

The Best is the Enemy of the Good: The Mental Health Act 2001 (Part 2)

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§1 – INTRODUCTION

This is the second of two articles examining the *Mental Health Act 2001*, the main piece of mental health legislation in the Republic of Ireland. The first article, published in the previous edition of the journal, dealt with the new admission, detention, leave and transfer provisions². This concluding article examines the new safeguards: the Mental Health Commission and the new tribunal and consent to treatment procedures.

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§1 – CONSENT TO TREATMENT

As a general statement, the consent to treatment procedures in the 2001 Act offer weaker protection for patients than those in force in England and Wales (*Mental Health Act 1983*), Scotland (*Mental Health (Care and Treatment) Scotland Act 2003*) and Northern Ireland (*Mental Health (Northern Ireland) Order 1986*).

As with these other Acts, there are specific procedures concerning psychosurgery, ECT, medication, and ‘other’ treatments.

Definition of ‘consent’

What constitutes ‘consent’ is defined in section 56. It ‘means consent obtained freely without threats or inducements, where:

- (a) the consultant psychiatrist responsible for ... the patient is satisfied that [s/he] ... is capable of understanding the nature, purpose and likely effects of the proposed treatment; and

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² See *Journal of Mental Health Law*, May 2008, pp 21–37.

- (b) the consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment.'

Requirement (b) is not found in the 1983 Act and is a useful statutory protection.

Whether particular conduct constitutes a 'threat or inducement' may be difficult to determine. For example, what is the position where a consultant tells a patient who is unwilling to have ECT that the consultant is likely to be in a position to revoke the order following a course of ECT? Is this an inducement, part of the duty to give 'adequate information' about the likely effects of the treatment on the patient's mental state and symptoms, or both of these things? If the patient then consents, has that consent been obtained freely, which is arguably not quite the same thing as being given freely?

Psychosurgery

Section 58 provides that psychosurgery shall not be performed on a patient unless the patient consents in writing to the psychosurgery and it is authorised by a tribunal.

The tribunal must review any proposal for psychosurgery. Having done this, it must either (a) authorise the psychosurgery 'if it is satisfied that it is in the best interests of the health of the patient concerned,' or (b) if it is not so satisfied, refuse to authorise it.

Again, the drafting is rather loose. What is the position where a tribunal is satisfied that psychosurgery is in the best interests of the health of the patient but not that the patient has capacity to consent to the treatment? In other words, the tribunal is of the opinion that the patient is not capable of understanding the nature, purpose and likely effects of the proposed treatment. Although the tribunal believes that the patient's signed consent is legally worthless, as drafted this is not a matter for it. Likewise, what is the position where the tribunal believes that the patient's written consent was not obtained freely or that they were not given adequate information? Again, as drafted these are not matters which affect the tribunal's decision.

A second problem concerns the definition of 'a patient.' The psychosurgery safeguards, and Part 4 generally, only apply to 'patients'. According to the interpretation section, 'a person to whom an admission order relates is referred to in this Act as "a patient."'

It is strange that the definition of a patient does not also refer to people who are subject to renewal orders. Nevertheless, it is clear that the consent procedures apply equally to people whose admission orders have been renewed. No other interpretation is tenable given the renewable 3-month medication periods referred to in section 60.

What though of voluntary patients, some of whom may lack capacity to consent to having the treatment? Is the statutory intention that psychosurgery given to a voluntary patient does not need to be authorised by a tribunal because the recipient is not 'a patient' for the purposes of the 2001 Act? Given the drafting and the ambit of consent provisions in similar jurisdictions, it seems unlikely that 'voluntary patients' are 'patients' for the purposes of the ECT and medication safeguards in Part 4. Is the legal position the same therefore as concerns psychosurgery?

Electro-convulsive therapy

Section 59 provides that a programme of electro-convulsive therapy shall not be administered to a patient unless either s/he has consented in writing to its administration or (if unable or unwilling to consent) it

has been approved by the patient's consultant and 'authorised ... by another consultant psychiatrist following referral of the matter to him or her' by the former.

