

# The Legal Powers to Detain the Mentally Ill in Ireland: Medicalism or Legalism?

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# The Legal Powers to Detain the Mentally Ill in Ireland: Medicalism or Legalism?

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# ABBREVIATIONS

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CRPD-	Convention on the Rights of Persons with Disabilities
ECHR-	European Convention on Human Rights
ECtHR-	European Court of Human Rights
GP-	General Practitioner
MHC-	Mental Health Commission
TP-	Treating Psychiatrist
SU-	Service User
1945 Act-	Mental Treatment Act 1945
2001 Act-	Mental Health Act 2001



# ABSTRACT

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## **The Legal Powers to Detain the Mentally Ill in Ireland: Medicalism or Legalism?**

**Jennifer Brown**

The thesis examines the extent to which medicalism and legalism have influenced the legal powers of detaining the mentally ill in Ireland from the late eighteenth century to date. Utilising academic literature, government publications and original interviews with treating psychiatrists and service users, the thesis provides the first comprehensive socio-legal analysis of the law concerning mental health detention, the interpretation of the law and the operation of the law in Irish society. It transpires that a specific approach to the legal powers of detention became embedded in Irish society's response to mental illness. This approach provided psychiatry with significant power in the detention, care and treatment of the mentally ill and society ardently relied on psychiatry to manage the perceived social problem caused by mental illness. Simultaneously, legal powers of detention dominated by medicalism have been ingrained in the Irish psyche. Over time, however, legalism evolved as a result of the widespread critique of psychiatry's role in the detention of the mentally ill. Furthermore, a strong line of international law established that the rights of the mentally ill in detention required greater protection. These developments were subsequently enshrined in the Irish law governing the legal powers of detention and new provisions were introduced that reduced psychiatry's control in the detention of the mentally ill. Despite these changes to the law governing the legal powers of detention, it has been found that further movement in the direction of legalism will require a more comprehensive shift among those applying the law, in particular, the judiciary and the psychiatric profession.

# CHAPTER 1

## INTRODUCTION

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### 1.09 Introduction

In analysing the evolution of the legal powers to detain the mentally ill, it becomes apparent that various historical and contemporary legal and sociological influences have had a determinate effect on the manner in which this is regulated in Ireland. Concurrently, the law has played a definitive role in the evolution of the Irish mental health system, indeed, as Fennell has outlined, in terms of its influences, discourse, ideas and structures the law is a source of the mental health system.<sup>1</sup> This is particularly valid in the Irish case which in 1817, through legislation, established one of the oldest, enduring and extensive public asylum systems in the world. Similar systems were not seen in England until 1845 and Scotland until 1857.<sup>2</sup> Consequently, Reuber believes that it is of little surprise that the country boasting the oldest public asylum system in the world came to have the highest percentage of their population in mental health detention in the world.<sup>3</sup> However, despite the early legal establishment of an asylum system, from this point onwards Irish legislation tended to lag behind that of the developed world. In the creation of new legislation there was significant reliance on English legislation that was often ten years its predecessor. Thus, for example, many of the provisions of the Mental Treatment Act 1945 are broadly similar to that of the English Mental Health Act 1930. Similarly, the establishment of mental health tribunals and a Mental Health Commission under the Mental Health Act 2001, are akin to the tribunals established under the English Mental Health Act 1959 and the Commission established under the Mental Health Act 1983.

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<sup>1</sup> Phil Fennell, "Law and Society: The Legal Constitution of the Psychiatric System" (1986) 13(1) *Journal of Law and Psychiatry* 35.

<sup>2</sup> Markus Reuber, 'Moral Management and the 'Unseen Eye': Public Lunatic Asylums in Ireland, 1800-1845' in Elizabeth Malcolm and Greta Jones (eds), *Medicine, Disease and the State in Ireland 1650-1940* (Cork University Press 1999) 208-233.

<sup>3</sup> In 1955 Ireland had 7.1 persons per 1000 of the population in in-patient psychiatric treatment, the second highest position on the list was the USSR which had 6.1, followed by the US that had 5.1 and then Northern Ireland which had 4.4. WHO, *Annual Epidemiological and Vital Statistics* (1955); Markus Reuber, "The architecture of psychological management: the Irish asylums (1901-1922)" (1996) 26 *Psychological Medicine* 1179, 1187.

The nineteenth century witnessed a period of rapid asylum expansion not only in Ireland but also in Britain, Europe and America.<sup>4</sup> For some, this expansion has been attributed to the effects of an urbanising society's increased sensitivity to the ever growing public presence of the insane in the crowded cities and towns.<sup>5</sup> This sensitivity emerged at a time when society's attitude to the suffering of those who had previously been outcast became more humane.<sup>6</sup> Additionally, it has been claimed that an actual increase in the incidence of insanity occurred during this time as a result of rising alcoholism, rising rates of neurosyphilis and possibly rising rates of schizophrenia.<sup>7</sup> Given the apparent 'epidemic of insanity' in Ireland, a question naturally arises as to its source. If the source of mental illness is biological then it is incumbent upon the psychiatric profession to care for and treat the ill. Psychiatry is a specialism of medicine; a traditional caring profession that is underlined by benevolent and humanistic principles. However, these benign characteristics of the psychiatric profession are called into question when the biological nature of mental illness is disputed. There is now a significant volume of work which contests the biological nature of mental illness and instead attributes it to the social control of deviance through psychiatry.<sup>8</sup> In Ireland, it is argued that various social forces were responsible for the advancement of the asylum system, as opposed to a biological epidemic of insanity.<sup>9</sup>

The thesis focuses on the role of the law in mental health detention. As will be seen the law influenced the creation of an asylum system which provided for high rates of detention, yet

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<sup>4</sup> See generally Andrew Scull, *Museums of Madness: The Social Organisation of Insanity in Nineteenth-Century England* (Allen Lane 1979); Roy Porter, *Mind Forg'd Manacles: A History of Madness in England from the Restoration to the Regency* (Harvard University Press 1987); Michael Foucault, *Madness and Civilisation: A History of Insanity in the Age of Reason* (Plon 1961, Pantheon 1965); Robert Castel, *The Regulation of Madness: The Origins of Incarceration in France* (University of California Press 1988); Andrew Scull, *Social Order/Mental Disorder: Anglo-American Psychiatry in Historical Perspective* (University of California Press 1989).

<sup>5</sup> See generally Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (Wiley 1998); Edward Shorter, *A Historical Dictionary of Psychiatry* (Oxford University Press 2005); Andrew Scull, *Museums of Madness: The Social Organisation of Insanity in Nineteenth-Century England* (Allen Lane 1979).

<sup>6</sup> See generally Michael Foucault, *Madness and Civilisation: A History of Insanity in the Age of Reason* (Plon 1961, Pantheon 1965); Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (Wiley 1998); Edward Shorter, *A Historical Dictionary of Psychiatry* (Oxford University Press 2005).

<sup>7</sup> Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (Wiley 1998) 48-65; Edward Shorter, *A Historical Dictionary of Psychiatry* (Oxford University Press 2005) 5; Edward Hare "Schizophrenia as a Recent Disease" (1988) 153 *British Journal of Psychiatry* 521.

<sup>8</sup> See generally RD Laing, *The Divided Self* (Penguin 1965); Thomas Scheff, *Being Mentally Ill* (Aldine 1966); Erving Goffman, *Asylums* (Penguin 1968); Thomas Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (Harper and Row 1960); David Ingleby, 'Understanding Mental Illness' in David Ingleby (ed), *Critical Psychiatry: The Politics of Mental Health* (Penguin 1981); Geoff Baruch & Andrew Treacher, *Psychiatry Observed* (Routledge and Kegan Paul 1978); Philip Bean, *Compulsory Admissions to Mental Hospitals* (John Wiley & Sons 1980).

<sup>9</sup> See generally Damien Brennan, *Irish Insanity; 1800-2000* (Routledge 2014).

subsequently, the high rates of detention had a deterministic influence on the creation, operation and interpretation of new mental health law. The role of law in regulating mental health systems has come to engender great contention in the legal, historical and sociological disciplines alike. This conflict is multifaceted but is centred upon the role of psychiatry in the detention of the mentally ill and the manner in which the law should control this. The primary conflict in relation to the philosophy of mental health detention has been the extent to which legal regulation should control psychiatric power. In this manner the evolution of mental health law has been seen in terms of a pendulous movement between two extremes of medicalism and legalism.<sup>10</sup> Socio-legal analysis is used to determine why the legal powers to detain the mentally ill developed in the way they did, who influenced them and what their impact was.

## **1.02 Research Question**

The purpose of the thesis is to analyse the influence of this medicalism and legalism in the powers to detain the mentally ill in Ireland. The research question relates to adults only. Powers to detain mentally ill children differ from those for adults and are outside the scope of this thesis. The thesis examines the development of legal powers to detain the mentally ill and focuses on the law, the judicial interpretation of the law and the operation of the law from the late 1700s to early 2014. In doing so it examines significant changes in approach from a socio-legal perspective utilising the medicalism and legalism theories.

## **1.03 Methodology**

In recent years a purely doctrinal analysis of the law has been criticized on the grounds that it is a rigid, inflexible and inward looking approach to understanding what the law is and the operation of the legal system.<sup>11</sup> Concurrently, the benefits of using other disciplines such as sociology, political science, economics, psychology, history and feminism as aids to legal research have been widely recognised. This inter-disciplinary or socio-legal research is thought to provide a more realistic and refined understanding of the law. It does so by filling the gap between ‘law in books’ and ‘law in action’ and allows for an understanding of the operation of law in society.<sup>12</sup> For this reason, the thesis utilises and combines different

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<sup>10</sup> See generally Kathleen Jones, *A History of the Mental Health Services* (Routledge and Kegan Paul 1972).

<sup>11</sup> D.W. Vick, ‘Interdisciplinary and the Discipline of Law’ (2004) 31 *Journal of Law and Society* 164; Reza Banakar and Max Travers (eds), *Theory and Methods in Socio-Legal Research* (Hart Publishing 2005); 1-27.

<sup>12</sup> Mike McConville and Wing Hong Chui (eds), *Research Methods for Law* (Edinburgh University Press 2007) 1-16.

methods. Firstly, the thesis draws on sociological and historical analysis to explain the influence of medicalism and legalism in the evolution of the legal power to detain in Ireland. Sociology, concerned generally with the study of society, focuses on society as a whole without restricting its knowledge to any one institutional dimension of society.<sup>13</sup> It thus offers the possibility of providing a more comprehensive analysis of the role of law within the broader social and political context of mental health detention.<sup>14</sup> Historical analysis is also essential as it provides the background to, and again, an understanding as to why the law developed in the way that it did. It is believed that a doctrinal analysis of the law and the case law would fail to provide an adequate understanding of the law, its creation, its amendment and its impact on its subjects, those charged with its application and wider Irish society. For example, a purely doctrinal analysis of the Mental Treatment Act 1945 would fail to explain how psychiatry professionalised in Ireland and came to occupy the dominant role in mental health detention.

Despite the criticisms of doctrinal analysis, at times it is essential, thus a doctrinal analysis of the statutes, their judicial interpretation, relevant academic literature and government reports<sup>15</sup> is provided. However, where it has been impossible to find any information on a particular aspect of the research question, it has been necessary to conduct qualitative research. Socio-legal scholarship employs a wide range of applied social science methods including quantitative and qualitative research.<sup>16</sup> Therefore in the examination of mental health tribunals in Ireland, original interviews with treating psychiatrists and service users are employed to analyse the operation of the legal power to detain. These qualitative interviews are used as there is limited information available on the operation of Irish mental health tribunals and this was deemed the best approach to elucidating information, given the constraints imposed by the legislation.

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<sup>13</sup> Mathieu Deflem, *Sociology of Law; Visions of a Scholarly Tradition* (Cambridge University Press 2008) 7.

<sup>14</sup> On socio-legal theory and research methods see generally Mike McConville and Wing Hong Chui (eds), *Research Methods for Law* (Edinburgh University Press 2007); Reza Banakar and Max Travers (eds), *Theory and Methods in Socio-Legal Research* (Hart Publishing 2005); Mathieu Deflem, *Sociology of Law; Visions of a Scholarly Tradition* (Cambridge University Press 2008); Roman Tomasic, *The Sociology of Law* (Sage Publications 1985).

<sup>15</sup> Department of Health and Children, *Review of the Operation of the Mental Health Act 2001; Findings and Conclusions* (2007); Mental Health Commission, *Report on the Operation of Part 2 of the Mental Health Act 2001* (2008); Department of Health and Children, *Interim Report of the Steering Group on the Review of the Mental Health Act 2001* (2012).

<sup>16</sup> See generally Reza Banakar and Max Travers (eds), *Theory and Methods in Socio-Legal Research* (Hart Publishing 2005).

## 1.04 Medicalism & Legalism

In establishing an explanatory device by which mental health laws can be understood this thesis utilises theories of legalism and medicalism. However, the law's role in the regulation of the legal power to detain has engendered significant debate about such legalism and medicalism. The seminal work conducted in this area has focused on English and Welsh mental health legislation.<sup>17</sup> In examining the Irish legislation, this work has been instructive. Indeed, the evolution of legalism and medicalism has followed the same trajectory in both countries. From the work conducted to date it is seen that as mental health legislation has evolved over time, the conceptions of medicalism and legalism have changed. A straightforward interpretation of these theories is provided by Fennell:

*“Legalism focuses on the coercive aspects of psychiatry such as detention, forcible treatment and restraint, and seeks to regulate them by imposing due process safeguards. Medicalism seeks to take advantage of the ideological role of law to submerge these coercive dimensions of psychiatry, and encourage their perception as medical treatments whose administration should be a matter of clinical judgement rather than a subject of legal regulation.”*<sup>18</sup>

The traditional justification for legally safeguarding the rights of the insane was the possibility that the determination of insanity was incorrect, or that the need for detention was unwarranted given the severity of the insanity.<sup>19</sup> Therefore, mental health laws, including the Lunacy Act 1890 and the Mental Treatment Act 1930 in England, and the Lunacy Acts 1821-1826 and the Criminal Lunatics Act 1838-1867 in Ireland, focused on safeguarding the individual's right to liberty. The legislation, which espoused legalism, prescribed statutory minimum standards to guide and restrict the discretion of the many decision makers in the detention process. Furthermore, the need for detention was determined by judges.

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<sup>17</sup> See generally, Kathleen Jones, “The limitations of the legal approach to mental health law” (1980) 3(1) *International Journal of Law and Psychiatry* 1; Larry O Gostin, ‘The Ideology of Entitlement: The Application of Contemporary Legal Approaches to Psychiatry’ in Philip Bean (ed), *Mental Illness: Trends and Changes* (John Wiley 1983) 27-54; Clive Unsworth, *The Politics of Mental Health Legislation* (Clarendon Press 1987); Phil Fennell, “Law and Society: The Legal Constitution of the Psychiatric System” (1986) 13(1) *Journal of Law and Psychiatry* 35; Nikolas Rose, “Unreasonable Rights, Mental Illness and the Limits of the Law” (1985) 12(2) *Journal of Law and Psychiatry* 199; Nicola Glover-Thomas, *Reconstructing Mental Health Law and Policy* (Butterworths 2002); Willis J Spaulding, “Mapping the New-Legalism of the English Mental Health System” (1989) 17(2) *Law, Medicine & Healthcare*, 187; Bernadette McSherry & Penelope Weller (eds), *Rethinking Rights-Based Mental Health Laws* (Hart Publishing 2010).

<sup>18</sup> Phil Fennell, *Treatment Without Consent; Law, Psychiatry and the Treatment of Mentally Disordered People since 1845* (Routledge 1996) 10.

<sup>19</sup> Willis J Spaulding, “Mapping the New-Legalism of the English Mental Health System” (1989) 17(2) *Law, Medicine & Healthcare*, 187.

