

Mental Health: The case for reform

**A Report by the
Law Society's Law Reform Committee**

July 1999

CONTENTS

Executive summary

Summary of recommendations

1. Introduction
2. Definitions
3. Categories of admission
4. Consent to medical treatment
- 5. Civil Liability / Access to Justice**
6. Adult care orders
7. Property management

Bibliography

EXECUTIVE SUMMARY

The Law Reform Committee of the Law Society of Ireland was established in November 1997 in order to identify and focus upon specific areas of the law in need of update and reform. It aims to contribute towards improving the quality, fairness and effectiveness of Irish legislation in a number of selected areas. It also seeks to represent the views of the Society's members in relation to a number of legislative initiatives and to enhance the Society's contribution to the development of Irish law. More generally, it aims to build relationships between the Law Society and others involved in the review of law and policy, including senior policy-makers and the voluntary sector.

After having surveyed all members of the Society and a wide selection of groups in the voluntary sector, the Committee has identified a number of priority areas for law reform, including that of mental health. Representatives of the Committee have already established contacts with officials within the Department of Health and Children who are involved in framing policy in this area and the Committee is aware that new legislation is currently being prepared.

It is in this context that the Committee has undertaken an examination of current Irish legislation on mental health, of judicial deliberation on the application of this legislation, and of the proposals for reform contained in the Government's 1995 White Paper, *A New Mental Health Act*. In addition, with a view to identifying best practice in this area, the Committee has undertaken a comparative study of the operation of mental health legislation in a number of similar jurisdictions, including England and Wales, Scotland, Northern Ireland and New South Wales. It has also found it useful to refer briefly to developments in a number of other jurisdictions. Where appropriate, this report refers to the relevant legislative provisions existing in these jurisdictions in order to highlight the shortcomings in Irish legislation and to suggest legislative amendments which might help to prevent injustice.

This report has been submitted to the Department of Health and Children and the Department of Justice, Equality and Law Reform and will be circulated to members of the Judiciary and of the Oireachtas and to voluntary bodies with an involvement in the area of mental health policy. It is hoped that its findings and recommendations will lead to concrete improvements in the law relating to mental health and will help to ensure fair and balanced treatment for those in need of the protection of the law.

SUMMARY OF RECOMMENDATIONS

1

That the criteria for involuntary commitment to a mental institution be more clearly defined or that detailed guidance on each of the criteria be provided.

2

That a 'least restrictive alternative' principle be introduced against which any decision to commit could be tested.

3

That a right to a minimum level of psychiatric service provision be introduced by statute.

4

That alternative facilities be provided for categories of persons excluded from liability to detention.

5

That formal safeguards be extended to voluntary patients.

7

That adult care orders be used to transfer unwilling patients to hospital.

8

That measures be introduced to enable the proposed Mental Health Review Board to order 'planned discharge'.

9

That measures be introduced to encourage legal representation before the proposed Mental Health Review Board.

10

That a "general authority to act reasonably" be introduced in relation to everyday care decisions regarding incapacitated adults.

11

That measures be introduced to encourage wider consultation regarding health care decisions.

13

That criteria or guidance be developed for a 'best interests test' in relation to health care decisions.

14

That an accessible and simplified Code of Practice be developed in relation to health care decisions.

15

That a right of appeal in relation to health care decisions be established in the first instance to the proposed Mental Health Review Board.

16

That the Powers of Attorney Act, 1996 be extended to include health care decisions among personal care decisions.

17

That statutory restrictions on the taking of civil actions by mentally ill people be removed and that such civil action be facilitated by the Civil Legal Aid scheme.

18

That a procedure be established whereby civil actions can be taken on behalf of mentally ill people by an official body at the request of the Mental Health Review Board.

19

That an inclusive, responsive and clearly defined system of adult care orders be introduced.

20

That the Ward of Court procedures be simplified and integrated with the admission and detention procedures.

MENTAL HEALTH – THE CASE FOR REFORM

1. Introduction

The primary objective of mental health legislation must be to provide a framework within which decisions can lawfully be taken on behalf of those who are unable to take decisions for themselves or are unable to communicate their decisions. Such legislation will also be concerned with the physical protection of mentally incapacitated persons, their carers, and the public at large. To this end, legislation inevitably provides for the compulsory detention of mentally incapacitated persons in certain circumstances, under the *parens patriae* power vested in the State. It should be self-evident that any restriction on the liberty of such people and any interference with their rights must be kept to a minimum, and their dignity and self-respect fostered.

This area of law is one which will require ongoing periodic update and reform in order that it might appropriately reflect society's evolving understanding of mental illness and of the needs and rights of the mentally ill. Also, it must appropriately address the changing needs of society. Note, for example, the continuing increase in the proportion of elderly people in our population.¹

Current Irish mental health legislation is contained in the Mental Treatment Act, 1945, as amended.² It has been argued convincingly that many of the provisions of the 1945 Act are now outdated in relation to developments in the practice of psychiatry and, further, that those provisions relating to civil commitment are incompatible with requirements arising under the European Convention on Human Rights and with the United Nations Principles for the Protection of Persons with Mental Illness.³ It has also been pointed out that current Irish legislation is out of step with the mental health regimes of other comparable jurisdictions, including Northern Ireland, Scotland, and England and Wales.⁴

This report is concerned solely with the issue of civil commitment and with legal issues following from the civil detention of persons suffering from mental illness, such as the management of their affairs. Issues not directly related to civil commitment, such as the criminal or civil⁵ liability of those suffering mental illness, are beyond the scope of this paper.

¹ See, in relation to similar demographic trends in the UK, the statistics produced in G. Ashton, *Elderly People and the Law*, (Butterworths, 1995), at 1.

² The 1945 Act has been amended by 8 subsequent pieces of legislation up to and including the Health Act, 1970.

³ See Mary Keys, "Mental Treatment Legislation: Are The White Paper Proposals Adequate?", *Dli – The Western Law Gazette*, Summer 1998, 51-58, at 51.

⁴ *Ibid.*

⁵ See the Law Reform Commission *Report on the Liability in Tort of Mentally Disabled Persons*, (LRC 18-1985) (Sept. 1985).

2. Definitions

2.1 Proposals in the White Paper

2.1.1 Mental disorder

For the purposes of involuntary admission, the Government White Paper proposes to define “*mental disorder*” as meaning:

mental illness, significant mental handicap and severe dementia.

“*Mental illness*” would be defined as:

a state of mind which affects a person’s thinking, perceiving, emotion or judgement to the extent that he or she requires care or medical treatment in his or her own interests or the interests of other persons.

“*Significant mental handicap*” would be defined as:

a state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning where this is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.

“*Severe dementia*” would be defined as:

a deterioration of the brain which significantly impairs intellectual function affecting thought, comprehension and memory and which is associated with severe psychiatric or behavioural symptoms such as severe physical aggression.

The White Paper proposes to exclude explicitly personality disorder, addiction, and, in view of domestic and international concern on the issue, social deviance, from the definition of mental disorder in new legislation.

2.2 New South Wales

2.2.1 Mentally ill person / mentally disordered person / mental illness:

Under the 1990 Mental Health Act of New South Wales, a person may only be admitted involuntarily to a psychiatric institution and detained if they are a “*mentally ill*” or a “*mentally disordered person*”. The former is defined under section 9 of that Act as follows:

A person is a mentally ill person if they suffer from a mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of them is necessary:

- *for the person’s own protection from serious harm, or*
- *for the protection of others from serious harm.*

In considering whether a person is a mentally ill person, the continuing condition of the person, including any likely deterioration in that condition, is to be taken into account.⁶

Under section 10:

A person is a mentally disordered person (whether or not they suffer from mental illness) if their behaviour is so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control is necessary for:

- *the person’s own protection from serious physical harm, or*
- *to protect others from serious physical harm.⁷*

⁶ See R. Wheeler, “Procedures Under the Mental Health Act”, in *The Lawyers Practice Manual* (New South Wales).

⁷ *Ibid.*

Both definitions make reference to “*mental illness*” which is itself defined in Schedule 1 of the 1990 Act:

Mental illness is a condition which seriously impairs (temporarily or permanently) the mental functioning of a person which is characterised by the presence of one or more of the following symptoms:

- *delusions*
- *hallucinations*
- *serious disorder of thought form*
- *a severe disturbance of mood*
- *sustained or repeated irrational behaviour indicating the presence of any one or more of the above symptoms.*⁸

With regard to these definitions, section 11(1) is particularly instructive in that it provides that a person is not to be considered mentally ill or mentally disordered merely because of any one of the following:

- *a particular political opinion, belief or activity*
- *a particular religious opinion, belief or activity*
- *a particular philosophy*
- *a particular sexual preference or sexual orientation*
- *sexual promiscuity or immoral conduct*
- *illegal conduct*
- *developmental disability*
- *taking of alcohol or other drugs*
- *anti-social behaviour.*

However, the legislation provides that serious psychological effects of alcohol or drug taking may be regarded as a symptom of mental illness or disorder.

