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**Submission on the Review of the Mental Health Act, 2001**

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This is a personal submission, based on my eight years of consultant experience in Liaison Psychiatry. Liaison Psychiatry is the sub-specialty of psychiatry concerned with the expert delivery of mental health care in the acute medical setting and includes patients who present to the Emergency Department, as well as psychiatric emergencies among inpatients in the medical setting. Liaison Psychiatry services also provide assessment and treatment of mental health difficulties which arise in both inpatient and outpatient settings – ranging from functional or medically unexplained conditions, to depressive disorders and adjustment disorders which arise in the context of other illnesses, psychiatric symptoms in the context of organic brain disorders such as traumatic brain injuries, delirium and encephalitis, and a range of conditions which can impact on an individuals' ability to manage their physical illness. Liaison Psychiatrists have specialist training in the management of the conditions which occur at the interface of medicine and psychiatry.

Much of the content of the Act and the proposed revisions have very little to do with the day-to-day work of Liaison Psychiatrists: my focus here is on the aspects of the proposal which directly affect the welfare of the patients I meet.

## 1. Comorbid mental and physical healthcare needs in the emergency setting

The section which has the greatest impact on our patients and our work is covered by Recommendations 44-47. This section appears to have been written with little cognisance of the real and practical issues of managing comorbid mental and physical health care needs in an emergency, and the recommendations are wholly impractical. It addresses medical treatment prior to psychiatric admission, and seems to suggest responsibility of Approved Centre Clinical Directors for care at Emergency Departments/ medical wards, and does not mention how this will relate to the liaison psychiatry team.

Point 46 states:

> *"The 24 hour timeframe for the admission process to the approved centre should commence on arrival at the emergency department, hospital or clinic as though it was the approved centre named in the application and the appropriate assessment and the making of an order should be done within that timeframe by the Clinical Director of the approved centre or by a Consultant Psychiatrist on the staff of the approved centre after consultation with a Mental Health Professional of another discipline."*

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This appears to suggest that an Approved Centre consultant psychiatrist should travel to the Emergency Department, rather than any care in the medical setting being led by the consultant liaison psychiatrist employed by that hospital, which appears to be a duplication of effort. It also raises the question of who the “mental health professional of another discipline” might be. Should they also be on the staff of the Approved Centre? This would require two team members to leave their usual duties and travel to an Emergency Department or other medical setting which may not be on the same site with resource implications, and where there is a specialist team designed to do this work.

The 24 hour time frame does not consider the patient’s physical health condition and the impact that this may have on the ability to make a decision on whether or not the patient meets the criteria for an involuntary admission under the Mental Health Act. Patients may require medical investigation or treatment for conditions which may overlap with existing of possible mental disorders, for example following a head injury, if a neuropsychiatric condition such as encephalitis is being excluded. Some patients may be unconscious in ICU following self-poisoning.

Point 47 states:

> *"Throughout this period when the patient is at the emergency department, hospital or clinic, responsibility for the mental health treatment of the person should remain with the Clinical Director (CD) of the approved centre to which the patient is being admitted."*

In many cases the Approved Centre may be at a different site to that where medical care is being delivered. For example a patients who initially presents to Letterkenny Hospital with self-inflicted lacerations in the context of acute mental illness and requires plastic surgery input will be transferred to University Hospital Galway for same. It would appear to be impractical to require the CD of Letterkenny in this example to provide governance for the care of patients 200 miles away. What currently happens in these situations is that if a person requires medical treatment this is delivered in the acute hospital setting, and the liaison psychiatry team provide mental healthcare to that person during this medical or surgical admission. If the person is declining medical or surgical treatment this is not of course covered by the MHA 2001, but is a question of mental capacity to make this decision. If they require a MHA 2001 admission when fit for discharge from the medical or surgical unit where they are admitted, at this point the process of involuntary admission is initiated.

It also changes completely the current provisions of the Act requiring that a patient is detained only to an Approved Centre. These recommendations suggest that a patient could be detained to an Emergency Department, and in addition has wide implications for the governance of liaison psychiatry teams, who are currently responsible for the mental health care of patients in the medical setting.

Furthermore we have concerns about this occurring in instances where there is no need for emergency medical treatment, but in the absence of a psychiatric bed being available this could potentially be considered an interim option. Emergency Departments are not the appropriate setting for the delivery of mental health care,

but as bed numbers continue to drop and with the failure to provide robust urgent community options such as multidisciplinary crisis teams, they are increasingly becoming the chief point of access for mental health care. It is important that the Act does not undermine the efforts of policy documents such as A Vision for Change and the Emergency Medicine Programme to keep Emergency Departments for undifferentiated presentations and to ensure people with primary mental health care needs are treated in the setting which is safest for them and provides the more therapeutic environment.