The fact that the patient's consultant nominates the second-opinion doctor is an obvious weakness, and this part of the Part 4 scheme duplicates the scheme in Northern Ireland.

As with psychosurgery, one problem in practice may be too flexible an approach as to what constitutes consent. The key factual issue is usually not whether the person has signed a consent form but whether they had capacity to understand what they were signing, and capacity to understand the nature, purpose and likely effects of the treatment referred to in it. One must also then look at the adequacy of the information they were given.

The 2001 Act provides that a programme of ECT shall not be administered except in accordance with rules made by the Commission. These rules are the *Rules Governing the Use of Electro-Convulsive Therapy* (R-S59(2)/01/2006) (Mental Health Commission, Dublin, 1 November 2006).

There is also a code of practice on giving ECT to voluntary patients: *Code of Practice Governing the Use of Electro-Convulsive Therapy for Voluntary Patients* (COP-S33/02/2008) (Mental Health Commission, Dublin, January 2008).

Medication

Section 60 deals with giving medication for mental disorder. It is poorly drafted:

60.– Where medicine has been administered to a patient for the purposes of ameliorating his or her mental disorder for a continuous period of 3 months, the administration of that medicine shall not be continued unless either–

(a) the patient gives his or her consent in writing to the continued administration of that medicine, or

(b) where the patient is unable or unwilling to give such consent–

(i) the continued administration of that medicine is approved by the consultant psychiatrist responsible for the care and treatment of the patient, and

(ii) the continued administration of that medicine is authorised (in a form specified by the Commission) by another consultant psychiatrist following referral of the matter to him or her by the first-mentioned psychiatrist,

and the consent, or as the case may be, approval and authorisation shall be valid for a period of 3 months and thereafter for periods of 3 months, if, in respect of each period, the like consent or, as the case may be, approval and authorisation is obtained.

The statutory scheme for medication is therefore essentially the same as for ECT: treatment requires the patient's consent or, if they are unable or unwilling to consent, the authorisation of a second consultant.

Several difficulties arise in addition to those already raised above about the quality of any consent apparently given in writing.

What is the position if a patient consents to further medication at the three-month point but then, a month later, seeks to withdraw the consent on experiencing unpleasant side-effects? As drafted, the scheme seems to allow the treatment to continue for a further two months before a second opinion is required.

Consider then the case of a patient who refuses further treatment with risperidone at the three-month point. The patient's consultant approves its continued administration and a second consultant authorises it. A month later the consultant changes the antipsychotic to olanzapine. Is a further second-opinion required at this stage? The wording of section 60 – 'the administration of that medicine shall not be continued ...' suggests that a second-opinion in respect of olanzapine is only required three-months after 'that medication' is started.

Similarly, what if a patient detained on 1 January is prescribed antipsychotic X, this is changed to antipsychotic Y on 1 February, and then on 1 March antipsychotic Y is replaced by antipsychotic Z? Is it the case that she is now not entitled to a second opinion until she has been on antipsychotic Z for three months?

Other treatments

The general position is that treatments other than those specified above require the patient's consent. There is, however, a caveat in relation to incapacitated patients. A patient's consent is not required if s/he is incapable of consenting to the treatment by reason of their mental disorder and, in the opinion of their consultant psychiatrist, the treatment is necessary to safeguard their life; to restore their health; to alleviate their condition; or to relieve their suffering.

Seclusion and restraint

Section 69(1) provides that a person shall not place a 'patient' in seclusion or apply mechanical means of bodily restraint unless such seclusion or restraint is determined, in accordance with the rules made by the Commission, to be necessary for the purposes of treatment or to prevent the patient from injuring themselves or others and unless the seclusion or restraint complies with such rules. The term 'patient' here expressly includes a voluntary patient and a child in respect of whom an order under section 25 is in force.

The relevant rules are the *Rules Governing the use of Seclusion and Mechanical Means of Bodily Restraint* (R-S69 (2)/02/2006) (Mental Health Commission, Dublin, 1 November 2006). There is also a *Code of Practice on the Use of Physical Restraint in Approved Centres* (COP-S33(3)/02/2006) (Mental Health Commission, Dublin, 1 November 2006).

