juridogenic Harm : Statutory Principles for the New Mental Health Tribunals" (2001) 25 Psych. Bull.331.

caused by visits to centres by legal representatives and second opinion consultants; access to independent second opinion assessment reports prior to the Mental Health Tribunal occurring; and uncertainty over who is responsible for sending forms to the Commission. It is also suggested that procedures for informing patients and service providers of Mental Health Tribunal decisions are unclear.

Peay proposes that tribunals should be required to follow a set order of proceedings[28].This might mean. For example, that evidence from the patient would be heard first and cross examined, followed by evidence from the health authority. This proposal would not be difficult to implement, and would help to ensure that procedural fairness is maintained as "the order of proceedings can influence the weight given to the various elements of evidence that are presented, and so the chances of discharge"[29].

6. Holding Powers

The Act provides for a 24 hour holding power over voluntary patients. While voluntary patients have the right to leave an approved centre, they may be prevented from leaving by a nurse or doctor using the statutory holding power until they are assessed with a view to either detention or discharge. The MHC *Reference Guide*[30] states the following in relation to the holding power:

- Risk must be assessed during the period and appropriate risk management strategies put in place to reduce likelihood of harm and deterioration of mental well being.
- All efforts should be made by the approved centre to encourage voluntary consent to remain for examination before a holding power is used.
- An examination should take place without delay and within the 24 hour period.
- The Act provides no right to treat during this period and in the absence of consent treatment is justified only under common law doctrine of necessity and based on the best interests of the patient.

The degree of intervention should be the minimum necessary to meet safety needs of all. Comments which have arisen with regard to this section include

J. Peay, (1983) Tribunals on Trial: A Study of Decision – Making under the Mental Health Act (Clarendon Press, Oxford, 1989)

P.Bartlett and R.Sandland,(2003) Mental Health Law: policy and Practice (2nd ed., Oxford University Press, Oxford):

[30] Mental health Commission (2005) reference Guide to the 2001 Act. Dublin : Stationery Office.

"The requirement for the provision of guidance /information with regard to preparatory documentation for patients so they are aware of conditions of temporary detention under s.23 (1) would be useful".

Clarification on the Clinical practice form [31] that the 24- hour period is calculated from the time the patient indicates that he or she wishes to leave the centre not when the relevant staff member decides to detain the patient under s. 23 (1).

However one submission indicated that they felt for observatory purposes and assessment that the 24hour period was too short.

Others have reported that the requirement for a person to indicate that he or she wishes to leave is too restrictive and that the consultant psychiatrist should be permitted to detain the person if the criteria for a mental disorder are met. A voluntary patient whose condition deteriorates to the extent that he or she would meet the criteria for a mental disorder cannot have their status changed unless they indicate a wish to leave the approved centre. Examples have been raised in this regard whereby individual's detention was deemed unlawful by the Tribunal due to the fact that they didn't attempt to leave the unit and as such was not covered by a section 23 detention. In such instances the case has been referred to the High Court whereby the verdict has been given to discharge the patient and go through the whole admission procedure again.

This is farcical in the extreme it belittles the patient adds further stress on the family and makes a nonsense of the nurse /clinician's judgment. The provisions of the Mental Health Act dealing with holding powers seem to deviate from the terms of the White Paper which proposed that nurse be given holding powers to detain a patient in an approved centre for up to six hours within which time the person must be examined by a medical practitioner and a consultant psychiatrist may hold such a patient for a period of 48 hours within which time procedures for detention must be completed.[32]

7. Discharge with leave, Absence without leave, Change of legal status

Section 26(1) of the Mental Health Act 2001 provides that the consultant psychiatrist responsible for the care and treatment of a patient may grant permission in writing to the patient to be absent from the approved centre concerned for such period as he or she may

[31] Mental Health Commission, *Clinical Practice Form: Mental health Act Section 23(10: Power to Prevent Voluntary Patient (Adult) From Leaving an Approved Centre.*

[32] See para.3.34.

specify in the permission being a period less than the unexpired period provided for in the relevant admission order, renewal order or order under section 25.
Section 26 (2) provides that where a patient is absent from an approved centre pursuant to subsection (1) , the consultant psychiatrist may, if he/ she is of the opinion that it is in the interest of the patient to do so, withdraw the permission granted under subsection (1) and direct the patient in writing to return to the approved centre.