2.3.1 Commentary

In comparison to the definitions contained in the legislation of New South Wales, those provided in the Irish White Paper setting out the criteria for commitment can be described as vague and undefined. For example, the definition of “mental illness” is a circular and subjective one in that it refers to a person being so affected that he requires care or medical treatment. Also, the criteria for mental disorder proposed in the White Paper do not require that a person must be incompetent before being committed nor that appropriate treatment must be available in the centre where the person is to be detained. It has been pointed out elsewhere that this “lack of specificity and clarity will vest excessive discretion in doctors over fundamental rights, including personal liberty, autonomy, bodily and psychological integrity”.⁹ Cooney and O’Neill suggest limiting the threshold criterion for involuntary commitment to “*severe mental disorder*”, defined by the Mental Health Law Project in 1977 to mean

*“a severe impairment of emotional processes, ability to exercise conscious control of one’s actions or ability to perceive reality or reason to understand, which impairment is manifested by instances of grossly disturbed behaviour or faulty perceptions”.*¹⁰

They point out that this definition requires both severe impairment and gross behaviour or perceptions. Further, they suggest that there should be additional general requirements of “*dangerousness*” (presumably based on established risk assessment techniques), “*incompetency*” and “*treatability*”, and that a general “*principle of the least restrictive alternative*” should apply to all decisions to commit a person to a mental institution.¹¹

2.3.2 Recommendations

The Law Reform Committee believes that the criteria for involuntary commitment to a mental institution as defined in the White Paper, are unacceptably vague and open to subjective

⁸ *Ibid.*

⁹ See, T. Cooney and O. O’Neill, *Psychiatric Detention: Civil Commitment in Ireland*, (Baikonur, 1996), at 143.

¹⁰ See “Civil Commitment” (1977) 3 *Mental Disability Law Reports* 75, cited in Cooney and O’Neill, *ibid.*, at 145.

¹¹ *Ibid.*, at 145-148.

interpretation. It suggests that more detailed statutory definitions or, at the very least, detailed guidance on each of the criteria, are needed. Also, the Committee views the suggested additional general requirements of “dangerousness”, “incompetency” and “treatability” with interest and believes these concepts to be worthy of further consideration. Finally, it would strongly support the inclusion in legislation of a general “least restrictive alternative” principle which would function as a test of the proportionality of any decision to commit.

3. Categories of Admission

3.1 Current Irish Legislation

Under existing legislation, there are three categories of and procedures for admission to psychiatric hospitals: ‘Voluntary Admission’, ‘Temporary Admission’ and the admission of a ‘Person of Unsound Mind’ (PUM).¹² The latter two categories involve compulsory detention. Each of these categories can be further divided into public (“chargeable”) and private admissions with somewhat different procedures applying in each case.

3.1.1 Voluntary Admission:

3.1.1.1 Admission Procedure

The current admission procedure for a voluntary patient is relatively straightforward and requires completion of the “blue form”. An application must be made to the person in charge of the psychiatric institution, or to any other medical officer properly authorised in that capacity, to have the patient received in that hospital. The application may only be made by the patient himself or by the patient’s parents or guardian where he is aged less than 16 years. In the case of a patient aged less than 16 years, the application must be accompanied by the recommendation of a medical practitioner who has recently examined the patient and is of the opinion that he will benefit by the proposed reception. A voluntary patient will only be received into the hospital and treated where there is accommodation available that is not required for a person of unsound mind (PUM). In order to have himself discharged, a voluntary patient must give written notice of his wish to leave and will then be entitled to leave the institution after the expiration of a period of 72 hours. Should he become mentally incapable of expressing a wish to be discharged, he must be discharged within 28 days of becoming incapable into the custody of such person as the person in charge of the institution approves. There are slight but insignificant procedural differences between the admission procedures for public and private voluntary patients. For example, no restrictions are specified in relation to the medical practitioners who may make a recommendation in relation to private voluntary patients though there are restrictions as to who may certify such patients or recommend or certify public voluntary patients.¹³

3.1.1.2 Proposed Reforms

The White Paper proposes to remove the formality of signing a voluntary admission form so that admission would be in the same way as admission to any ward of a general hospital. Also, it proposes to remove the requirement that voluntary patients give 72 hours notice of intention to leave the institution. It is further proposed to give authorised nurses legal authority to hold a voluntary patient for up to six hours within which time he must be examined by a medical practitioner and to provide that a consultant psychiatrist may hold a voluntary patient for a period of 48 hours within which time procedures for detention must be completed.¹⁴

3.1.2 Temporary Admission:

3.1.2.1 Admission Procedure

Currently, in order to have a person admitted as a temporary patient, an application must be made to the person in charge of the psychiatric institution and the prescribed “pink form” must be completed. The application may be made by the patient’s spouse or relative or, in the case of a public patient, the appropriate community welfare officer (CWO) at the request of the spouse or relative. Where the

¹² For an exhaustive account of each of the procedures for admission, see P. Casey and C. Craven, *Psychiatry and the Law*, at 457-490.

¹³ A medical practitioner is disqualified in relation to the patient where he is interested in the payments (if any) to be made on account of the taking care of the person, or if he is the spouse, parent, step-parent or parent-in-law, child, step-child or child-in-law, sibling, step-sibling or sibling-in-law, or guardian or trustee of the patient, or if he is a medical officer of a district mental hospital. See section 190(5), Mental Treatment Act, 1945 (as inserted by section 19(2), Mental Treatment Act, 1961).

¹⁴ Paras. 3.32 - 3.34.

applicant is someone other than a spouse, relative or CWO, the application must explain why it was not made by one of those parties, the connection between the applicant and the patient and the circumstances relating to the application. The application must be accompanied by a certificate from a medical practitioner certifying that he has examined the patient within seven days of the application and is of the opinion either that the patient:

- is suffering from mental illness, requires not more than six months treatment and is unfit for treatment as a voluntary patient; or
- is an addict requiring at least six months treatment.

In the case of a private patient, the certificate must be signed by two medical practitioners certifying that each of them is of the above opinion having separately examined the patient.¹⁵ Once the relevant person within the psychiatric institution has made an order to have the patient received and detained, the applicant or any person so authorised by him may, within seven days, convey the patient to the institution. The hospital authority may co-operate in making arrangements for the patient's removal. However, the patient may be conveyed directly to the proposed institution, in the absence of an order, within seven days of the grant of a medical certificate sought in the course of an application. He may be detained at the institution for a period of 12 hours, during which time the order must be made or refused. Before conveying the patient to the institution in this manner, the applicant must inform him of the nature of the medical certificate and of his right to request a second medical opinion. Where he requests a second opinion, he may not be conveyed to the psychiatric institution unless a second concurring opinion, in writing, is obtained.

3.1.2.2 Detention

A temporary patient may initially be detained for a period of up to six months and this period may be extended where the chief medical officer of the psychiatric institution is of the opinion that the patient will not have recovered within that period. The original detention may be extended by a series of periods, none of which must exceed six months and the aggregate of which must not exceed 18 months. Where the patient is an addict, each extension must be for less than six months and the aggregate period is limited to six months. When extending an order for detention, the chief medical officer must give notice to the patient and the original applicant setting out the circumstances relating to the extension and stating that the patient or applicant may object to the Inspector of Mental Hospitals.

3.1.2.3 Proposed Reforms

[See below, 3.1.3.3.]

3.1.3 Person of Unsound Mind (PUM):

3.1.3.1 Admission Procedure

In order to have a public patient admitted as a person of unsound mind, an application, accompanied by a statement of particulars, must be made to a medical practitioner for a recommendation that the patient be detained in a psychiatric institution. This application must be made on the prescribed "white form". In the case of a private patient, a one-step process is set down whereby an application is made for a reception order. As in the case of a temporary patient, the applicant may be the patient's spouse or relative of at least 21 years of age or a CWO at the request of the spouse or relative. Again, any other applicant must explain why it is they who are making the application and the relevant circumstances. The applicant must have seen the patient within 14 days of making the application. Before recommending detention, the medical practitioner to whom the application is made must have examined the patient within the previous 24 hours.¹⁶ Where an application for a recommendation is refused by a medical practitioner, the applicant must disclose the circumstances of the refusal in any subsequent application in respect of that patient. A different examination procedure applies in respect of a private patient, requiring two separate medical examinations by two medical practitioners. Special

¹⁵ This provision is designed to protect private patients from involuntary committal for the monetary gain of the private hospital or of the patient's family.

¹⁶ The question of what constitutes an examination for the purposes of committal has given rise to controversy and litigation. See *O'Reilly v Moroney* (Supreme Court, Unreported Judgment, 16 November 1993) and (High Court, [1992] 2 IR 145).

applications may be made by a member of the Garda Síochána or by a CWO in emergency situations. Where a Garda is of the opinion that it is necessary for the safety of the public or of the patient himself, he may take the patient into custody. He may also enter any house or premises to take him into custody. Having placed the patient in custody, the Garda must apply to a medical practitioner for a recommendation for the patient's reception and detention in a psychiatric institution.¹⁷ Similarly, the appropriate CWO must apply to a medical practitioner for a recommendation for reception and detention where he learns that a patient is not being properly cared for. This provision will apply where the patient is not under proper care or control, or is neglected or cruelly treated by any relative or other person in whose care or charge he is placed. If the patient is of no fixed abode, he may be taken into custody by the Gardai for the purpose of examination by a medical practitioner. In any case of reception and detention where the recommending medical practitioner certifies that an escort is required to ensure the safe conveyance of the patient to hospital, that certificate may be presented at any Garda Station where the Garda in charge must either request the resident medical superintendent (RMS) of the relevant psychiatric institution to arrange for an escort or himself arrange for such an escort. Upon arrival at the institution, the patient must be examined by the RMS or another medical officer acting on his behalf who will make an order for his reception and detention if satisfied that he is a PUM and is a proper person to be taken charge of and detained. In practice, this examination would invariably involve "a complete psychiatric and physical evaluation, often carried out initially by a member of the hospital staff and later (within 24 hours of admission) reviewed by a consultant psychiatrist."¹⁸

3.1.3.2 Detention

The sweeping powers contained in the Mental Treatment Act, 1945 (as amended) to deprive a person indefinitely of his liberty by the making of a chargeable patient reception order, and the lack of any automatic review of the decision to detain, have been the subject of widespread criticism, not least in the courts. In *SC v Smith & others*¹⁹, where it was argued that these sweeping powers were repugnant to the Constitution, Budd J distinguished *In re Philip Clarke*²⁰ by distinguishing between the powers of detention contained in section 165 and section 172 of the 1945 Act. In *Clarke's* case, which involved the former, where a Garda detained a person believed to be of unsound mind being of the opinion that it was necessary for the public safety or that of the person concerned, safety aspects were involved and to the fore. However, the making of a reception order under section 172 does not require such an opinion to be held but purports to allow detention of an infinite duration without automatic independent review. Having regard to the fact that the Health (Mental Services) Act, 1981,²¹ would have provided for an appeal against detention and an automatic review of long-term detention by a specialist tribunal, Budd J stated:

"In applying the touchstone of the constitution ... I have come to the conclusion that the effect of a chargeable patient reception order under sections 163, 171 and particularly section 172, which allows for detention ... without any automatic independent review, falls below the norms required by the constitutional guarantee of personal liberty. ... In the absence of an independent review of the decision to detain and the lack of an automatic review of long-term detention of a "white card patient" ... the provisions of section 172 of the Mental Treatment Act, 1945, as amended, are repugnant to the Constitution".