With the passing of time, legalism came to attribute anti-psychiatry connotations and medicalism evolved as an alternative. In support of medicalism, Jones has interpreted the term legalism in a negative sense, believing that as the mental health field is one of the least predictable it follows that it is one of the least appropriate for 'formalistic' or 'mechanistic' approaches of law. Rather, open textured law that is enabling and permits maximum medical discretion within a loose framework of regulation is preferable.<sup>20</sup> In this sense Jones believes that legal formalism results in an over emphasis on procedural correctness to the detriment of the substantive aim of treating the mentally ill. Furthermore, she believes that professional ethics ensure abuse is exceptional and, legislating for the exceptional results in disruption and damage to the psychiatric processes. It has been claimed that the 'juridogenic harm', an analogy of iatrogenic harm, caused by legal processes in the detention of the mentally ill can affect and undermine existing and future therapeutic relationships.<sup>21</sup> It is also argued that legalism can have stigmatising effects whereby the use of certain legislation and/or judicial determination in the detention process quasi-criminalises the mentally ill and contributes to their social exclusion.<sup>22</sup>

Opponents of medicalism see it as providing the possibility for uncontrolled medical discretion, which cannot be ensured to always act in the best interests of patients.<sup>23</sup> Bean describes how a mental health system governed by 'therapeutic rules', which bear analogy to medicalism, has several characteristics. The rules are loosely formulated to permit the minimum of control over the medical profession and permit the maximum use of professional discretion. Significantly, however, there is a divestment of the traditional legal processes and the usual legal rights of the citizen are absent.<sup>24</sup> Therefore, those who reject medicalism and support legalism, argue that a framework of legal rules is essential for the protection of patients.<sup>25</sup>

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<sup>20</sup> Kathleen Jones, "The limitations of the legal approach to mental health law" (1980) 3(1) *International Journal of Law and Psychiatry* 1, 8-9. See generally Kathleen Jones, *A History of the Mental Health Services* (Routledge and Kegan Paul 1972).

<sup>21</sup> William Obomanu & Harry Kennedy, "Juridogenic Harm: Statutory Principles for the New Mental Health Tribunals" (2001) 25 *Psychiatric Bulletin* 331.

<sup>22</sup> Kathleen Jones, "The limitations of the legal approach to mental health law" (1980) 3(1) *International Journal of Law and Psychiatry* 1.

<sup>23</sup> Phil Fennell, *Treatment Without Consent; Law, Psychiatry and the Treatment of Mentally Disordered People since 1845* (Routledge 1996) 10.

<sup>24</sup> Philip Bean, "The Mental Health Act 1959: Some Issues Concerning Rule Enforcement" (1975) 2(2) *British Journal of Law and Society* 225, 228.

<sup>25</sup> Nicola Glover-Thomas, *Reconstructing Mental Health Law and Policy* (Butterworths 2002) vi.

During the 1980s, Gostin urged reform based on what he termed a ‘new legalism’. In furtherance of the protection of patients’ rights, Gostin too championed the introduction of greater procedural safeguards and stricter regulation of psychiatry.<sup>26</sup> Far from being a part of the anti-psychiatry movement, Gostin believed that where compulsion was involved, the expert should minimally explain and justify their decision to a lay person, utilising objective behavioural criteria to support this.<sup>27</sup> The difference in Gostin’s new legalism was that his “ideology of entitlement” emphasised an enforceable right to care that was to be provided in the least restrictive setting as possible. Gostin linked concern for traditional rights to due process and review of detention by the courts with the ideology of entitlement to adequate treatment and services. The focus of legal restrictions on medical discretion was no longer focused solely on detention; instead, the ideology of entitlement also required limitations on the exercise of psychiatric power with respect to psychiatric care and treatment.<sup>28</sup> In essence legalism moved into the post commitment realm.

Gostin’s new legalism was enshrined in the English Mental Health Act 1983. In its operation, however, an alternative strategy to Gostin’s legalism emerged. Medical discretion in the treatment and also in the detention of voluntary patients was restricted, but it was restricted through the use of second medical opinions rather than judicial or mental health review tribunal pronouncements. These new restrictions, which ensured that decisions would continue to be made in the medical best interests of the detained, were acceptable to the psychiatric profession and were favoured over the hard and fast restrictions suggested by Gostin. Whether the use of second medical opinions is independent or provides a better restraint on arbitrary medical decision making than lawyers can is open to question. What is definitely at issue is the symbolic political significance to the patient.<sup>29</sup> Rose has cast doubt on the extent to which such provisions impact upon the detention process. For him a legalist form of mental health legislation that is rights based does not alter the decisions that are made about detention or treatment and does not provide effective monitoring and constraining of medical discretion. Instead, it merely causes a shift in the discourse and changes the

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<sup>26</sup> Larry O Gostin, “Perspectives on Mental health Reforms” (1982) 10 *Journal of Law and Society* 47; Larry O Gostin, ‘The Ideology of Entitlement: The Application of Contemporary Legal Approaches to Psychiatry’ in Philip Bean (ed), *Mental Illness: Trends and Changes* (John Wiley 1983) 27-54.

<sup>27</sup> *Ibid.*

<sup>28</sup> *Ibid.*

<sup>29</sup> Willis J Spaulding, “Mapping the New-Legalism of the English Mental Health System” (1989) 17(2) *Law, Medicine & Healthcare*, 187.



personnel involved.<sup>30</sup> Despite the fact that the new legalism focused on a broader conception of patient's right including the right challenge detention and treatment without consent, Unsworth has also highlighted how this legalism has, in a way, become a mode of medical power.<sup>31</sup> In this manner compliance with procedural safeguards can actually legitimise the medical decision to detain.<sup>32</sup> With respect to this issue, Fennell outlines how the new legalism, in reality, maintains the codification of clinical power and authority, especially in cases concerning treatment without consent.<sup>33</sup> Weller, comparably opines that patient rights have been lost in translation because of the continued acceptance of medical authority.<sup>34</sup>

Despite the difficulties with defining legalism and medicalism, and the criticisms thereof, this thesis draws from and builds on these theories.<sup>35</sup> In doing so the thesis utilises a specific definition of legalism and its correlative medicalism and analyses their influence on the legal powers to detain the mentally ill. While the literature concerning legalism and medicalism has since evolved to consider issues concerning treatment in England and Wales, the thesis is primarily restricted to considering the theories with respect to detention in Ireland at this point. The aim is to utilise these theories in an explanative manner and to provide some understanding as to the reasoning behind the creation, interpretation and operation of detention provisions in mental health law in Ireland. In this sense Unsworth's definition of legalism is most appropriate for the purposes of the thesis. For Unsworth, legalism, in the psychiatric context,

*“is focused upon relationships between mental health professionals, especially psychiatrists, and their patients, and entails the superimposition of legal duties and rights upon therapeutic and social responsibilities and expectations, principally for the protection of the patient or potential patient...the rule of law takes priority, if necessary at the expense of other*

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<sup>30</sup> Nikolas Rose, “Unreasonable Rights: Mental Illness and the Limits of the Law” (1985) 12 (2) *Journal of Law and Society* 199, 206-207.

<sup>31</sup> Clive Unsworth, *The Politics of Mental Health Legislation* (Clarendon Press 1987) 315-352.

<sup>32</sup> Clive Unsworth, *The Politics of Mental Health Legislation* (Clarendon Press 1987) 11-12.

<sup>33</sup> Phil Fennell, ‘Institutionalising the Community: The Codification of Clinical Authority and the Limits of Rights-Based Approaches’ in Bernadette McSherry & Penelope Weller (eds), *Rethinking Rights-Based Mental Health Laws* (Hart Publishing 2010) 13-51.

<sup>34</sup> Penelope Weller ‘Lost in Translation: Human Rights and Mental Health Law’ in Bernadette McSherry & Penelope Weller (eds), *Rethinking Rights-Based Mental Health Laws* (Hart Publishing 2010) 51-73.

<sup>35</sup> For a critique of Gostin's legalism see Nikolas Rose, “Unreasonable Rights, Mental Illness and the Limits of the Law” (1985) 12(2) *Journal of Law and Psychiatry* 199.

*considerations, including that which is deemed to be optimally therapeutic by professionals.*”<sup>36</sup>

For the purposes of the thesis, the actors involved are expanded to include the medical profession generally as opposed to mental health professionals solely. The definition of medicalism, for the purposes of the thesis, is derived from this definition of legalism. Medicalism is focused on the relationship between medical professionals and their patients. It provides minimum legal control over the medical profession to permit the maximum use of medical discretion upon therapeutic and social responsibilities and expectations, principally for the treatment of the patient or potential patient. That which is deemed optimally therapeutic by medical professionals takes priority, if necessary at the expense of other considerations, such as the civil rights of the patient or the procedural requirements of law.

### **1.05 Constitutional Rights, Human Rights and Mental Health Detention**

Given that the above discussion of legalism and medicalism refers often to the rights of persons the subject of mental health detention, at this point, it is appropriate to discuss the changing nature of these rights in some detail. In Ireland constitutional and human rights take precedence over legislation and common law. The list of constitutional rights that could be affected by mental health detention is lengthy, but primarily includes the right to liberty,<sup>37</sup> the right to bodily integrity<sup>38</sup> and the right to autonomy or self-determination.<sup>39</sup> The manner by which these rights have been argued in cases concerning mental health detention will be discussed in further detail in throughout the thesis. However, at this point it is necessary to highlight that until relatively recently the right to liberty was the only right that was challenged in relation to mental health detention in Ireland. More recently, there have been some challenges to the Mental Health Act 2001 concerning the treatment received by persons detained thereunder, and in particular their capacity to refuse this treatment.<sup>40</sup> This again is discussed in further detail below.<sup>41</sup>

At the international level the European Court of Human Rights (ECtHR) has played an influential role in protecting the rights of those affected by mental health detention at the state

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<sup>36</sup> Clive Unsworth, *The Politics of Mental Health Legislation* (Oxford University Press 1987) 20-21.

<sup>37</sup> Constitution, Article 40.4.1°.

<sup>38</sup> The right to bodily integrity was established as an unenumerated right in *Ryan v Attorney General* [1965] IR 294.

<sup>39</sup> The right to autonomy was established as an unenumerated right in *Re a Ward of Court (No. 2)* [2009] IEHC 236.

<sup>40</sup> *MX v HSE* [2013] IEHC 491.

<sup>41</sup> See page 156-157.

level.<sup>42</sup> The European Convention on Human Rights Act 2003 permits arguments about the European Convention on Human Rights (ECHR) to be made in all Irish courts. In addition all organs of the State must perform their functions in a manner compatible with the ECHR. Ultimately, there is the possibility to bring a case against the State to the ECtHR for failure to guarantee the rights enshrined in the ECHR.

The main Articles of the ECHR that are relevant to mental health detention are: Article 5, the right to liberty and security; Article 6, the right to a fair trial; Article 3, the prohibition of torture; and Article 8, the right to respect for private and family life. The ECtHR case law in relation to mental health detention deals with civil and political human rights that are essentially negative in character. These rights place limits on government power and interference with rights as opposed to socio-economic rights which require the State to provide mental health services. It places limits on government power and interference with rights in three main areas: detention, conditions of confinement and review of detention.<sup>43</sup> The jurisprudence of the ECtHR in relation to mental health detention, review and discharge has since 1979 built in the terms of Article 5 to create a number of clear requirements which are discussed in Chapter 4.<sup>44</sup>

The new legalism that was discussed above drew heavily on these negative rights but also argued that there should be effective access to cultural and socio-economic rights. Essentially, there was maturation in terms of the rights which legalism sought to protect, and they now included the rights to dignity, autonomy, privacy and the right to adequate care and

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<sup>42</sup> On mental health and the European Convention on Human Rights see generally; Lawrence Gostin et al, *Principles of Mental Health Law and Policy* (Oxford University Press 2010) 103-167; Peter Bartlett, Oliver Lewis & O Thorold, *Mental Disability and the European Convention on Human Rights* (Martinus Nijhoff 2007); Lawrence O Gostin & Lance Gable, "The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health" (2004) 63 *Maryland Law Review* 20; LO Gostin, "Human Rights of Persons with Mental Disabilities" (2000) 23(2) *International Journal of Law and Psychiatry* 125; Oliver Lewis, "Protecting the Rights of People with Mental Disabilities: the European Convention on Human Rights" (2002) 9(4) *European Journal of Health Law* 293; Johan Legemaate, "Involuntary Admission to a Psychiatric Hospital: Recent European Developments" (1995) 2(1) *European Journal of Health Law* 15; Oliver Thorold, "The Implications of the European Convention on Human Rights for United Kingdom Mental Health Legislation" (1996) 6 *European Human Rights Law Review* 619; G Richardson, "The European Convention and Mental Health Law in England and Wales: Moving Beyond Process?" (2005) 28(2) *International Journal of Law and Psychiatry* 127; Jim Murdoch "Safeguarding the Liberty of the Person: Recent Strasbourg Jurisprudence" (1993) 42(3) *International and Comparative Law Quarterly* 494; Kris Gledhill, "Human Rights Instruments and Mental Health Law: The English Experience of the Incorporation of the European Convention on Human Rights" (2006-2007) 34(2) *Syracuse Journal of International Law and Commerce* 358; G Niveau & J Materi, "Psychiatric Commitment: over 50 years of case law from the European Court of Human Rights" (2006) 22(7) *European Psychiatry* 427; Alasatir Mowbray, *Cases and Materials on the European Convention on Human Rights* (Oxford University Press 2011) 245-344..

<sup>43</sup> Lawrence Gostin et al, *Principles of Mental Health Law and Policy* (Oxford University Press 2010) 125-126.

<sup>44</sup> See n33.

service. New legalism has therefore also been termed rights-based legalism.<sup>45</sup> Traditionally, the legal rights were only applied and attributed to the rational legal person, and as the mentally ill were not considered rational, exceptions to the law such as restrictions on liberty were allowed. The significant change in the new legalism approach was that it no longer considered the mentally ill to be lacking rationality and there was an understanding that they were imbued with the same rights as others.<sup>46</sup>

The ECtHR has since then been prepared to attach positive rights to adequate treatment and care in mental health detention<sup>47</sup> and even to mental health services outside of detention.<sup>48</sup> More recently, the ECtHR has further considered a broader collection of rights in cases concerning guardianship and capacity of persons with mental illness. Significantly, in 2008 the ECtHR held that the placing of a man under guardianship without his knowledge and his subsequent detention in a mental hospital amounted to a violation of Articles 5, 6 and 8. The ECtHR opined that the “...interference with the applicant’s private life was very serious. As a result of his incapacitation the applicant became fully dependant on his official guardian in almost all areas of life.”<sup>49</sup> In a similar case in 2012, whereby the applicant was divested of his legal capacity and subsequently detained, the ECtHR found that there was a breach of Articles 5 and 6 but did not consider the Article 8 argument. Importantly, however, the ECtHR also found that the conditions of his detention were so degrading that they amounted to a violation of Article 3.<sup>50</sup>

The UN Convention on the Rights of Persons with Disabilities (CRPD) was enacted in 2006 and opened for signature in 2007. The CRPD focuses on the social model of disability and locates the ‘problem’ with disability in the social organisation and discriminatory attitudes of society.<sup>51</sup> Significantly, it makes no reference to involuntary detention of the mentally ill and

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<sup>45</sup> Bernadette McSherry & Penelope Weller (eds), *Rethinking Rights-Based Mental Health Laws* (Hart Publishing 2010).

<sup>46</sup> Willis J Spaulding, “Mapping the New-Legalism of the English Mental Health System” (1989) 17(2) *Law, Medicine & Healthcare*, 187, 189.

<sup>47</sup> *Aerts v Belgium* (1998) 29 EHRR 50, where the ECtHR held that the detention of a mentally ill person can only be lawfully effected in a hospital, clinic or other appropriate institution, not a prison.

<sup>48</sup> *Johnson v United Kingdom* 22520/93 (1997) ECHR 88, where the ECtHR held that release from detention could not be unreasonably delayed because of a lack of appropriate treatment options in the community.

<sup>49</sup> *Shtukaturvov v Russia* 44009/05 (2008) ECHR at 90.

<sup>50</sup> *Stanev v Bulgaria* 36760/06 (2012) ECHR.

<sup>51</sup> See generally Rosemary Kayess & Philip French, “Out of the darkness into the light? Introducing the Convention on the Rights of Persons with Disabilities” (2008) 8(1) *Human Rights Law Review* 1; Frédéric Mégret, “The disabilities convention; Human rights of persons with disabilities or disability rights?” (2008) 30(2) *Human Rights Quarterly* 494; Aart Hendricks, “UN Convention on the Rights of Persons with Disabilities” (2007) 14 *European Journal of Health Law* 273; Arlene S Kanter, “Promise and Challenge of the United Nations Convention on the Rights of Persons with Disabilities” (2006) 34(2) *Syracuse Journal of*

provides that persons with disabilities have the right to recognition everywhere as persons before the law and similarly enjoy legal capacity on an equal basis with others in all aspects of life.<sup>52</sup> The CRPD is significant in merging both civil and political rights with economic, cultural and social rights. Fennell argues that in terms of protecting the rights of the mentally ill going forward, there must be a re-conceptualisation of mental health rights into disability rights as it ‘lays greater emphasis on positive rights and upholds the social inclusion, anti-stigma and equality agenda, without losing sight of the key imperative of legality, due process and proportionality.’<sup>53</sup> While the CRPD obviously had no influence on the Mental Health Act 2001, it is likely that it will have an impact on legalism going forward, and this will be considered in relation to Irish mental capacity legislation in Chapter 6.