However, it should be noted that following the enactment of the European Convention on Human Rights Act 2003 the consultant's powers to withdraw the permission to be absent and to direct that patient to return to the approved centre must be exercised consistently with Article 5 (1) of the European Convention on Human Rights and following the decision of the European Court of Human Rights in K v. UK, [33] except in emergency situations , a patient should not be recalled to an approved centre in the absence " of objective medical evidence" that s/ he remains mentally disordered.
In the English Courts in R v. Hallstrom ex p. W[34], it was held that it was unlawful to use prolonged leave of absence as a means of ensuring that patients who did not need to be in hospital could be obliged to go on taking their medication outside. The court also ruled that it was unlawful to recall from leave a patient subject to section 3 solely in order to renew the authority to detain the patient if it was not appropriate and necessary for him to be detained in hospital for treatment. For the avoidance of doubt it is submitted that specific provision should be made by the Irish legislation for extension of leave to be granted without the necessity of a patient's returning to hospital.

The inclusion of CTO's would allow clinicians to supervise patients to comply with their drug /medicines regime and return them to the approved centre if required for their therapeutic benefit. This would allow for a phased discharge for the individual with the proper safeguards in place for supervising the individual and a more appropriate mechanism for referral back to the centre in this regard than currently exists.

If the MHT decides to revoke the admission or renewal order, it must direct that the patient be discharged. [35] There is no statutory power to make a conditional discharge,[36] defer a discharge, or direct that a patient's disorder be reclassified.[37].

[33] (1998) 40 B. M. L. R. 20
[34] [1986] Q. B. 1090
[35] S.18(1) (b)
[36] Compare s.73 (2) Mental Health Act 1983, which applies to restricted patients.
[37] Compare s.72 (5) Mental Health Act 1983. See R v Ashworth Hospital , ex p. B. [2003] E.W.C.A. Civ .547

In the review of Operation of the Act, clarification was requested as to the time and geographical criteria for defining absence without leave. The Minister stated that he did not consider this a matter appropriate to legislation; however he considered it would be helpful for the HSE and the MHC to develop guidance on this matter[38].

Eldergill notes that the Act does not make any provision at all for extending a patient's liability to detention where they are absent without leave at the time when renewal is due. He states:

"*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 the period".*[39]

Conclusion

The Mental Health Commission has produced reference guides to provide all those whose work may bring them into contact with persons suffering from a mental illness or a mental disorder with clear and practical understanding of the major objectives and requirement of the Mental Health Act. However all the indications are that there is a requirement to prepare a comprehensive code of practice for the 2001 Act. Having regard to the areas mentioned there appears to be a need for more information provided to patients and ease of use.

It is vitally important for all those key stakeholders involved and interfacing with those individuals with mental health difficulties consider how best to continue to achieve a productive inter agency working relationship.

We as a professional organisation value the opportunity to contribute to the Consultation on the Code of Practice on the Mental Health Act 2001. We are committed to professional based interventions designed to help service users and professionals collaborate in the treatment of mental illness. As discussed we urge the Mental Health Commission to lobby for the progression of the 2008 Mental Capacity Bill.

[38] *Review of the Operation of the Mental health Act 2001*, p21.
[39] Anselm Eldergill, "The Best is the Enemy of the Good: The Mental health Act 2001" (2008) J. Mental Health L.21 at 36

In preparation for this submission The Officer Board of the PNA would like to express their gratitude particularly to those individuals and branches who took the time to complete the Consultation Questions.

5. Are there **other areas** under the Mental Health Act 2001 that you would like to see further guidance on which are not included in Section 2?

I: I Nursing & the role of students!

6. What **impact,** if any, do you think a Code on the Act would have for staff, mental health services and other relevant organisations/people?

1. More transparency
2. Clear guidelines reduce the potential for error.
3. Does not leave room for individual Interpretations on aspects of the act.
4. Have a clear framework from which to work from
5. Staff members having greater confidence and autonomy using best practice guidlines

7. We want to develop a code that is user friendly and easy to use. Have you any thoughts on what **format or formats(s)** would be helpful to have the code in? Tick all that apply.

Full Hard copy x☐

Quick Reference Guide hard copy x☐

Web version x☐

Other, please specify:

8. Have you any **other comments or suggestions** you wish to make?

Yearly Refresher Courses on the MHA & facilitated brain storming sessions
Vignettes help explain rationale