¹⁷ This power has been upheld by the High Court as a "necessary and proper power for an emergency" and by the Supreme Court as "legislation ... of a paternal character, clearly intended for the care and custody of persons suspected to be suffering from mental infirmity and for the safety and well being of the public generally", *In re Philip Clarke* [1950] IR 235, at 237 and 247. This decision was approved in *SC v Smith & others* (Supreme Court, Unreported Judgment, 31 July, 1996).

¹⁸ Casey and Craven, at 478 (fn. 102). See also, Casey and Craven, at 31-5.

¹⁹ Unreported Judgment, High Court, 27 and 31 July 1995, Budd J.

²⁰ *Supra*, n. 16.

²¹ Enacted but never brought into force.

The Supreme Court, however, declined to take an equally critical stance.²² Regarding the absence of an independent review of the original decision to detain, the Supreme Court pointed out that:

“These decisions can be set aside in the appropriate circumstances by the court upon an application for judicial review or upon complaint made to the High Court in accordance with Article 40.4.2 of the Constitution ...”

The court was further satisfied that, as the sections of the Act which permit the detention of a PUM require that patient to be examined and certified by two separate medical practitioners:

“... [they] satisfy every reasonable requirement and do not constitute an attack upon the personal rights of the citizen”.

On the question of whether some form of judicial inquiry into a PUM’s continuing detention was necessary, the Supreme Court found that:

“In the exercise of the powers conferred and obligations imposed by the Act, the resident medical superintendent and the Minister are obliged to act in accordance with the principles of constitutional justice, are not entitled to act in an unlawful manner, are not entitled to act arbitrarily, capriciously, or unreasonably and must have regard to the personal rights of the patient, including the right to liberty, which can be denied only if the patient is a person of unsound mind and in need of care and treatment who has not recovered and must be particularly astute when depriving or continuing to deprive a citizen suffering from mental disorder of his/her liberty”.

It further noted that:

“Inherent in [the Act] is the obligation placed on the resident medical superintendent to regularly and constantly review a patient in order to ensure that he/she has not recovered and is still a person of unsound mind and is a proper person to be detained under care and treatment”.

The Court went on to suggest that the intervention of the courts would be justified where such review is not carried out regularly. It warned those concerned with the administration of the statutory provisions that they bear

“a heavy responsibility ... to ensure that no person detained pursuant to the provisions of section 172 of the Act is detained for any period longer than is absolutely necessary for his proper care and treatment and that the safeguards provided for in the Act be stringently enforced”.

However, having had regard to the presumption of constitutionality which the Act is entitled to enjoy and in particular the presumption that the Oireachtas intended the discretions and adjudications permitted by the Act to be conducted in accordance with the principles of constitutional justice, the Supreme Court concluded that:

“While it may be desirable that the necessity for the continuing detention of the person ... be subject to automatic review by an independent review board as provided for in the Mental Health Act, 1981 ... the failure to provide for such review in the Act has not been shown to render the provisions of the Act, and in particular section 172 thereof, constitutionally flawed because of the safeguards contained in the Act ...”

However, the provisions contained in section 207 of the 1945 Act, permitting transfer to the Central Mental Hospital (CMH), have been found to be unconstitutional.²³ In this case, a temporary patient,

²² Unreported Judgment, 31 July 1996 (272/95), *per* Hamilton CJ. The question of the validity of section 172 was referred to the Supreme Court by way of case stated in accordance with Article 40.4.3 of the Constitution.

²³ *RT v Director of the Central Mental Hospital & others*, [1995] 2 ILRM 354. On the use of section 207, see Creaby *et al*, “Section 207 of the Mental Health Treatment Act 1945: A Critical Review of Its Use 1955-1994”, (1995) *Medico-Legal Journal of Ireland*, Vol. 1, No. 1, 11-12.

transferred to the CMH from a health board psychiatric institution pursuant to these provisions, was detained there for 16 years. According to Costello J:

“If transferred under the section [s. 207], then they may be detained there lawfully after the expiration of that period [18 months] for an unlimited time ... The defects in the section are such that there are no adequate safeguards against abuse or error both in the making of the transfer order, and in the continuance of the indefinite detention which is permitted by the section. These defects not only mean that the section falls far short of internationally accepted standards but, in my opinion, render the section unconstitutional, because they mean that the State has failed adequately to protect the right to liberty of temporary patients.”²⁴

This decision would appear out of step with the later judgment of the Supreme Court in relation to section 172. However, in a similar case involving the transfer of a temporary patient to another facility for special treatment pursuant to section 208, the Supreme Court had earlier strictly and narrowly construed the power to restrict a patient’s liberty under the provision.²⁵ In this case, a temporary patient transferred to the Central Mental Hospital under section 208 was detained there although the original temporary certificate under which he had originally been detained had expired and had not been renewed. A unanimous Supreme Court granted his application for *habeas corpus*, Blaney J concluding that:

“This provision clearly proceeds on the basis that there is still a valid detention order in being pursuant to which the patient was being kept ...”

Indeed, the High Court decisions of Costello J and Budd J would appear to better reflect current Government thinking and the position in both international law and in comparable common law jurisdictions in relation to review of decisions to detain PUMs and of continuing detention.

The 1992 Green Paper acknowledges that the main deficiency in current Irish legislation, in relation to its conformity with international law and with the 1950 European Convention for the Protection of Human Rights and Fundamental Freedoms in particular, is the absence of a system of independent review of the decision to detain an involuntary patient.²⁶ A substantial body of case law concerning detained psychiatric patients has developed from decisions of the European Commission and Court of Human Rights from which a number of general principles can be deduced.²⁷ Also, in terms of international instruments, both the 1983 Council of Europe Recommendation Concerning the Legal Protection of Persons Suffering from Mental Disorders Placed as Involuntary Patients²⁸ and the 1991 United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Care²⁹ impact upon this area.

3.1.3.3 Proposed reforms

The White Paper proposes to streamline and harmonise the criteria and procedures for both categories of involuntary admission. Most significantly, the Government takes the view that the existing criteria for involuntary admission are too wide in scope and require amendment in order to comply with the Council of Europe Recommendation and the UN Principles. Under current legislation, a person with a mental handicap or who is mentally infirm may be classified as a person of unsound mind and involuntarily admitted on broad grounds without any qualification as to his behaviour or danger to himself or others. Therefore, it is proposed to include only the following criteria for involuntary admission of mentally disordered persons:

- “A person may be involuntarily admitted ... if he or she is suffering from a mental disorder and
- (a) because of that mental disorder, there is a serious likelihood of that person causing immediate or imminent harm to himself or to other persons; or

²⁴ At 368.

²⁵ *SC v Smith & others*, Supreme Court, Unreported Judgment, 14 July 1994.

²⁶ Para. 17.7 at 73. A summary of the European Convention as it affects people with a mental disorder is included in Appendix 2 of the 1995 White Paper.

²⁷ Enumerated in the Green Paper, para. 17.4 at 72.

²⁸ Recommendation No. R (83) 2, adopted 22 February, 1983 (reproduced in Appendix 2 of the 1995 DoHC White Paper).

²⁹ Adopted by the U.N. General Assembly, 17 December, 1991 (reproduced in Appendix 2 of the 1995 DoHC White Paper).

- (b) that in the case of a person whose mental disorder is severe and whose judgement is impaired, failure to admit or detain that person is likely to lead to serious deterioration in his or her condition or will prevent the giving of appropriate treatment that can only be given by admission...”

Therefore, it would no longer be possible to detain people whose primary problem is addiction or to detain a person of unsound mind because he or she is neglected or cruelly treated. It would be possible to treat or protect such people by less restrictive means than committal.³⁰

The White Paper proposes that the applicant would be required to be over 18 years of age and have had contact with the relevant person within the two days previous to making the application. The range of persons that may make an application would continue to include spouses and relatives³¹ but would be extended to include authorised officers of a health board, which would include public health nurses, clinical psychologists and social workers who have received special training for this purpose. It is also proposed that the Garda Síochána may make an application for involuntary admission for a person who appears to meet the criteria for detention where no spouse, relative or authorised officer is available or willing to make such an application. Spouses would be disqualified from making an application where the couple has separated or is in the process of separating or where an order has been sought or granted under the Family Law (Protection of Spouses and Children) Act, 1981. The Government proposes to harmonise admission procedures for private and public patients and to require only one medical recommendation to detain in either case. This is due to possible practical difficulties in securing two recommendations and in light of safeguards to be provided by means of the proposed Mental Health Review Board. The White Paper stops short of proposing to make formal training in psychiatry a requirement of medical practitioners making recommendations for involuntary admission³² and of proposing to legislate on the nature of the examination required, though it does propose that the recommending practitioner be required to state the nature of the examination carried out and to distinguish between facts observed by him and facts communicated by others.³³ The examination required would remain a matter of clinical discretion. Also, the examination would need to be conducted within two days of the application. Though the applicant would remain responsible for the patient’s transfer to hospital, the Government proposes to make it the responsibility of the receiving institution’s clinical director to arrange the transfer of an involuntary patient who refuses to travel to the institution. Where necessary, the clinical director would obtain a District Court order for the patient’s transfer. It is also proposed to make explicit in new legislation the power of the Garda Síochána to intervene “where a mentally disordered person who is the subject of an application for involuntary admission poses a threat to human life”. Provisions would also be included for apprehending and returning a detained patient who has left without permission. As a further safeguard, it is proposed to limit the decision to involuntarily detain a patient to an authorised consultant psychiatrist of the approved institution.

