

COMPULSORY DETENTION AND THE GENERAL PRACTITIONER IN IRISH MENTAL HEALTH LAW: ARMOUR OR WEAPON IN WRONGFUL COMMITTALS?

Faye Boland, Lecturer in Law, University of Liverpool¹

INTRODUCTION

Wrongful committal of spouses and family members has received a considerable amount of media attention in the nineteen nineties.² Marital breakdown has provided a backdrop for many of these publicised wrongful involuntary committals.³ More recently, public controversy has focused on appalling conditions and treatment regimes in many public psychiatric hospitals⁴, which many of the victims of wrongful committal have had to endure. However, the consequences of wrongful confinement in a psychiatric hospital are considerably more far-reaching than this. As stated in the debates preceding the Mental Treatment Act 1953, “a mere committal, even for a matter of 10 minutes might have the most serious results”.⁵ Firstly, the fact that the victims of wrongful committal have been on medication, has been used against them to suggest unreliability as regards custody of children or management of property.⁶ Secondly, committal can lead to many social inequalities such as difficulty obtaining insurance, assurance, a passport, visa⁷ and driving licence.⁸ Furthermore, hospitalisation as a psychiatric patient can attract considerable social stigma. As noted by Murphy *et al.*:⁹

“In the eyes of the general public a person becomes mentally ill only when he or she enters a psychiatric hospital. The label once given tends to stick. Once behaviour has been given the

¹ I would like to thank Dr V Boland, Ms S Boland and Dr N Glover for commenting on an earlier draft of this article.

² *RTE Guide* 10 April 1992 6, *Woman's Way* 17 July 1992 18, *Irish Press* 5 May 1992.

³ Cf: Boland and Laing, “Out of Sight and Out of Mind? A Feminist Perspective on Civil Commitment in Britain and Ireland” [1999/2000] *CIL* 257.

⁴ V. Browne, “Unanswered Questions on Mental Institutions” *Irish Times* 1 Dec 1999; V. Browne, “Prisoner and Patient Abuse that Shames the Doctors” *Irish Times* 15 Dec 1999; V. Browne, “Scandal in our Mental Hospitals is Revealed” *Irish Times* 10 Nov 1999; Cf: Boland and Laing, “Care, Coercion or Control? Women in the Mental Health System in Ireland, England & Wales” in Morris and Nott (Eds), *The Gendered Nature of Access to Health Care* (forthcoming, 2002).

⁵ Major DeValera Dail debates on the Mental Treatment Act 1953 Vol 143 Col 2468.

⁶ *The Examiner* 23 Jan 1997.

⁷ *Irish Press* 5 May 1992.

⁸ *Woman's Way* 17 Jul 1992.

⁹ Murphy *et al.*, “Attitudes Towards the Mentally Ill in Ireland” (1993) 10 *Ir J Psychol Med* 75 at 75. Cf: Barry, “Community Perceptions of Mental Disorder: An Irish Perspective” (1994) 15 *Ir J Psychol* 418 at 428 and 440.

mental illness label there tends to be a rejection of the person so labelled, while the general public is quite tolerant of unlabelled mental illness”.

The prevalence of wrongful committals is suggested by Mr Alan Shatter’s recent observation in the Dail:¹⁰

“As a lawyer who has practised in the area of family law for 25 years, I have had the experience in custody disputes between spouses over children where one or other falsely alleged that the spouse with whom they are in dispute is suffering from a psychiatric illness and should be detained in a psychiatric hospital. I have experience where husbands – it seems to be primarily something husbands do – have asked their GPs to have their wives committed under the Mental Treatment Acts. Some cases have gone to court where wives alleged they were wrongly admitted as involuntary patients at the behest of husbands approaching GPs who were unaware of the marital situation and who are led to believe they were acting properly in supporting such an application under the Mental Treatment Acts. This is not unusual because every year I would have two or three family law disputes going through my law firm where this type of difficulty arises and false allegations of psychiatric illness are made.”

A requirement of medical certification was introduced into the committal process in 1867¹¹ and by 1992, 90% of medical recommendations for involuntary civil committal under the 1945 Act were provided by a General Practitioner.¹² Carey *et al*’s survey of compulsory admissions to the Cavan/Monaghan psychiatric service found that, prior to certification, 79% of applicants first contacted their General Practitioner.¹³ Due to the prominent role of the General Practitioner in involuntary committals to psychiatric hospitals, the writer wishes to highlight particular areas of concern at their point of involvement. Although wrongful committals have faded from the public limelight, the danger of their occurrence remains of real concern. This is due to the broad detention criteria and lax commitment procedures under the Mental Treatment Act 1945 (the 1945 Act), the current legislation governing involuntary committal. These will be discussed further *below*. Additionally, the 1945 Act fails to define certain key terms and has no accompanying Code of Practice for the guidance of those who have to operate the machinery of compulsory committal. This provides considerable scope for subjective decision-making and unequal application of the detaining legislation. It is therefore also hoped that this article will alert General Practitioners, who are seen by the public as the first point of contact

¹⁰ Dail debates on the Mental Health Bill 1999 Vol 517 Cols 1010-1011.

