Mental Health Act Review Submission

General Comments

Firstly it is welcomed that the 2001 Act is being reviewed and amendments proposed however it is particularly regrettable that this is happening at a time when many of the clinicians most expert and familiar with its use are struggling to manage the demand for treatment serious mental illness during the pandemic and less available to give this process the attention it absolutely deserves in the interest of patients.

It is also regrettable that the Medical Experts in Psychiatry have been so ineffectively consulted throughout the process. Concerns regarding the composition of the Expert Group have already been expressed by the College of Psychiatrists particularly with regard to the absence of representation of Child and Adolescent Psychiatrists but am I correct in my understanding that NSUE was represented? There would be additional concerns if so and it would be worth reviewing how much the views of that organisation influenced opinion given that that group is no longer in existence albeit for reasons that have never been widely discussed.

Psychiatric illnesses can be as severe and life threatening as any cancer or cardiac condition. The ONLY reason we should require a Mental Health Act is to provide for those occasions when the severity of the illness threatens life or safety and coercion in r3elation to admission or coercive treatment is required. ALL other aspects of psychiatric treatment and care should be provided for in the Health Act. To do otherwise is to increase the utterly artificial "mind/body" divide and further stigmatise those with psychiatric illness and those who work so hard to treat them. The Guidance Document is – I believe – factually incorrect in stating that the 2001 Act "describes how people who need inpatient mental healthcare should be cared for and treated" – it is "To provide for the involuntary admission to approved centres of persons suffering from mental disorders etc" ie ONLY relates to those being treated against their will – which I believe should be the case.

Many of the amendments appear heavily influenced by societal views and legal preoccupations and demonstrate a lack of involvement of those actively working on the frontline or a basis in statistical analysis of current practice or a clinical evidence base. Given the number of years the present Act is in place it is concerning that with the exception of case law quotations there is no clinical evidence or feedback referenced such as audit of inappropriate use of the Act or clinical outcomes of patients who had Orders revoked due to legal technicalities? There is a suggestion that the legislation is attempting to subtly reflect changing opinions and thinking but it is important to remember that Serious Mental illness itself is essentially unchanged and very serious indeed.

The Mental Health Commission (MHC) was effectively "created" by the Act – but it does not "own "the Act. This is clear when – as a clinician – I have had concerns in relation to the use of the Act and have sought advice from the MHC. I have been advised to seek my own legal advice ie they are not the authority as it were. The Department sought the views of the MHC specifically in 2019 however and the HSE. As a consultant working for the HSE with over 30 years' experience in Psychiatry I can report that I have no sense of any of my concerns relating to the Act having been included in either response. The lack of specific consultation with the Medical Expert Group ie College of Psychiatrists

of Ireland is especially hard to understand. Should we need legislation for the treatment of Cancer or Cardiac conditions would we omit specific consultation with the relevant Professional Bodies???

So the "Expert Group" - because of its composition was not in a position to provide the extensive views and experience of the vast majority of Medical Experts in the field: the important stakeholders whose opinions have been sought have been the MHC which was created by the Act, the HSE which is an employing body but did not effectively consult the Medical Experts involved and the public. It therefore appears that the best means by which the views of the Medical Experts in the Treatment of Psychiatric Illness can contribute to Legislation for the Involuntary Treatment of Patients with Psychiatric Illness is via this process as members of the public.

Comments Regarding Definitions

Mental illness is already adequately defined in the 2001 Act. The addition of "complex and changeable" is unnecessary and actually suggests a vagueness" about diagnosis that is unhelpful we know and recognise serious mental illness. The statement "requires" treatment is open to significant challenge and interpretation – "requires" in what sense and whose opinion?

Caution is advised if "tests" are to be included and treatment will need to be clearly defined – particularly if the tests or treatments are not available within the Approved Centre or would require restraint. The clinician does not want to be in a position where eg "re feeding" might be allowable under the Act but not safe in the physical environment.

The Amendments appear to suggest the effective removal of the current "3(b)" grounds for detention ie it would only be in cases of immediate and serious risk. Given that risk assessment and prediction is an extremely challenging aspect of practice this may result in patients being deprived of their right to treatment.

The concept that persons move from being "absolutely" detainable to "immediately" no longer meeting criteria is not based on clinical experience or evidence. Patients generally improve gradually with a degree of fluctuation. Short "choppy" use of the Act will likely leave patients worse off.

The term patient is the correct term for any person receiving medical treatment which all those attending a psychiatrist are.