§2 – MENTAL HEALTH COMMISSION

The Mental Health Commission is the key body in terms of ensuring the proper operation of the Act, and safeguarding the rights of citizens under the statute.

Constitution

By section 35, the Commission consists of 13 members appointed by the Minister. Of the members, there must be one practising barrister or solicitor; three registered medical practitioners; two registered nurses; one social worker; one psychologist; one representative of the general public; three representatives of voluntary bodies; and one health board chief executive. There must be at least four female and four male members. Members of the Commission hold office for a period not exceeding five years.

Functions

The Commission's functions include appointing tribunals and tribunal members; establishing the tribunal panel of consultant psychiatrists; arranging a legal aid scheme for patients; preparing and reviewing a code

of practice; appointing the Inspector of Mental Health Services; maintaining a register of approved centres; prescribing statutory forms; prosecuting offences; and making rules concerning the use of seclusion and mechanical restraint.

Statistics

The Commission has published a number of very useful papers summarising the use made of the Act and the judgments of the High Court. These can be found on its website: www.mhcirl.ie.

There were 388 transitional patients detained under the *Mental Treatment Act, 1945* on the commencement date. In the 11 month period from 1 November 2006 to end September 2007 there were 1,894 admission orders and 1,101 renewal orders were made. There were 1,902 Mental Health Tribunal hearings during that period and 19 appeals to the Circuit Court against tribunal decisions, of which five reached the hearing stage.³ It appears that none of these five appeals were successful.

§3 – MENTAL HEALTH TRIBUNALS

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 Commission assigns a legal representative and directs a member of the medical panel to examine the patient. The doctor appointed has 14 days within which to examine the patient, interview the consultant, inspect the patient's records and prepare a report for the 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.

Constitution and administration

The Act provides that the Commission shall from time to time appoint one or more tribunals, each of which shall be known as a Mental Health Tribunal, to determine such matters as may be referred to it by the Commission under section 17. Under the Act, the matters that may be referred to a tribunal are review proceedings following the making of an admission or renewal order; proposals to transfer a patient to the Central Mental Hospital; and proposals for psychosurgery.

Each tribunal consists of three members: a practising barrister or solicitor of 7 years standing, who acts as the chairperson; a consultant psychiatrist; and a lay member.

The Commission has devised *Procedural Guidance & Administrative Protocols* for tribunals.

The terms on which members are appointed

The terms of appointment may be problematic. Section 48 provides that a member of a tribunal shall hold office for such period not exceeding three years. Furthermore, a tribunal member 'may at any time be removed ... by the Commission if, in the Commission's opinion, ... his or her removal appears to the Commission to be necessary for the effective performance by the tribunal of its functions.'

³ See *Summary of Article 40.4 Judgments since Commencement of the Mental Health Act 2001*, Mental Health Commission, Dublin (24 October 2007), p.1.

A tribunal appointment is therefore a part-time appointment for three years made by a non-judicial body, which can remove the member at any time if it believes this is necessary for the effective performance of the tribunal's functions. Whether this appointment scheme complies with the minimum requirements of the European Convention on Human Rights must be doubtful. For example, in *Findlay v United Kingdom* (1997) 24 EHRR 221 at para. 73, the court stated that, 'In order to establish whether a tribunal can be considered as "independent", regard must be had inter alia to the manner of appointment of its members and their term of office, the existence of guarantees against outside pressures and the question whether the body presents an appearance of independence.'

The general principle is that a person exercising judicial functions should not be placed in a position where her or his freedom to discharge those functions without fear or favour, affection or ill-will, might be or appear to be jeopardised by his relationship with the executive. The fact that the Mental Health Tribunals are only quasi-judicial bodies was hinted at in *MR v Cathy Byrne & Others, Sligo Mental Health Services Respondent and Mental Health Tribunal (Notice Party)* (2 March 2007),⁴ where Mr Justice Neill said that, 'The principal reform is the establishment of the Mental Health Commission and Mental Health Tribunals, thus providing for a quasi-judicial intervention for the purposes of the independent review of detention of persons in approved centres alleged to be suffering from "mental disorders".'