## 1.06 Thesis Outline & Structure

The thesis is primarily limited to civil legal powers to detain; however, at certain points in the history of Irish mental health detention the criminal detention procedures have played a significant and influential role. Indeed, the Criminal Lunatics Acts 1838-1867 were the primary mode of entry into the asylum until the enactment of the Mental Treatment Act 1945 (the 1945 Act) and are therefore discussed in some detail. Subsequently, the examination focuses on civil detention, in particular, the legal powers to detain established in the 1945 Act and the Mental Health Act 2001 (the 2001 Act). Unsworth has highlighted that, in particular, admission procedures have historically provided the most sensitive indication of the prevalence of legalism and for this reason they are a primary focus of the thesis.<sup>54</sup> Additionally, the legal provisions in the 2001 Act which provide for a multi-disciplinary review of the medical decision to detain also provide compelling indications as to the prevalence of legalism or medicalism and are a necessary focus of the thesis as well. In terms of the admission and review provisions in the 2001 Act, the European Convention on Human

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*International Law and Commerce* 287; Tina Minkowitz, “United Nations Convention on the Rights of Persons with Disabilities and the Right to be Free from Non Consensual Psychiatric Interventions” (2006) 34(2) *Syracuse Journal of International Law and Commerce* 405; Anna Lawson, “United Nations Convention on the Rights of Persons with Disabilities: New Era or false Dawn” (2006) 34(2) *Syracuse Journal of International Law and Commerce* 563; Peter Bartlett, “The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law” (2012) 75(5) *Modern Law Review* 769; Phil Fennell & Urfan Khaliq, “Conflicting or complementary obligations? The UN Disability Rights Convention, the European Convention on Human Rights and English law” (2011) 6 *European Human Rights Law Review* 662; Eilionoir Flynn, *From Rhetoric to Action; Implementing the UN Convention on the Rights of Persons with Disabilities* (Cambridge University Press 2011).

<sup>52</sup> CRPD, Article 12.

<sup>53</sup> Phil Fennell, ‘Institutionalising the Community: The Codification of Clinical Authority and the Limits of Rights-Based Approaches’ in Bernadette McSherry & Penelope Weller (eds), *Rethinking Rights-Based Mental Health Laws* (Hart Publishing 2010) 7.

<sup>54</sup> Clive Unsworth, *The Politics of Mental Health Legislation* (Oxford University Press 1987) 1-2.

Rights and its interpretation by the European Court of Human Rights has had a significant influence and is therefore discussed where relevant. Finally, the judicial interpretation of the law and/or its operation can be illustrative of the judicial preference for a medicalist or legalist system of mental health law.

Chapter 2 examines the influence of medicalism and legalism from 1780 to 1921 and reveals the factors that allowed medicalism to dominate the evolution of legal powers to detain. Chapter 3 provides an examination of the influence of medicalism in the detention of the mentally ill from 1921 to 1990. In particular it analyses the influence of medicalism in the development, enactment and judicial interpretation of the 1945 Act. Chapter 4 examines the influence of medicalism and legalism from 1990 to 2014. It explains the factors that resulted in the articulation of legalism in the 2001 Act but questions the dominance of legalism in its operation and judicial interpretation. A significant feature of the 2001 Act was the establishment of Mental Health Tribunals (MHTs) which review the medical decision to detain. Chapter 5 assesses the nature and operation of MHTs to determine the extent to which they adhere to legalism or medicalism. Chapter 6 provides conclusions.

### **1.07 Language & Terms Used**

At this point, it is important to highlight the nature of the language used in the legislation and throughout the thesis. The labels which are attached to persons who are the subject of mental health detention have long been considered stigmatising. Such stigma flows both from informal and formal or professional language used. Terms such as ‘mental illness’ and ‘patient’ are criticised for their indiscriminate adoption of a medical interpretation of mental illness. When the biological nature of mental illness is contested these labels naturally become a point of controversy. These terms are used throughout the thesis, not because of the author’s endorsement of a medical interpretation of mental illness but because the terms are historically accurate. The thesis utilises the language of the time as it provides a revealing insight into the approach to mental illness and is, in itself, conspicuous of the intention of the legislation. So, in the early stages of the asylum, insanity had yet to be conceived of as an illness. Detention was the primary purpose of the legislation. The Lunacy Act 1821-1826 and the Criminal Lunatics Act 1838-1867 utilised the terms insane, lunacy and asylum. With the introduction of the Mental Treatment Act 1945, the title of the Act was evidence of the new purpose of the legislation - the treatment of the mentally ill. Insanity had been transformed into an illness that could be cured by the psychiatric profession, provided that treatment was

obtained. The terms of the Act consequently referred to the mentally ill, who were to be detained in mental hospitals. Again with the title of the Mental Health Act 2001, the choice of wording was significant. The title of the Act and the terms used signified a broadening of psychiatric influence. Psychiatry was no longer solely responsible for the treatment and eradication of mental illness, but was now responsible for its prevention too. Through a positive and preventative re-orientation of psychiatry the role of the psychiatrist expanded into the provision of general mental health care and welfare for the nation. Mental illness was further aligned with other physical illness and the site of intervention was changed to approved psychiatric centres and units located in general hospitals.

## 1.08 Conclusion

To date many studies have focused on various aspects of the law, the history or the sociology of mental illness in Ireland.<sup>55</sup> None, however, have applied these approaches contemporaneously nor examined the law, its operation and interpretation collectively. In doing so the thesis therefore provides a comprehensive analysis of the evolution of powers to detain the mentally ill in Ireland from the late 1700s to date. In addition, the thesis provides the first detailed account of the operation of Irish MHTs, utilising field research involving qualitative interviews. Cumulatively, the thesis provides an original contribution to the existing academic knowledge on Irish mental health law.

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<sup>55</sup> With regard to Irish mental health law see generally: Patricia Casey & Ciaran Craven, *Psychiatry and the Law* (Oak Tree Press 1999); Anne-Marie O'Neill, *Irish Mental Health Law* (First Law 2005); Darius Whelan, *Mental Health Law and Practice* (Roundhall 2009); Brendan D Kelly, "Mental Health Law in Ireland, 1821 to 1902: Building the Asylums" (2008) 76(1) *Medico-Legal Journal* 19; Brendan D Kelly, "The Mental Treatment Act 1945 in Ireland: an Historical Inquiry" (2008) 19(1) *History of Psychiatry* 47; With regard to the history of mental illness in Ireland see generally: Joseph Robins, *Fools and Mad: A History of the Insane in Ireland* (Institute of Public Administration 1986); Dermot Walsh & Antoinette Daly, *Mental Illness in Ireland 1750-2002* (Health Research Board 2004); Elizabeth Malcolm, *Swift's Hospital: A History of St. Patrick's Hospital, Dublin, 1746-1989* (Gill and Macmillan 1989); Joseph Reynolds, *Grangegorman, Psychiatric Care in Dublin since 1815* (Institute of Public Administration 1992); Markus Reuber, 'Moral Management and the Unseen Eye: Public Lunatic Asylums in Ireland, 1800-1845' in Greta Jones & Elizabeth Malcolm, *Medicine, Disease and the State in Ireland, 1650-1940* (Cork University Press 1998); With regard to the sociology of mental illness in Ireland see generally: Mark Finnane, *Insanity and the Insane in Post-Famine Ireland* (Croom Helm 1981); Damien Brennan, *Irish Insanity: 1800-2000* (Routledge 2014); Abbey Hyde, Maria Lohan & Orla McDonnell, *Sociology for Health Professionals in Ireland* (Institute of Public Administration 2004).

## CHAPTER 2

# ORIGINS OF MEDICALISM & LEGALISM IN THE LEGAL POWERS TO DETAIN THE INSANE

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### 2.01 Introduction

This chapter examines the origins and evolution of the legal powers to detain the insane from the late eighteenth century to the early twentieth century when Ireland gained independence from Britain. Through a historical examination, the origins and development of medicalism, and to a lesser extent legalism, become apparent and as a result a more adequate account of current powers of detention emerges. It is argued that the changing responses to insanity were neither the result of chance nor the product of a mere accumulation of incremental, *ad hoc* decisions absent of any underlying dynamic or logic. While the chapter examines the economic, social and political developments that influenced the creation of legislation concerning the powers to detain the insane, the primary focus is on the law and the operation of the law.

### 2.02 The Origins of Government Provision for the Insane; Workhouses & Prisons

During the first half of the eighteenth century in Ireland, the “insane” were typically viewed as wild animals absent of reason.<sup>56</sup> The majority of the insane would have been kept in the family home. Early Irish law actually obliged the kin of the insane, aged or physically disabled to care for them.<sup>57</sup> The insane would likely have experienced cruelties as many would have been kept chained in outhouses, pits and makeshift cages in the family home. Where the insane were not cared for in the family home they would have been homeless, wandering at large throughout the country, subject to ridicule and torment.<sup>58</sup> Despite this lack of care, exploitation of the insane was against the law and one could not enter into a contract with a lunatic, incite a lunatic to commit a crime or “impregnate or cause two lunatics to mate.”<sup>59</sup>

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<sup>56</sup> Andrew Scull, *Museums of Madness: The Social Organisation of Insanity in Nineteenth-Century England* (Allen Lane 1979) chs 1 and 2.

<sup>57</sup> Fragmentary text *Do brethaib gaire* (Appendix 1 No.28) as quoted in Fergus Kelly, *Early Irish Law* (Dublin Institute for Advanced Studies 2009) 94.

<sup>58</sup> Joseph Robins, *Fools and Mad: A History of the Insane in Ireland* (Institute of Public Administration 1986) 38.

<sup>59</sup> Fergus Kelly, *Early Irish Law* (Dublin Institute for Advanced Studies 2009) 94.



The latter half of the eighteenth century witnessed a period of economic expansion in Ireland. By the end of the eighteenth century, the effects of agricultural, industrial and commercial development were everywhere to be seen. Dublin, Cork and other centres had expanded and the population had risen from less than 2.5 million in the early eighteenth century to perhaps 5 million by 1800.<sup>60</sup> The expansion in the economy and the population meant that families no longer had the capabilities to care for the insane at home and an ever increasing number were to be found destitute in the newly formed and populated towns and cities. The insane became a visible and public problem.<sup>61</sup> In 1796 Marquis de Latocnaye commented that ‘one of the most painful spectacles to be seen in nearly all the principal towns of Ireland is the number of weak-minded persons in the streets.’<sup>62</sup> Although in many cases families were no longer providing for the insane, government intervention was limited and strongly linked to the control and punishment of the ‘undeserving poor’.<sup>63</sup> Ireland at the time was under British colonial rule. Political thought was not directed towards responsibility for people within Ireland, which was reflected in the absence of a Poor Law.<sup>64</sup>

By the end of the eighteenth century, however, a combination of political, economic and social factors had created a bleak and threatening national landscape. The facade of prosperity that had emerged during the eighteenth century concealed dangerous weaknesses: the agricultural economy was very weak and the manufacturing enterprises were in general smaller and less technologically advanced than their English and Scottish counterparts.<sup>65</sup> Thus, towards the end of the eighteenth century Ireland was over populated with an ailing economy which was leading to deteriorating social conditions. Furthermore, the continued Irish struggle for independence from Britain resulted in a precarious political situation and general public unrest.<sup>66</sup> The more visible the poor became, the more they were considered a threat to social order. This new perception resulted in a general change in the response to deviance in which the beginnings of centralised and highly organised government control

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<sup>60</sup> See generally, RF Foster, *Modern Ireland; 1600-1972* (Allen Lane 1988).

<sup>61</sup> Dermot Walsh, “The ups and downs of schizophrenia in Ireland” (1992) 13 *Irish Journal of Psychiatry* 12.

<sup>62</sup> Marquis de Latocnaye, *Promenade d’un Francaise dans l’Irlande 1796-7* (Dublin 1917) 63-4.

<sup>63</sup> Mairéad Considine & Fiona Dukelow, *Irish Social Policy, A Critical Introduction* (Gill and MacMillan 2009) 1-8.

<sup>64</sup> Gerard O’Brien, “The Establishment of Poor-Law Unions in Ireland, 1838-43” (1982) 23(90) *Irish Historical Studies* 97.

<sup>65</sup> See generally, RF Foster, *Modern Ireland; 1600-1972* (Allen Lane 1988).

<sup>66</sup> Joseph Robins, *Fools and Mad: A History of the Insane in Ireland* (Institute of Public Administration 1986) 68.

were seen through increased segregation of deviants from the normal population and more refined differentiation in the varieties of deviance.<sup>67</sup>

Initial moves had already been made in this direction with the establishment of several workhouses under an Act of 1772 which sought to relieve the public of the nuisance of proliferating beggars, particularly in the cities and towns.<sup>68</sup> The 1772 Act was primarily punitive rather than charitable in design although it did distinguish ‘deserving’ and ‘undeserving poor’. The undeserving poor, generally beggars, could be committed forcibly to workhouses while the deserving poor, generally the infirm, could be admitted voluntarily. The Dublin House of Industry (workhouse) provided the first form of public provision for the insane whereby ten lunatic cells were established in the workhouse in 1776.<sup>69</sup> However, even where there was no specific provision, the insane came to form a large segment of the inmates of the workhouses nationwide.<sup>70</sup>

In addition to the workhouses, the insane were also detained in prisons. Prison conditions during the eighteenth century were extremely poor. Following investigations on the matter by various parliamentary committees, the Prisons Act 1786 and its Amendment in 1787 attempted to improve some of the squalid conditions for those detained through the creation of the post of an inspector-general of prisons. In keeping with the government’s new effort to segregate and classify groups in society, the Prisons (Amendment) Act 1787 provided for specialised ‘lunatic’ wards in the few workhouses dotted throughout the country.<sup>71</sup> These lunatic wards were not the product of benevolent intentions, but rather, an attempt to make the workhouses and the prisons more efficient and the inmates more manageable. The infirm in general interfered with workhouse and prison discipline, the insane in particular caused chaos and demoralisation. The lunatic wards allowed for better control of the insane and better control of the rest of the inmates in the prisons and workhouses.<sup>72</sup> Nevertheless, the insane were still considered as part of the wider class of the poor or the criminal. As such it

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<sup>67</sup> Stanley Cohen & Andrew Scull (eds), *Social Control and the State, Historical and Comparative Essays* (Martin Robinson & Company Ltd 1983) 150.

<sup>68</sup> 11 & 12 Geo. III (Ire.), c.30; G Nichols, *History of the Irish Poor Law* (London 1856) pp51-7.

<sup>69</sup> Joseph Robins, *Fools and Mad: A History of the Insane in Ireland* (Institute of Public Administration 1986) 35.

<sup>70</sup> BD Kelly, “Mental illness in 19<sup>th</sup>-century Ireland: a qualitative study of workhouse records” (2004) 171(1) *Irish Journal of Medical Science* 53.

<sup>71</sup> Markus Reuber, ‘Moral Management and the Unseen Eye: Public Lunatic Asylums in Ireland, 1800-1845’ in Greta Jones & Elizabeth Malcolm, *Medicine, Disease and the State in Ireland, 1650-1940* (Cork University Press 1998).

<sup>72</sup> Mark Finnane, *Insanity and the Insane in Post-Famine Ireland* (Croom Helm 1981) 21.

was two magistrates who determined whether they should be detained under this prison legislation.<sup>73</sup>

In the end, only four wards were provided in the workhouses under the Prisons Act 1787 and during the rest of the eighteenth century England made no further specialised provision for the insane.<sup>74</sup> Public provision aside, some private attempts were made to provide for the insane. Unlike England, there was no extensive system of private asylums, however, some private asylums were established on a voluntary basis.<sup>75</sup> St. Patrick's Hospital, established as a result of the bequest of Jonathan Swift was the first asylum in the country. It opened in 1757 and by 1789 had approximately 109 inmates.<sup>76</sup> In a mode typical of eighteenth-century Dublin hospitals, it was sustained by voluntary donations and parliamentary grants. The Cork Lunatic Asylum was founded in 1799 by Dr William Saunders Hallaran. Around this time there was also a modest growth in the number of private asylums in Ireland.<sup>77</sup>

The eighteenth century marked the beginnings of the government's involvement in the classification of different groups in society and the segregation of the deviant through detention. For the purposes of this chapter it marked the beginning of the government's involvement in establishing specific detention provisions for the insane. These concepts of classification and segregation through detention were to remain dominant into the nineteenth century and were to have a significant impact on the development of the asylum system.