Empirical research has shown that the initial detention period of six months is unduly long³⁴ and so it is proposed to introduce a treatment order of 28 days duration, which may be extended by a consultant psychiatrist by a period of three months, by a further period of six months and by periods of one year thereafter. The proposed Mental Health Review Board would review any initial detention after a year and subsequent extensions of detention every two years. Also, it is proposed to include in new legislation provisions for leave of absence of detained patients for specific occasions or as a trial period of suitability for discharge. Any conditions attached to leave would be subject to review by the Mental Health Review Board.

New legislation would require that involuntary patients be informed of the nature of their detention, the review procedure and their right to an appeal.

³⁰ For example, by means of a system of adult care orders (see below).

³¹ A 1992 DoH survey found that of 3,000 involuntary admissions, almost 90% of applications were made by a spouse or relative, see White Paper, para. 3.9.

³² 90% of medical recommendations for involuntary admission were made by general practitioners. See survey, *ibid.*

³³ On what constitutes an examination for the purposes of committal, see *O’Reilly v. Moroney* (Supreme Court, Unreported Judgement, 16 November 1993) cited in Casey and Craven, *supra*, n. at 470.

³⁴ White Paper, para. 4.3.

Significantly, the White Paper proposes an independent review, by the proposed Mental Health Review Board, of each decision to detain and to extend a detention order. It concedes that current review and appeal procedures do not satisfy Ireland's obligations under the European Convention which requires provision of a review by a "judicial" body of the lawfulness of a detention order. An administrative body independent of the original decision-makers would suffice. Similarly, the UN Principles recommend a review of every decision to detain by a judicial body or other independent and impartial body established by domestic law.³⁵ It is proposed that the Mental Health Review Board would:

- review every initial decision to detain;
- review each decision to extend detention;
- review all detention orders extending detention by one year, and subsequent extensions at two-yearly intervals;
- hear appeals against a detention order or the extension of a detention order;
- review any conditions attached to the temporary release of a detained patient;
- arrange for the provision of second opinions in relation to consent to treatment;
- review decisions to transfer patients to the Central Mental Hospital or other special psychiatric centres;
- review the appropriateness of the continuation of a child treatment order if the child had been the subject of an order for longer than one year;
- to approve the participation in clinical trials of patients without the capacity to consent provided that the Board is satisfied that there is a reasonable expectation of benefit to the patient's health.

Though its members would be appointed by the Minister for Health for three year terms, the Board would be given the necessary statutory authority to guarantee its independence. Its chairman would be a lawyer of high standing. The Board would appoint a panel of psychiatrists, lawyers and lay persons to carry out its functions in relation to appeals and review of the detention of those on orders which permit detention for a year. At least one panel would be appointed for each health board area. An appeal against an order or an extension would be limited to one per order or extension. There would be an appeal to the High Court against a decision of the Board. There will be a right to legal representation and the Government propose to extend the provisions of the Scheme of Civil Legal Aid and Advice to include hearings of the Board. However, access to the Scheme would continue to be means tested.

³⁵ Para. 5.3.

3.2 New South Wales

Two categories of admission are created under the NSW Mental Health Act 1990: voluntary admission and involuntary admission.

3.2.1 Voluntary Admission:

Under section 17 of the 1990 Act, the criterion for admission of an informal or voluntary patient is that the medical superintendent is of the view that the person is likely to benefit from care or treatment. All voluntary patients may discharge themselves from the hospital at any time³⁶ unless the medical superintendent, satisfied that the person is a mentally ill person, has him made an involuntary patient under sections 18 and 18A. Where a patient has been in continuous care for a period longer than 12 months, the Mental Health Review Tribunal must review the case once every 12 months and may order the patient's discharge.³⁷ A person under 14 years of age may not be admitted as a voluntary patient over the objection of his parents and the parents of a person aged between 14 and 16 must be notified of an admission. A person subject to a guardianship order may be voluntarily admitted only at the request of the guardian, as approved by the Guardianship Tribunal.³⁸

3.2.2 Involuntary Admission:

A patient may be taken to and detained in a psychiatric hospital against their will as a mentally disordered person or a mentally ill person in the following circumstances:

- on the certificate of a medical practitioner (Schedule II admission);³⁹
- on the certificate of an accredited person (appointed by the Director-General of Health to provide a facility for scheduling in remote areas where a medical practitioner may not be readily available);⁴⁰
- on a written request from a relative or friend (may only occur where remoteness or urgency makes it impracticable to have the person seen by a medical practitioner);⁴¹
- after being apprehended by the police;⁴²
- on a court order under section 33 of the Mental Health (Criminal Procedure) Act, 1990;⁴³
- on information from a welfare officer who believes the person to be mentally ill or mentally disordered;⁴⁴
- following an order by an "appropriate person", for medical examination and completion of a schedule ("appropriate person" includes a magistrate).⁴⁵

In practice, most involuntary admissions are made on the certificate of a doctor, after apprehension by the police or following an order from a magistrate at a local court.

3.2.2.1 Admission Procedure

As soon as practicable after admission an involuntary patient must be given an oral explanation and written statement of his rights under the Mental Health Act 1990 in language the patient can understand.⁴⁶ He must be examined by the medical superintendent (or delegate) within 12 hours of arriving and must not be detained unless certified to be mentally ill or mentally disordered.⁴⁷ If detained, the patient must be examined by a second doctor as soon as practicable and if the medical superintendent is not a psychiatrist, the second doctor must be.⁴⁸ If the

³⁶ Section 65.

³⁷ Section 63.

³⁸ Section 12(2).

³⁹ Section 21.

⁴⁰ *Ibid.*

⁴¹ Section 23.

⁴² Section 24.

⁴³ Section 25.

⁴⁴ Section 26.

⁴⁵ Section 27.

⁴⁶ Section 30.

⁴⁷ Section 29.

⁴⁸ Section 32.

second doctor certifies the patient to be a mentally ill person, the medical superintendent must arrange for the person to be brought before a magistrate.⁴⁹ If the second doctor is not of the view that the detained patient is mentally ill or mentally disordered, another doctor must conduct an examination. If, in the third examination, the patient is found not to be mentally ill or mentally disordered, he must be released. If found to be mentally ill, he must be brought before a magistrate. It is the duty of the medical superintendent to bring a patient considered to be a mentally ill person before a magistrate as soon as practicable.⁵⁰

If the medical superintendent forms the view that a patient is mentally disordered rather than mentally ill, the patient is not taken before the magistrate. He may be detained in hospital for no longer than three working days and must be examined at least once every 24 hours during this detention by a medical practitioner.⁵¹ He may not be detained as a mentally disordered person on more than three occasions in one month.

Magistrates regularly visit NSW hospitals (*i.e.* on a set day of the week at each hospital) and conduct inquiries under section 41 of the 1990 Act to determine, whether or not, on the balance of probabilities, a patient is a mentally ill person and should remain detained or be discharged. Patients appearing at the magistrate's hearings have, *inter alia*, the right to:

- have relatives and or friends notified of the hearing;⁵²
- legal representation (or representation by another person with the approval of the magistrate);⁵³
- minimum medication, consistent with proper care, which does not interfere with their ability to communicate;⁵⁴
- an interpreter, if necessary;⁵⁵
- access to medical records unless refused by the magistrate (though a patient's legal representative has an unconditional right to access the records).⁵⁶

If a person is found to be a mentally ill person, the magistrate may:⁵⁷

- order the discharge of the patient to the care of a relative or friend who undertakes to care properly for the person;
- order that the person be made the subject of a Community Treatment Order⁵⁸ (for a maximum of six months and provided that certain conditions are met);
- direct that a person be made a temporary patient in the specified hospital for such period (maximum of three months) as is considered necessary – provided no other care of a less restrictive kind is appropriate and reasonably available.

The Mental Health Review Tribunal⁵⁹ has an extensive jurisdiction to determine matters relating to patients detained in hospitals after the initial magistrate's hearing, including:

- applications for the extension of temporary orders;
- applications to classify patients as "continued treatment patients";
- appeals;

⁴⁹ Section 38.

⁵⁰ *Ibid.*

⁵¹ Section 35.

⁵² Section 38.

⁵³ Section 43. Free legal representation is provided by the Legal Aid Commission through the Mental Health Advocacy Service though patients can also use private lawyers or community legal centres. The MHAS also provides legal representation for many people appearing before the Mental Health Review Tribunal and provides representation for the subject of applications at the Guardianship Tribunal on request only. It also provides telephone advice regarding mental health law, accepting reverse charge calls.

⁵⁴ Section 31.

⁵⁵ Section 41.

⁵⁶ Section 45.

⁵⁷ Under section 51.

⁵⁸ Under sections 118-120, Community Treatment Orders (and Community Counselling Orders) are orders which may be made by the Magistrate or the Mental Health Review Tribunal requiring a person to accept medication and other treatment whilst residing in the Community.

