The Forgotten People

Ireland’s Mental Health legislation has been dragged into the 21st century by the replacement of the Mental Treatment Act, 1945 with the Mental Health Act, 2001. The shift from the medical model to a rights based approach was heralded as being in line with both the European Convention on Human Rights and the Convention on the Rights of Persons with Disabilities, in reality though it leaves much to be desired. The majority of patients within the Mental Health System are voluntary patients and as such have no access to the statutory safeguards that have been put in place for the minority, those that are admitted involuntary.

‘The Forgotten People’ looks at the position of voluntary patients within the mental health system and the difficulties that are presented to them in order to safeguard against deprivation of liberty along with the courts’ interpretation of the rights-based legislation and the lack of statutory safeguards for them. The invoking of habeas corpus for voluntary patients is the only method open to them to protect against deprivation of liberty and this can often depend on the capacity of the person and their ability to invoke the procedure. The attitude of the judiciary is paramount to ensuring that the legislation that is apparently that of a ‘rights based’ model is endorsed and ensures that those rights granted are respected.

The lack of capacity legislation in Ireland raises concern with regard to compliance with Article 12 of the Convention on the Rights of Persons with Disabilities. The current laws, contained in the Lunacy Regulations Ireland Act, 1871 are outdated, inappropriate and in need of urgent reform and yet the Government continue failing to produce the over promised legislation to the most vulnerable of our society.

Amnesty International has completed a review of the Mental Health Act, 2001 with the view to reform. Their views along with many respected academics are the foundation of the opinion expressed within ‘The Forgotten People’ that attempts to highlight the urgent need to respect the rights based approach to the legislation by the courts, the gaping hole that the lack of forthcoming capacity legislation forms along with the lack of conformity with European conventions. It is hoped that this paper will further highlight the plight of voluntary patients within Irish Mental Health Services and push the issuing of the capacity legislation that is well overdue, but stagnant.
THE FORGOTTEN PEOPLE.
The position of voluntary patients within the Irish mental health system and the absence of statutory safeguards to protect them against deprivation of liberty.

Introduction.

The **Mental Health Act, 2001** defines “voluntary patient” as “a person receiving care and treatment in an approved centre who is not the subject of an admission order or a renewal order”.¹ Throughout the remainder of the Act, the term “patient” is used to mean a patient detained in accordance with the Act and not a voluntary patient therefore none of the statutory safeguards applicable to patients as outlined in the Act are applicable to voluntary patients. This paper will look at the position of voluntary patients within the Irish Mental Health system by analysing their position both prior and post the **2001 Act**, and outline the absence of statutory safeguards available to them to protect against deprivation of liberty.

Analysis

Ireland’s **Mental Health Act, 2001** was fully implemented in 2006 and aimed to bring Irish legislation more in line with international standards such as the European Convention of Human Rights and United Nations Principles for the Protection for Persons with Mental Illness.²

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¹ **Mental Health Act, 2001** s. 2 (1) [hereinafter 2001 Act].
The 2001 Act replaced the Mental Treatment Act, 1945 with the most significant aspect being a shift in focus from the medical discretion model to more rights based approach. The reality of the situation, however, shows how few rights it bestows, and how little protection it provides, for the majority of service users in the Mental Health field.

The Position of Voluntary Patients

Voluntary patients represent 91.04% of admissions to psychiatric units, in 2009, of the 20,195 patients admitted for treatment, 18,562 of these were classed as voluntary. The statistics are mirrored when one examines first time admissions in so far as 91.6% of all first time admissions were voluntary patients and yet the legislation enacted to provide protection to one of the most vulnerable sectors of society does not count for the vast majority. The word “voluntary” is not defined within the 2001 Act and one might assume “that the person should have the mental capacity to agree to their treatment”, this is not always so. Counsel for the patient in the E.H. v Clinical Director of St.Vincent’s Hospital argued that the patients’ detention was unlawful as she lacked capacity to become a voluntary patient and that therefore, at no time, from December 10th to December 22nd 2008 , was she free to leave the premises. O’ Neill J, in the High Court found that the detention was

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3 Mental Treatment Act, 1945 [hereinafter 1945 Act].
4 Keys M., Mental Health Act 2001, Roundhall Sweet & Maxwell, Dublin, 2002 at 8 [hereinafter Keys].
6 Ibid. at 42.
7 Whelan D., Mental Health Law & Practice Civil and Criminal Aspects, Roundhall, Dublin, 2009 at 5-11 [hereinafter Whelan].
8 [2009]IEHC 69 [hereinafter EH].
indeed lawful relying on the broad scope of the definition of a “voluntary patient”. Kearns J, in the subsequent appeal to the Supreme Court, did not seem to express any concern over the “lack of capacity” issue as regards a patient who may be classed as voluntary “even though they may not have capacity to consent to their admission on a voluntary basis”. Wards of Court, “those who have mental illnesses, and those who do not have mental illness but are improperly placed in approved centres, are deprived of the procedures under the Act” as they fall into the voluntary category.