### **2.03 The Birth of the Asylum 1817 to 1830**

The birth of the asylum system in Ireland must be seen as intimately connected to a whole series of historically specific and closely interrelated changes in the Irish political, economic and social situation.<sup>78</sup> Aspirations for a stable and prosperous Irish society saw a concerted

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<sup>73</sup> Mark Finnane, *Insanity and the Insane in Post-Famine Ireland* (Croom Helm 1981) 22.

<sup>74</sup> Dermot Walsh & Antoinette Daly, *Mental Illness in Ireland 1750-2002* (Health Research Board 2004) 14.

<sup>75</sup> Private asylums grew as well, but never figured nearly as prominently and there was approximately less than 5 at the start of the nineteenth century- Joseph Robins, *Fools and Mad: A History of the Insane in Ireland* (Institute of Public Administration 1986) 80. In the case of the few private institutions supported by charitable donations, admission was extremely difficult to secure- Elizabeth Malcolm, *Swift's Hospital: A History of St. Patrick's Hospital, Dublin, 1746-1989* (Gill and Macmillan 1989); Brendan D Kelly, "Mental Health Law in Ireland, 1821 to 1902: Building the Asylums" (2008) 76(1) *Medico-Legal Journal* 19.

<sup>76</sup> See generally Elizabeth Malcolm, *Swift's Hospital: A History of St. Patrick's Hospital, Dublin, 1746-1989* (Gill and Macmillan, 1989); Greta Jones & Elizabeth Malcolm, *Medicine, Disease and the State in Ireland 1650-1940* (Cork University Press 1999) 29.

<sup>77</sup> Brendan D Kelly, "Mental Health Law in Ireland, 1821 to 1902: Building the Asylums" (2008) 76(1) *Medico-Legal Journal* 19, 20.

<sup>78</sup> Indeed other influential work to date on the history of psychiatry has also looked at the particular exigencies of the country in question. See Michael Foucault, *Madness and Civilisation: A History of Insanity in the Age of Reason* (Plon 1961, Pantheon 1965); Andrew Scull, *Museums of Madness: The Social Organisation of Insanity*

effort to establish social order in the face of disorder, political discord, over-population and a weak agrarian economy.<sup>79</sup> For centuries Ireland had been under British colonial rule. In 1800 the Act of Union, under which Ireland and Britain became one political unit, abolished the Irish Parliament which had existed in one form or another since the thirteenth century.<sup>80</sup> Quite simply, Britain did not trust it to govern Ireland effectively, especially when Britain was at war with revolutionary Napoleonic France. Against much opposition, advocates of the Union argued that it would create a stable Ireland, with a higher standard of living comparable to that of England and sought a 'programme of conciliation and reform' including an attempt to ameliorate the conditions of the poor'.<sup>81</sup> Government intervention grew throughout the century yet the nature of this colonial administration meant that the emerging social interventions were designed for control and maintenance of order rather than the provision of welfare for the populace.<sup>82</sup>

As it had been in the eighteenth century, the guiding principles for social intervention in the nineteenth century were classification and segregation, albeit, in an intensified form. These two concepts were now considered prerequisites for any progressive and well organised society. The insane had contributed to social disorder in the country and now it was believed that their disruptive presence in prisons and workhouses could be avoided by their complete segregation. For centuries, in the absence of institutions, the insane had been tolerated; now that tolerance was fading as the system of prisons and workhouses offered the possibility of controlling them.<sup>83</sup> By the nineteenth century, however, these institutions increasingly came to be seen as inappropriate for the detention of the insane and further segregation was required.<sup>84</sup> Following previous failed attempts to establish provincial asylums in Ireland, due

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*in Nineteenth-century England* (Allen Lane 1979). RD Laing, *The Divided Self: An Existential Study in Sanity and Madness* (Penguin 1960); David Cooper, *Psychiatry and Anti-Psychiatry* (Tavistock Publications Ltd 1967); Erving Goffman, *Asylums* (Anchor 1961); David J Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (Little Brown 1971).

<sup>79</sup> Mark Finnane, *Insanity and the Insane in Post-Famine Ireland* (Croom Helm 1981) 18-19.

<sup>80</sup> In reality it was neither an Irish nor an independent Parliament as Catholics could not vote until 1793 and never had the right to sit in the Irish Parliament. Neither was it independent as the executive branch of government, the Lord Lieutenant, was appointed by the crown and was not answerable to the Parliament. Furthermore, Poyning's Law, imposed on Ireland in 1495, restricted the Irish Parliament from taking action on any law that was not pre-certified by the crown. But in the last quarter of the eighteenth century, the Irish Parliament, led by MP Henry Grattan, persuaded the crown to allow more independence. One result of liberalization was the Irish Constitution of 1782 which modified Poyning's Law.

<sup>81</sup> McDowell as quoted in Mark Finnane, *Insanity and the Insane in Post-Famine Ireland* (Croom Helm 1981) 22.

<sup>82</sup> Mel Cousins, *Explaining the Irish Welfare State: An Historical Comparative and Political Analysis* (Edwin Mellen Press 2005) 9.

<sup>83</sup> Joseph Robins, *Fools and Mad; A History of the Insane in Ireland* (Institute of Public Administration 1986) 60.

<sup>84</sup> Mark Finnane, *Insanity and the Insane in Post-Famine Ireland* (Croom Helm 1981) 22.

to opposition on the grounds of taxation, a government grant was secured in 1810 for the establishment of a separate general asylum for the insane.<sup>85</sup> The Richmond Asylum, built between 1810 and 1815, replaced the lunatic ward of the Dublin House of Industry and became the major and only centre of public care for the insane in the country. In 1814 the Richmond Lunatic Asylum was opened with accommodation for 300 lunatics.<sup>86</sup> It quickly became overcrowded and it was clear that systematic reform throughout Ireland, not only Dublin, was needed.<sup>87</sup>

Between 1812 and 1817, the Chief Secretary of Ireland was Robert Peel. During this time he set about asserting the power of central government in the social control of the Irish populace. Most notable of his efforts were measures for the policing of Ireland and the establishment of the system of public asylums. In both cases he was of the view that the Irish gentry were unwilling or unable to ensure the disciplinary measures necessary for the good government of Ireland.<sup>88</sup> Between 1814 and 1816 Peel directed two inquiries into the public care of the insane. These inquiries recommended the formation of district asylums ‘exclusively appropriated to the reception of the insane’. The Committees responsible for the inquiries were of the opinion that it was the duty of the government to provide for the insane and as such there needed to be central control of an additional four or five asylums country wide. As a result, the Lunacy (Ireland) Act 1821 was passed and in conjunction with amending Acts in 1825 and 1826 resulted in the construction of eight asylums in the first stage of the foundation of an asylum system in Ireland.<sup>89</sup> In 1825 the first asylum was established in Armagh followed by a further eight in Ballinasloe, Belfast, Carlow, Clonmel, Derry, Limerick, Maryborough and Waterford.<sup>90</sup> The initial asylums were conservative in size

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<sup>85</sup> A Select Committee of the House of Commons in 1804 concluded that there was a greater need for public provision for the insane in Ireland than in England. The Committee recommended the construction of four asylums to reduce the numbers residing in prisons and workhouses. As a result a Bill for the establishment of four provincial asylums to cater for 1,000 insane persons was initiated but failed due to opposition on the grounds of taxation and interference with local interests. See Joseph Robins, *Fools and Mad: A History of the Insane in Ireland* (Institute of Public Administration 1986) 60; Mark Finnane, *Insanity and the Insane in Post-Famine Ireland* (Croom Helm 1981) 23.

<sup>86</sup> Eoin O’Brien, Lorna Browne & Kevin O’Malley (eds) *The House of Industry Hospitals 1772-1787: The Richmond, Whitworth and Hardwicke (St. Laurence’s Hospital): A Closing Memoir* (The Anniversary Press 1988) 36. The Richmond Asylum was placed under separate management in 1838 and in 1921 became Grangegorman Mental Hospital, a name later changed to St. Brendan’s Hospital

<sup>87</sup> Brendan D Kelly, “Mental Health Law in Ireland, 1821 to 1902: Building the Asylums” (2008) 76(1) *Medico-Legal Journal* 19; Markus Reuber, “The architecture of psychological management: the Irish asylums (1801-1922)” (1996) 26(6) *Psychological Medicine* 1179.

<sup>88</sup> Mark Finnane, *Insanity and the Insane in Post-Famine Ireland* (Croom Helm 1981) 14.

<sup>89</sup> Mark Finnane, *Insanity and the Insane in Post-Famine Ireland* (Croom Helm 1981) 25-27.

<sup>90</sup> Joseph Robins, *Fools and Mad: A History of the Insane in Ireland* (Institute of Public Administration 1986) 66; Damien Brennan, *Irish Insanity; 1800-2000* (Routledge 2014) 61.

compared with those constructed from the mid-1830s onwards. For example, Ballinasloe only had 150 beds.<sup>91</sup> Significantly, the development of a public asylum system preceded the establishment of a similar system in England. The early implementation of this policy has been attributed to the ease with which a colonial administration could impose policies and laws on otherwise dissenting parties at a local level, as it could be done with force if necessary. This option was lacking in England.<sup>92</sup>

The original enthusiasm in the establishment of the asylums had led to an optimistic expectation about the cure of the insane. Instead, many of the insane remained incurable and accumulated in the asylum without any expectation of early discharge.<sup>93</sup> The asylums quickly became overcrowded and the overcrowding led to deterioration in the care provided.<sup>94</sup> More asylums were needed and by 1830 several had been built nationwide, with still more planned.<sup>95</sup>

## **2.04 Moral Treatment & the Medical Take-Over**

The initial development of the asylum system was stimulated by the view that, given the proper setting, moral treatment offered the prospect of cure for many forms of insanity.<sup>96</sup> Moral treatment was a therapeutic approach that had emerged as an alternative to traditional “medical” treatments for the insane. This approach believed that a cure for insanity was possible but through humane management as opposed to the orthodox medical treatments which were primitive in nature and mostly involved bloodletting, purging and physical restraints such as chains and manacles. Moral treatment repudiated the use of force, preferring the use of ‘moral control’, a therapy by which psychological ascendancy would be established over the lunatic by the moral governor through character, expertise and moral example.<sup>97</sup> It had its origins in post-revolutionary France where, Philippe Pinel famously

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<sup>91</sup> Damien Brennan, *Irish Insanity; 1800-2000* (Routledge 2014) 61.

<sup>92</sup> Mark Finnane, *Insanity and the Insane in Post-Famine Ireland* (Croom Helm 1981) 31; Pauline Prior, “Prisoner or patient? The official debate on the criminal lunatic in nineteenth-century Ireland” (2004) 15(2) *History of Psychiatry* 177.

<sup>93</sup> Brendan D Kelly, “Mental Health Law in Ireland, 1821 to 1902: Dealing with ‘the Increase of Insanity in Ireland’” (2008) 76(1) *Medico-Legal Journal* 26.

<sup>94</sup> Markus Reuber, “The architecture of psychological management: the Irish asylums (1801-1922)” (1996) 26(6) *Psychological Medicine* 1179.

<sup>95</sup> Joseph Robins, *Fools and Mad: A History of the Insane in Ireland* (Institute of Public Administration 1986) 65-67.

<sup>96</sup> Markus Reuber, “The architecture of psychological management: the Irish asylums (1801-1922)” (1996) 26(6) *Psychological Medicine* 1179.

<sup>97</sup> Andrew Scull, *Insanity of the Place/Place of Insanity, Essays on the History of Psychiatry* (Routledge 2006) 115.

struck the chains from the limbs of lunatics in the Paris asylums.<sup>98</sup> In reality it was actually Pinel's assistant, Pussin, who removed the shackles at a later date, nevertheless, Pinel can be credited with transforming French perception of the mad into the sick.<sup>99</sup> In Britain, the same principles were being applied by a Quaker family, the Tukes, who founded the hugely influential York Retreat for the insane.<sup>100</sup> The moral treatment used in the York Retreat emphasised the importance of the relationship between the governor and the insane and believed that the use of reward and punishment, reason and emotion would help relieve the symptoms of insanity. The moral governor established comprehensive rules and constant surveillance, enforced by simple rewards and punishments. Sanity was to be restored through self-discipline.<sup>101</sup> Moral treatment demonstrated how the existing responses to insanity were actually unnecessary cruelties and Pinel and Tuke were held as enlightened reformers of their time. However, accepting only the benevolent aspects of moral treatment fails to recognise its role in social control and Scull and Foucault have questioned its undisputed humanitarian intentions.<sup>102</sup> For Scull through moral treatment the main instruments of control in the asylum became the graded punishment and reward system, shame and guilt became the new methods of coercion, and by establishing good work habits the lunatic could be rehabilitated as a productive member of society.<sup>103</sup>

The manner of care established in the first public asylum in Ireland, the Richmond Asylum, and other asylums thereafter was based on moral treatment. Dr Jackson the physician to the Richmond Asylum stressed moral treatment, comfort and a therapeutic environment. Dr Saunders Halloran in Cork advocated a similar approach.<sup>104</sup> However these two physicians were the exception to the norm and the majority of the asylums were run by a governor, a layman, who was referred to as the 'moral governor'. As the role of the asylum was in the management and guidance of the lunatic, not his subjection to physical treatment, moral

<sup>98</sup> William F Bynum, 'Rationales for Therapy in British Psychiatry, 1770–1835' in Andrew Scull (ed), *Madhouses, Mad-Doctors, and Madmen: The Social History of Psychiatry in the Victorian Era* (Athlone/University of Pennsylvania Press 1981) 35–57.

<sup>99</sup> Dora B Weiner, 'Le geste de Pinel: The history of a psychiatric myth' in Mark S Micale & Roy Porter (eds), *Discovering the History of Psychiatry* (Oxford 1994), 244.

<sup>100</sup> Anne Digby, 'Moral Treatment at the York Retreat' in William Bynum, Roy Porter and Michael Shepard (eds) *The Anatomy of Madness* (Tavistock 1985) Vol 2, 52–72.

<sup>101</sup> Andrew Scull, *Insanity of the Place/Place of Insanity, Essays on the History of Psychiatry* (Routledge 2006) 115.

<sup>102</sup> Michael Foucault, *Madness and Civilisation: A History of Insanity in the Age of Reason* (Plon 1961, Pantheon 1965); Stanley Cohen & Andrew Scull (eds), *Social Control and the State, Historical and Comparative Essays* (Martin Robinson & Company Ltd 1983) 145–152.

<sup>103</sup> Stanley Cohen & Andrew Scull (eds), *Social Control and the State, Historical and Comparative Essays* (Martin Robinson & Company Ltd 1983) 152–153.

<sup>104</sup> Arthur P Williamson, "Psychiatry, moral management and the origins of social policy for mentally ill people in Ireland" (1992) 161(9) *Irish Journal of Medical Science* 155.

treatment had no real medical basis and there was no need for medical management. There was also nothing in the training of a physician or apothecary that qualified them for the moral governor role. As a result most appointments made were of non-medical personnel. However, it was accepted that there should be a physician on the staff appointed to treat any physical illness. These were employed in a visiting capacity only.<sup>105</sup>

## **2.05 Psychiatric Professionalisation & the Origins of Medicalism**

The fact the moral treatment did not end medical involvement in the care of the insane has been attributed to the ingenuity and political astuteness of a number of Irish physicians who used the asylum to effectuate the professionalisation of psychiatry.<sup>106</sup> There are several fundamental characteristics of a profession. Members of a profession are thought to have expertise in a specific body of knowledge, that is formulated through specialised education and training. They provide a service, of which they have a monopoly, through the exclusion of or dominance over similar occupations. In furtherance of this monopolisation, external supervision and interference is excluded and internal supervision of the profession is promoted. Cumulatively this provides the profession with income, power and prestige.<sup>107</sup> When the asylums were first established in Ireland there was no profession of psychiatry, as the asylum system expanded, however, this changed and the characteristics of an Irish psychiatric profession emerged. Through the asylum, physicians advanced their own social status as a profession, which was dependent on them achieving dominance over similar occupations and a monopoly control of insanity in general.

As mentioned, most of the asylums were run by lay moral governors, however, several influential members of the medical profession strongly objected to their administration by lay men and resented both their status as the principal officer and their lack of a professional qualification.<sup>108</sup> In some asylums physicians had actually been appointed to the role of moral governor, for example Dr Robert Stewart in Belfast in 1835 and Dr James Flynn in Clonmel in 1841. In these asylums the physicians established a medical system of asylum control. In

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<sup>105</sup> Joseph Robins, *Fools and Mad: A History of the Insane in Ireland* (Institute of Public Administration 1986) 92.

<sup>106</sup> Stanley Cohen & Andrew Scull (eds), *Social Control and the State, Historical and Comparative Essays* (Martin Robinson & Company Ltd 1983) 154.