⁵⁹ Created under section 252 of the Mental Health Act, 1990.

- review of forensic patients;
- review of long-term informal / voluntary patients;
- applications to administer electro-convulsive therapy (ECT);
- applications to approve surgical treatment;
- applications for financial management orders; and
- applications for Community Treatment Orders and Community Counselling Orders.

The Tribunal comprises a president and deputy president, who are senior lawyers, and many part-time members. It always sits as a panel of three, comprising a lawyer, a psychiatrist and another suitably qualified person. The Tribunal describes its proceedings as using the “non-adversarial rights and review model”. It conducts its hearings with as little formality and technicality as proper consideration of the case permits. Also, it is not bound by the rules of evidence and may inform itself of any matters as it sees fit.⁶⁰ People appearing before the tribunal may be legally represented or represented by another with the Tribunal’s approval. The Supreme Court has jurisdiction under the Mental Health Act to consider appeals from a person dissatisfied with a Tribunal decision.⁶¹

In addition, there is a system of official visitors who visit each hospital at least once each month and have access to all registers, files and patients who may lodge a request to see an official visitor. Also, there is a Health Care Complaints Commission, an independent commission which receives and investigates complaints regarding the provision of health services. The Commission also operates a Patient Support Office which attempts to solve disputes at a local level before the matter proceeds to a formal complaint.

⁶⁰ Section 267.

⁶¹ Sections 281-286.

3.3 Scotland

Mandatory review of psychiatric detentions was introduced in Scotland as early as 1960 and the average daily number of detained patients plummeted as a result.⁶² It was introduced as a result of consideration by the Dunlop Committee in Scotland of the recommendations of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency 1954-57. Scottish mental health legislation was consolidated and further amended slightly by the current Mental Health (Scotland) Act, 1984. On 18th December 1998, the Scottish Health Minister, Sam Galbraith, announced a fundamental review of Scottish mental health law under a committee to chaired by the Rt. Hon. Bruce Millan. One reason for establishing this Committee is the aim of ensuring full compliance with a 1992 UN General Assembly Resolution on “The Protection of Persons with Mental Illness and the Improvement of Mental Health Care”⁶³ and the Council of Europe, Committee of Ministers 1983 Recommendation “Concerning the Legal Protection of Persons Suffering from Mental Disorder Placed as Involuntary Patients”.⁶⁴

Though it would be unwise to speculate as to the likely outcome of the Millan Committee, it is reasonable to expect that it will recommend adoption of those proposals contained in the Scottish Law Commission’s draft Incapable Adults Bill upon which there is broad-based unanimity.⁶⁵ These include a new and more appropriate form of guardianship with flexible powers, and the introduction of the “designated sheriff” by whom mental health and mental disability matters will normally be heard and who will thus develop special expertise in such matters.⁶⁶

Under current Scottish legislation, a particular anomaly arises with regard to the essential requirement of “treatability” for detention. This recently came to light in the *Reid* case,⁶⁷ which concerned the continuing detention of a patient following a conviction for culpable homicide in 1967. He challenged his detention on the grounds that his condition was not treatable and was not in fact being treated. The House of Lords confirmed that treatability was an essential element of the criteria for detention and that the treatability test “is satisfied only if such treatment is likely to alleviate or prevent a deterioration of the person’s condition”. However, the Lords applied a very broad definition of “treatment” stating that:

“[I]t includes nursing, and it also includes care and training under medical supervision ... It is also wide enough to include treatment which alleviates or prevents a deterioration of the symptoms of the mental disorder, not the disorder itself which gives rise to them”.⁶⁸

It hardly seems satisfactory that, in considering the definition of treatment, the Lords considered public safety:

“bearing in mind that the purpose of a restriction order is to protect the public against the risk that the patient may commit further offences if he is given his discharge.”⁶⁹

The House of Lords strongly hinted that the issue should be addressed by Scottish Parliament.⁷⁰

Also, there is considerable concern that, under current Scottish legislation, there may be an unacceptable gap between the written safeguards contained in the legislation and their circumvention in practice, and that there is insufficient control of the use of “emergency exceptions” to avoid protections and procedures which otherwise apply.⁷¹

⁶² Mental Health (Scotland) Act, 1960. See A, Ward, “A Review of Mental Health Law At Last”, *The Journal of the Law Society of Scotland*, Vol. 44, No. 2 and 3 (February and March 1999) 20-26.

⁶³ UNGA Res. A/46/721, adopted 18 February, 1992.

⁶⁴ Council of Europe, Rec. No. R(83)2, adopted 22 February, 1983.

⁶⁵ See “Alliance with a Clear Objective”, *The Journal of the Law Society of Scotland*, Vol. 43, No.5, (May 1998) at 13.

⁶⁶ See A. Ward, *supra*, at 20

⁶⁷ *R v. Secretary of State for Scotland*, 1999 SLT (HL) 279.

⁶⁸ *Ibid.*, per Lord Hope of Craighead.

⁶⁹ *Ibid.*

⁷⁰ See A. Ward, *supra*, at 25.

⁷¹ *Ibid.*, at 26.

3.4.1 Commentary

There is considerable disappointment that the White Paper does not propose to provide for a statutory minimum level of service provision in all health boards as of right.⁷² Access to services would continue to be at the arbitrary discretion of each health board. Also, while the exclusion of certain categories of persons, such as addicts not having an accompanying mental disorder, from liability to detention is to be welcomed, it would appear necessary that alternative facilities are provided. The number of homeless mentally disordered people is growing,⁷³ as is the number of such people among the prison population,⁷⁴ and the White Paper proposals may exacerbate this situation. Similarly, the practice of “lodging”⁷⁵ is not alluded to in the White Paper and if no discretion to lodge is included in new legislation, alternative facilities may again have to be provided.

Though the White Paper proposes to make voluntary admission less formal, the need for some safeguards remains. The Law Commission of England and Wales has recommended the extension of certain safeguards to voluntary patients, for example, the right to a second opinion for treatment for those unable to give valid consent. There appears to be no reason why the proposals for information rights for detained patients contained in the White Paper should not be extended to voluntary patients.

It has been suggested that the requirement for a District Court order to transfer an unwilling patient to hospital may be unnecessary where delays are not in the patient’s interest and that it may disadvantage seriously ill patients in remote areas. Though it is unclear how onerous a procedure would be involved in acquiring such an order, the District Court is used under child care legislation to remove a child from its parents and there is no reason to assume that it would be any less effective in the mental health area.⁷⁶ Otherwise, it appears likely that the proposed Garda emergency powers would be used instead of the court order. This would run counter to the intention of similar legislation in other jurisdictions. For example, the Code of Practice for Northern Ireland states that the patient must be transported in the most humane and least threatening way consistent with his needs for safety.⁷⁷ It would appear self-evident that use of the proposed Garda emergency powers should be severely limited.

Also, it is suggested that the Mental Health Review Board should not be limited to deciding whether to discharge but should have the option of directing the discharge at a future specified date. This would allow for “planned discharge” whereby social support, supervised aftercare and placement of patients could be required and arranged.⁷⁸ Also, legal representation is to be encouraged before the Mental Health Review Board, possibly by means of a relaxation of the civil legal aid means test, as research in England and Wales demonstrated that significantly more patients who had legal representation were discharged.⁷⁹

3.4.2 Recommendations

- **Introduction of a statutory minimum level of service provision as of right.**
- **Provision of alternative facilities for categories of persons excluded from liability to detention, such as addicts or the homeless.**
- **Extension of formal safeguards to voluntary patients.**
- **Use of Adult Care Orders to transfer unwilling patients to hospital.**

⁷² See, for example, the Dutch Medical Treatment Contracts Act, 1995.

⁷³ Eastern Health Board Annual Report for 1996. See generally, M. Keys, “Issues for the New Mental Health Act”, (1997) *Medico-Legal Journal of Ireland*, Vol. 3, No. 3, 97-102.

⁷⁴ See, C. Smith, H. O’Neill, J. Tobin, D. Walshe and E. Dooley, “Mental disorders detected in an Irish prison sample”, *Criminal Behaviour and Mental Health*, Vol. 6, (1996), 177-183, at 178.

⁷⁵ Under section 261 of the 1945 Act, “A person not of unsound mind may be lodged as a boarder in a mental institution...”

⁷⁶ See “Adult Care Orders”, *infra*, section 6.

⁷⁷ Mental Health (N.I.) Order 1986 Code of Practice (HMSO, Belfast, 1993). See M. Keys, *supra*.

⁷⁸ See J. Wood, “Reform of the Mental Health Act, 1983: An Effective Tribunal System?”, 162 *British Journal of Psychiatry*, 14-22, cited in M. Keys, *supra*.

⁷⁹ Genn and Genn, *Effectiveness of Representation at Tribunals: Report to the Lord Chancellor’s Department*, (1989).

- **Measures to allow the proposed Mental Health Review Board to order “planned discharge”.**
- **Measures to encourage legal representation before the proposed Mental Health Review Board.**

4. Consent to Medical Treatment

4.1 Proposals in the White Paper

4.1.1 Treatment of Mental Disorders

The Mental Treatment Act, 1945 did not deal with the issue of informed consent to treatment of detained patients and it was widely assumed that consent to treatment was not required of an involuntarily detained patient even though, under common law, physical treatment is unlawful without a person's consent unless the treatment is urgently necessary.⁸⁰ The Supreme Court has accepted that the right to choose whether or not to undergo medical treatment is a personal right protected under the Constitution⁸¹ but also that it is one which may validly be restricted.⁸² Both the Council of Europe Recommendation and the UN Principles recommend that the approval of an independent authority prescribed by law should be required where the patient is incapable of understanding the nature of the treatment. The UN Principles go even further in relation to psycho-surgery and other intrusive and irreversible treatments, recommending that such treatments should only be carried out where the patient has given informed consent and an independent body is satisfied that there is genuine informed consent and that the treatment best serves the health needs of the patient.