The introduction of a third category of patient and formal capacity assessments will have very significant implications for clinicians and will require considerable additional sessions/manpower.

Incidentally while the term "RCP" and Responsible Treating Psychiatrist is constantly used by the MHC I do not believe there is a legal definition?

Why change from "Mental Health Tribunal" to "Review Board" – this is not explained and why is it necessary?

Comments Regarding Guiding Principles

I would reject utterly the removal of "Best Interests", the concept of which has been key in my experience to the better management of patients and a core aspect of medical ethics. The

suggestion that it should be removed and replaced with alternatives that are acknowledged by the Expert Group might be difficult to define is hard to fathom and likely reflects the lack of Expert Medical Experience underlying the process.

Comments Regarding Criteria for Detention

Not sure why these are being changed – there are no grounds under the current Act for detention solely on the basis of risk or mental illness or dementia or intellectual disability and there has always been a requirement that there must be a likely benefit of treatment. The definition of "material extent" has been open to interpretation however.

Comments on Authorised Officers.

One of the major concerns regarding use of the current Act has been the relative disregard for the rights of those coerced into admission consequent on the Application and Recommendation aspects of the Act but for whom no Order was subsequently made. The MHC has not sought to examine why so many of those brought under the Act have not been subsequently detained. In effect the only governance has been the decision of the Consultant Psychiatrist and the process increasingly used in cases of distress, intoxication or those in conflict/behaviourally disturbed with no evidence of mental illness. Again I have personally brought to the attention of the MHC my concerns in relation to a case where a patient had been brought under the Act on multiple occasions over a number of years with no documented Mental Illness. The use of an Authorised Officer in all cases would certainly likely improve the Governance of the admission process but given the additional delay this will inevitably involve it would require gardai to be in a position to hold patients for considerably longer than is currently the position. Again the evidence with regard to how this would improve patient experience and outcome would be helpful along with estimation of cost. For example patients might prefer to be rapidly brought to the Approved Centre than held in a cell waiting for an Authorised Officer if this will take 24 hours or more? Can we learn from other jurisdictions where Social Workers are involved in all Admissions under Mental Health Legislation?

It is confusing for the Expert Report to suggest that the sequencing of the Authorised Officer and Medical Practitioner Review is not relevant but that the documentation must follow a particular Order?

There should be provision for more humane transport of patients with Mental Illness than potentially handcuffed in a Police Van. There are models elsewhere of trained Ambulance Staff and alternative suitable transport and it is regrettable this has not been addressed in the amendments.

It would be medically unacceptable to hold the Clinical Director/Psychiatrist responsible for the care and treatment provided by another consultant in the ED/Medical/Surgical Ward to a patient detained under the Act but requiring this treatment before being brought to the Approved Centre as is recommended (47).

Comments on Interdisciplinary approach to care and treatment.

The consultant contract clearly states that the consultant is clinically independent and retains responsibility for the patient. The suggestion therefore that this lead clinical expert should have to document that they had sought the opinion of "another mental healthcare worker" before signing an Admission Order is utterly unacceptable and one would have to question why it has been proposed? What purpose does it serve? We have MDTs and MDT care plans and I cannot think of any patient who could be admitted without the involvement of many team members. Why add to the already onerous requirement for documentation? Is the other healthcare worker to carry out an assessment equivalent to that of the Consultant before expressing their opinion? Does the opinion have to be in agreement? By all means increase MDT numbers and ensure – for example – that every inpatient unit has a dedicated psychologist .

Comments on changing timeframes.

The pandemic and other MHC requirements have already resulted in very limited timeframes for the holding of Mental Health Tribunals (MHTs). Add to that the need to have the Legal Representatives and Consultant Psychiatrists available at the same time in the context of busy and unpredictable demand in an acute health care setting and it is an on-going challenge to schedule the MHTs even within the 21 days currently provided for. More importantly however – the timeframes should relate to the clinical evidence. How many seriously ill patients recover sufficiently within a proposed two week time frame to justify such a proposal? We should have the evidence available to assist with this question. Too short a time frame may risk increasing the need for Renewal Orders and result in prolonging admissions because a very ill person will likely still meet criteria for detention within the first 10 days (MHTs are usually held a little before the latest possible date) and a Renewal Order will then be made. If the 21 days' timeframe remains it may be that on approaching the three week period revocation may be possible and so no Renewal Order. The statistics should help with basic modelling here along with clinical response times to treatments. This is about medical illness and the legislation should be informed and shaped by this – not arbitrary or legal concepts.

