The MHA 2001 from a Clinician's Perspective

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How MHA 2001 impacts on clinical practice

- "Picture Boy" for civil libertarianism?

OR

- "A watered down" 1945 MTA ?

MHA 2001-a huge leap forward

- improved protection for people admitted involuntarily for treatment of mental illness
- Provided for setting up of the MHC, drawing welcome attention to issues of policy and codes of practice
- Inspired by ECHR

Mental Health Tribunals

- Primarily serve as an independent review board to determine whether the patient is suffering from a mental disorder as defined in Section 3 MHA and to ensure they have been *legally* detained
- Occasionally to authorise transfer of a patient for specialist treatment in the CMH
- Ancillary functions-e.g. MHTS can also help the clinician to focus on treatment goals and a discharge plan.

Shortcomings

Review by the DOHC found that BOTH mental health service users and providers reported a range of difficulties with the new legislation

Some issues had been flagged *before* the "roll-out" of the Act

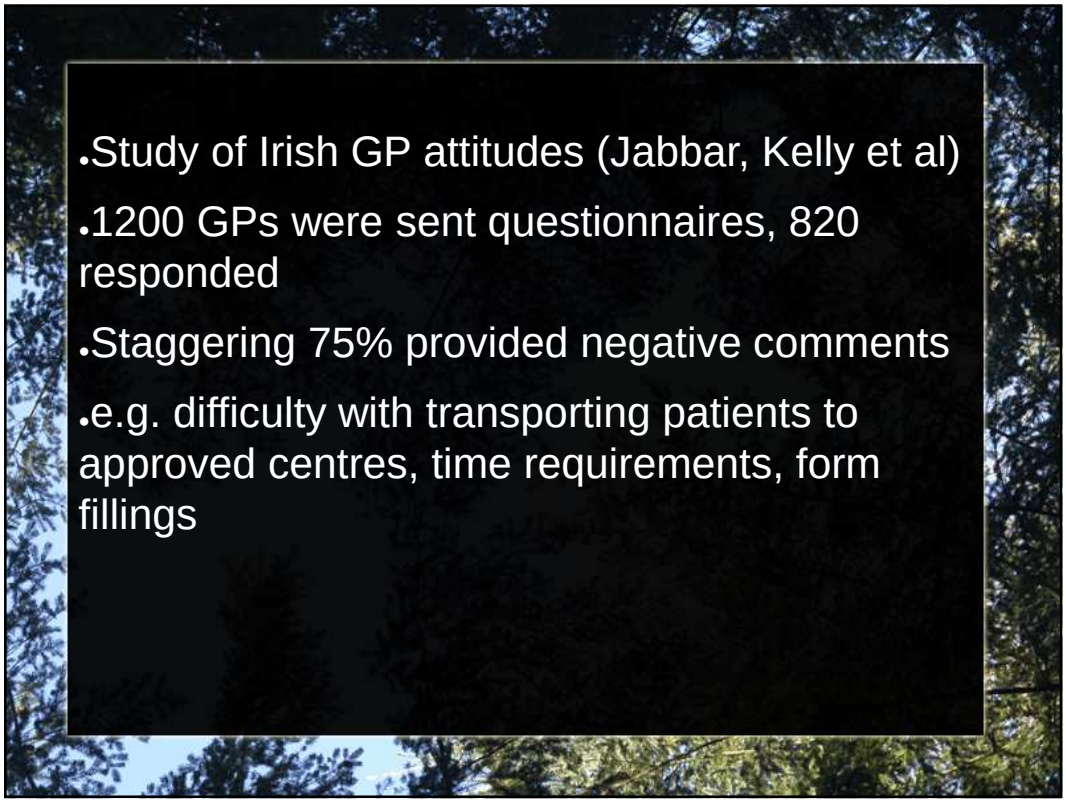
- Conduct of Tribunals-issue of process and setting rather than the Act itself
- Problems with the timing in the process-not getting a true picture of the clinical condition
- Adversarial nature -negative effect on therapeutic alliance
- "Side-lining" of voluntary patients because of excessive administrative workload associated with compliance.
- Insufficient resources to compensate for time spent on the tribunal process.