The Government proposes that, in relation to the requirement of consent, new mental health legislation would distinguish between two categories of treatment:

- (i) Treatment requiring the patient's consent and a second opinion (including psycho-surgery and any other form of irreversible surgical treatment to be prescribed by regulations). Such treatments could not be given to voluntary or detained patients incapable of giving consent unless two independent people, one of whom must be a medical practitioner, certified that the patient understood the treatment and was capable of giving informed consent. These independent people would be appointed by the Mental Health Review Board and would be acting on its behalf.
- (ii) Treatment requiring consent or a second medical opinion (including the administration of medicine for mental disorder after three months of medication and electro-convulsive treatment (ECT)). This provision would only apply to detained patients. The person providing the second medical opinion would have to be satisfied that the patient lacked capacity to consent or was unreasonably withholding such consent and that the treatment was in the best interests of the patient's health. It is proposed that the second medical opinion would be set out and recorded in a form prescribed by Regulation.

It is proposed that consent should be in writing and that new legislation would provide for a right of patients or persons acting on their behalf to appeal to the High Court against decisions to treat on grounds that proper procedures to seek consent were not followed or that treatment without consent was not justified.

⁸⁰ "If medical treatment is given without consent it may be trespass against the person in civil law, a battery in criminal law, and a breach of the individual's constitutional rights." Per Denham J, *In the matter of A Ward of Court (withholding medical treatment) (No. 2)*, [1996] 2 IR 100 at 156.

⁸¹ Hamilton CJ has referred to this right "as an aspect of the right to privacy which should be protected as a 'personal' right by Article 40.3.1, *ibid*, at 125, while Denham J has approved it "as an aspect of a person's right to bodily integrity under Article 40, s. 3 of the Constitution, which was first recognised by Kenny J in *Ryan v Attorney General* [1965] IR 294 ...", *ibid*, at 156.

⁸² For example, in *SC v Smith and others*, Supreme Court, Unreported Judgment, 31 July 1996 (272/1995), though referring generally to the constitutionality of the Mental Treatment Act, 1945, section 172, Hamilton CJ stated that "the sections which permit of such detention do not constitute an attack upon the personal rights of the citizen but rather vindicate and protect the rights of the citizens concerned by providing for their care and treatment and are not repugnant to the Constitution ...". Also, Hamilton CJ has cited, with approval, an extra-judicial comment of Costello J that stated "... like other 'personal' rights identified by the Courts, the right is not an absolute one, and its exercise could in certain circumstances be validly restricted", *In the matter of A Ward of Court (withholding medical treatment) (No. 2)*, *supra*, at 125, [citing Costello, J, "The Terminally Ill: The Law's Concern (1986) XXI Ir. Jur. (n.s.) 35].

4.1.2 Clinical Trials

Section 8(7) of the Control of Clinical Trials Act, 1987 provides that a patient without capacity to consent to participate in a clinical trial can only participate if a written and signed consent is given for such participation by a person or persons independent of the person conducting the trial who in the opinion of the ethics committee is competent to give a decision on such participation. However, the Council of Europe Recommendation states that clinical trials of products or therapies not having a psychiatric therapeutic purpose on detained mental patients should be forbidden.⁸³ Also, a new Protocol to the European Convention contains a strong provision that the participation of detained mental patients in medical research should be forbidden, even with the patient's consent, unless it is reasonably expected to benefit his health.⁸⁴ Therefore, the Government proposes to augment and strengthen the safeguards contained in the 1987 Act by including, in new mental health legislation, a condition that the participation of patients without capacity to consent in clinical trials be approved by the proposed Mental Health Review Board and that the Board must satisfy itself that there is a reasonable expectation of direct or indirect benefit to the patients' health.

4.2 England and Wales

Since the decision of the House of Lords in *Re F*,⁸⁵ the English courts have provided some guidance to health care professionals on the provision of medical treatment to mentally incompetent adults⁸⁶ but much uncertainty remained.⁸⁷ Therefore, in 1995, the Law Commission published its report on *Mental Incapacity*.⁸⁸ In December 1997, the British government issued a green paper⁸⁹ which broadly accepts the Law Commission's proposals but has invited further consultation on specific issues.

4.2.1 The Test for Capacity

The Law Commission has proposed a two-point test, comprising a diagnostic threshold and a functional test. The latter would only apply where a patient could not satisfy the diagnostic threshold due to "mental disability".⁹⁰ The proposed functional test is similar to that set out in *Re C*,⁹¹ i.e.

- whether the patient could comprehend and retain the information given;
- whether he believed the information given; and
- whether he used the information to arrive at a choice.

The U.K. Government has accepted the Law Commission's recommendation that there should be a code of practice to provide detailed guidance to health care professionals on assessing capacity.

⁸³ Article 5.3.

⁸⁴ This Protocol is expected to be adopted by the Government shortly. See, White Paper, para. 10.24.

⁸⁵ [1990] 1 AC 1.

⁸⁶ See for example, *Airedale NHS Trust v Bland* [1993] AC 789; *Re W (Mental Patient)* [1993] 1 FLR 381.

⁸⁷ See generally, J. V. McHale, "Mental Incapacity: Some Proposals for Legislative Reform", (1998) 24 *Journal of Medical Ethics*, 322-327, who points out that many non-therapeutic procedures such as clinical trials and genetic screening were of questionable legality.

⁸⁸ Law Commission, *Mental Incapacity*, Report No. 231, HMSO, 1995. This report followed publication of three consultation papers: *Mentally incapacitated adults and decision making: a new jurisdiction* (consultation paper no. 128, 1993); *Mentally incapacitated adults and decision making: medical treatment and research* (consultation paper no. 129, 1993); *Mentally incapacitated and other vulnerable adults: public law protection* (consultation paper no. 130, 1993).

⁸⁹ Lord Chancellor's Department, *Who Decides? Making Decisions on behalf of Mentally Incompetent Patients*, December 1997.

⁹⁰ Defined as "a disability or disorder of the mind or brain, whether permanent or temporary, which results in an impairment or disturbance of mental functioning". This differs from the test of "mental disorder" contained in the Mental Health Act 1983 in order that the new law should not be regarded as only applicable to psychiatric patients.

⁹¹ [1994] 1 WLR 290. This case involved a patient detained in Broadmoor who suffered from chronic paranoid schizophrenia and needed a leg amputation in life-threatening circumstances. He successfully sought an injunction preventing amputation then or at any time in the future. In addition to outlining the components for capacity, the Court effectively permitted an advance directive as to the patient's future wishes regarding treatment.

4.2.2 Best Interests

The House of Lords established in *Re F* that, while no one had the power to consent on behalf of a patient, treatment was to be given on the basis of necessity, where this was in the “best interests” of the incapacitated adult. What constituted best interests was to be referable to the so-called *Bolam* test.⁹² The Law Commission identified two possible options, a best interests test or a substituted judgement test,⁹³ and opted for the former. However, rather than proposing a *Bolam*-based best interests test the Report set out a number of criteria which should be considered when assessing a patient’s best interests:

“The ascertainable past and present wishes and feelings of the person concerned and the factors the person would consider if available to do so; the need to permit and encourage the person to participate or improve his or her ability to participate as fully in anything done for and any decision affecting him or her; the views of other people whom it is practical and appropriate to consult about the person’s wishes and feelings and what would be in his or her best interests; and whether the purpose for which any action or decision can be as effectively achieved in a manner less restrictive of the person’s freedom of action.”

The Government has accepted these criteria in principle but has invited further consultation as to their application in practice. In particular, there is concern over how to deal with differences of opinion which arise between those consulted, whether the guidance should take into account religious or cultural factors in determining a patient’s best interests, and the extent to which relatives and carers can be expected to put the interests of the patient entirely before their own where their own welfare is at stake.

However, it is recognised that in some situations it should be possible to depart from the best interests criteria. For example, the Law Commission has suggested that, in deciding whether to withdraw artificial nutrition / hydration from an unconscious patient with “no prospect of recovery”,⁹⁴ the best interests test is not applicable though they conceded that reference could nevertheless be made to the criteria. This type of situation arose in the *Bland*⁹⁵ case where the House of Lords emphasised the importance of such cases being referable to the courts. The Law Commission has commented that when sufficient case law has developed it might be possible to make such decisions by reference to a second opinion procedure rather than to the courts. Also, the Commission suggests that there may be instances where it should be possible for procedures to be performed for the benefit of persons other than the mentally incompetent patient, e.g. genetic screening.

4.2.3 General Authority to Act Reasonably

To avoid the uncertainty which may attend many everyday decisions regarding incapacitated adults, the Law Commission recommended the creation of a general authority to act reasonably, stating that it should be:

“lawful to do anything for the personal welfare or health care of a person who is, or is reasonably believed to be, without capacity in relation to the matter in question if it is in all the circumstances reasonable for it to be done by the person who does it.”

The general authority would exclude detention, compulsion or the doing of anything to which the patient objects. The U.K. Government has invited views as to the appropriateness of the authority as recommended by the Commission.

4.2.4 Advance Statements / Directives

There have been many calls for the legal recognition of advance statements which would enable a person, having capacity at the time that the statement was made, to manage the end of his life to some

⁹² *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118.

⁹³ Whereby the decision is made on the basis of the approach the patient would have taken had he had capacity.

⁹⁴ The Royal College of Physicians has issued guidelines concerning “patients who have no prospect of recovery who are either unconscious or in a permanent vegetative state”.