<sup>107</sup> William J Goode, "Encroachment, Charlatanism and the Emerging Profession: Psychology, Sociology and Medicine" (1960) 25(6) *American Sociological Review* 902; Anne Rogers & David Pilgrim, *A Sociology of Mental Health and Illness* (3<sup>rd</sup> Ed, Open University Press 2005) 121.

<sup>108</sup> Arthur P Williamson, "Psychiatry, moral management and the origins of social policy for mentally ill people in Ireland" (1992) 161(9) *Irish Journal of Medical Science* 155.



other asylums where there were lay moral governors, there was a significant medical influence also. In Carlow the visiting physician Dr John Jacob had established complete authority over the lay moral governor. As a result, treatment of those detained in the Carlow asylum was medical as opposed to moral with 41 residents taking medication for the cure of insanity.<sup>109</sup> However, this was not the norm and it took further developments for the establishment of medical dominance.

One of the first moves towards the establishment of a distinct psychiatric profession in Ireland was the creation of a professional organisation; the Association of Medical Officers of Asylums and Hospitals for the Insane. Founded in 1841, the Association drew its membership from the medical staff of the asylums in Britain and Ireland.<sup>110</sup> The Association held annual meetings for the consideration of common interests and purposes. It is unclear whether any Irish representation attended the first two meetings, but at the third meeting Dr Robert Stewart of Belfast attended and the subsequent year acted as secretary.<sup>111</sup> Given the fact that the asylums were predominantly run by lay persons the Association had a somewhat precarious start. Dr Stewart, along with other medics campaigned against this. Most notably, Dr John Jacob circulated a pamphlet in 1834 ridiculing the idea of anyone other than a medic being competent to apply moral treatment.<sup>112</sup> With the passage of time, the Association grew in importance and by 1853 was publishing its own journal. The *Asylum Journal* which later became the *Asylum Journal of Mental Science* in 1855, the *Journal of Mental Science* in 1858 and the *British Journal of Psychiatry* in 1963, provided a fundamental ‘means of vivifying and extending and uniting’ a scattered membership, and forming the centre of the profession’s vitality.<sup>113</sup> From the beginning the Journal showed a lively interest in Irish affairs.<sup>114</sup>

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<sup>109</sup> Mark Finnane, *Insanity and the Insane in Post-Famine Ireland* (Croom Helm 1981) 40.

<sup>110</sup> Andrew Scull, *The Most Solitary of Afflictions, Madness and Society in Britain, 1700-1900* (Yale University Press 1993) 232-266.

<sup>111</sup> Dermot Walsh, ‘History of the Mental Health Services in Ireland; A Nation Once Again’ <<https://sites.google.com/site/iimhlinireland2010/iimhl-ireland/mental-health-in-ireland-1/history-of-mental-health-services-in-ireland>> accessed 3 July 2014.

<sup>112</sup> Joseph Robins, *Fools and Mad: A History of the Insane in Ireland* (Institute of Public Administration 1986) 94.

<sup>113</sup> Comments by John Charles Bucknill in his ‘Presidential Address’ (1860) 7 *Journal of Mental Science* 4-5 in Andrew Scull, *The Most Solitary of Afflictions, Madness and Society in Britain, 1700-1900* (Yale University Press 1993) 233.

<sup>114</sup> Dermot Walsh, ‘History of the Mental Health Services in Ireland; A Nation Once Again’ <<https://sites.google.com/site/iimhlinireland2010/iimhl-ireland/mental-health-in-ireland-1/history-of-mental-health-services-in-ireland>> accessed 3 July 2014.

Another crucial move in the professionalisation of psychiatry was made at the legislative level around this time. Up until, 1843 the Inspectors of Prisons were also responsible for the inspection of asylums and therefore their position made them influential as the main advisors on lunacy matters to the Lord Lieutenant (British monarch's official representative and head of the Irish executive during British rule). However, they showed little interest in the issue of the insane and were very tolerant and sparing in their criticisms of both public and private asylums.<sup>115</sup> In 1841, Dr Francis White, a surgeon in the Richmond Asylum, initiated a campaign to secure medical participation in the development of lunacy policy. White criticised the inspections of the asylums by the Inspectors of Prisons, claiming they were of no benefit. White's campaigning had brought him to notice and when one of the inspectors died later that year he was appointed as an Inspector of Prisons. During his time in this role he worked to establish a separate Lunacy Inspectorate and in his new position he was in a position to influence the Government on such matters.<sup>116</sup>

The General Rules for the Governance of All District Lunatic Asylums 1843<sup>117</sup> were the first step in which White sought to establish medical control of the asylums. Such rules were necessary, as White explained to the 1843 Committee on the Lunatic Poor, because the asylums had not fulfilled their object of cure in spite of their significant cost. He implied that the lack of medical management of the asylums was to blame for this failure and what was needed was a set of rules which would define the duties of the various officers involved.<sup>118</sup> When it was agreed to establish these Rules, White drafted them without recourse to any asylum personnel, with the exception of some of the medical officers. The result was a complete reversal of previous responsibilities in the asylum. The 1843 Rules standardised the asylum regulations and in practice served to consolidate medical authority within them.<sup>119</sup> Under the Rules, the visiting physician became responsible for the 'moral and medical treatment' of the insane as well as advising governors as to when they should be discharged. In the furtherance of these duties, the physician was required to attend the asylum 3 days a week where there were more than 250 lunatics in residence. The result was that the governor

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<sup>115</sup> Since 1787 the inspector of prisons in Ireland had been responsible for inspecting private asylums, with the establishment of the district asylums they were directed to inspect them also -Mark Finnane, *Insanity and the Insane in Post-Famine Ireland* (Croom Helm 1981) 41; Joseph Robins, *Fools and Mad: A History of the Insane in Ireland* (Institute of Public Administration 1986) 83.

<sup>116</sup> Mark Finnane, *Insanity and the Insane in Post-Famine Ireland* (Croom Helm 1981) 39-47.

<sup>117</sup> These rules were published within the Inspector General, *Report on the District, Local and Private Lunatic Asylums in Ireland 1843* (1844) Appendix No 3, 43-48.

<sup>118</sup> Mark Finnane, *Insanity and the Insane in Post-Famine Ireland* (Croom Helm 1981) 39-47.

<sup>119</sup> Damien Brennan, *Irish Insanity; 1800-2000* (Routledge 2014) 71.

became the agent of the physician.<sup>120</sup> While it was accepted by White that the governors had felt slighted by the new rules he believed that upon careful consideration the Lords Committee would realise the new arrangements were advantageous to ‘public and patient’. The possibility of any other opinion on the matter was dismissed with references made to the exclusive authority of medical expertise. When commenting on the objection to medical control by the previous Inspector of Prisons, White stated that Major Woodward, not being a medical man could not be held to have the best experience in such matters.<sup>121</sup> The assertion of medical expertise was the basis for the profession’s claim to the management of asylums despite the fact that this expertise had no factual basis at this point.

Subsequently, the Office of Lunacy was created in 1846.<sup>122</sup> The legislation which created it provided for two posts of Inspectors of Lunacy who had the duty of inspecting and reporting on asylums and other institutions caring for lunatics once a year and was detached from the prison system. The role of the Inspectorate was not only the review of standards of care in the asylums but also to manage the direction of the whole system.<sup>123</sup> In this manner, external interference and supervision of the asylum and the medical treatment therein was displaced and internal medical supervision was achieved. White and another physician, Dr Nugent, were appointed as the first Inspectors of Lunatics. While the qualifications for the post were undefined in the legislation, it was assumed from the beginning that only physicians would be appointed. White, and his fellow Inspector Nugent, then set out to consolidate the medical influence in the review of the system and its development and operation.<sup>124</sup>

White and Nugent wanted to replace the lay governors in the asylums as had already been achieved in those outlined above. The English and Scottish members of the Association of Medical Officers of Asylums and Hospitals for the Insane also vehemently supported their Irish colleagues in lobbying for the appointment of physicians in all public hospitals.<sup>125</sup> White and Nugent began to remove the lay management of the asylums as soon as was possible,

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<sup>120</sup> *Ibid*; Mark Finnane, *Insanity and the Insane in Post-Famine Ireland* (Croom Helm 1981) 39-47; Joseph Robins, *Fools and Mad: A History of the Insane in Ireland* (Institute of Public Administration 1986) 95.

<sup>121</sup> Mark Finnane, *Insanity and the Insane in Post-Famine Ireland* (Croom Helm 1981) 43. See also Arthur P Williamson, “Psychiatry, moral management and the origins of social policy for mentally ill people in Ireland” (1992) 161(9) *Irish Journal of Medical Science* 155 for a discussion about the contest between physicians and the lay moral managers.

<sup>122</sup> Dermot Walsh, ‘History of the Mental Health Services in Ireland; A Nation Once Again’ <<https://sites.google.com/site/iimhlinireland2010/iimhl-ireland/mental-health-in-ireland-1/history-of-mental-health-services-in-ireland>> accessed 3 July 2014.

<sup>123</sup> 8 & 9 Vic., c.107. Mark Finnane, *Insanity and the Insane in Post-Famine Ireland* (Croom Helm 1981) 32.

<sup>124</sup> Joseph Robins, *Fools and Mad: A History of the Insane in Ireland* (Institute of Public Administration 1986) 92.

<sup>125</sup> Mark Finnane, *Insanity and the Insane in Post-Famine Ireland* (Croom Helm 1981) 45.

initially by replacing those who retired or died. In addition, any new asylum now had a medical governor appointed *ab initio*. By 1853, nine of the fourteen asylums were controlled by physicians and in 1859, only one lay manager remained.<sup>126</sup>

As a result of the replacement of the moral governors of the asylums with physicians, a conflict had arisen between the role of this new medical manager and the visiting physician. It was argued that the role of the visiting physician demeaned that of the resident physician who was now believed to be the expert in insanity. Consequently, the post of Resident Medical Superintendent was established under the Asylum Rules 1862. These Rules established the definitive authority of the Resident Medical Superintendent in the asylum who was provided with complete responsibility for the medical and moral treatment of all residents and for the domestic management of the asylum. The visiting physician's role was reduced to that of a consultant. This new found authority in the asylum created the conditions for the emergence of a new specialisation in Irish medicine; psychiatry. Its emergence was not determined by its theoretical or practical superiority in the treatment of the insane but rather by institutional politics.<sup>127</sup>

Other measures such as the attempt to enhance the exclusivity of the psychiatric knowledge by seeking to establish a specialist teaching school in St. Patrick's Asylum were made by White. While this school never came to fruition, perhaps because hospital resources became restricted in the Famine, it is evidence of his incredible foresight in his attempts to further the profession.<sup>128</sup> A more successful endeavour in influencing the running of the asylum in accordance with medical principles came with the Inspectors of Lunacy's attendance at the meetings of asylum boards. On their suggestion they were subsequently made *ex officio* members of all the district asylum boards by the Lord Lieutenant and involved themselves fully in all matters concerning the development of the asylums, except financial matters.<sup>129</sup> Cumulatively, these measures resulted in a medical monopoly over the asylum system.

It was on the basis of their control over the new and expanding asylum system that psychiatry made use of its medical identity to construe a particular status and authority to its work. While psychiatry was slow to establish itself as a profession of power and status, through its

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<sup>126</sup> Joseph Robins, *Fools and Mad: A History of the Insane in Ireland* (Institute of Public Administration 1986) 96.

<sup>127</sup> Mark Finnane, *Insanity and the Insane in Post-Famine Ireland* (Croom Helm 1981) 47.

<sup>128</sup> Elizabeth Malcolm, *Swift's Hospital, A History of St Patrick's Hospital, Dublin 1746-1989* (Gill and MacMillan 1989) 117-121.

<sup>129</sup> Joseph Robins, *Fools and Mad: A History of the Insane in Ireland* (Institute of Public Administration 1986) 96.

work in the asylum it came to be the dominant force in insanity.<sup>130</sup> The government effectively handed over the asylums to physicians and as a result had largely removed the institutions and those detained therein from the public arena.<sup>131</sup> Through the ingenuity and political astuteness of certain physicians and their organisational power, psychiatry was established as a profession. The monopoly over the asylum provided the potential for defining the social reality in which the members of psychiatry were to function.<sup>132</sup> In doing so the psychiatric profession became the dominant agent in all matters concerning insanity, as is evidenced not only in the treatment and care of those detained but also in the inspection of the asylums by the Inspectors of Lunacy and their membership of the asylum boards. Importantly, psychiatry's involvement in the asylum, its role in detention and the monopoly over the legitimate treatment of insanity formed the foundation of psychiatric control over various forms of behaviour. It was now psychiatry that determined who was insane, what was normal or not, and who could be subject to detention, and thus, their power extended far beyond the asylum. Consequently, these developments resulted in the birth of medicalism whereby psychiatry was provided with complete control over the treatment and care of the insane in Ireland.

## 2.06 The Law & the Insane

As stated in the introduction, legal provisions concerning detention admission processes provide good indications as to the existence of medicalism or legalism. Therefore, it is necessary to examine these in order to get an understanding of the development of medicalism or legalism during this period. During the early stages of asylum building medical opinion was not yet indispensable. Accordingly, admission to the first public asylum, the Richmond Asylum, was based on a certificate of insanity signed by a clergyman, a magistrate (judge) or a physician.<sup>133</sup> It is no coincidence that members of the three traditional professions of religion, law and medicine were provided with this authority, for these bodies had a significant power and prestige in society as a result of their professional status.<sup>134</sup> Although the purpose of the legislation was not to control medical discretion, it could be said

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<sup>130</sup> Andrew Scull, *Insanity of the Place/Place of Insanity: Essays on the History of Psychiatry* (Routledge 2006) 112.

<sup>131</sup> Mark Finnane, *Insanity and the Insane in Post-Famine Ireland* (Croom Helm 1981) 47.

<sup>132</sup> Keith MacDonald, *The Sociology of the Professions* (Sage Publications 1995) 8.

<sup>133</sup> Joseph Robins, *Fools and Mad: A History of the Insane in Ireland* (Institute of Public Administration 1986) 64.

<sup>134</sup> See generally Keith MacDonald, *The Sociology of the Professions* (Sage Publications 1995).

that these provisions represented an early form of legalism in that they were designed to prevent arbitrary detention.

Subsequently, the legislation which provided for the first round of asylum building, the Lunacy (Ireland) Act 1821, established a detention procedure which corresponded with the emerging ideals of the asylum system.<sup>135</sup> The rhetoric of the asylum system was care rather than punishment, therefore it was no longer a magistrate or clergyman who determined the suitability of detention, and in line with medicalism, this now came within the sole remit of the physician. Applications for admission to the district asylums needed to be accompanied by a medical certificate of insanity and a statement from next of kin confirming poverty. The person seeking admission of a friend or relative also had to provide an undertaking to take back this person when requested to do so by the asylum board.<sup>136</sup> The requirement for medical certification could be seen as peculiar given that, at the time, the manner of care established in the asylums was moral treatment, which was administered by lay men. As stated, entry into the asylum had previously been decided by one of three professionals; magistrates, clergymen or physicians. However, the new purpose of the asylum was care and treatment. Physicians had traditionally been involved in the care and treatment of people in general and therefore, out of these three professionals, physicians were now the most appropriate people for the job. In 1843, this medicalism was further developed whereby the Asylums Rules provided that, in an emergency, the physician could detain on his own authority without the approval of the asylum board.<sup>137</sup>

Specific legislation governing detention in private asylums was also enacted. In 1844 there were approximately 14 private asylums detaining 299 people, approximately 12% of the total population of the insane in public and private asylums.<sup>138</sup> For these, the Private Asylums Act 1842 provided that all admissions should be at the instance of an order made by a relative or friend. The detention required certification from two physicians who had separately examined the proposed lunatic and who were independent from the asylum and its proprietors. The private asylums also required licences, whereas charitable and public asylums did not. In addition they were subject to inspections every six months by the two Inspectors of Lunacy

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<sup>135</sup> Department of Health, *Report of the Commission of Inquiry on Mental Illness* (Stationary Office 1966) 9.

<sup>136</sup> Brendan D Kelly, "Mental Health Law in Ireland, 1821 to 1902: Building the Asylums" (2008) 76(1) *Medico-Legal Journal* 19.

<sup>137</sup> Inspectors General, *Report on the District, Local and Private Lunatic Asylums in Ireland 1843* (1844) Appendix No 3, 44.