¹¹ Finnane, *Law and the Social Uses of the Asylum in Nineteenth-Century Ireland* in Tomlinson and Carrier (eds), *Asylum in the Community* (1996), p 95.

¹² White Paper *A New Mental Health Act* Pn.1824 (1995), at 35 Cf: Gibbons *et al* “Committal Procedures in Ireland” (1992) 85 *IMJ* 91.

¹³ Carey *et al*, “Involuntary Admissions to a new District Mental Health Service - Implications for a new Mental Treatment Act” (1993) 10 *Ir J Psychol Med* 139 at 142.

in cases of mental disorder,¹⁴ to the continuing danger of wrongful committals. The Mental Health Act 2001 (the 2001 Act) will replace the current legislation governing compulsory detention but the requisite ministerial orders bringing its provisions into force have not yet been signed.¹⁵ The new provisions will then be examined, with a view to ascertaining the extent to which the 2001 Act will safeguard against wrongful committals.

The Law

(a) The Certification Process

Under the 1945 Act detained patients are divided into two categories: temporary and persons of unsound mind. Different procedures apply to these patients and within each category different procedures may again apply, depending on whether the patient is a chargeable or a private patient. Applications under the 1945 Act are normally made by a spouse or relative¹⁶ who must be 21 years of age or over.¹⁷ In respect of an application for a temporary patient reception order, the relative's application will be made to the person in charge of the hospital and must be accompanied by a medical recommendation from a registered medical practitioner to the effect that, following examination, in his/her opinion the patient is suffering from a mental illness requiring not more than six months treatment for recovery and on account of his/her mental state is unsuitable for treatment as a voluntary patient or is an addict who requires at least six months preventive and curative treatment for recovery.¹⁸ Alternatively the relative will obtain a medical recommendation, following examination, to the effect that the patient is a person of unsound mind who requires care and treatment and is unlikely to recover within six months.¹⁹

The 1945 Act's failure to define an examination has been described as "the first weak link in a chain of events that can lead to casual involuntary committal. . . [a] loophole [that] has been exploited by unscrupulous spouses and relatives for years".²⁰ What constitutes an examination varies from case to case, and the most cursory of meetings can fulfil the legal requirement.²¹

¹⁴ Barry, *op cit* n 9 at 436 and 440.

¹⁵ Private Communication with the Department of Health and Children 13 Sept 2001.

¹⁶ White Paper *A New Mental Health Act op cit* n 12 at para 3.2 An application for admission may also be made by a community welfare officer, or, in certain circumstances any interested person. Relative is defined to exclude in-laws.

¹⁷ Mental Treatment Act 1945 s184 (3A) (as inserted by the Mental Treatment Act 1961 s16(1)) and s185(3A) (as inserted by the Mental Treatment Act 1961 s17(1)) (temporary private patients); Mental Treatment Act 1945 s162(4) (persons of unsound mind) and s177(5) (persons of unsound mind, private).

¹⁸ Mental Treatment Act 1945 s184(4). Cf: Mental Treatment Act 1945 s185(5) (temporary private patients).

¹⁹ Mental Treatment Act 1945 s163(2)(b). Cf: Mental Treatment Act 1945 s178(2)(b) (persons of unsound mind, private).

²⁰ O'Shea, "Some Thoughts on the Law Relating to the Admission Procedures to Psychiatric Hospitals in the Republic of Ireland Today" (1993) *Dli* 77 at 78-79 quoting Keating "Psychiatric Committal Examinations Leave System Open to Abuse" *Irish Times* 2 Jan 1992.

²¹ *Ibid*, p 78.

At a minimum one would expect some communication between the doctor and patient and reasonable proximity between them.²² Yet in *O'Reilly v Moroney*,²³ a majority of the Supreme Court held that a Doctor had properly examined the patient by observing her outburst of hysteria and violence towards her husband from a distance of twelve to fifteen yards. The doctor was not the appellant's General Practitioner, and did not know the name of her General Practitioner but had been told that the appellant had threatened to commit suicide. (The *O'Reilly* case was subsequently taken before the European Court of Human Rights and deemed admissible by the Commission²⁴ but in February 1997 a friendly settlement was reached with the Irish Government and O'Reilly received an award of £14,000 damages).²⁵

It is not necessary to examine a temporary patient on admission to hospital, merely that the admitting doctor consider the application and the certificate.²⁶ (Fortunately a person of unsound mind must be examined on arrival).²⁷ This places a heavy burden on the medical practitioner making the recommendation for a temporary patient reception order, to carry out as thorough an examination as possible.²⁸ Furthermore, any hint of spousal disharmony between the applicant and patient should lead to increased caution on the part of the General Practitioner.²⁹ However judicial pronouncements have not always suggested the need for increased vigilance by the General Practitioner in these circumstances. Thus, in *Murphy v Greene*³⁰ McCarthy J. noted that:

“when a medical practitioner is called on to deal with a situation such as existed on the night in question, the law does not require a standard of precision such as might be appropriate to other aspects of medical practice” and that “[t]he standard of reasonable care under the Act may be quite different from such standard in ordinary medical practice.”