⁹⁵ *Op. cit.*

extent. There is no UK legislation regarding advance statements but their validity has received judicial recognition in some circumstances.⁹⁶ Development of advance statements has received support from the House of Lords Select Committee on Medical Ethics⁹⁷ and in 1995 the British Medical Association issued guidance on their use.⁹⁸ The Law Commission recommended the introduction of legislation on the issue and suggested as a definition:

“a refusal made by a person aged 18 or over with the necessary mental capacity, of any medical, surgical or dental treatment or other procedures and intended to have effect at any subsequent time when he or she may be without capacity to give or refuse consent.”

The U.K. Government has invited consultation on this definition and both the Government and the Law Commission have emphasised that an advance statement cannot make lawful an action which is otherwise unlawful and so could not legalise mercy killing. Also, patients could not insist upon treatment which is not supported by medical opinion. There is also concern that advance statements would not unintentionally prevent the use of treatments developed after the statement had been drafted, that vulnerable people should not draft statements under pressure but only as the result of an informed, considered choice free from undue influence, and that statements should not apply where a woman patient subsequently becomes pregnant. The Government has endorsed the Law Commission’s recommendation that, in contrast to the US position, advance statements should not be applicable only where the patient is in a terminal condition. The U.K. Government has commented that the advance statement is not:

“to be seen in isolation, but against a background of doctor / patient dialogue and the involvement of other carers who may be able to give an insight into what the patient would want in the particular circumstances of the case.”

4.2.5 Special Authorisation

The House of Lords suggested in *Re F* that in the case of certain medical procedures undertaken on mentally incompetent adults, such as sterilisations, it would be appropriate to seek prior judicial approval. The Law Commission recommended that in certain situations judicial approval, or at least some form of “second opinion”,⁹⁹ should be obtained. It further recommended that in some situations the authorisation in the form of a second doctor’s certificate would be more appropriate. The Government’s Green Paper did not take a position on the issue but simply invited consultation as to whether judicial or other approval should be required for procedures such as sterilisation, abortion, donation of blood, bone-marrow and both regenerative and non-regenerative tissue by a mentally incompetent person.

4.2.6 Clinical Research

In the wake of the *Re F* decision,¹⁰⁰ the legality of performing non-therapeutic research upon mentally incompetent adults is uncertain. Therefore, the Green Paper has invited views as to whether it should be permitted and whether the safeguards proposed by the 1996 Council of Europe Convention on Biomedicine and Human Rights¹⁰¹ are sufficient. The Convention sets out the criteria to be considered in deciding whether to permit such research including:

- the fact that research of comparable effectiveness cannot be undertaken upon competent adults;
- the results of the research will benefit the individual’s health;
- the necessary consents have been given; and
- the individual concerned does not object.¹⁰²

⁹⁶ For example, *Re T* [1992] 4 All ER 649, in which the right of Jehovah’s Witness patients to reject blood transfusions, even where this may result in death, was confirmed.

⁹⁷ HL Paper No. 21 (1993-4), paras. 181-215.

⁹⁸ *Advance statements about medical treatment: code of practice with explanatory notes*, London, BMJ Publishing Group, 1995.

⁹⁹ Such as approval given under a power in regard to a continuing power of attorney or the approval of a court-appointed manager.

¹⁰⁰ *Op. cit.*

¹⁰¹ DIR/JUR (96) 14. The UK government is currently considering becoming a signatory to the Convention.

¹⁰² *Ibid.*, Article 16.

The Law Commission has recommended the establishment of a committee to scrutinise proposals for the involvement of mentally incompetent adults in non-therapeutic trials. Initial approval would be given by this committee and further approval by a third party, whether court, attorney or manager, would be required. Further approval would not be required in the case of observational research.

4.2.7 Powers of Attorney

The Enduring Powers of Attorney Act, 1985 does not include powers relating to the medical treatment of incompetent adults and the Law Commission has recommended that a person should be able to appoint a “treatment proxy”. However critics, including the House of Lords Select Committee on Euthanasia,¹⁰³ have pointed out that these proposals present the same practical problems as advance statements. Also, there would be potential for overlap and conflict between advance statement arrangements and treatment proxy arrangements. The U.K. Government has accepted the Commission’s recommendation that the power of attorney could be amended or withdrawn at any time and that it should be capable of variation by the courts where this is in the donor’s best interests, subject to the donee’s willingness to take on additional responsibility. The Law Commission rejected a proposal that the donor’s capacity to execute a power of attorney should be subject to a certificate from a doctor and a solicitor but the Green Paper invited views as to what safeguards would be necessary.

4.3 Scotland

Subject to limited exceptions to which special legislative requirements apply, Part X of the Mental Health (Scotland) Act, 1984 removes from a detained patient the right to refuse consent to any treatment for mental disorder, with no provision for judicial determination of the scope for such drastic deprivation of basic rights which may be appropriate in individual cases. Also, there is no statutory requirement upon those imposing treatment to consult with the patient, to explain, or to seek to agree a course of treatment. There is no right for people (when competent to do so) to make advance refusals of specified treatments or categories of treatment. There is no right of appeal to the courts regarding any issue of forced treatment (as opposed to detention). There is widespread agreement among commentators that most, if not all, of these missing elements will be required to ensure that a reformed code achieves minimum internationally required safeguards for human rights.¹⁰⁴ Ward contrasts this situation with that of the Canton of Geneva, where treatment without consent is limited to life-threatening situations¹⁰⁵ and where a “psychiatric will” (*i.e.* an advance directive or living will concerning psychiatric treatment) has been upheld.¹⁰⁶ Also, he alludes to the concept of “consent” in Dutch law which requires “evident willingness” and which, in its absence, imposes the safeguards contained in procedures for involuntary treatment.¹⁰⁷

4.4.1 Commentary

The Law Commission’s proposals are complex, combining requirements for judicial approval, second opinion, and application of a best interests test in some situations and not in others. However, many of these practical difficulties could be overcome by means of a clear and comprehensive code of practice. Also, it is proposed that judicial approval would be sought in a “judicial forum”, a specialist jurisdiction in the form of an enhanced court of protection. This would require restructuring of the court system. Further, it is would appear inevitable that the complex procedures proposed would involve additional costs.¹⁰⁸ The proposed procedures in the Irish White Paper appear to mirror the English proposals. Also, the introduction of a general authority to act reasonably would appear to be a

¹⁰³ HL Paper No. 21 (1993-4), para. 270.

¹⁰⁴ See A. Ward, *supra*, at 25.

¹⁰⁵ Law of the Canton of Geneva of 6 December 1987, Article 5.

¹⁰⁶ Decision of the Administrative Tribunal of the Canto of Geneva on 7 March 1995 in *K v. Departement de l’Action Sociale et de la Sante* A(702) 1992 – ASAN.

¹⁰⁷ Dutch Mental Health Act, 1984.

¹⁰⁸ See J. Stone, “Mental Incapacity: Reform at Last?”, (March, 1998) *Solicitors Journal*, Vol. 142, 259.

very convenient legal device which would permit carers to carry out their everyday tasks and obviate the need for excessive legislative detail.

Though there must remain a clear distinction between consent and consultation – valid consent can only be given by the patient or by those authorised and empowered by law to give consent on behalf of the patient – it would be highly desirable in many situations to encourage wider consultation, *e.g.* in determining “best interests”. It should also be noted that wider consultation can sometimes run counter to the requirements of confidentiality. It is suggested that notice be taken of the outcome of the UK Government’s continuing consultation as to the application in practice of the “best interests test” criteria proposed by the Law Commission for England and Wales.¹⁰⁹

The Law Reform Committee would be concerned that a code of practice, though commendable in theory, may take some time to put in place. However, it is also concerned that the procedures would be unnecessarily complex and would urge that every effort be made to ensure that they should be simplified. Also, it is suggested that the right of appeal should be to the MHRB in the first instance and only then to the High Court. The Committee would be anxious to only involve the High Court as a last resort because the costs would discourage many people who might otherwise go in an informal way to the MHRB.

The Law Reform Committee proposes extending the scope of the enduring power of attorney contained in Part II of the Powers of Attorney Act, 1996 so as to include health care decisions among personal care decisions. This would contribute to the consolidation and simplification of personal care procedures.

4.4.2 Recommendations

- **Introduction of a general authority to act reasonably in relation to everyday care decisions regarding incapacitated adults.**
- **Measures to encourage wider consultation regarding care decisions.**
- **Development of “best interests test” criteria.**
- **Development of an accessible and simplified code of practice in relation to care decisions.**
- **Creation of a right of appeal in relation to health care decisions to the Mental Health Review Board in the first instance and only then to the High Court.**
- **Extension of the Powers of Attorney Act, 1996 to include health care decisions among personal care decisions.**

¹⁰⁹ *Op. cit.* See also, Memorandum of Comments by the Mental Health and Disability Committee of the Law Society of Scotland on the General Medical Council Draft Guidance: Consent – the Ethical Considerations (August 1998).