<sup>138</sup> Damien Brennan, *Irish Insanity; 1800-2000* (Routledge 2014) 132; Joseph Robins, *Fools and Mad: A History of the Insane in Ireland* (Institute of Public Administration 1986) 82. In 1844 there were 2136 persons resident in public asylums, Damien Brennan, *Irish Insanity; 1800-2000* (Routledge 2014) 130.

as opposed to the annual inspection of public asylums. Where the asylum was not run by a physician, it was required that one visit fortnightly.<sup>139</sup> These enhanced protective requirements had their origins in English agitation over private asylums, of which there were many.<sup>140</sup> The distinction between the admission and detention of private and pauper lunatics also highlights the histories of the two classes. Public asylums were seen by the government as paternalistic institutions erected for the care of the insane poor. As no direct financial advantage would issue to the asylum governors in the committal of a poor person, one medical certificate was a sufficient safeguard to ensure correct admission. Alternatively, private asylums were places of profit where wealthy people might be detained to the pecuniary advantage of the asylum owner. As there was a higher risk of unwarranted detention, heightened safeguards were needed and two medical certificates were deemed necessary to protect against abuse. Thus, for the rich, whose rights required more protection we see the beginnings of legalism, albeit, in a form that relied on medical discretion and control.

Although the thesis is primarily concerned with civil detention procedures, it is necessary to consider the Criminal Lunatics (Ireland) Act 1838, as through its abuse it became the primary manner by which persons entered the asylum in Ireland during the latter half of the nineteenth century. The 1838 Act was enacted to provide for the detention of ‘criminal lunatics’ and sought to make ‘provision for the better prevention of crime being committed by persons insane’. However, there was no requirement for the person to have committed a crime; they just had to be presumed to be dangerous. Given that the 1838 Act concerned the detention of *criminal* lunatics, two magistrates were responsible for ordering the detention and could call to their assistance any physician to certify the person as a dangerous lunatic or idiot. The criminal lunatic would be committed to a prison where they would remain until they were discharged by an order of two magistrates (including one who had signed the committal warrant) or until they were transferred to an asylum by order of the Lord Lieutenant.<sup>141</sup> Although there was the option of using medical evidence to inform their decision, the magistrates were free not to do so and could make the committal on their own judgement or ‘from other proof’. This other proof could be an unsworn statement from the person seeking

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<sup>139</sup> Joseph Robins, *Fools and Mad: A History of the Insane in Ireland* (Institute of Public Administration 1986) 82.

<sup>140</sup> Mark Finnane, *Insanity and the Insane in Post-Famine Ireland* (Croom Helm 1981) 91-92.

<sup>141</sup> Mark Finnane, *Insanity and the Insane in Post-Famine Ireland* (Croom Helm 1981) 91.

the committal.<sup>142</sup> While it is difficult to attribute to the 1838 Act a definitive legalism label, a conjectural explanation is that, as it was criminality that was at issue, it was adjudged that expertise in this area lay with magistrates rather than physicians. Therefore, there was no role for medical discretion and there was some need to protect the rights of those accused.

In reality, the extent to which this legalism resulted in the protection of those accused was negligible and the 1838 Act was subject to wide abuse. The 1838 Act was used in inventive ways to have persons detained in asylums by those involved in its operation, including families, physicians and the magistrates.<sup>143</sup> There was great laxity in its administration by magistrates; where medical advice was sought it was often unquestioned, and the use of unreliable and unsworn evidence was common. This form of admission became the most popular mode of detention in Ireland during the nineteenth century.<sup>144</sup> From the beginning it was much easier to have a person detained under the 1838 Act, as unlike an ordinary admission to a district asylum, there was no requirement of proof of poverty. Also, the usual form of admission to an asylum required a responsible person to take back the lunatic when called on to do so by the asylum board. Admission under the 1838 Act avoided this. As the person was now a 'criminal lunatic' the judicial procedure encompassed a government responsibility for his care and the protection of society.<sup>145</sup> There was also no definition of insanity and this provided the possibility for detention on a wide range of grounds. In this manner there were many cases where admissions to asylums were not on the basis of insanity but rather the wish to remove persons from the community for other, less benign, reasons.<sup>146</sup>

During its thirty years in existence the Criminal Lunatics Act 1838 created a series of crises for both the asylum system and the prisons to which 'dangerous lunatics' were detained until they were transferred to an asylum.<sup>147</sup> This state of affairs led to an amendment in the law in 1845 that provided that a person could not be detained as a 'dangerous lunatic' without evidence on oath of one or more credible witnesses given before the committing magistrates.<sup>148</sup> This new provision and other efforts made by the Inspectors of Lunacy, such

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<sup>142</sup> *Ibid.*

<sup>143</sup> See generally Mark Finnane, 'Law and the social uses of the asylum in nineteenth century Ireland' in John Carrier & Dylan Tomlinson (eds), *Asylum in the Community* (Routledge 1996).

<sup>144</sup> Pauline Prior, "Dangerous Lunacy: The Misuse of Mental Health Law in Nineteenth-Century Ireland" (2003) 14(3) *Journal of Forensic Psychiatry & Psychology* 525.

<sup>145</sup> Mark Finnane, *Insanity and the Insane in Post-Famine Ireland* (Croom Helm 1981) 92.

<sup>146</sup> Pauline Prior, "Dangerous Lunacy: The Misuse of Mental Health Law in Nineteenth-Century Ireland" (2003) 14(3) *Journal of Forensic Psychiatry & Psychology* 525.

<sup>147</sup> *Ibid.*

<sup>148</sup> Section 10 of the 8 & 9 Vic., c.107



as the compiling of a registry of criminal and dangerous lunatics somewhat reduced the numbers in prisons, nevertheless, these efforts to exert control over judicial behaviour were not enough to resolve the many problems that had been created, in particular, acute overcrowding. The 1838 Act was not repealed until 1867. Various reasons are proffered for this delay, the most important being that there was already serious overcrowding of the asylums too. The first ten district asylums had been intended to accommodate 1,220 people but by 1843 they housed 2,028 people and this number continued to grow.<sup>149</sup> When new asylums were built they quickly became overcrowded and the response remained the same; build more or add extensions.<sup>150</sup> If the law were to change and require the detention of dangerous lunatics in asylums as opposed to prisons, there would be an unmanageable pressure placed on the system.<sup>151</sup>

In 1867 the Lunacy (Ireland) Act was enacted and provided that dangerous lunatics could only be committed to an asylum. Admission was now based on the order of two magistrates with a compulsory certificate of dangerousness from a physician. Discharge was secured on the certificate of the medical superintendent or visiting physician.<sup>152</sup> In line with medicalism, medical certification was no longer dispensable. At the hands of the magistrates a crisis had evolved, medical input was therefore required to ensure only those who were actually dangerously insane were detained. Despite the intentions, however, the change in law had little effect. By 1890 the Dangerous Lunatics Act 1867 was behind three out of four male admissions and almost seven out of ten female admissions. In this manner it had remained, and continued until after the end of the Union in 1921 to remain, the primary mode of entering the public asylum. The Inspectors of Lunacy, the asylum boards and the asylum physicians were critical of this approach claiming that it negatively affected the individual and their family and friends by labelling them as a criminal.<sup>153</sup> Through the use of the

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<sup>149</sup> Select Committee of the House of Lords Appointed to Consider the State of the Lunatic Poor in Ireland (1843) iv.

<sup>150</sup> Damien Brennan, *Irish Insanity; 1800-2000* (Routledge 2014) 58-92.

<sup>151</sup> Pauline Prior, "Dangerous Lunacy: The Misuse of Mental Health Law in Nineteenth-Century Ireland" (2003) 14(3) *Journal of Forensic Psychiatry & Psychology* 525.

<sup>152</sup> *Ibid.*

<sup>153</sup> Mark Finnane, *Insanity and the Insane in Post-Famine Ireland* (Croom Helm 1981) 102.

Criminal Lunatic Acts 1838-1867, insanity became intimately linked with criminality.<sup>154</sup> This contrasts with the situation in England where insanity was linked with poverty.<sup>155</sup>

## 2.07 Explaining Asylum Expansion

In late nineteenth-century, the Lunacy Inspectorate undertook an examination of insanity in Ireland. Numbers in the asylums had significantly increased from the inception of the first asylum and this was causing a significant financial burden on the public purse. The Lunacy Inspectorate assumed that an increase in the asylum population reflected an increase in insanity. Reasons cited for the increase in the incidence of insanity in Reports of the Inspectorate and leading psychiatrists at the time included heredity, alcohol, intermarriage, the drinking of tea of an inferior quality, and the dietary change (among the peasantry) from porridge to bread and tea.<sup>156</sup> By today's standards such explanations are questionable.

Since Foucault's *Folie et Dérison* opened the door for the interpretation of insanity as a socio-political rather than biological phenomenon, most social historians have attributed asylums' growth to social, rather than biological factors.<sup>157</sup> The impact of industrialisation and capitalism on asylum utilisation has been observed by Foucault in France and Scull and Porter in England.<sup>158</sup> For them, asylums were an exhibition of a modernising culture; a resource developed by a society who now had the economic power to strive towards an ideal of civilisation that required the control of the insane.<sup>159</sup> In turn, the professional staff and growing admissions helped to legitimise the nineteenth-century asylum, thus lowering the

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<sup>154</sup> Oonagh Walsh, 'Lunatic and criminal alliances in nineteenth-century Ireland' in Peter Bartlett & David Wright (eds), *Outside the Walls of the Asylum: the History of Care in the Community 1750-2000* (The Athlone Press 1999) 225.

<sup>155</sup> See generally Peter Bartlett, *The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth-Century England* (University of Leicester Press/Cassell 1999); Peter Bartlett, "The asylum, the workhouse and the voice of the insane poor in nineteenth-century England" (1999) 21(3) *International Journal of Law and Psychiatry* 421.

<sup>156</sup> Inspector of Lunacy, *Annual Report on the District, Local and Private Lunatic Asylums of Ireland* (1894); Dermot Walsh & Antoinette Moran, *Mental Illness in Ireland 1750-2002: Reflections on the Rise and Fall of Institutional Care* (Health Research Board 2004) 23; BD Kelly, "Dr William Saunders Hallaran and psychiatric practice in nineteenth-century Ireland" (2008) 177(1) *Irish Journal of Medical Science* 79.

<sup>157</sup> See generally Michael Foucault, *Madness and Civilisation: A History of Insanity in the Age of Reason* (Plon 1961, Pantheon 1965).

<sup>158</sup> See generally Michael Foucault, *Madness and Civilisation: A History of Insanity in the Age of Reason* (Plon 1961, Pantheon 1965); Andrew Scull, *Museums of Madness: The Social Organisation of Insanity in Nineteenth-Century England* (Allen Lane 1979); Roy Porter, *Mind Forg'd Manacles: A History of Madness in England from the Restoration to the Regency* (Harvard University Press 1987).

<sup>159</sup> See generally Roy Porter, *Mind Forg'd Manacles: A History of Madness in England from the Restoration to the Regency* (Harvard University Press 1987).

threshold for deviant behaviour that families were willing to tolerate.<sup>160</sup> Significantly, however, these theories are not easily applied to the Irish situation. The application of these theories would suggest that Ireland's asylum expansion is attributable to the industrialisation and capitalisation of Irish society. However, as highlighted, Ireland's experience of industrialisation and capitalism was limited, yet Ireland had the highest asylum usage in the world. Furthermore, non-industrialised regions, particularly along the west coast of Ireland, had the highest rate of detention in asylums.<sup>161</sup>

In Ireland the rise in asylum numbers instead is attributed to a host of economic, social and political factors. During the nineteenth century the economic situation in Ireland faced deepening crisis. It was against this background that the Poor Law Act 1838 was enacted. The Poor Law emphasised control and maintenance of order, and also reinforced the distinction between 'deserving' and 'undeserving poor'.<sup>162</sup> From the beginning there were serious problems with imposing a British model of poor relief in Ireland. Firstly, the scale of destitution in Ireland was far greater than that in Britain and there was very little difference between ratepayers and the destitute. Therefore, the workhouse could not act as a deterrent in the way that it might in Britain's industrialised, wage-labour economy.<sup>163</sup> Moreover, the workhouse was the only provision made for the poor as opposed to other provisions in Britain.<sup>164</sup> The differences between the British and the Irish Poor Laws were deliberate. There was reluctance to provide anything for the poor in Ireland in general but the alternative of continued dependence on repression would most certainly have led to insurrection. Accordingly, these restrictions were imposed on what was believed to be a work shy and rebellious nation.<sup>165</sup> The harsh conditions of the workhouse were designed to deter persons and entry into it was seen as a disgrace and a sign of family failure.<sup>166</sup> Despite the introduction of the Poor Law, economic conditions remained weak and the Great Famine of 1845-50 is often seen as the culmination of a classic crisis of subsistence; a rising population

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<sup>160</sup> See generally Andrew Scull, *The Most Solitary of Afflictions: Madness and Society in Britain, 1700–1900* (Yale University Press 1993).

<sup>161</sup> See generally Nancy Scheper-Huges, *Saints, Scholars and Schizophrenics: Mental Illness in Rural Ireland* (Berkeley University of California Press 1979).

<sup>162</sup> Mairéad Considine & Fiona Dukelow, *Irish Social Policy, A Critical Introduction* (Gill and MacMillan 2009) 6.

<sup>163</sup> G Cook, *The Development of Social Security in Ireland (Before and After Independence)* (University of London Dissertation 1990) 14 as quoted in Anthony McCashin, *Social Security in Ireland* (Gill and MacMillan 2004) 9.

<sup>164</sup> Anthony McCashin, *Social Security in Ireland* (Gill and MacMillan 2004) 9-10.

<sup>165</sup> Joseph Robins, *Fools and Mad: A History of the Insane in Ireland* (Institute of Public Administration 1986) 68.

<sup>166</sup> BD Kelly, "Mental illness in 19<sup>th</sup>-century Ireland: a qualitative study of workhouse records" (2004) 171(1) *Irish Journal of Medical Science* 53.

pressing against the ceiling of limited resources. The Famine caused an unmanageable reliance on the workhouses in the absence of any other measures taken by the government.<sup>167</sup> The workhouses which had come to be occupied by the starving and diseased were given a new role and a stigma that had not been anticipated. During the Famine, in particular, there was a rapid increase in overall asylum figures, but also the numbers of insane in the workhouses. The asylums, however, stood in contrast to the feared workhouse and were often seen as necessary, charitable institutions and were likely to have been used as an alternative way to secure food.<sup>168</sup>

Alternatively, the asylums may have been used to get rid of unwanted family members for other reasons. It was in this manner that the Criminal Lunatics Acts 1838-1867 had come to be significantly abused as seen above.<sup>169</sup> Workhouse masters also took advantage of the 1838 Act. As asylums could not refuse to accept any person admitted under the 1838 Act, many workhouse masters would have persons detained thereunder and transferred to an asylum. Many of these persons could have indeed been troublesome, yet perhaps did not suffer from insanity of the degree which required detention in an asylum.<sup>170</sup> The transferral of persons from the workhouses to the asylums was a particular issue for the Inspectors of Lunatic Asylums. Legislation was passed towards the end of the nineteenth century aimed at reducing

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<sup>167</sup> In the first year of the Famine, 1845–6, Sir Robert Peel’s Tory government responded reasonably effectively to the partial failure of the crop by instituting public works and selling off imported grain at controlled prices. The Whig government that took office in June 1846, with its policy of laissez-faire, rejected any interference in the market, relying instead on an expanded public works programme. In February 1847, faced with evidence of large-scale suffering and death, the Government reluctantly authorised the provision of free food. Over the next eight months soup kitchens provided emergency rations to an estimated three million people. From September, however, the government insisted that the soup kitchens be phased out, leaving those still in need to be cared for entirely within the already overburdened workhouse system, a decision widely regarded as contributing to the heavy death toll that continued over the next three years. See generally, Mary E Daly, *The Famine in Ireland* (Dundalgan 1986); Cathal Póirtéir, *The Great Irish Famine* (RTE/Mercier Press 1995).

<sup>168</sup> Damien Brennan, *Irish Insanity; 1800-2000* (Routledge 2014) 68; Mark Finnane, *Insanity and the Insane in Post-Famine Ireland* (Croom Helm 1981) 129; Greta Jones & Elizabeth Malcolm, *Medicine, Disease and the State in Ireland 1650-1940* (Cork University Press 1999) 186. Bartlett has argued that in England for the insane exposed to the worst of eighteenth century conditions in the workhouses it is clear that the nineteenth century asylums offered an improvement in the standard of care. See generally Peter Bartlett, *The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth-Century England* (University of Leicester Press/Cassell 1999); Peter Bartlett, “The asylum, the workhouse and the voice of the insane poor in nineteenth-century England” (1999) 21(3) *International Journal of Law and Psychiatry* 421.