Another major shortcoming of the 1945 Act is its failure to define mental illness/unsound mind. The result of this is that “the Act leaves the psychiatrist [and general practitioner] to apply his own subjective criteria as to who should and should not be confined”.³¹ This failure, coupled with the absence of a Code of Practice for the guidance of those who operate the machinery of compulsory committal, can lead to an inconsistent application of the detaining legislation. Fortunately, the 2001 Act will promote

²² O'Neill, “*O'Reilly v Moroney and the Mid Western Health Board*; Highlighting the Case for Mental Health Law Reform” (1994) 12 *ILT* at 211.

²³ [1992] 2 IR 145.

²⁴ *O'R v Ireland* Eur Comm of Human Rights No.241 96 1994.

²⁵ Keys, “Mental Treatment Legislation: Are the White Paper Proposals Adequate?” (1998) *Dli* 51 at 52.

²⁶ Mental Treatment Act 1945 s184(5) (temporary chargeable patients) and s185(6) (temporary private patients).

²⁷ Mental Treatment Act 1945 s171(1) (persons of unsound mind, chargeable).

²⁸ Keys, *op cit* n 25 at 52.

²⁹ Spellman, “Certifying Under the Mental Treatment Act 1945; Pitfalls for General Practitioners” (1996) 6 *MLJI* 60 at 61.

³⁰ [1990] IR 566, [1991] *ILRM* 404.

³¹ Tom Cooney, Chairman of the Irish Council for Civil Liberties, quoted by *The Irish Press* 19 Sept 1986.

consistency by providing a definition of mental disorder,³² which will significantly narrow the criteria for detention. This will be discussed further *below*.

The time limits imposed by the 1945 Act are exceedingly complex and allow the possibility of abuse by unscrupulous relatives. In the case of a temporary patient reception order, the medical examination must have taken place no earlier than seven days before the date of the application,³³ while the medical examination must be carried out within 24 hours of receipt of the application in the case of persons of unsound mind (chargeable).³⁴ This may lead to wrongful committals as an illness may be sporadic or episodic and may have subsided since the patient was examined.³⁵ Even more alarming is the absence of a time limit between the examination and recommendation/private patient reception order in the case of persons of unsound mind. This gives rise to the possibility that a doctor might receive an application within 24 hours of having examined the patient but might not sign the medical recommendation for some time afterwards. Furthermore, the parties have another 7 days following the making of the medical recommendation/private patient reception order in which to convey a person of unsound mind to hospital.³⁶

The danger for temporary patients inherent in the absence of a time limit between the examination and the medical recommendation is lessened to some extent by the provision of a time limit of 7 days between the medical examination and conveying the patient to hospital.³⁷ Where a temporary patient reception order has been made by a medical officer of the hospital on the basis of the application and medical certificate, the applicant or any person authorised by him has seven days from the date *on which the order was made* in which to convey the patient to the institution named in the order.³⁸

In *Bailey v Gallagher*³⁹ the patient was removed from his house by the Gardai and taken to a Garda station on the basis of a medical certificate that had been issued 9 days earlier. When the certifying doctor was contacted by the defendant's solicitor he failed to order the patient's immediate release. Keane J. held that the defendant doctor should have averted to the fact that the medical certificate was spent and that there was no lawful justification for the removal of the plaintiff to the garda station. He added:

“It was at least arguable that the defendant was bound to ascertain whether the certificate upon which the detention was based was still in force. It was reasonable to expect that the

³² Mental Health Act 2001 s3(1).

³³ Mental Treatment Act 1945 s184(4) and s185(5) (private patients).

³⁴ Mental Treatment Act 1945 s163(1)(a) as amended by s7(1) of the Mental Treatment Act 1961.

³⁵ Boland and Laing, “Out of Sight and Out of Mind? A Feminist Perspective on Civil Commitment in Britain and Ireland” *op cit* n 3 at 262-263.

³⁶ Mental Treatment Act, 1945 s167(2) (persons of unsound mind, chargeable) and s181(3) (persons of unsound mind, private).

³⁷ Mental Treatment Act 1953 s5(1)(a) (temporary patients chargeable and private).

³⁸ Mental Treatment Act 1945 s186(1)(a).

³⁹ [1996] 2 ILRM 433.

defendant would be alive to the legal consequences and it could be fairly contended that a doctor should be aware, if only in the most general terms, of the strict requirements that must be met before citizens can be deprived of their liberty under the Mental Treatment Act 1945.”

Spellman considers that this onus is too high, as General Practitioners do not possess the same level of expertise, resources and time as hospital-based clinicians do.⁴⁰ Furthermore, once the medical certificate is completed by the doctor s/he appears *functus officio* so why should s/he have responsibility for the applicant’s actions in seeking to proceed with a spent application?⁴¹ However, a knowledge of mental health law on the part of General Practitioners would undoubtedly be a step in the right direction towards preventing wrongful committals⁴² (there will, of course, always be occasions where legislative requirements are not strictly observed by those who deal with them in practice). If General Practitioners are not aware of the legislative safeguards against wrongful committal then it may well be unrealistic to expect relatives to observe them.