Panel of psychiatrists

The Act requires the Commission to establish a panel of consultant psychiatrists to carry out independent medical examinations under section 17.

By section 17, when the Commission receives a copy of an admission or renewal order, it must direct a member of the panel to examine the patient, review their records and to interview the consultant psychiatrist, in order to determine in the interest of the patient whether the patient is suffering from a mental disorder.

Within 14 days, the panel member must provide the tribunal with a written report on the results of the examination, interview and review, and copy it to the patient's legal representative. The tribunal must have regard to this report before determining the review.

Mental Health Legal Aid Scheme

The Commission assigns a legal representative to represent the patient, from the Mental Health Legal Aid Scheme, unless the patient engages a solicitor themselves. According to the Commission, the purpose of assigning a legal representative is to enable the patient to present their case to the tribunal in person or through the legal representative, so that their views are articulated and any relevant material or submissions are placed before the tribunal. Where a patient is unable or unwilling to give instructions, the appropriate course for the legal representative will be to listen to the patient's views and to articulate them in the patient's best interest. A legal representative appearing before the tribunal in proceedings under this Act shall be entitled to the same privileges and immunities as a legal representative in a court.

The tribunal must arrange to give the patient or their legal representative a copy of any psychiatric report furnished to the tribunal under section 17, and also an indication in writing of the nature and source of any relevant information which has come to their notice in the course of the review.

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).

The Commission is developing quality assurance proposals for legal representatives of the kind developed by the Legal Services Commission in England and Wales. The initial position taken by the Law Society was not to accept them. There is no good evidence base in England and Wales that supports the view that these kinds of bureaucratic intervention by non-practitioners adds anything to the protection afforded to clients by professional training, a professional code and investigation by the professional body. There is much anecdotal evidence to suggest that such measures drive practitioners away from legal aid work. The key to any successful professional service is recruiting good calibre candidates, good training, continuing education, adequate funding and a strong professional body that is able to enforce standards of conduct.

Rules and procedure

There are no tribunal rules. Much is therefore left to a tribunal's discretion although section 49 makes some provision for giving directions and similar matters:

Directions concerning the attendance of the patient

A tribunal may, for the purposes of its functions, direct in writing the responsible consultant psychiatrist to arrange for the patient to attend before it. However, a patient shall not be required to attend if, in the opinion of the tribunal, such attendance might be prejudicial to his or her mental health, well-being or emotional condition.

Directions concerning the attendance of witnesses

A tribunal may, for the purposes of its functions, direct in writing any person whose evidence is required by the tribunal to attend before it. The reasonable expenses of witnesses directed to attend shall be paid by the Commission.

Directions concerning the production of documents

A tribunal may, for the purposes of its functions, direct any person attending before it to produce to the tribunal any document or thing in his or her possession or power specified in the direction. It may also direct in writing any person to send to it any document or thing in his or her possession.

General power to give directions

A tribunal may, for the purposes of its functions, give any other directions for the purpose of the proceedings concerned that appear to it to be reasonable and just.

The hearing

The Commission has set a standard that a minimum of three days notice of a hearing must be given to members and those required to attend.

Tribunal hearings are generally held at approved centres and the Commission appoints a Mental Health Tribunal Clerk to provide administrative assistance to the tribunal.

At a sitting of a tribunal, each member of the tribunal has a vote, and every question must be determined by a majority vote, including it seems points of law.

A tribunal must 'hold sittings' when undertaking a review. In other words, the statute precludes making a decision on the papers.