<sup>169</sup> In the 1840s in St. Patrick’s Asylum the majority of admissions were on the basis of family matters. While the majority of detainee’s were single, most were living with their families prior to detention and most were committed by a family member. In only about 5 per cent of admissions did the application not come from a family member- Elizabeth Malcolm, *Swift’s Hospital: A History of St. Patrick’s Hospital, Dublin, 1746–1989* (Gill and MacMillan 1989) 144-153; Greta Jones & Elizabeth Malcolm, *Medicine, Disease and the State in Ireland 1650-1940* (Cork University Press 1999) 186.

<sup>170</sup> Brendan D Kelly, “Mental Health Law in Ireland, 1821 to 1902: Building the Asylums” (2008) 76(1) *Medico-Legal Journal* 19, 23; Oonagh Walsh, ‘Lunatic and criminal alliances in nineteenth-century Ireland’ in Peter Bartlett & David Wright (eds), *Outside the Walls of the Asylum: the History of Care in the Community 1750-2000* (The Athlone Press 1999).

the numbers in the asylums by transferring them to workhouses or by allowing the Asylum Committees establish auxiliary asylums in unused workhouses or other suitable buildings for the reception of chronic lunatics, who were not dangerous and did not require specialised care and treatment.<sup>171</sup>

In this manner during the nineteenth century a complicated relationship had developed between the asylum, the workhouse and the prison. While there is little doubt that these three institutions would always have had a close relationship due to their role in social control, the Dangerous Lunatics Act of 1838 determined this course.<sup>172</sup> The lack of alternatives to the asylum and the lack of cure for those detained meant that numbers in the asylums continued to increase.<sup>173</sup> However, instead of developing new approaches to improve the current system or tackle the root problems, the approach was merely to build auxiliary asylums for chronic incurable lunatics or transfer them to vacated workhouses or other suitable buildings.<sup>174</sup> There is little doubt that there was a mutually re-enforcing pattern of asylum building and detention where the sudden availability of asylum beds led to increased rates of presentation by the insane who had previously lived with families, in workhouses or were homeless.<sup>175</sup>

The vastness of the asylum system must not be underestimated and in some parts of the country it would have been hard to reduce both politically and economically. This was especially true in rural Ireland where the asylums were one of the largest employers and the largest consumers of locally produced goods.<sup>176</sup> At the same time there was scant support for

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<sup>171</sup> Brendan D Kelly, "Mental Health Law in Ireland, 1821 to 1902: Building the Asylums" (2008) 76(1) *Medico-Legal Journal* 19.

<sup>172</sup> Bartlett argues that in the English context the asylums legislative roots are in the pre-1834 Poor Law, and throughout the nineteenth century it remained an institution directed towards the poor. The asylum was not administratively separate from the nineteenth century Poor Law and both shared administration at the local level. The asylums also did not oust the Poor Law's jurisdiction in insanity, rather large numbers of the insane remained in other forms of poor relief, usually residing in the workhouse or living on outdoor relief. Thus the asylum was not a separate institution but one acting in tandem with the Poor Law. Elements of this analysis can be applied to Ireland, although with a later starting point following the enactment of the Poor Law 1838 in Ireland. See Peter Bartlett, *The Poor Law of Lunacy: The Administration of Pauper Lunatics in Mid-Nineteenth-Century England* (University of Leicester Press/Cassell 1999).

<sup>173</sup> Dermot Walsh & Antoinette Moran, *Mental Illness in Ireland 1750-2002: Reflections on the Rise and Fall of Institutional Care* (Health Research Board 2004) 19-23.

<sup>174</sup> Markus Reuber, "The architecture of psychological management: the Irish asylums (1801-1922)" (1996) 26(6) *Psychological Medicine* 1179.

<sup>175</sup> Brendan D Kelly, "Mental Health Law in Ireland, 1821 to 1902: Dealing with 'the Increase of Insanity in Ireland'" (2008) 76(1) *Medico-Legal Journal* 26; Markus Reuber, "The architecture of psychological management: the Irish asylums (1801-1922)" (1996) 26(6) *Psychological Medicine* 1179.

<sup>176</sup> Oonagh Walsh, 'A lightness of mind: gender and insanity in nineteenth-century Ireland' in Margaret Kelleher and James H Murphy (eds) *Gender Perspectives in 19<sup>th</sup>-Century Ireland: Public and Private Spheres* (Irish Academic Press 1997); Dermot Walsh, "Delivery of psychiatric care to those mentally ill in Ireland: proposals for change" (1988) 25(5) *Journal of the Statistical and Social Inquiry Society of Ireland* 147; Damien Brennan, *Irish Insanity; 1800-2000* (Routledge 2014) 141.

their further financing. The full burden of the first manifestations of a welfare state, the introduction of the Poor Law in 1838 and the realisation that those needing care in the asylum system well exceeded that originally envisaged, was felt by those who had to foot the bill, the ratepayers. The Irish population had almost halved between 1841 and 1911, from approximately eight to four million, however, the number detained in asylums during this time increased from approximately 3,000 to 24,655.<sup>177</sup> Consequently, in 1870 £166,000 was required for the maintenance of the district asylums and this increased to £602,000 in 1914, more than half the amount spent on poor relief in that year. Given the huge growth in the expense of the asylums, it is of little surprise that the fiscal burden constituted the central political question of asylum management during the latter half of the nineteenth century.<sup>178</sup>

The fact that there were no reformers advocating a change in the asylum system must be attributed in large part to the office whose main responsibility was the control of the asylum system, the Lunacy Inspectorate. From the 1870s onwards the Lunacy Inspectorate had demonstrated an inability or a want to pursue anything more than routine administrative functions and little change was shown in asylum policy.<sup>179</sup> To add to the lack of innovative personnel in the Inspectorate, the office was plagued with conflicts of interest. The Inspectors were members of the board of control, the body whose duty was the planning and construction of district asylums. Furthermore, they had been made *ex officio* members of all asylum boards from 1853 to 1861. Therefore, any criticism of the asylum system, the buildings and the conditions of those confined in them, could ultimately be attributed to their failure as an efficient and competent inspectorial administration. Moreover, the Inspectors Nugent and Hatchell (whom succeeded White) and indeed all Inspectors between 1845 and 1921 themselves had personal conflicts of interest. Both were medical men. Nugent was a member of the Medico-Psychological Association. His alliances were thus very much on the side of the psychiatric profession. Even more, Hatchell was father to two of the twenty two district asylum medical superintendents in the later 1880s. The fact that the Inspectors were involved in all facets of the running of the asylum and had personal affiliations and alliances with those in charge of them meant that the possibilities of impartial inquiry into the conditions of asylums generally and into cases of ill-treatment more specifically were limited. This situation led to cover-ups and excuses in addition to disputes between inspectors and boards of governors, between governors and superintendents and even between inspectors

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<sup>177</sup> Damien Brennan, *Irish Insanity: 1800-2000* (Routledge 2014) 64.

<sup>178</sup> Mark Finnane, *Insanity and the Insane in Post-Famine Ireland* (Croom Helm 1981) 63.

<sup>179</sup> *Ibid.*

and superintendents.<sup>180</sup> It also ensured the continued adherence to medicalism in the operation of the asylum system but at this point its continuation was under threat.

## **2.08 Psychiatry's 'Second Revolution' & the Medicalisation of Insanity**

Despite the asylums' therapeutic ideals, little therapy was provided in the significantly overcrowded institutions. The moral treatment that had flourished at the beginning of the nineteenth century had declined rapidly. Although no definitive explanation can be provided for this, it can be assumed that the tendency to build very large asylums during the century made it impossible for the medical superintendent to keep in touch with those detained and necessitated their being left, to a large extent alone, in overcrowded asylums. There is little doubt that moral treatment was replaced by isolation and restraint. In detention these people did not impose upon the public conscience and their safe custody was seen to be necessary to prevent harm occurring to themselves or others. This was accepted by the public for the various reasons explained above.

While the primacy of psychiatry in caring for the insane had been firmly established this had been achieved without any real tangible success in curing the insane. By the twentieth century the expense of the asylums and the lack of success in curing the insane meant that psychiatry was facing a crisis of legitimacy. The First World War had also resulted in a serious questioning of the dominant bio-determinist model of psychiatry. This was built on the assumption that insanity was hereditary, the result of an impaired gene pool. Eugenics had emerged out of these assumptions and eugenic policies of sterilisation and separation<sup>181</sup> were openly advocated in Britain<sup>182</sup> and Ireland.<sup>183</sup> During the War, those fighting began to break down with 'shellshock'. Significantly, the officers were breaking down at a higher rate than the lower ranks. These officers and soldiers could not be construed as being genetically inferior and so this posed a crisis for the hereditarianism construct of insanity.<sup>184</sup> Around this time Freud established a new diagnosis of 'neurosis' the symptoms of which included stress,

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<sup>180</sup> Mark Finnane, *Insanity and the Insane in Post-Famine Ireland* (Croom Helm 1981) 64.

<sup>181</sup> The influence of the Catholic Church in Ireland meant that the more drastic eugenic measures discussed at the time such as sterilisation were rejected, however, it was believed that separation could achieve similar results.

<sup>182</sup> See Matthew Thomson, *The Problem of Mental Deficiency: Eugenics, Democracy, and Social Policy in Britain c.1870-1959* (Oxford University Press 1998); Donald MacKenzie, "Eugenics in Britain", (1976) 6(3-4) *Social Studies of Science* 499; J Moncrieff & MJ Crawford, "British psychiatry in the 20th century - observations from a psychiatric journal" (2001) 53(3) *Social Science & Medicine* 349.

<sup>183</sup> Greta Jones, "Eugenics in Ireland: The Belfast Eugenics Society 1911-1915" (1992) 28(109) *Irish Historical Studies* 81.

<sup>184</sup> Anne Rogers & David Pilgrim, *A Sociology of Mental Health and Illness* (3<sup>rd</sup> Ed, Open University Press 2005) 142.

depression, anxiety, obsessive behaviour and hypochondria. Freud's claim that neurosis was the manifestation of an individual's internal struggles, not the product of a physical condition, transformed the conception of insanity from an organic and physical theory to a psychological and sociological one.<sup>185</sup> It therefore expanded the understanding of insanity by including various forms of deviant behaviour and emotional problems. Psychotherapy, or talking therapy, was used to treat neurosis. On the back of this, new specialties were developed, including clinical and educational psychology, psychoanalysis, criminology and social work which emerged in the first two decades of the twentieth century.<sup>186</sup> Some of these were relatively autonomous and, at least temporarily, contested psychiatry's dominance during this period.<sup>187</sup> However, unlike psychiatry, these other specialties lacked independent control of the institutions within which they worked and remained resigned to bureaucratic subordination.<sup>188</sup>

Psychiatry remained resilient and as seen with its response to moral treatment it owed its existence to the ability to absorb foreign practices. This continued to be the formulation for success in the twentieth century. Though psychoanalysis and psychotherapy was in many ways incompatible with the rest of psychiatry, it nevertheless provided the profession with an approach to the neuroses and the resulting alliance proved so successful that it was termed psychiatry's second revolution.<sup>189</sup> In addition, psychiatry was enabled to extend its practice beyond the asylum population that formed its conventional jurisdiction, to other sites of intervention such as the psychiatric casualties of war,<sup>190</sup> the management of childhood<sup>191</sup> and alcoholism,<sup>192</sup> to name but a few. In this manner Freud had supplied a new optimism in the treatment of insanity at a time where this was desperately required for the profession's

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<sup>185</sup> Peter Conrad & Joseph W Schneider, *Deviance and Medicalisation: From Badness to Madness* (Mosby 1980) 52-53.

<sup>186</sup> Stanley Cohen & Andrew Scull (eds), *Social Control and the State, Historical and Comparative Essays* (Martin Robinson & Company Ltd 1983) 161.

<sup>187</sup> Andrew Scull, "The mental health sector and the social sciences in post-World War II USA: Part 1: Total war and its aftermath" (2011) 22(1) *History of Psychiatry* 11.

<sup>188</sup> Andrew Abbott, *The System of Professions: An Essay on the Division of Expert Labor* (University of Chicago Press 1988) 307-308.

<sup>189</sup> Stanley Cohen & Andrew Scull (eds), *Social Control and the State, Historical and Comparative Essays* (Martin Robinson & Company Ltd 1983) 161.

<sup>190</sup> Martin Stone, 'Shellshock and the Psychiatrists' in William Bynum, Roy Porter and Michael Shepard (eds) *The Anatomy of Madness* (Tavistock 1985) 242-271.

<sup>191</sup> Nikolas Rose, *The Psychological Complex: Psychology, Politics, and Society in England 1869-1939* (Routledge and Kegan Paul 1985) 197-209; David Ingleby, "The Psychology of Child Psychology," (1973) 5 *The Human Context* 557; Peter Conrad & Joseph W Schneider, *Deviance and Medicalisation: From Badness to Madness* (Mosby 1980) 145-172; See generally M Horn, *Before It's Too Late: The Child Guidance Movement in the United States* (Temple University Press 1989).

<sup>192</sup> Peter Conrad & Joseph W Schneider, *Deviance and Medicalisation: From Badness to Madness* (Mosby 1980) 73-110.



legitimacy, and ensured their continued dominance in the asylum system into the twentieth century.<sup>193</sup>

Up to this point, Irish psychiatry had developed outside the realm of general medicine in Ireland.<sup>194</sup> Several psychiatrists began to recognise the need for and urged a closer link with general hospitals and public health services. In 1921 a conference of the Irish district asylums, attended by members of the psychiatric profession from around the country, was held and several recommendations were made that forged a closer relationship with the general health services. In furtherance of the professionalisation of psychiatry it was recommended that an Irish Medico-Psychological Association be set up as an examining body and that the Medico-Psychological Association of Great Britain and Ireland be so recognised. Notably, they recommended that it be a condition of employment for all persons entering the asylum service as attendants or nurses from June 1921 onwards to be only given probationary contracts as opposed to permanent contracts until they had obtained a recognised Medico-Psychological Association certificate of proficiency in mental nursing. Nurses naturally provided healthcare, whereas previously wardens were simply required to control and care for the insane. It was also recommended that the management committees should change the names of the institutions under their control from district lunatic asylums to district mental hospitals.<sup>195</sup>

Accordingly, it can be claimed that this period witnessed the “medicalisation” of insanity whereby insanity came to be defined in medical terms, medical language was used to describe it, a medical framework was adopted to understand it and medical interventions were used to “treat” it.<sup>196</sup> In the past, deviant behaviour in the form of insanity was defined in religious and criminal terms as immoral, sinful or illegitimate. With the growth of the asylum and the instatement of psychiatry this deviant behaviour became more and more subject to medicalisation and treated as a health problem. This was despite the fact that very few mental disorders had a proven biological cause or cure. Based on this medicalisation the domain of psychiatry began to expand and while new treatments such as psychotherapy were embraced, the fixed centre of psychiatry remained the physiological approach which linked the

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<sup>193</sup> Peter Conrad & Joseph W Schneider, *Deviance and Medicalisation: From Badness to Madness* (Mosby 1980) 52-53.

<sup>194</sup> Department of Health, *Report of the Commission of Inquiry on Mental Illness* (Stationary Office 1966) 15.

<sup>195</sup> Joseph Reynolds, *Grangegorman, psychiatric Care in Dublin since 1815* (Institute of Public Administration 1992) 225; See generally JF Sweeney, “The Role of the Irish Division of the Royal Medico-Psychological Association in the Development of Intellectual Disability Nursing in Ireland” (2011) 28(1) *Canadian Bulletin of Medical History* 95.

<sup>196</sup> Peter Conrad, “Medicalization and Social Control” (1992) 18 *Annual Review of Sociology* 211.

profession most visibly to the rest of medicine. Without this link the profession's power would be hugely reduced as the link provided the essential lifeline of respectability and trust.

## **2.09 Conclusion**

The development of an asylum system and powers of detention that enshrined medicalism and legalism were the result of a series of historically specific and closely connected changes in Irish society's political, economic and social structure and correlative transitions in the intellectual and cultural perspectives of its population. The early nineteenth century saw the creation of the specific policy of segregation and detention for the management of the insane and as such the asylum came to be an indispensable social institution. The psychiatric profession played an essential role in the asylum's legitimation and by 1921 the asylum system had transitioned from lay operation, treatment and inspection to the complete medical operation, treatment and inspection which coincided with the professionalisation of psychiatry and the medicalisation of insanity.