The Government has recognised the importance of General Practitioners recommending involuntary admission being fully familiar with new mental health legislation and has also been cognisant of the need for health boards to organise training programmes for General Practitioners on the implications for them of new legislation, before it comes into operation.⁴³ The judiciary also appears to have acquired such an expectation of General Practitioners in recent years. As noted *above*, in *Bailey v Gallagher*⁴⁴ Keane J. was of the view that “a doctor should be aware, if only in the most general terms, of the strict requirements that must be met before citizens can be deprived of their liberty under the Mental Treatment Act 1945” while in *SC v Smith and Others*⁴⁵ the Supreme Court went further, requiring a knowledge of constitutional as well as mental health law on the General Practitioner’s part.

Another matter of concern is the common practice⁴⁶ of filling out both temporary forms and person of unsound mind forms. Carey *et al* found 5% of patients surveyed presenting with both a temporary form and a person of unsound mind form.⁴⁷ This occurred in areas where Garda Superintendents insisted on completed person of unsound mind forms before Garda escorts

⁴⁰ Spellman, “S260 of the Mental Treatment Act 1945 Reviewed” (1996) 2 *MLJI* 20 at 23.

⁴¹ Spellman, “Certifying Under the Mental Treatment Act 1945; Pitfalls for General Practitioners” *op cit* n 29 at 61.

⁴² Cf. Carey *et al*, *op cit* n 13 at 143.

⁴³ White Paper *A New Mental Health Act Pn 1824 op cit* n 12 at 36 para 3.18.

⁴⁴ *Supra* n 39.

⁴⁵ 272/95 (Transcript) 31 July 1996.

⁴⁶ Keys, *op cit* n 25 at 51 says that “Often in these circumstances both forms are filled out, the P.U.M. procedure to procure the escort and the Temporary one to establish the status of the patient on arrival at the hospital. There is a requirement on the committal form that the P.U.M. admission be used where the patient is not suitable for treatment as either a Temporary or a Voluntary patient, so the practice of using both is questionable”.

⁴⁷ Carey *et al*, *op cit* n 13 at 141.

would be provided.⁴⁸ This gives rise to the obvious danger that an individual who needs no more than six months treatment as a temporary patient will be detained indefinitely⁴⁹ as a person of unsound mind.

(b) The Relative's Involvement

Another serious deficiency in the 1945 Act which facilitates wrongful committals, is the absence of a requirement that the General Practitioner providing the medical recommendation should know the patient or the applicant.⁵⁰ Hence committal by *locum* General Practitioners is possible and a clear danger exists that unscrupulous relatives may make an application for involuntary committal while the patient's General Practitioner is away. Of particular concern is Gibbons *et al's* survey of temporary admissions to St.Brendan's Hospital, which found that amongst General Practitioner committals (80%), most were locum General Practitioners.⁵¹ In crisis situations it is likely that a General Practitioner who knows the patient well will be in a better position to defuse the situation without resorting to involuntary admission.⁵² This could involve persuading the patient's family to abandon the idea of hospitalisation completely or persuading the patient to enter hospital voluntarily (where hospitalisation is necessary). The General Practitioner's ability to influence the attitudes of families towards patients has also been noted elsewhere.⁵³

Almost 90% of the total number (3,000) of compulsory admissions in Ireland in 1992 were instigated by a spouse or relative.⁵⁴ A clear danger of bias exists where the applicants are the recommending General Practitioner's patients⁵⁵ and is particularly acute where the General Practitioner is not acquainted with the patient. Where pressure is brought to bear on the General Practitioner by the applicant it may be even more difficult to maintain objectivity.⁵⁶ These dangers are illustrated by Carey *et al* who, while finding no evidence of "deliberate abuse" of the 1945 Act, have found indications of excessive and inappropriate recourse to certification by some relatives *and General Practitioners*.⁵⁷ They found a core group with repeated compulsory admissions during the study period and concluded that some relatives and General Practitioners may have a learned "certification response" as a way of dealing with difficult behaviour.⁵⁸ They were disturbed by their finding that a group of General Practitioners certified at a considerably higher rate than their colleagues.⁵⁹ English commentators have been similarly critical of General Practitioners for inappropriate referrals for

⁴⁸ *Ibid.*

⁴⁹ Mental Treatment Act 1945 s172(1)(chargeable) and s181(1)(b)(private).

⁵⁰ Keys, *op cit* n 25 at 51.

⁵¹ Gibbons *et al*, "Committal Procedures in Ireland" (1992) 85 *IMJ* 91 at 91.

⁵² *Ibid* p 92.

⁵³ "Mental Health Care in General Practice and Public Health" (1962) 6 *JIMA* 82 at 82.

⁵⁴ *Irish Times* 3 Aug 1995 Cf: Carey *et al*, *op cit* n 13 at 141.

⁵⁵ Boland and Laing, "Out of Sight and Out of Mind? A Feminist Perspective on Civil Commitment in Britain and Ireland" *op cit* n 3 at 264.

⁵⁶ *Ibid* .

⁵⁷ Carey *et al*, *op cit* n 13 at 139.

⁵⁸ *Ibid*, p 143.