We are concerned for the potential that this may be seen as a mechanism to transport a medically unwell patient who is refusing medical care (e.g. a confused elderly person with delirium secondary to a urinary tract infection) to an Emergency Department. It will be difficult in practice to make a decision on whether the person has a primary medical or psychiatric condition until investigations can be performed.

## 2. Treatment prior to completion of the admission order

Recommendations 48-49 refer to treatment prior to completion of the admission order. Recommendation 48 states:

> *"Treatment should not be provided to a patient without consent prior to an admission order being completed unless the Consultant Psychiatrist after consultation (to be officially recorded) with another Health Care Professional is of the opinion that it is necessary in emergency circumstances."*

This recommendation applies to that time period between the arrival of the patient in the Approved Centre and the review by a consultant psychiatrist within 24 hours with a view to making a decision on whether or not an Admission Order is required. By definition, the consultant psychiatrist has not yet seen the patient, and this situation could only arise out of hours when the consultant is not at the Approved Centre. Usually, any decisions in the time period are made by the NCHD on call, in consultation with the consultant psychiatrist on call. Where the patient is in an Approved Centre, the NCHD on call could discuss the need for emergency treatment with mental health nursing staff, and with the consultant psychiatrist on call, in line with current practice. The need to discuss with a non-prescriber seems unnecessary as they will not have the required expertise to inform this decision.

The term "health care professional" is unclear – presumably it means "mental health care professional" as in recommendation 46. It is difficult to understand what a Health Care Professional from another speciality could bring in this instance.

This recommendation becomes further complicated (and unworkable) if the patient is in a medical setting (Recommendations 44-47 suggest this may potentially be possible). In most general hospitals there is just an NCHD on site out of hours: there is no other mental health care professional available.

## 3. The Authorised Officer and delays for emergency healthcare

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Points 34-41 address the role of the Authorised Officer and suggest that they will be involved in every admission under the Mental Health Act. There are certainly benefits to an increased role for Authorised Officers, especially where the Application for an involuntary admission may impact on the patient's relationship with family members. However, unless this is heavily resourced with national cover 24/7, it will negatively impact on timescales of admissions of people in Emergency Departments especially out of hours, which is not patient-centred care. This will result in patients waiting longer in Garda stations if this is where the Act is initiated. Where the Act is being initiated in an Emergency Department, there are likely to be significant delays resulting in the patient being in an inappropriate environment longer than is necessary.

At present if a patient who has presented to the Emergency Department needs to be admitted under the MHA, either a family member or a member of Emergency Department staff can make the application, which means that the admission can be expedited, and the patient can potentially be safely in a bed within half an hour. Waiting for an Authorised Officer to arrive, especially out of hours, will inevitably cause significant delays of many hours. Longer waits have resource implications as there may be a need to have Special Observations by a member of nursing or security staff to avoid absconsion. More concerningly it increases the risk of patients absconding and coming to harm, either directly due to suicidal acts or risk taking behaviours as a result of mental illness, as well as the risk of deterioration in mental health.

This raises the question of how many Authorised Officers would need to be on call for a city like Dublin to attend all of the Garda Stations and the Emergency Departments, and whether or not it is possible to recruit them. We believe that such resources would be better used in improving the staffing levels out of hours in Emergency Departments to reduce the wait times experienced by patients.

A further point may arise where in an emergency situation, where following the usual process of review in the Emergency Department by a NCHD or CNS with consultant review or oversight, it is deemed that the patient requires an admission, and they are not able to consent to this. Under the recommended changes, if the Authorised Officer decides the person does not meet the criteria, and it is impossible to proceed with the admission. In this instance where a specialist consultant opinion is undermined by an Authorised Officer, where does medico-legal responsibility lie, and are there any remedies available to the consultant (who currently carries medicolegal responsibility) for the outcome of this decision.

## 4. Access to care

Page 15 of the report states *"any revised definition agreed should raise the standard of proof required to conclude that a person is suffering from a 'mental disorder' in an effort to limit the number of involuntary admissions taking place to the greatest extent possible."*

While there is an understandable wish to reduce the number of involuntary admissions, it is important to consider the motivations for this, and the likely consequences. Is there evidence that people are being inappropriately detained, or does this drive have a purely ideological basis? In the absence of evidence that people are being inappropriately detained, we need to consider the consequences of reducing the number detained by raising the threshold. This will inevitably lead to people not accessing the care they need in a timely manner, and while it has a veneer of care, it will ultimately result in the most vulnerable patients being disenfranchised and struggling even more than they currently do in accessing care. Untreated mental illness creates significant difficulties for this individual, and contributes to the numbers of people with severe mental illness in custodial settings and living in homelessness.