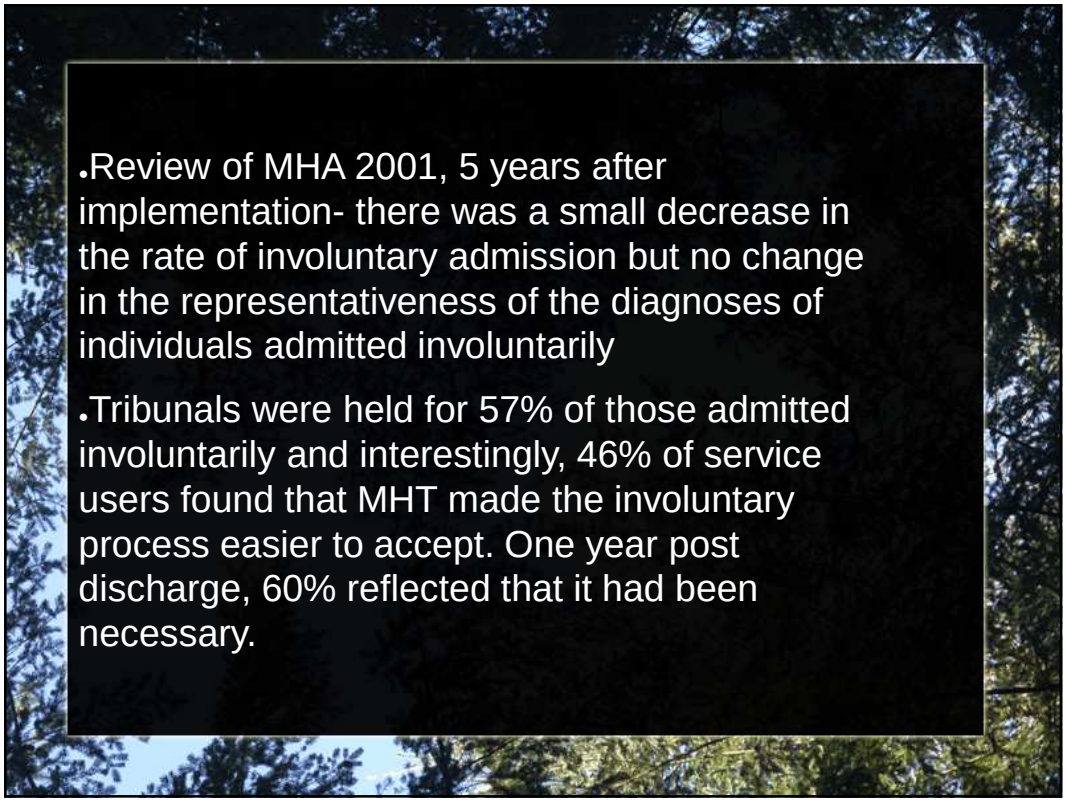
- College of Psychiatrists of Ireland said it was incompatible with recommendations made in
- VISION FOR CHANGE 2006

- Disruption to therapeutic activities at approved centres
- Administrative uncertainties
- Extra responsibilities on RCP e.g.
- form filling, preparing for and attending MHTs, liaising with solicitors and second opinion psychiatrists, teaching junior doctors about the Act and codes of practice

- Experience of psychiatrist in other jurisdictions reflected the views in ROI
- 65%-"voluntary patients had suffered as a result"
- 59%- their own out of hours workload had increased
- Patient groups in Scotland also highlighted this disruption to care for voluntary patients (Smith et al) Psychiatr Bull 2007

- National study by O Donoghue Moran et al ,
- 238 psychiatrists were interviewed, 70% response rate. 32% of responders felt care of involuntary patients had improved, but 48% felt that Voluntary patients care had deteriorated. Junior doctor training had been reduced in 57% of placements, and 87% reported an increase in on call workload. Only 23% reported sufficient increase in consultant personnel in their service.


•Study of Irish GP attitudes (Jabbar, Kelly et al)
•1200 GPs were sent questionnaires, 820 responded
•Staggering 75% provided negative comments
•e.g. difficulty with transporting patients to approved centres, time requirements, form fillings


•Review of MHA 2001, 5 years after implementation- there was a small decrease in the rate of involuntary admission but no change in the representativeness of the diagnoses of individuals admitted involuntarily
•Tribunals were held for 57% of those admitted involuntarily and interestingly, 46% of service users found that MHT made the involuntary process easier to accept. One year post discharge, 60% reflected that it had been necessary.