⁵⁹ *Ibid*.

compulsory admission.⁶⁰ Bean attributed these inappropriate referrals to a poor knowledge of the mental health legislation⁶¹ and of psychiatry but also to a possible sudden improvement in the patient's condition by the time the psychiatrist arrived.⁶² Sheppard's survey of General Practitioner compared with other referrals for compulsory admission (i.e. by family, psychiatrists, other health professionals, police, social workers and others) has found that fewer General Practitioner referrals (43%) were subsequently compulsorily admitted than other referrals (66%),⁶³ suggesting that some English General Practitioners are "trigger happy" and that they are less able to distinguish between the need for treatment and the need for compulsory treatment.⁶⁴ In many cases General Practitioners may not have adequately explored the appropriateness of compulsion or the possibility of voluntary admission, despite having been in a better position to persuade the patient to enter hospital informally.⁶⁵ Evidence exists that social problems play a more important part in English General Practitioners' decisions to refer, compared with lay referrers, suggesting that, while aware of the negative elements of social problems, General Practitioners may often have underestimated the positive influence of social networks, either by persuading the patient to enter hospital, or providing sufficient support in the community.⁶⁶

As noted *above*, not too long ago the courts were less aware of the danger of wrongful committal by relatives. This is evident in Henchy J's observation in *O'Dowd v North Western Health Board*⁶⁷ that:

"The human psyche is so complex and concealed, human conduct so susceptible of different interpretations, clinical tests so apt to mislead, and the aetiology of certain types of mental illness so lacking in precision, that a psychiatrist or a doctor plying his psychiatric skills may be driven, in the absence of an opportunity of long term and close observation, to acting to some extent on second-hand information, particularly information supplied by someone who lives with, or who has been in close contact with the patient. This is particularly so when the doctor's services are called upon to determine a course of action based on a complaint of dangerously irrational behaviour. If he supplements his personal observation and clinical examination with *apparently* reliable information vouchsafed by persons who have had due opportunity to observe the patient's conduct and who do not *seem* to have an

⁶⁰ Bean, *Compulsory Admissions to Mental Hospitals* (1980), p 162; Sheppard, "General Practitioners' Referrals for Compulsory Admission Under the Mental Health Act, I: Comparison With Other GP Mental Health Referrals and II: the Process of Assessment" (1992) 16 *Psych Bull* 138 at 139 and 140.

⁶¹ Cf: Humphreys and Ryman, "Knowledge of Emergency Compulsory Detention Procedures among General Practitioners in Edinburgh: Sample Survey" (1996) 312 *BMJ* 1462; Humphreys, "Psychiatrists' Knowledge of Mental Health Legislation" (1999) *JMHL* 150.

⁶² Bean, *op cit* n 60.

⁶³ Sheppard, *op cit* n 60 at 140.

⁶⁴ *Ibid*, p 141.

⁶⁵ *Ibid*.

⁶⁶ *Ibid*.

⁶⁷ [1983] ILRM 186.

axe to grind, and if on the basis of that combination of insights he makes what transpires to be a wrong diagnosis or an unnecessary mode of treatment, he is not necessarily negligent".⁶⁸

However, during the 1990's, circumstances of marital disharmony have become a recurring theme in civil suits against Medical Practitioners and psychiatric institutions.⁶⁹ Thus the Government's 1992 Green Paper on Mental Health commented that:

"Considerable public concern has been expressed that current procedures, which emphasise the role of the spouse and relatives in initiating an application for detention, may encourage applications which have more to do with marital and family disharmony than with mental disorder".⁷⁰

The Supreme Court decision of *Bailey v Gallagher*,⁷¹ now alive to the danger of wrongful committal occurring in these circumstances, has recently urged that:

"This committal was taking place against a background of marital discord which indicated the need for even greater caution than the care which the law expects in every case of doctors exercising their far reaching powers under this legislation".

Thankfully it would appear that the psychiatric services have also become more cautious in relation to domestic committals,⁷² as has the Association of General Practitioners in relation to cases of marital discord.⁷³ It is to be hoped that this concern will be reflected in increased vigilance on the part of individual General Practitioners when applications for involuntary committal are made in circumstances of marital disharmony.

At present, some protection is provided for patients of unsound mind from unscrupulous relatives and relatives with whom tension exists, by the requirement that the medical recommendation contain a statement of the facts upon which the medical practitioner has formed his/her opinion that the person is a person of unsound mind, distinguishing facts observed by him/herself and facts communicated by others.⁷⁴ With increasing awareness of the danger of wrongful committal by family members, it is to be hoped that General Practitioners will become more wary of facts communicated by others. The Government's White Paper in 1995 would have extended this safeguard to all involuntary patients.⁷⁵ However, it is lamentable that the 2001 Act, discussed *below*, does not contain such a requirement.

⁶⁸ Emphasis supplied.

⁶⁹ Spellman, "S260 of the Mental Treatment Act 1945 Reviewed" *op cit* n 40 at 23.

⁷⁰ *Green Paper on Mental Health* Pl 8918 (1992), at 82 para 19.8.

⁷¹ [1996] ILRM 433.

⁷² Spellman, "S260 of the Mental Treatment Act 1945 Reviewed" *op cit* n 40 at 23.

⁷³ *Private Communication to General Practitioners*, August 1999.

⁷⁴ Mental Treatment Act 1945 s163(2)(c) (persons of unsound mind, chargeable) and s178(2)(d) (persons of unsound mind, private).

⁷⁵ White Paper *A New Mental Health Act* Pn 1824 *op cit* n 12 at para 3.19.