Multiple short treatments with repeated relapses are cognitively damaging and worsen prognosis. The Act should assist in preventing this where possible – not risk increasing the possibility.

Before making any changes to Section 26 Leave there should be a review of WHY it may be being used as it is. Has there been any audit to underpin the new suggestion? Is there a need to consider introducing a Community Treatment Order?

Comments on Enhancing Safeguards

The whole Appeals Process needs reform and I cannot really see evidence of this in the Report.

Section 19 Appeals I believe inappropriately involve the RCP - effectively on behalf of the MHC leading to the risk of a damaged therapeutic relationship. The current Appeal is against the decision of the MHT so the suggestion that the Respondent might be any other than the MHC is hard to

understand. The fact that the outcome rests on the present mental state and not the MHT process or actual decision itself has meant the relevance of having such an Appeal has already been legally questioned.

The usefulness of holding a Tribunal after the patient has been discharged and the Order revoked needs to be evaluated. All these matters have a cost and there are many deficits that could be addressed with funds released by avoidance of non-therapeutic processes. The governance of the lodging of such appeals is of concern – some Legal Representatives lodge Section 19 Appeals almost as a "matter of course" and when asked patients have told me they were told "this is just something we should do" and admitted they did not understand what it meant.

There is no consideration for the safeguarding of patients when their right to treatment is infringed by revocations on a legal technicality that cannot be cross examined because the RP has no legal representation. This needs to be addressed urgently.

Comments on Mental Health Tribunals

What is the intention behind a change of name to "Mental health Review Boards"? This is not clear. If the intention is to give an image of something less formal or legal I think that a cynical and disingenuous act – these are very much legal processes and should be as an individual is being deprived of their liberty.

In fact the increasingly adversarial nature of the MHTs needs to be addressed. I believe it inevitable that because of this there will be a demand from RCPs that they be legally represented in order to protect patients from having their Right to Treatment infringed due to revocations based on legal and not clinical argument. For example I recently was concerned about an outcome where a very ill patient had an Order revoked due to a Legal Submission that the form itself (Patient Notification Form) was misleading. The patient is now reportedly very unwell in the community and independent legal advice sought by the HSE considered that the decision made by the MHT was in error and flawed – but the patient has suffered as a result and will likely suffer a distressing readmission including the presence of the Gardai which he finds most distressing.

The MHA should not be involved with legislating for a "psychosocial report". All treatments are based on a "Biopsychosocial model" in any case.

Comments on change of status from voluntary to involuntary

It may be helpful for there not to be a requirement for a patient to seek to leave before considering the use of Section 23 of the Current Act (change of status) but the use of exactly the same process as for a non-admitted patient seems unnecessary. Is there a suggestion that the opinion of a consultant psychiatrist already familiar with the patient needs to be confirmed by a General Practitioner who is being brought in for the purpose of the recommendation. At present it is another Consultant Psychiatrist who assess in relation to the change in status? You are in effect lowering the level of Specialisation with regard to this decision?

I absolutely agree the MHC should be notified if this process is started and this should be the same in the Community ie if the Act is used AT ALL to coerce a person it should be reported to the MHC.

Comments on decisions re Capacity

This will have significant implications for clinical time use if formally assessed and the timing of the assessment will need to be considered.

Comments on Information and individual care planning.

As a medical specialty psychiatric practice has always involved a plan of care for the patient. The development of MDTs has led to the use of Care Plans and worryingly their use or rather the manner in which they are being required to be used remains a cause for concern for many consultants. Again the evidence base is not robust and given the time commitment involved there needs to be a proper analysis of outcome and cost before further developing the concept. No medical clinician would or should be asked to produce a recovery plan – but while clinicians are recovery focused a recovery plan is something every patient should be encouraged to develop. It should not be legislated for and the intrusion into clinical autonomy and patient treatment is concerning. Again the Act should serve the rights of those detained the specifics of medical treatment should be left to the clinicians with regard to the Health Act, the Medical Council and the Professional bodies.

Comments on regulation/inspection

It is not clear why a reduction in frequency is suggested – I see no reason why this should happen

Comments on the MHC

The MHC should concern itself primarily with the coercive aspects of psychiatric care and treatment. We should work towards de-stigmatising psychiatric illness by reminding all that these are medical illnesses and medical (including psychological) treatments albeit with psychosocial basis should be considered under the Health Act with a separate Mental Health Act only required for the coercive aspects of care.

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