## 5. Prescribing

Recommendation 93 states:

> *"Section 60 should also be amended so that medicine may be administered to a detained patient without capacity for the purpose of ameliorating his or her condition for a period not exceeding 21 days. The recommendation to continue the administration of medicine beyond 21 days must be made by the treating Consultant who must also consult with another Mental Health Professional of a different discipline involved in the treatment of the patient and this must be officially recorded."*

There is no clear rationale why a consultant psychiatrist, who is a medical specialist in the management of mental illness should consult another professional who does not have expertise in prescribing or psychopharmacology. This requirement can only delay patient care and to no end. If consultation is required it should be with someone with the required specialist expertise i.e. another consultant psychiatrist.

## 6. Eating disorders

One important omission from this Report is reform of the management of eating disorders. As liaison psychiatrists, we look after the mental health care of the sickest people with anorexia nervosa who are treated in the acute hospital setting. These treatments are required due to either critically low body weight, serious complications of starvation or refeeding and/or the need for refeeding, and are directed in accordance with the MARSIPAN guidelines.[1 2] Anorexia nervosa has the highest mortality rate of all mental disorders, and where body weight is critically low, the urgent primary focus of treatment is weight restoration. If the patient is unable to accept food, they may require feeding via a naso-gastric tube, which may need to be delivered under restraint. The Mental Health Commission does not believe that this lifesaving treatment of severe eating disorder falls within the remit of the Act as it stands.

In the instances where people require treatment against their will, this currently occurs under the 'Wardship' procedure. This was introduced as being the only

available legal framework to address this issue, in the absence of it being facilitated by the Mental Health Act 2001. However, as a High Court hearing is required, patients cannot be treated until the Order is granted, which can take up to two days. Without urgent feeding, some patients are put at unnecessary risk without the ability to provide immediate feeding, In addition, Wardship is an unnecessarily paternalistic and discriminative remedy for an acute mental health disorder, requiring that the person is declared "unable to manage their person or affairs". These cases are heard in public at the High Court, often incurring extensive media coverage, which is distressing for the patient, their family and their treating clinicians.

In contrast, several other jurisdictions, including Australia, New Zealand, and the UK, allow for full treatment of eating disorders. In the UK, the 1983 Mental Health Act (England and Wales), is the preferred legal framework for treatment in preference to using the Mental Capacity Act 2005. [3]

We believe that the Mental Health Act is the more appropriate mechanism for the treatment of severe eating disorders, given that it is a mental illness, and is accepted as such under the Mental Health Act. However, without leave to treat the patient under the Mental Health Act. the Act fails to function effectively for these patients, and revision is urgently required to bring their treatment in line with that of other patients with a mental disorder.

## 7. Final points

There are other points of concern among the recommendations of this report, such as the requirement to formally get an opinion of a non-doctor about the involuntary administration of meds (Recommendation 96). This person would by definition know relatively little about medications; consulting with another consultant would be more likely to be useful in gaining an expert view. This recommendation is unprecedented in any other area of specialist medical care and is highly unacceptable.

Regarding the membership of the Mental Health Commission, Recommendation 140 states:

> *"The criteria for membership should be based on the necessary skills and competencies required to govern."*

It is more important that members have expert knowledge of various components of the management of and recovery from mental disorders than 'skills and competencies' to govern. This specialist knowledge would benefit patient care and the regulation of services to provide the highest possible level of care.

## 8. In conclusion

Much of the Review fails to take into account the reality of mental illness, and the welfare of patients, who are not well served by delays and obstacles to treatment. In an ideal world it would not be necessary to detain anyone for treatment, but as we do

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not live in an ideal world, but rather a most imperfect world beset with various ills and sufferings, it is incumbent on us as specialist doctors in the diagnosis and treatment of mental illness to advocate for measures which minimise the suffering of our patients.

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31st March 2021

## References

1. Royal College of Psychiatrists RCP, Royal College of Pathologists. . MARSIPAN: Management of Really Sick Patients with Anorexia Nervosa (College Report 189). 2nd Edition ed. London Royal College of Psychiatrists, 2014.
2. Royal College of Psychiatrists RCP, Royal College of Pathologists. . Junior MARSIPAN: Management of Really Sick Patients under 18 with Anorexia Nervosa (College Report CR168). London: Royal College of Psychiatrists, 2012.
3. UK NGA. Eating Disorders: Recognition and Treatment. 2017

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