At present, the opinion of one General Practitioner will suffice in the case of a public patient although two General Practitioners must certify, following separate examinations, in the case of a private temporary patient.⁷⁶ (Two medical practitioners will make a reception order for a private person of unsound mind).⁷⁷ The effect of this system of “class lunacy”⁷⁸ is that poorer patients have less protection from wrongful committal.⁷⁹ Under the Health (Mental Services) Act 1981, which was never brought into force,⁸⁰ two doctors would have been required to certify that a patient needed to be detained for treatment. The Minister for Health reserved the right to designate an area or prescribe the circumstances by regulations in which one recommendation would be sufficient. However a majority of respondents to the Government’s Green Paper on Mental Health considered that the recommendation of one medical practitioner would be sufficient, owing to the practical difficulties involved in securing two medical recommendations.⁸¹ Furthermore, seriously ill patients would be put at a disadvantage in certain parts of the country, or during unsociable hours.⁸² Carey *et al* have suggested that a requirement of presenting mental abnormality and reasons why compulsory admission is essential “might be a more practical way of restricting excessive recourse by GPs to certification”.⁸³ This would at least encourage General Practitioners to question the appropriateness of compulsion and to consider alternatives to compulsory hospitalisation.

However in the case of a temporary chargeable patient the applicant has an obligation to inform him/her that s/he may obtain a second medical opinion.⁸⁴ The recent High Court decision of *Kiernan v Harris and Others*⁸⁵ demonstrates that this obligation will be taken seriously by the courts in a subsequent suit under the 1945 Act⁸⁶ for wrongful committal. If a second opinion is requested, the patient may not be conveyed to hospital unless the second opinion, in writing agrees with that expressed in the medical certificate.⁸⁷ However, in practice, the applicant is not likely to be informed of this legal obligation.⁸⁸ Furthermore, there is no onus on the General Practitioner to inform the patient of this right.⁸⁹

The 1945 Act, therefore, contains a number of defects which facilitate wrongful committals of family members. The judiciary has responded by

⁷⁶ Mental Treatment Act 1945 s185(4).

⁷⁷ Mental Treatment Act 1945 s178(1).

⁷⁸ Finnane, *op cit* n 11 at 102.

⁷⁹ Boland and Laing, “Out of Sight and Out of Mind? A Feminist Perspective on Civil Commitment in Britain and Ireland” *op cit* n 3 at 263.

⁸⁰ Green Paper on Mental Health *op cit* n 70 p 70.

⁸¹ White Paper A New Mental Health Act Pn 1824 *op cit* n 12 at para 3.16.

⁸² *Ibid.*

⁸³ Carey *et al*, *op cit* n 13 at 143.

⁸⁴ Mental Treatment Act 1953 s5(3)(a).

⁸⁵ *In Re the Mental Treatment Act 1945 and in Re Intended Proceedings: Kiernan v Harris and others* High Court Transcript 1996/43 1A

⁸⁶ Mental Treatment Act 1945 s260.

⁸⁷ Mental Treatment Act 1953 s5(3)(a).

⁸⁸ Spellman, “Certifying Under the Mental Treatment Act 1945; Pitfalls for GPs” *op cit* n 29 at 61

⁸⁹ *Ibid.* Cf: *Bailey v Gallagher* [1996] 2 ILRM 433.

placing the onus on the General Practitioner to be alert to the dangers that are prevalent in cases of marital discord and to be aware of the relevant mental health law. While a knowledge of the law would undoubtedly go a long way towards reducing the danger of wrongful committal, reform of the wide detention criteria and lax commitment procedures that prevail under the 1945 Act is crucial. It is, therefore, heartening to note the enactment of the Mental Health Act 2001, which will reform the law on involuntary civil commitment. The extent to which this Act will safeguard against wrongful committals will now be addressed.

Reform

The Mental Health Act 2001 (the 2001 Act) will streamline and harmonise the complicated admission procedures that currently prevail under the 1945 Act as well as the criteria for compulsory detention. The 2001 Act requires a registered medical practitioner to examine the patient within twenty four hours of receiving the application.⁹⁰ This compares favourably with the current requirement of seven days under the 1945 Act, in the case of a temporary patient.⁹¹ However no time limit is provided between the medical examination and the medical recommendation. The Government's 1995 White Paper proposed a time limit of 24 hours between the medical examination and subsequent medical recommendation⁹² and it is regrettable that the 2001 Act contains this omission. The 2001 Act appears to assume that the issuing of the medical recommendation will coincide in point of time with the relative's application but this might not occur in practice. In this way, the 2001 Act will continue to facilitate the committal of a patient whose illness has subsided since examination. This danger is made more acute by the fact that, under the 2001 Act, the medical recommendation shall remain in force for 7 days before expiring.⁹³ These requirements are a backward step in terms of preventing wrongful committals, as under the 1945 Act a temporary patient must be conveyed to hospital no later than 7 days after the date of the examination, whereas under the 2001 Act no time frame is provided between the examination and transfer to hospital.