At sittings, the tribunal 'may receive submissions and such evidence as it thinks fit.' By section 49, the tribunal must, however, make provision for:

- (a) notifying the consultant psychiatrist responsible ... and the patient or his or her legal representative of the date, time and place of the relevant sitting of the tribunal,
- (b) giving the patient ... or his or her legal representative a copy of any report furnished to the tribunal under section 17 and an indication in writing of the nature and source of any information relating to the matter which has come to notice in the course of the review,
- (c) subject to subsection (11), enabling the patient ... and his or her legal representative to be present at the relevant sitting ... and enabling the patient ... to present his or her case ... in person or through a legal representative,
- (d) enabling written statements to be admissible as evidence ... with the consent of the patient or ... representative,
- (e) the examination by or on behalf of the tribunal and the cross-examination by or on behalf of the patient ... (on oath or otherwise as it may determine) of witnesses before the tribunal called by it,
- (f) the examination by or on behalf of the patient ... and the cross-examination by or on behalf of the tribunal ... of witnesses before the tribunal called by the patient the subject of the review,
- (g) the determination by the tribunal whether evidence at the tribunal should be given on oath,
- (h) the administration by the tribunal of the oath to witnesses before the tribunal, and
- (i) the making of a sufficient record of the proceedings of the tribunal.

According to the *Procedural Guidance & Administrative Protocols*, 'To put the patient at ease, it is recommended that where it is required that evidence be taken directly from the patient this be done as early in the hearing as is reasonably possible. Due consideration should be given by the mental health tribunal to each patient's mental health, well being or emotional condition when evidence is being heard.'

Whether proceedings are inquisitorial or adversarial

The *Procedural Guidance & Administrative Protocols* also state that 'the Mental Health Commission takes the view that under no circumstances should mental health tribunals be conducted in an adversarial manner. An inquisitorial approach which seeks to protect each patient's human rights and is governed by best interest principles, Section 4(1), is viewed by the Commission as the most effective manner in which to conduct a mental health tribunal.'

Although such a view has also sometimes been advanced by the senior courts in England and Wales, it is difficult to view such a statement as anything other than a fairly complete misunderstanding of the legal position. Mental Health Tribunal proceedings do, of course, have strong inquisitorial elements. For example, the tribunal members determine the procedure and call and question witnesses. However, equally obviously, there are strong adversarial elements, that are not part of a pure inquisitorial approach. Generally, there are parties, and those parties have rights. The patient has statutory rights to be present and to present their case; to call witnesses; and to cross-examine witnesses. Written statements are only admissible as evidence with the consent of the patient or their representative. The model is therefore a mixed inquisitorial-adversarial model, but hopefully not confrontational.

Right to a hearing in public

By section 49(9), 'sittings of a tribunal ... shall be held in private.' Unlike in England and Wales, no provision at all is made for a public hearing at the request of the patient. In due course, the argument will

no doubt be made in some case that an absolute bar of this kind contravenes Article 6 of the European Convention on Human Rights. It is necessary to balance the patient's desire for a hearing in public against, having regard to matters such as their reasons for requesting a public hearing and the likely effects on their mental state, treatment and rehabilitation.

The tribunal's powers

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.

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

In *T O'D v Central Mental Hospital, HSE (Respondent) and Mental Health Commission (Notice Party)* (25 April 2007), the Central Mental Hospital made a series of very basic errors in relation to the new detention provisions. 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 have been grounds for judicial review:

"26. ... I have no doubt that in referring to these sections that concern the administration of involuntary detention, s.18(1) refers to the entirety of them and not simply to more minor matters as to typing, time or procedure. 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, 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.

In this regard, the Mental Health Tribunal was entitled to have regard to the fact that Mr O'D. was at all material times suffering from a serious psychiatric illness which required that he should be treated and which treatment was of assistance to him and to the community. In addition, they were

obliged, in my judgment, to have regard to the fact that if the applicant had been discharged, which would have been the effect of their refusal to uphold the order, the applicant himself would have been at immediate risk from his paranoid delusional fantasies as would those with whom he might come into close contact. 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.”

A somewhat different approach was taken in *WQ v Mental Health Commission, Central Mental Hospital, Mental Health Tribunal (Respondents)* (15 May 2007), where Mr Justice O’Neill stated that section 18(1) only excuses failures of a minor or insubstantial nature, which do not cause injustice. This approach is likely to be preferred to that of Mr Justice Charleston.