- In other studies by clinicians examining the rates of involuntary admissions under MHA 2001- no change in demographic and clinical characteristics of individuals compared with the previous legislation
- One study (Clancy et al) 2008 found an increase in age of detainees under the MHA
- Ng and Kelly (2012) found a higher rate of detention (67.7 per 100,00) in North Inner City Dublin compared with the national average (38.5 per 100,000)
- Immigrants are also more likely to have involuntary status -

Solutions??

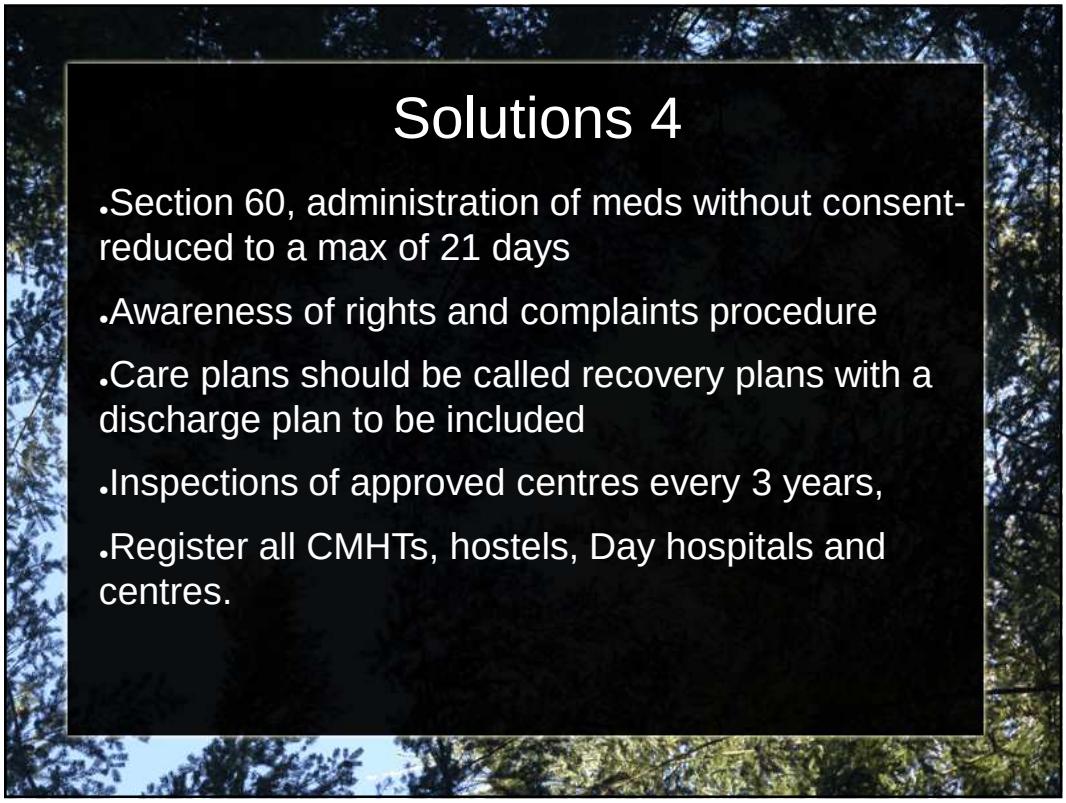
- Report of Expert Group on Review of MHA 2001 was released earlier this year
- Guiding principle of “best Interest” to be replaced by “wills and preferences” paradigm
- Term “mental illness” should remain but definitions and thresholds for involuntary admission should be higher
- Need for greater clarity on how the *severity* of a mental disorder is determined

Solutions 2

- Consensus that people with intellectual disability and severe dementia alone, should not be detained in psychiatric institutions – previously criticised by European Committee for Prevention of torture
- Definition of treatment -should include other tests required for purpose of safeguarding life and restoring health
- Should ***exclude*** provision of a safe environment only.

Solutions 3

- Section 26 leave of absence for a max of 14 days
- Some would argue that this may *prolong* detention
- Change of status would require an authorised officer instead of a second psychiatrist
- Administration of treatment to a patient who lacks capacity – only after consultation with another mental health professional of a different discipline


Solutions 4
•Section 60, administration of meds without consent- reduced to a max of 21 days
•Awareness of rights and complaints procedure
•Care plans should be called recovery plans with a discharge plan to be included
•Inspections of approved centres every 3 years,
•Register all CMHTs, hostels, Day hospitals and centres.