The 2001 Act will also harmonise the admission procedures for public and private patients by requiring only one medical recommendation in either case. The medical practitioner must be satisfied that the patient is suffering from a mental disorder,⁹⁴ which is defined as⁹⁵ mental illness, severe dementia or significant intellectual disability where (a) because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons or (b)(i) because of the severity of the illness, disability or dementia, the judgement of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission and (ii) the reception,

⁹⁰ Mental Health Act 2001 s10(2).

⁹¹ Mental Treatment Act 1945 s184(4) and s185(5) (private patients).

⁹² White Paper A New Mental Health Act Pn.1824 *op cit* n 12 at para 3.19.

⁹³ Mental Health Act 2001 s10(5).

⁹⁴ Mental Health Act 2001 s10(1).

⁹⁵ Mental Health Act 2001 s3(1).

detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent. (Mental illness, severe dementia and significant intellectual disability are also defined in the 2001 Act).⁹⁶

By defining mental disorder, the 2001 Act will reduce the scope for subjective decision-making in the realm of involuntary commitment. The new legislative requirements additionally, focus on the need for compulsory hospitalisation, while simultaneously narrowing the detention criteria. The latter is also achieved by requiring severe dementia and significant intellectual disability, by introducing a treatability requirement and by excluding the personality disordered, socially deviant and addicts, including alcoholics, from the compulsory commitment regime.⁹⁷ The newly created Mental Health Commission will be required to issue guidelines in relation to these matters.⁹⁸ It is highly desirable that the Mental Health Commission's proposed Code of Practice⁹⁹ provide definitions on what constitutes personality disorder and social deviance, together with guidance on the interpretation of the new detention criteria, in order to promote consistency in the operation of the new legislation and in order to further reduce the excessive certification by some General Practitioners that has been noted elsewhere.¹⁰⁰ For these reasons, training should also be provided to General Practitioners on the operation of the new legislation. However, the 2001 Act contains no reference to such training¹⁰¹ and the importance of this should not be under-estimated.

The 2001 Act defines an examination as a personal examination carried out by a registered medical practitioner or a consultant psychiatrist of the process and content of thought, the mood and the behaviour of the person concerned¹⁰² and thus, will give women like Mrs O'Reilly the opportunity to have their version of the story heard. This safeguard is reinforced by section 4(2) of the 2001 Act which provides *inter alia* that where it is proposed to make a recommendation in respect of a person, the person shall, so far as is reasonably practicable, be notified of the proposal and be entitled to make representations in relation to it and before deciding the matter due consideration shall be given to any representations made. However the value of section 4(2) is negated by the provision¹⁰³ that the registered medical practitioner need not inform the person of the purpose of the examination if in his/her view the provision of such information might be prejudicial to the person's mental health, well-being or emotional condition.

Additionally, as noted *above*, the 2001 Act contains no requirement that the medical recommendation should state the facts upon which the General Practitioner has formed his/her opinion, distinguishing facts perceived by

⁹⁶ Mental Health Act 2001 s3(2).

⁹⁷ Mental Health Act 2001 s8(2).

⁹⁸ Mental Health Act 2001 s8(3).

⁹⁹ Mental Health Act 2001 s33(3)(e).

¹⁰⁰ Carey *et al*, *op cit* n 13 at 143.

¹⁰¹ Cf: Keys, "Guarded Welcome for Mental Health Bill 1999" (2000) *MLJ* 28 at 31.

¹⁰² Mental Health Act 2001 s2(1).

¹⁰³ Mental Health Act 2001 s10(2).

him/herself from facts communicated by others, as is currently required for persons of unsound mind.¹⁰⁴ Nor does the Act require that the doctor should be acquainted with the patient. These concerns at the General Practitioner's point of involvement are compounded by a number of other points at which the Government has lost sight of the danger of wrongful committal. Despite widening the scope of potential applicants,¹⁰⁵ separating spouses are not disqualified as spousal applicants.¹⁰⁶ As only separated spouses are disqualified as spousal applicants, wrongful committal of spouses in circumstances of marital disharmony will remain a real concern.¹⁰⁷ Furthermore, the 2001 Act increases the detaining hospital's holding power from 12 to 24 hours pending the making of an admission order,¹⁰⁸ thereby prolonging any unnecessary period of detention. Where treatment is perceived to be necessary it can now be administered over a longer time span, thereby reducing to a minimum the number of people who need to be detained for longer periods. However, the lengthened holding period may also increase the overall number of people involuntarily admitted to hospitals as, medical practitioners may be more inclined to recommend admission if the consequences of admission are thought to be limited.¹⁰⁹ An admission order shall remain in force for 21 days¹¹⁰ and although the 2001 Act provides for review of detention by an independent mental health tribunal,¹¹¹ this may occur up to 21 days after the admission order has been made,¹¹² a period which can be further extended.¹¹³ As on average, detained patients are released within 17 days,¹¹⁴ a detained patient might not have their detention reviewed until after their discharge.¹¹⁵ The proposed system of reviewing detention may, therefore, be of little comfort to a patient who has been wrongfully detained.

CONCLUSION

Following a number of civil suits arising out of the wrongful committal of spouses in circumstances of marital discord, the judiciary have stipulated that General Practitioners should know the law and have indicated a need for

¹⁰⁴ Mental Treatment Act 1945 s163(2)(c) (persons of unsound mind, chargeable) and s178(2)(d) (persons of unsound mind, private).