The tribunal’s decision and reasons

The tribunal’s decision must be recorded on a form prescribed by the Commission. Form 8 is used to record decisions to affirm or revoke an admission or renewal order. Form 9 is used to record decisions to extend the period of an admission or renewal order by up to 14 days. Adjournments are, of course, sometimes necessary.

The tribunal’s decision and reasons must be given in writing to the Commission, the consultant psychiatrist responsible for the patient, the patient, their legal representative, and to any other person to whom, in the opinion of the tribunal, such notice should be given. The Commission guidelines state that decisions should wherever reasonably possible be given on the day of the hearing; and if not, as soon as possible thereafter and within the period specified in the Act.

Adequacy of reasons

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),

“In approaching an assessment of the decision of the Tribunal as revealed by the record of it, both as to substance and form, in my view, it is not appropriate to subject the record to intensive dissection, analysis and construction, as would be the case when dealing with legally binding documents such as statutes, statutory instruments or contracts. The appropriate approach is to look at the record as a whole and take from it the sense and meaning that is revealed from the entirety of the record. This must be done also in the appropriate context; namely the record must be seen as the result of a hearing which has taken place immediately before the creation of the record, and it must be read in the context of the evidence both oral and written which has just been presented to the Tribunal. The record is not to be seen as, or treated as a discursive judgment, but simply as the record of a decision made contemporaneously, on specific evidence or material, within a specific statutory framework. i.e. the relevant sections of the Act of 2001 as set out above.”

While that is generally correct, it would appear that a very low standard indeed was set in this case. The tribunal’s reasons did not reveal any consideration at all of whether the applicant’s condition would deteriorate, whether the absence of a renewal order would prevent the administration of appropriate treatment that could only be given by involuntary admission, or whether the patient’s condition would benefit to a material extent by the making of the renewal order. In addition, the tribunal’s finding, that “In the event of her being changed to a voluntary status compliance with medication and D.T. would not be guaranteed”, applied an inappropriate test or standard.

The overriding test must surely always be whether the tribunal is providing both parties with the materials which will enable them to know that the tribunal has made no error of law in reaching its finding of fact.⁵ The patient must know why the case advanced in detail on his behalf had not been accepted.⁶ Proper, adequate and intelligible reasons should be given which grapple with the important issues raised and can reasonably be said to deal with the substantial points that have been raised.⁷ However, the reasons for the decision cannot be read “in the air”. Although the reasons may not be clear or immediately intelligible on their face, the decision is addressed to parties, who are an informed audience and so well aware of what issues were raised and the nuances raised by those issues.⁸ Nor should the reasons be subjected to the analytical treatment more appropriate to the interpretation of a statute or a deed. The necessity for giving reasons is often underscored by the fact that it is often very important to know the reason why an application has been turned down.

Privilege

Tribunal documents, reports and statements are absolutely privileged.

Circuit Court appeals

Section 19 provides for an appeal to the Circuit Court against a decision of a tribunal. No appeal lies against an order of the Circuit Court other than an appeal on a point of law to the High Court.

If the tribunal affirms the order being reviewed, the patient has 14 days within which to appeal to the Circuit Court. The Circuit Court will revoke an order if it is shown to its satisfaction that the patient is not suffering from mental disorder at the time of the Circuit Court hearing. As drafted, the Circuit Court is not concerned with the second issue of failure to comply with the statutory procedures.

The procedure for Circuit Court appeals is set out in Order 47A of the *Circuit Court Rules 2001*, which was inserted by the *Circuit Court Rules (Mental Health) 2007*. It takes some three to four weeks to get a hearing in Dublin. In other areas, such as Galway, it seems that appeals have been given no priority and must take their place in the list.

The fact that the Circuit Court is not concerned with a tribunal’s finding as to whether any failure to comply with the statutory admission or renewal procedures has caused injustice or affected the substance of the order may be unfortunate. It means that the way of appealing this part of the tribunal’s finding is through habeas corpus or judicial review proceedings. Arguably, a single appeal procedure, encompassing both factual and legal findings, would be more efficient.