5 Civil Liability /Access to Civil Justice

5.1 Current Irish Legislation

Under section 260 of the 1945 Act, it is necessary for a person who wishes to take civil proceedings, in respect of any act purporting to have been done in pursuance of the Act, to satisfy the High Court before the proceedings are instituted that “there are substantial grounds for contending that the person against whom the proceedings are to be brought acted in bad faith or without reasonable care”.¹¹⁰ Such a provision was originally introduced under English law with the aim of protecting doctors from unfounded litigation.¹¹¹ Henchy J. once described section 260 as one which “re-enacts a bar to litigation which existed in the law of lunacy in England since the Lunacy Act, 1890.”¹¹² It currently operates to protect applicants, medical and nursing personnel and members of the Garda Síochána. However, it has operated in a very restrictive manner.¹¹³ The same standard is applied to the substantive proceedings if leave is granted. Recently, however, the Supreme Court has unanimously endorsed a strict construction of section 260 on the grounds that, as a *prima facie* curtailment of a citizen’s constitutional right of access to the courts, it must be strictly construed so as to ensure that this right is not unnecessarily curtailed.¹¹⁴ The Government is of the opinion that such an explicit provision remains necessary to protect those involved in involuntary detentions, though it proposes to reduce the burden of proof from that of “substantial grounds” to “reasonable grounds” for contending that the defendant acted in bad faith or without reasonable care.¹¹⁵

5.2.1 Commentary

In comparison to other jurisdictions, the proposed new restriction on civil actions appears excessive. In both the law of Northern Ireland and of England and Wales, reform significantly reduced the burden of proof and leave will now be granted if the case deserves further investigation, even if it is unlikely to succeed. Also, these jurisdictions have specifically excluded local or public authorities from the protection of the section, thereby making it less likely that individual staff would be exposed to claims. Also, the section fails to refer to any particular category of patient, thereby creating uncertainty as to whether it applies to voluntary patients. Finally, as patients must go to the High Court to seek leave to proceed, commensurate costs are incurred even if the claim is within the jurisdiction of the Circuit Court.

¹¹⁰ See generally, J. Spellman, “Section 260 of the Mental Treatment Act, 1945 Reviewed”, (1998) *Medico-Legal Journal of Ireland*, Vol. 4, No. 1, 20-24.

¹¹¹ Its introduction was precipitated by a successful action in negligence against a doctor for wrongful detention which resulted in a threatened certification strike by doctors because of their perceived vulnerability to legal actions by patients. See M. Keys, “Issues for the New Mental Health Act”, *op. cit.*

¹¹² *O’Dowd v. North-Western Health Board* [1983] I.L.R.M. 1986. See J. Spellman, “Certifying Under the Mental Treatment Act 1945: Pitfalls for General Practitioners”, (1996) *Medico-Legal Journal of Ireland*, Vol. 2, No. 2, 60-61.

¹¹³ Of five reported cases taken under section 260, only one has been successful in being granted leave to pursue the action, namely *Bailey v. Gallagher* [1996] 2 I.L.R.M. 433.

¹¹⁴ See *Bailey v. Gallagher*, *ibid.* See also, *Murphy v. Greene* [1990] 2 I.R., *per* Finlay, CJ.

¹¹⁵ White Paper, para. 10.29. Casey and Craven regard the proposed provision as “a similar restriction”, *op. cit.*, at 458.

5.2.2 Recommendations

The Law Reform Committee is strongly opposed to any restrictions on civil action. It is suggested that such civil action should be facilitated by procedures in the Civil Legal Aid Act. It should be possible for civil actions to be taken on behalf of mentally ill people by an official body, such as the General Solicitor for Minors and Wards of Court, at the request of the Mental Health Review Board.

6. Adult Care Orders

6.1 Proposals in the White Paper

At present, there is no legal means of protecting a mentally disordered adult who is being abused, exploited or neglected, other than by detention under the 1945 Act or by making the person a Ward of Court. The Government has decided not to adopt the proposals contained in the Green Paper to include provisions for a supervision order as it was considered that a supervision order would have placed a heavy responsibility on the professional staff responsible for the patient without giving them the authority to enforce it. It was proposed during consultation that such supervision orders would include conditions requiring the patient to live at a specified place and attend specified places at specified hours for treatment, occupation, education or training. It is now proposed to introduce an adult care order to protect such people and to provide for their care according to the best standards of practice.

The adult care order would be modelled on the child care order established under the Child Care Act, 1991. An application would be made to the court, by a person so authorised by a health board, for the court's approval to the placement of the subject in the care of a relative, a health board or a voluntary agency. The applicant would need to produce evidence that the subject suffered from a mental disorder,¹¹⁶ that there were reasonable grounds to believe that the subject had suffered or was at risk of abuse, neglect or exploitation, and that the subject required care or protection which he would be unlikely to receive except under a care order. The court would determine the duration of the order though procedures are also proposed for an emergency order of up to eight days duration.

"*Mental disorder*" for the purposes of an adult care order would be defined more widely than for involuntary admission. "*Mental disorder*" would be defined as:

*mental illness, mental handicap or mental infirmity.*¹¹⁷

"*Mental illness*" would be defined as:

a state of mind which affects a person's thinking, perceiving, emotion or judgement to the extent that he or she requires care or medical treatment in his or her own interests or the interests of other persons.

"*Mental handicap*" would be defined as:

a state of arrested or incomplete development of mind which includes impairment of intelligence and social functioning.

"*Dementia*" would be defined as:

a deterioration of the brain which significantly impairs intellectual function affecting thought, comprehension and memory.

However, addiction, social deviance and personality disorder, without an accompanying mental disorder, would be excluded explicitly as grounds for an adult care order.

6.2.1 Commentary

The proposal to introduce adult care orders is generally to be welcomed. However, it appears unnecessarily restrictive to only permit evidence to be given by a consultant psychiatrist in application proceedings. It might be appropriate to permit evidence to be given by a consultant geriatrician or even a general practitioner who should be given some role in relation to a community-orientated protective option. Also, there may be some confusion between the role of the court, which would initially decide on the duration of the order, and the Mental Health Review Board, which would decide for or against continuation of the order. It is suggested that the legislation should permit evidence to be given by "any interested person" at the discretion of the court, and that applications for care orders might also be brought by any interested person.

6.2.2 Recommendations

¹¹⁶ To be provided by a consultant psychiatrist authorised for this purpose. White Paper, para. 8.7.

¹¹⁷ *Ibid.*, para. 8.8.

The Law Reform Committee supports the introduction of adult care orders but suggests that the procedures relating to the grant of such orders be designed so as to ensure the process is as inclusive, responsive and efficient as possible.

7 Property Management

7.1 Proposals in the White Paper

7.1.1 Wards of Court

The current Irish law on wardship is contained in the Lunacy Regulation (Ireland) Act, 1871, under which jurisdiction to appoint a ‘committee’ to manage the ward’s affairs is vested in the President of the High Court. Section 283 of the Mental Treatment Act, 1945 states that:

“no power, restriction or prohibition contained in the Act shall apply in relation to a person of unsound mind under the care of a judge of the High Court or of a judge of the Circuit Court”.

This provision was included to avoid interference with the Court’s powers. Therefore, a Ward of Court cannot be detained in a psychiatric institution, discharged or transferred except under an order made by the President of the High Court. During consultation, it was generally felt that the admission procedure governing Wards of Court was slow and cumbersome and so the Government proposes that wards be subject to the same admission procedures as other patients. In such cases, the clinical director would be required to notify the Registrar of Wards immediately.

7.1.2 Enduring Power of Attorney

An enduring power of attorney is one which comes into force when the person who granted it loses the mental capacity to manage their affairs. This device is particularly suitable for people with recurring mental illness or progressive brain diseases such as Alzheimer’s disease.

[Statutory provisions relating to enduring powers of attorney can now be found in Part II of the Powers of Attorney Act, 1996]

7.2 New South Wales

7.2.1 Protected Estates Order

When a Magistrate makes an order to detain a person, he must consider the patient’s capacity to manage their affairs.¹¹⁸ If not satisfied that the person can manage their affairs, the Magistrate must either order that they be managed by the Protective Commissioner or refer the matter to the Mental Health Review Tribunal (MHRT). Applications for protected estate orders may be made to the MHRT while the person is a patient in hospital, or to the Supreme Court or Guardianship Tribunal at any time.¹¹⁹ A voluntary patient may request that his affairs be managed by the Protective Commissioner, but may revoke this order in writing at any time.¹²⁰ The estate must be managed so that the person’s interests are protected. The Act also requires the Protective Commissioner or private manager to consult with the person’s family about any major decisions¹²¹ and to preserve personal items as far as is reasonably practicable.¹²² The Protective Commissioner or private manager can charge set fees for the administration of the estate.¹²³ When the subject of a protected estates order ceases to be a patient, the Protective Commissioner may review whether continued management is necessary and may decide to terminate that management.¹²⁴ A discharged patient may also appeal to the MHRT for the order to be revoked,¹²⁵ while any person made the subject of an order may appeal against the order to the Supreme Court.¹²⁶

7.2.2 Enduring Power of Attorney

¹¹⁸ Protected Estates Act, 1983, section 16.

¹¹⁹ The Supreme Court and Guardianship Tribunal may commit the management to the Protective Commissioner or to another person.

¹²⁰ Sections 62-64.

¹²¹ Section 50.

¹²² Section 51.

¹²³ Section 8.

¹²⁴ Section 38.

¹²⁵ Section 31.

¹²⁶ Section 21.

Any legally capable person may appoint a power of attorney which allows that attorney to conduct transactions on the person's behalf. The power of attorney can remain valid even after the person has lost capacity to manage their own affairs. During the period of a protected estates order, any power of attorney is suspended until the order expires.

7.2.3 Guardianship

Guardianship allows for substitute decision-making in relation to personal, but not financial, matters.

7.3.1 Commentary

The complex procedures involved in applications to have a person made a Ward of Court should be streamlined and simplified to provide more accessible protection for patients' property. Also, the Law Reform Committee suggests that the Wardship procedure should become intrinsically linked with the detention procedures, so that the property of a person who is detained against their will is automatically protected. In other words, when a detention order is made, the Wards of Court Office should be immediately notified, and the wardship procedure commenced by the General Solicitor, unless there is an enduring power of attorney in existence.

7.3.2 Recommendations

The Law Reform Committee recommends that the Ward of Court procedures be simplified and integrated with the detention procedures.

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