**Capacity**

The issue of capacity with regard to voluntary patients is one which raises concern on many levels. Article 12 of the Convention on the Rights of Persons with Disabilities protects the right to equal recognition before the law of all persons with disabilities. This requires “a legal framework to guarantee the right of people lacking capacity to participate to the fullest extent possible in decisions which concern them and the provision of assistance to enable them to do so” , thus protecting autonomy, one of the rights the 2001 Act claims to provide. However the E.H. case referred to the paternalistic nature of the legislation, and as such, the

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10 Whelan *supra* note 7 at 5-36.
11 National Disability Authority’s Submission to the Review of the Mental Health Act, 2001 <http://www.google.ie/search?gcx=w&sourceid=chrome&ie=UTF-8&q=National+Disability+Authority%E2%80%99s+Submission+to+the+Review+of+the+Mental+Health+Act%2C+2001#hl=en&sa=X&ei=HjPRTqPjCs7hAe2h_CwDQ&ved=0CBYQwUoAQQ&g=National+Disability+Authority+Submission+to+the+Review+of+the+Mental+Health+Act,+2001&spell=1&bav=on.2,or.r_gc.r_pw.,cf.osb&fp=ac2ba719342aae2b&biw=1366&bih=667>, (date accessed 15th November 2011)
12 Convention on the Rights of Persons with Disabilities [hereinafter CRPD].
14 2001 Act, s 4(3) In making a decision under this Act concerning the care or treatment of a person (including a decision to make an admission order in relation to a person) due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy.
autonomy of the patient does not appear to be high on the list of rights that the majority of patients appear to enjoy under the legislation. “The Supreme Court failed to acknowledge that the purpose of the legislation had changed with the introduction of the 2001 Act to one which was aimed at protecting and respecting the rights of people with mental disorders”.  

There is no guidance in the 2001 Act on how the issue of capacity is judged. However, it does explicitly outline the requirements for patients to be regarded as having consent for treatment. Dr. Brendan Kelly explains “the term ‘patient’ refers only to involuntary patients so the 2001 Act does not require informed consent of voluntary patients and does not even require that voluntary patients possess capacity”. This severe contrast shows the opposite ends of the continuum that patients within Mental Health Services in Ireland co-exist.

The current laws are contained in the 1871 Lunacy Regulations Ireland Act and are outdated, inappropriate and in need of urgent reform. Capacity legislation should be clear and accessible, should permit a coherent uniform legislative understanding of legal capacity to be put in place which would apply in all situations. It could seek to

17 2001 Act, s 56 (a) “Consent”, in relation to a treatment of a patient, means consent “obtained freely without threats or inducements, where the consultant psychiatrist responsible for the care and treatment of the patient is satisfied that the patient is capable of understanding the nature, purpose and likely effects of the proposed treatment and the consultant psychiatrist has given the patient adequate information, in a form and language that the patient can understand, on the nature, purpose and likely effects of the proposed treatment”.
18 Kelly, B.D., Mental health legislation and human rights in England, Wales and the republic of Ireland, IJLP 10.1016 09/10/2011 at 3.3.2 [hereinafter Kelly].
achieve an appropriate balance between autonomy and protection by promoting the interests of vulnerable adults and would also be an appropriate vehicle to deal with the consequences of a finding of lack of capacity.\textsuperscript{20} Unfortunately although much has been discussed regarding the issue of capacity it has, once again been returned to the Governments back boiler for later consideration, and although it is promised for publication late 2011, the promise has been left unfulfilled. Amnesty International Ireland recommends that the definition of a voluntary patient within the \textit{2001 Act} should be amended to include only those persons who have the capacity to make such a decision and who have genuinely consented to their admission to a psychiatric institution and continue to consent. Those “persons who have been declared to lack legal capacity to make medical decisions, and are considered to be in need of psychiatric detention, should be admitted to approved centres in a similar manner to involuntary patients under the Act with all the ensuing safeguards necessary to ensure their lawful detention under the Constitution and Article 5 of the ECHR”.\textsuperscript{21}