Habeas corpus and Article 40.4

Challenges to admission and renewal orders, and to tribunal decisions, may also be brought by way of habeas corpus proceedings under Article 40.4 of the Constitution of Ireland:

40.4. 1° No citizen shall be deprived of his personal liberty save in accordance with law.

2° Upon complaint being made by or on behalf of any person to the High Court or any judge

5 *Bone v. Mental Health Review Tribunal* [1985] 3 All E.R. 330; *Alexander Machinery (Dudley) Ltd. v. Crabtree* [1974] I.C.R. 120 at 122.

6 *R. v. Mental Health Review Tribunal, ex p. Clatworthy* [1985] 3 All E.R. 699.

7 *R. v. Mental Health Review Tribunal, ex p. Pickering*

[1986] 1 All E.R. 99; *Bone v. Mental Health Review Tribunal* [1985] 3 All E.R. 330; *Seddon Properties Ltd. v. Secretary of State for the Environment* (1978) 42 P. & C.R. 26; *Re Poyser and Mills’s Arbitration* [1964] 2 Q.B. 467 at 478.

8 *R. v. Mental Health Review Tribunal, ex p. Pickering* [1986] 1 All E.R. 99.

thereof alleging that such person is being unlawfully detained, the High Court and any and every judge thereof to whom such complaint is made shall forthwith enquire into the said complaint and may order the person in whose custody such person is detained to produce the body of such person before the High Court on a named day and to certify in writing the grounds of his detention, and the High Court shall, upon the body of such person being produced before that Court and after giving the person in whose custody he is detained an opportunity of justifying the detention, order the release of such person from such detention unless satisfied that he is being detained in accordance with the law ...

Where the High Court has ordered a patient's release, it has often directed delayed release in order to allow time for the patient to be detained under a valid admission order.

As previously noted, the court has taken a paternalistic approach to the legislation.

§4 – CONCLUDING REMARKS

There is much to commend. The strengths of the legislation include a relatively strong Mental Health Commission; supervision by tribunals of proposed transfers to the Central Mental Hospital; automatic tribunal referrals following admission and renewal; and the holding of tribunal hearings within 21 days.

On the debit side, the drafting is often weak. Apart from the ambiguities already referred to, there are no rectification provisions, which is an unfortunate error. No provision is made for transfers in and out of the jurisdiction, in particular with the United Kingdom.

There are also significant omissions compared with United Kingdom statutes. For example, the statute does not contain any community alternatives to detention, such as guardianship or supervision orders. There are no rehabilitation provisions of the kind found in Northern Irish legislation. The role of the applicant is limited to triggering a medical admissions process, rather than deciding whether an application is appropriate having regard to the medical recommendations. There is no duty to provide after-care to persons discharged from section. No provision is made for patients' correspondence or for making admission orders in criminal proceedings; and nor are there any pre-trial diversion powers. As in Northern Ireland, the legislation is very much based on a medical model: the psychiatric profession is dominant; the consent to treatment provisions are weak; the tribunal and legal representation and legal aid schemes are administered through a health service body; the next-of-kin or nearest relative has no power to discharge the patient or to block admission in cases where dangerousness is not an issue⁹; there are no independent managers of approved centres with discharge powers; and the Inspector of Mental Health Services must be a consultant psychiatrist. Furthermore, the tribunal's powers are relatively limited when reviewing an admission or renewal order. They may discharge or not discharge. There is no power to direct discharge on a future date, and no power to direct or recommend leave or transfer. Patients have no statutory right to obtain their own psychiatric report, and there is no after-care or social circumstances assessment to aid the tribunal. Overall, the scheme is good but not the best.

⁹ *This is perhaps slightly surprising given that Article 41 of the Constitution provides that, '1° The State recognises the Family as the natural primary and fundamental unit group of Society, and as a moral institution possessing inalienable and imprescriptible rights, antecedent and superior to all positive law. 2° The State, therefore, guarantees to protect the Family in its constitution and authority, as the necessary basis of social order and as indispensable to the welfare of the Nation and the State.'*