¹⁰⁵ Mental Health Act 2001 s9(2) lowers the age of applicants to 18 years and s2(1) defines a spouse to include a heterosexual cohabitee of not less than 3 years.

¹⁰⁶ Mental Health Act 2001 s9(8).

¹⁰⁷ Boland and Laing, "Out of Sight and Out of Mind? A Feminist Perspective on Civil Commitment in Britain and Ireland" *op cit* n 3 at 279.

¹⁰⁸ Mental Health Act 2001 s14(2).

¹⁰⁹ Department of Health *Green Paper on Mental Health* Pl.8918 *op cit* n 70 at para 20.4.

¹¹⁰ Mental Health Act 2001 s15(1).

¹¹¹ Mental Health Act 2001 s18(1). Cf: Boland and Laing, "Human Rights and Mental Health Law in Ireland, England and Wales: Challenging Compulsory Detention under Article 5 of the ECHR" *forthcoming* [2000/2001] *CIL*.

¹¹² Mental Health Act 2001 s18(2).

¹¹³ Mental Health Act 2001 s18(4).

¹¹⁴ *Irish Times* 28 Dec 2000.

¹¹⁵ de Vries, "The New Mental Health Bill – Failing to be Progressive" (1999) *MLJI* 19 at 24; Keys, "Guarded Welcome for Mental Health Bill 1999" *op cit* n 101 at 30; Webb *et al*, "Comments from an Adult Psychiatric Service on the Mental Health Bill 1999" (1999) *MLJI* 14 at 16.

greater caution in circumstances of marital disharmony. This approach has involved a shift in focus from the complexities of the 1945 Act, whose shortcomings have been discussed *above*, to the practitioners who have to operate the legislation. Section 260 of the 1945 Act affixes the plaintiff in a civil suit for wrongful committal with a very high standard of proof by requiring him/her to prove substantial grounds for the contention that the defendant acted in bad faith or without reasonable care, before being given leave to sue. No doubt the near impossibility of bringing a successful civil suit against a General Practitioner has led the judiciary to provide General Practitioners with deterrents against wrongful committal.

The vague nature of the Irish *parens patriae* model of civil commitment “leave[s] physicians open to the charge that some patients might be committed not with the aim of providing treatment, but because they have proved troublesome to their families or society”.¹¹⁶ However, the 1945 Act is, in many ways to blame for this. The defects in the 1945 Act which have facilitated wrongful committals include its failure to define the medical examination, mental illness and unsound mind; the absence of a requirement that the General Practitioner should be acquainted with the patient or applicant; the absence of a time limit between the medical examination and recommendation; and the permitted time span between the examination and application (temporary patients) and between the recommendation and hospitalisation (persons of unsound mind). Thankfully, the Mental Health Act 2001 holds the promise of some improvement. However, the 2001 Act also has a number of shortcomings and it is regrettable that further safeguards against wrongful committal remain necessary. These include reducing the permitted time frame between the medical recommendation and hospitalisation, providing a time limit between the medical recommendation and examination and a requirement that the medical recommendation distinguish between facts perceived by the General Practitioner and facts communicated by others. Induction for General Practitioners on the requirements of the new legislation and the publication of a Code of Practice providing guidance on the civil commitment criteria will also be necessary in order to safeguard against wrongful detention of family members. It is also desirable that the forms that will be used for the purpose of certification should require the General Practitioner to state the reasons why compulsory admission is essential in order to focus his/her mind on the necessity of compulsory hospitalisation.

The 2001 Act stipulates that in making a decision under the Act concerning the care or treatment of a person the best interests of the person shall be the principal consideration with due regard being given to the interests of other persons who may be at risk of serious harm if the decision is not made.¹¹⁷ The 2001 Act provides additionally, that in making a decision under the Act concerning the care or treatment of a person due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy.¹¹⁸ No mention is made of the patient’s right to liberty. Yet,

¹¹⁶ Gibbons and Walshe, “Committal law in Ireland” (1993) *Ir J Psychol Med* 104 at 105.

¹¹⁷ Mental Health Act 2001 s4(1).

¹¹⁸ Mental Health Act 2001 s4(3).

as noted by deVries, the certifying General Practitioner should at all times be mindful of the patient's right to liberty and should act in his/her best interests.¹¹⁹ This may necessitate a change in attitude on the part of some General Practitioners. Changes in attitude cannot be legislated for and this may prove to be the biggest challenge facing mental health law reformers. Professional education will, no doubt, lead to increased vigilance on the part of certifying General Practitioners and it is also hoped that this article will be of some value in achieving this goal.

Finally, it should be noted that the 2001 Act has legislated for a reduction in the civil standard of proof, requiring the plaintiff merely to show reasonable grounds for the contention that the person against whom the proceedings are to be brought acted in bad faith or without reasonable care, before being given leave to sue.¹²⁰ It may well be the increased likelihood of successful suits by patients for wrongful committal that will provide the greatest impetus towards safeguarding the liberty of the patient and preventing their wrongful committal.

¹¹⁹ deVries, *op cit* n 115 at 22.

¹²⁰ Mental Health Act 2001 s72(1).