\textbf{Admission Procedure}

The admission of voluntary patients\textsuperscript{22} to an approved centre has altered considerably from provisions laid down in the \textit{1945 Act}. Then the definition of a “voluntary patient” included a provision “acting by his own accord…to submit himself voluntarily for

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\begin{itemize}
\item Amnesty International Ireland, Mental Health Act 2001: Review at 63. \hfill<http://www.amnesty.ie/sites/default/files/CHAPTER%203.pdf> (date accessed 20\textsuperscript{th} November 2011) [hereinafter Amnesty]
\item 2001 \textit{Act}, s 29.
\end{itemize}
treatment for illness of a mental or kindred nature” and there was a formal admission procedure. The requirement to fill an admission form has now disappeared, however, it is considered good administration practice to use an admission form for voluntary patients, similar to those used for entering a general hospital for medical procedures to include a consent provision. There is no requirement to inform the voluntary patient at the time of admission that they may only be denied the right to leave if they meet the conditions for involuntary care, therefore repercussions of not having a formal admission procedure for voluntary patients that is fully informed and patient centred, further denies the right to autonomy. To contrast this, an involuntary patient is entitled to a clinical examination within 24 hours of the admission order application being made, and a second opinion within 21 days. The involuntary patient is also entitled to receive information regarding the availability of legal representation, a guide as to the proposed treatment for the duration of their treatment, which will be stated, their right to communicate with the Inspector and that their detention will be reviewed by a Tribunal. They are also to be informed that they are entitled to be admitted as a voluntary patient, which if they chose, will negate the statutory safeguards granted to them by their status as an involuntary patient.

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23 1945 Act, s 3 “Voluntary patient” means a person who acting by himself or in the case of a person less than 16 years of age, by his parent or guardian, submits himself voluntarily for treatment for an illness of a mental or kindred nature.

24 Mental Health Commission, Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre (2009), at 22.2.

25 Kelly, supra note 18 at 4.

26 2001 Act, s 14.

27 2001 Act, s 15.

28 2001 Act, s 16.

29 2001 Act, s 18.

30 2001 Act, s 16.
**Deprivation of Liberty**

Voluntary patients are not at liberty to leave when they wish. “The legislation specifies that where a voluntary patient (including an incapacitated, non-protesting patient) indicates a wish to leave, he or she must be assessed to see if criteria for involuntary detention are met.”

The assessment has to take place within a 24 hour time period, before formal detention can take place. While this may seem an improvement on the provisions of the 1945 Act, where the detention period in such a case was 72 hours, it defies the ordinary meaning of the word “voluntary” and surely defines deprivation of liberty thus breaching Article 5 of the European Convention on Human Rights, and thereby re-enforcing the argument for a definition of the term “voluntary”.

While there is a requirement to inform the Mental Health Commission each time a re-categorisation from voluntary to involuntary patient occurs under section 24 there is no such requirement of account where the holding power under section 23 is invoked and the individual is not subsequently detained under section 24. It is recommended by Amnesty that this accounting deficit be rectified and that each time section 23 is invoked it is to be reported to the Mental Health Commission.

The procedure of re-categorisation of the patient was tested in *Q (J) v The Governor of St. Patrick’s Hospital and Others* where following a voluntary admission the consultant psychiatrist felt that the patient should be admitted involuntarily in order to

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31 Kelly, *supra* note 18.
32 2001 Act s. 23(1).
33 2001 Act s 24.
34 European Convention on Human rights[hereinafter ECHR]
35 Amnesty, *supra* note 21 at 66.
36 *Ibid.* at 68.
provide treatment. Since the applicant did not indicate a wish to leave, the treating psychiatrist did not feel he could invoke section 23 but did invoke section 24 and detained her. 38 O’Higgins J did not accept that this was merely a procedural error as in order to be detained under section 24 one had to be in section 23 detention. While he felt that the result may be desirable and the right outcome “the law cannot be bent so far by virtue of purposive interpretation as to do violence to the words of the Act itself”. 39 The principle consequence that arose from O Higgins J judgment and exposed a “lacuna in the 2001 Act, namely the Act does not expressly provide for a person who is admitted to an approved centre, who thereafter refuses treatment whilst not indicating that they wish to leave, but nonetheless satisfy the criteria for involuntary admission” 40 and therefore cannot be detained pursuant to the 2001 Act.

HL v United Kingdom 41 highlights the issue, the case involved the informal (voluntary) admission under English Mental Health Act 1983 of a young man with autism. His foster family were prevented from seeing him and took legal action on the grounds he was not free to meet them or leave hospital. The European Court of Human Rights (ECtHR) held there was a breach of Article 5 of the Convention, which protects against the arbitrary deprivation of liberty, in that there was a deprivation of liberty as the staff had complete and effective control over his care and movements. 42 It further found that where admission to a psychiatric facility constituted a ‘deprivation of liberty’, the absence of a formal admission mechanism for incapable patients was a breach of the individual’s right to liberty as protected by

38 Ibid.
39 Ibid. at 105.
40 Ibid. at 108.
41 [2004] ECHR 45508/99 [hereinafter Bournewood]
42 Donnelly, M, Treatment for Mental Disorders and Protection of Patients’ Rights, Mental Health and Human Rights Seminar Centre for Criminal Justice and Human Rights, Law Faculty, University College Cork, 25 October 2007 at 8.
Article 5 of the ECHR. This was the case even if the person was compliant and did not resist admission and was thereby ‘voluntary’. 43

In order to rectify the current situation within Ireland, Amnesty recommends an express provision to provide voluntary patients with adequate and accessible information regarding their rights. This provision should be introduced on a statutory footing. The information should include their rights regarding discharge, consent to and refusal of treatment along with information on seclusion and restraint and complaints. 44

**Habeas Corpus**

The Irish Constitution contains a guarantee to vindicate citizens’ right to liberty and states that no person shall be deprived of their liberty except in accordance with law. 45 The method of challenging detention as an unlawful detention is through a *habeas corpus* application. 46 This should induce a speedy inquiry as to the legality of the detention and the detained person is to be released on foot of a finding of illegal deprivation of liberty. There are two problems with the *habeas corpus* application in Ireland which call into question its adequacy. “First, the decision of the Supreme Court in *Croke v Smith (No2)* 47 weakened *habeas corpus* as a protection against unlawful depravation of liberty in context of persons with a mental disorder, and second, *habeas corpus* is not practically available to incapable compliant because it

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43 *Ibid.* at 10

44 Amnesty, *supra* note 21 at 69.

45 *Bunreacht na hEireann* 40.4.

46 *Ibid.* 40.4.2-5.

47 [1998] 1 IR 101[hereinafter *Croke*].
is necessary to initiate proceedings”\textsuperscript{48} The \textit{Croke} case involved an application challenging section 172 of the \textit{1945 Act} which allowed for indefinite detention without any automatic review of persons of unsound mind. While the \textit{2001 Act} has removed the possibility of a challenge like this appearing for involuntary patients, the 91\% majority of patients that are the voluntary patients still fall into this category.

While the original High Court case regarding \textit{Croke v Smith}\textsuperscript{49} was enlightening for its time engaging with Article 5 ECHR it, however, adopted a paternalistic nature to the legislation and yet noted the gaps in the mandatory information to be provided to patients and realising the importance of the patient fully understanding the \textit{habeas corpus} application procedure in order to induce it. Budd J further realised that due to capacity, or lack of it, there were severe practical restrictions placed upon the patients.\textsuperscript{50} He referred the question of the validity of section 172 to the Supreme Court by way of case stated.

The Supreme Court had a totally different take on the issue. They did not refer to Article 5 of the ECHR nor did they discuss the acknowledgement of the Irish legislature for the need to reform mental health law in order to comply with the ECHR. They spoke at length about the presumption of Constitutionality, found section 172 to be valid and therefore would be applied using the principles of constitutional justice.\textsuperscript{51} The \textit{habeas corpus} application of \textit{Croke} failed at a time where there were no statutory safeguards in place for automatic periodic review for involuntary patients, so it could be held true that the voluntary patients today face the

\textsuperscript{48} Murray, C, \textit{Safeguarding the right to liberty of incapable compliant patients with a mental disorder in Ireland}, (2007) 14 (1) DULJ at 4 [hereinafter Murray].
\textsuperscript{49} (31 July 1995, unreported), High Court.
\textsuperscript{50} Ibid. at 119.
\textsuperscript{51} Murray, \textit{supra} note 48 at 6.
same regime and lack of safeguards that will place them at the same level as patients under the 1945 Act.

As stated above, the second issue that *habeas corpus* faces is the reality of a patient realising that *habeas corpus* is available to them and having the capacity to invoke it. For incapable compliant patients they have to be aware that the mechanism is available. The application then has to be taken by a next friend and they also require legal representation, all of which provide huge hurdles to some of societies most vulnerable.

*Bournewood* was called on in the *EH* case in *habeas corpus* proceedings as the ECtHR "reiterated that the right to liberty is too important in a democratic society for a person to lose the benefit of Convention protection for the single reason that they may have given themselves up to be taken into detention, especially when it is not disputed that the person is legally incapable of consenting to, or disagreeing with, the proposed action."  

Even though the ECtHR had found the UK in breach of Article 5(1) and Article 5(4) of the ECHR, the Irish Supreme Court still maintained the paternalistic view of the 2001 Act and found no grounds that deprivation of liberty existed. It is recommended by Amnesty International Ireland that steps be taken by the Legislature to remedy the current situation. The definition of voluntary patient within the 2001 Act, should include those only with legal capacity to make such a decision who genuinely consent to their admission to a psychiatric institution and provision for continued consent should also be present. Should capacity not be present, then the patient

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52 Ibid. at 14.
53 *Bournewood*, supra note 41 at 90.
should be admitted along the formal lines of the 2001 Act thereby being safeguarded by the procedures as laid down in the 2001 Act.\textsuperscript{54}

**Looking Forward**

The *Vision for Change* document is a report of the expert group on Mental Health Policy which was published in 2006. It recommends a multi-disciplinary approach to addressing the factors that contribute toward mental health issues. It recommends that there is a passing from institutional treatment to a more community based recovery approach “so service users learn to understand and cope with their mental health difficulties and build on their inherent strengths”.\textsuperscript{55} This would place voluntary patients in a situation where their right to autonomy would be respected and Ireland would begin to be compliant with ECHR and United Nations Principles for the Protection for Persons with Mental Illness. The proposed implementation deadline for the recommendations within a *Vision For Change* is 2012 however this looks unachievable. The director of Mental Health Reform, Orla Barry, called on TDs to ensure the implementation of the Government’s mental health policy, “TDs are clearly aware that mental health issues are best treated within the community and recognise that this is not yet happening”.\textsuperscript{56} However proposed cuts in the approaching budget could jeopardise the modernisation of Mental Health Services in Ireland.\textsuperscript{57}

\textsuperscript{54} Amnesty, *supra* note 21.
\textsuperscript{56} <http://www.irishtimes.com/newspaper/health/2011/1122/1224307943239.html> (date accessed 26\textsuperscript{th} November 2011)
\textsuperscript{57} Mental Health Reform, Promoting Improved Mental Health Services, <http://www.mentalhealthreform.ie/uncategorized/cuts-to-mental-health-will-lead-to-system-collapse/> (date accessed 16\textsuperscript{th} November 2011) [hereinafter MHR].
Conclusion

While the law still promotes voluntary admission and treatment as a preferred alternative to involuntary admission and treatment it does so providing none of the statutory safeguards or rights the 2001 Act was designed to implement for the majority of patients.\textsuperscript{58} The Act explicitly outlines the requirements for involuntary patients to be regarded as having capacity but it does not outline similar requirements for voluntary patients. Indeed, the legislation does not even require that voluntary patients possess capacity in order to be voluntary patients in the first instance. Perhaps capacity legislation, long-promised, but now gone back to consultation will help compliance with Article 12 of Convention on the Rights of Persons with Disabilities.

The 2001 Act, while conferring rights on patients within the mental health services of Ireland has only granted them to a minority and voluntary patients are left in a position where little or no statutory safeguards.

While the 2001 Act may have impacted on mental healthcare in Ireland with its ‘rights based approach’, the legislators need to ensure that there are statutory safeguards granted to all ‘patients’, voluntary and involuntary, with and without capacity, in order to ensure that deprivation of liberty is avoided. The Government too must ensure funding for Mental Health Services as without resources being made available to Mental Health Services it is in danger of collapsing.\textsuperscript{59}

\textsuperscript{58} Kelly, supra note 18 at 4.
\textsuperscript{59} MHR, supra note 55.
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