Although the civil aspects of detention were consistent with medicalism, the primary manner of detention under the Criminal Lunatics Acts 1838-1867 was not. By 1921 there was growing dissatisfaction with the role of the magistrates in the detention of the insane as they were seen as a contributing factor to the vast over-crowding of the asylum system. Furthermore, as a result of the burgeoning medicalisation of insanity, their role was increasingly being seen as inappropriate. This was the predominant influence on the re-orientation of powers of detention in the twentieth century and provides an understanding as to the specific type and form of medicalism that developed in Ireland which became so embedded in the treatment and detention of the mentally ill. Despite the varying influence of medicalism and legalism, what this period had established was a policy of segregation and detention that has remained a constant since then.

## CHAPTER 3

### INFLUENCE OF MEDICALISM IN THE MENTAL TREATMENT ACT 1945

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#### **3.01 Introduction**

This chapter examines the advancement of medicalism in mental health detention from the early twentieth century up to 2001 when new legislation concerning mental health detention was enacted. In a similar manner to the previous chapter, it is necessary to examine the approach to mental health detention in the twentieth century to better understand and explain the rationale behind current legal powers of detention. The end result of a series of specific and closely connected changes in Irish society's political, economic and social structure and correlative shifts in the perspectives of its population was that insanity was considered an illness by the early twentieth century. Moreover, psychiatry had emerged as the authoritative profession in the treatment of this illness. This new motivation dominated the detention of the 'mentally ill' in Ireland during the twentieth century, conspicuously evidenced by the change in terms used; mental illness as opposed to insanity and mental hospital as opposed to asylum.

The primary focus of the chapter is the enactment of the 1945 that provided psychiatry with complete control in the detention of the mentally ill. The 1945 Act governed the legal powers of detention for over 50 years. Utilising socio-legal theory, this chapter examines the influence of medicalism and legalism on the legal powers of detention provided in the 1945 Act, their operation by doctors and their interpretation by the Courts throughout this period. In doing so the chapter examines the anti-psychiatry, de-institutionalisation and human rights movements and the impact they had on the legal powers to detain at an international level and in Ireland.

### 3.02 Mental Health Policy in Independent Ireland

In the opening decades of the twentieth century government intervention and welfare provision were becoming increasingly accepted in Ireland.<sup>197</sup> Areas of the public and private sphere that previously went unregulated were transformed by new legislation covering topics such as welfare, children, health, housing, education, land, agriculture and services.<sup>198</sup> In 1922, the Irish Free State came into being and reflective of the new government's desire to bestow rights upon its citizens the first Irish Constitution was enacted. The 1922 Constitution provided for the protection of certain fundamental rights, including the right to liberty, and vested the courts with the express power to invalidate legislation adjudged to infringe such rights.<sup>199</sup> There was also a desire to increase the welfare provisions in the Free State which resonated with wider international trends in the development of welfare systems.<sup>200</sup> However, the Irish civil war accompanied the establishment of the Free State from 1922 to 1923 and in its aftermath the reconstruction of Ireland's economy and civil society was the primary aim. This was a difficult task owing to the effects of a sustained conflict, recession and a subsequent trade war with Britain between 1932 and 1938. Thus, despite the promising signs for the development of social policy at the turn of the century, the early decades were marked by a conservative and cautious approach to welfare expenditure.<sup>201</sup>

Nonetheless, some advances were made during this period which affected mental health policy. The Department of Local Government and Health was created in 1925 with responsibility for the asylum system. The same year the Local Government Act renamed asylums as mental hospitals, as had been advocated at the 1921 Irish district asylums conference. The asylum system continued to pose a significant issue for the government in terms of its huge population and correlative cost; in 1925 there were 19,562 people in detention.<sup>202</sup> As a result between 1906 and 1925 four Commissions were established which

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<sup>197</sup> Mairéad Considine and Fiona Dukelow, *Irish Social Policy, A Critical Introduction* (Gill and MacMillan 2009) 83-146; See generally Mel Cousins, *Explaining the Irish Welfare State, An Historical Comparative and Political Analysis* (Edwin Mellen Press 2005).

<sup>198</sup> See for example: Workmen's Compensation Act 1897, Old Age Pension Act 1908, Children's Act 1908, Housing Act 1908, National Insurance Act 1911.

<sup>199</sup> Irish Constitution 1922. Other fundamental rights included the inviolability of the home; freedom of conscience and the free practice of religion; freedom of expression as well as the right to assemble peacefully; and the right to education.

<sup>200</sup> Donnacha Seán Lucey, "These Schemes Will Win for Themselves the Confidence of the People": Irish Independence, Poor Law Reform and Hospital Provision" (2014) 58(1) *Medical History* 46, 65.

<sup>201</sup> Mairéad Considine and Fiona Dukelow, *Irish Social Policy, A Critical Introduction* (Gill and MacMillan 2009) 24-40; Donnacha Seán Lucey, "These Schemes Will Win for Themselves the Confidence of the People": Irish Independence, Poor Law Reform and Hospital Provision" (2014) 58(1) *Medical History* 46.

<sup>202</sup> Damien Brennan, *Irish Insanity; 1800-2000* (Routledge 2014) 125.

dealt, to a greater or lesser extent, with issues relating to the provision for the mentally ill in Ireland.<sup>203</sup> The Report of the Commission on the Sick and Destitute Poor including the Insane Poor 1927 highlighted the serious problems of overcrowding and the lack of treatment in the asylums.<sup>204</sup> It recommended significant changes to the system of care for the insane in Ireland including the establishment of a system of auxiliary mental hospitals in old workhouses, the development of outpatient clinics and the introduction of a voluntary admission status.

While other advances in the health sector were made during the 1930s, including the development of a network of hospitals throughout Ireland, the response to mental illness remained stagnant.<sup>205</sup> It is likely that reform of the asylum could not be contemplated until an adequate health system was established in Ireland. By the 1940s, there was the belief that implementation of the recommendations made by the 1927 Commission combined with psychiatry's early treatment of mental illness would decrease the mental hospitals' population as greater numbers would be cured through the use of psychiatric treatment. Accordingly, new legislation was required to give effect to this.

### **3.03 The Influence of Medicalism on the Mental Treatment Act 1945**

The professionalisation of psychiatry and the medicalisation of insanity that were discussed in the previous chapter played a pivotal role in the twentieth century when new mental health legislation was considered. Based on developments in the nineteenth century, psychiatry had come to be seen as an esteemed body in society, respected by the general population and other professions. While the operation and inspection of the asylums was dominated by medicalism, the legal powers of detention were not. The subsequent analysis of the 1945 Act examines how the creation, operation and interpretation of the 1945 Act by the legislature, psychiatry and the judiciary came to be dominated by medicalism. The importance of the 1945 Act is not to be underestimated. Indeed, as Unsworth and Fennell have established "law actually constitutes the mental health system, in the sense that it authoritatively constructs,

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<sup>203</sup> Viceregal Commission on Poor Law Reform (1906); the Royal Commission on the Care and Control of the Feeble-Minded (1908); Royal Commission on the Poor Laws and Relief of Distress; Commission on the Relief of the Sick and the Destitute Poor, Including the Insane Poor (1927).

<sup>204</sup> Royal Commission on the Poor Laws and Relief of Distress; Commission on the Relief of the Sick and the Destitute Poor, Including the Insane Poor (1927) 101-108.

<sup>205</sup> Brendan D Kelly, "The Mental Treatment Act 1945 in Ireland: an historical inquiry" (2008) 19(1) *History of Psychiatry* 47.

empowers, and regulates the relationships between the agents who perform mental health functions.”<sup>206</sup>

#### **a. Influence of Medicalism in the General Provisions of the Mental Treatment Act 1945**

This section considers the influence of medicalism in the general provisions of the 1945 Act including its aim and purpose, the establishment of medical exclusivity and authority, the definition of mental illness, the creation of voluntary admission and outpatient treatment and the provision of medical immunity from litigation.

##### **i. *The Aim & Purpose of the Mental Treatment Act 1945***

The drafting of the 1945 Act had been instigated and executed by a doctor who was the Parliamentary Secretary to the Minister for Health at the time. In addition to his personal examination of the issues presented by mental illness, there was reliance on information provided by psychiatrists engaged in the administration of mental health services.<sup>207</sup> Debates on the Mental Treatment Bill saw politicians display deference to the psychiatric profession. In introducing the Bill, the Parliamentary Secretary made it clear that complete confidence was to be entrusted in the psychiatric profession in the deliverance of their duties under it. Significantly, there was virtually no opposition to the Bill and where there were any criticisms of it, it was intimated that, as laymen, the politicians concerned could not understand the specifics. Similarly, other politicians were of the belief that the Bill would be better discussed by “medical experts” as it dealt primarily with medical matters.<sup>208</sup>

The purpose of the 1945 Act was unashamedly the treatment of the mentally ill. It was claimed by the legislature that the overall aim of the 1945 Act was to remove the stigma associated with lunacy and the asylums and treat mental illness as the disease that it was. This stigma was believed to be a barrier to the early treatment and cure of mental illness; it meant that persons delayed seeking treatment for themselves or their family members until it was too late to effect any cure. The detention of persons under the Criminal Lunatics Acts 1838-1867 had created a specific stigma whereby detention in mental hospitals had come to be associated with the negative connotations of criminality. The influence of medicalism is seen

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<sup>206</sup> Clive Unsworth, *The Politics of Mental Health Legislation* (Clarendon Press 1987) 5; Phil Fennell, “Law and Society: The Legal Constitution of the Psychiatric System” (1986) 13(1) *Journal of Law and Psychiatry* 35.

<sup>207</sup> Brendan D Kelly, “The Mental Treatment Act 1945 in Ireland: an historical inquiry” (2008) 19(1) *History of Psychiatry* 47, 55.

<sup>208</sup> Committee on Finance – Mental Treatment Bill, 1944- Second Stage, Dáil Debates, Volume 95, no. 8, 29 November 1944.

by removing the powers of detention from the magistrates; the 1945 Act sought to “totally depart from this procedure and to deal with persons suffering from mental derangement as patients who are mentally ill and who should be arranged for and treated by medical practitioners”.<sup>209</sup> The political espousal of medicalism also aimed to secure public acceptance of the shift from insanity to mental illness which would allow for early treatment and cure. The 1945 Act completely changed the discourse and insanity was now to be understood as a medical disease that could be treated and cured. It was believed that this would prevent the over accumulation of non-curable cases in the mental hospitals and consequently there would be a reduction in State expenditure on the provision of services. Throughout the resulting provisions of the 1945 Act the acceptance of medicalism is evident.

## **ii. Medical Exclusivity & Authority**

### *Resident Medical Superintendent*

The 1945 Act determined that a doctor, known as the resident medical superintendent, was to be in charge of and resident in each district mental hospital.<sup>210</sup> The administration of mental hospitals was separate from that of general hospitals until the 1960s and essentially the medical superintendent worked with little supervision from any higher authority.<sup>211</sup>

### *Inspector of Mental Hospitals*

As before, to ensure standards were upheld in the mental hospitals, the 1945 Act provided for the post of Inspector of Mental Hospitals who was required to be a doctor.<sup>212</sup> The powers and duties of the Inspector were vast. The Inspector was required to inspect each mental hospital and every part of it at least once a year, but also, whenever they saw fit. Furthermore, he/she was required to assess the mental and bodily condition of all the residents, the facilities, the propriety of the detentions and the discharges. Special attention had to be paid to the situation of any detained person where the propriety of their detention was in doubt and the Inspector was required to inform the Minister of Health if he/she thought the detention required further consideration. The Minister could then order the Inspector to conduct another examination of

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<sup>209</sup> Dr Ward, Parliamentary Secretary, Mental Treatment Bill, 1944- Second Stage, Dáil Debates, Volume 95, no. 8, 29 November 1944, 14.

<sup>210</sup> Mental Treatment Act 1945, s 94.

<sup>211</sup> The Mental Treatment Act 1945, Part III, IV, V and VI provided that the business of managing the hospitals was the responsibility of mental hospital authorities. This power was subsequently transferred to local authorities under the Health Authorities Act 1960 and ultimately to current health boards; Padraig O’Morain, *The Health of the Nation* (Gill and Macmillan 2007) 70.

<sup>212</sup> Mental Treatment Act 1945, s 12.

the patient, and having considered this, the Minister could discharge the patient if he/she thought this was proper. Where the institution was not run by a mental hospital authority, the Inspector and the resident medical superintendent of the nearest mental hospital would be required to examine the patient and the Minister would consider their report and discharge the patient if he/she thought this was proper. The Inspector was also required to make an annual report on each mental institution.<sup>213</sup> In line with medicalism, these measures provided for psychiatric exclusivity and prevented any non- medical oversight in the care and treatment of the mentally ill detained in mental hospitals.

### **iii. *Defining Mental Illness***

Demonstrative of the open-textured law espoused by medicalism, notably, the 1945 Act did not contain a definition of ‘mental illness’. Given the trust placed in psychiatry it was seen as unnecessary to circumscribe those who could be detained. Consequently, the range of persons who could be detained under the 1945 Act was unlimited by the legislature as the definition of mental illness became a subjective determination by medical professionals on a case by case basis. Indicative of psychiatry’s role in the maintenance of social order, a wide range of persons could be subject to detention, including alcoholics and addicts.<sup>214</sup> Significantly, a person believed to be of unsound mind that was not under proper care or control or was neglected or cruelly treated by any relative or other person having the care or charge of him could also be detained in a mental hospital.<sup>215</sup>

### **iv. *Voluntary Admission & Outpatient Treatment***

The 1945 Act supplied psychiatry with a previously absent legitimacy by providing for treatment on a voluntary basis.<sup>216</sup> Previously, a patient had to be detained in a mental hospital before he/she could receive treatment. This formality and certification was believed to have acted as a deterrent to persons who could avail themselves of treatment at the early stages of illness. Early treatment was believed to be essential to reducing the numbers resident in the mental hospitals who required prolonged or permanent treatment, as was the “considered opinion of specialists engaged in the treatment of mental disease.”<sup>217</sup> Therefore, to allow easier access to treatment it was essential to remove all the formalities such as certification

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<sup>213</sup> Mental Treatment Act 1945, Part XVIII.

<sup>214</sup> Mental Treatment Act 1945, s 3.

<sup>215</sup> Mental Treatment Act 1945, s 166.

<sup>216</sup> Mental Treatment Act 1945, Part XV.

<sup>217</sup> Mental Treatment Bill, 1944- Second Stage, Dáil Debates, Volume 95, no. 8, 29 November 1944, 16.



and formal detention which were likely to deter or discourage patients from seeking treatment of their own accord.

Other provisions of the 1945 Act advanced the idea of ‘outpatient treatment’ and provided for the establishment of consulting rooms and clinics. Here, patients could seek medical advice and treatment without being formally admitted to a mental hospital.<sup>218</sup> Another form of outpatient treatment and detention that was included in the 1945 Act was ‘boarding out’. This would allow mental hospital authorities to board out patients in private dwellings.<sup>219</sup> The rationale for this was that there were large numbers of patients who did not need to be detained in institutions as they were not dangerous. A mental hospital authority could appoint a committee to visit patients boarded-out and to report on their condition and that of their dwellings.<sup>220</sup>

Most of these provisions had been advocated by prominent Irish psychiatrists and the Commission on the Relief of the Sick and the Destitute Poor, including the Insane Poor 1927 for some time.<sup>221</sup> For example, Dr Connolly Norman of Grangegorman Mental Hospital Dublin, had repeatedly promoted the idea of ‘boarding out’ for patients with mental illness.<sup>222</sup> In addition the need for voluntary admission status had been highlighted as urgently required by many different bodies including the Commission and psychiatrists alike.<sup>223</sup> Medicalism was again reflected in these new approaches as it was believed that easier access to and less formality in receiving medical treatment would result in more cures and less burden on the State. Importantly, psychiatry retained ultimate control in the treatment of mental illness despite the change in detention status or location of those being treated. These provisions significantly extended psychiatry’s control by broadening its subjects of treatment. Psychiatry was no longer restricted to treating people in mental hospitals, now they could treat persons on an out-patient basis and voluntarily. The provisions also further aligned psychiatry with medicine through the use of ‘consulting rooms’ and ‘outpatient clinics’, sites and terms that are medical in nature.

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<sup>218</sup> Mental Treatment Act 1945, s 24.

<sup>219</sup> Mental Treatment Act 1945, s 209.

<sup>220</sup> Mental Treatment Act 1945, s 209(4).

<sup>221</sup> Royal Commission on the Poor Laws and Relief of Distress; Commission on the Relief of the Sick and the Destitute Poor, Including the Insane Poor (1927).

<sup>222</sup> Joseph Reynolds, *Grangegorman, Psychiatric Care in Dublin since 1815* (Institute of Public Administration 1992) 159.

<sup>223</sup> See article by an Anonymous Psychiatrist ‘Insanity in Ireland’ (1994) *The Bell* as quoted in Brendan D Kelly, “The Mental Treatment Act 1945 in Ireland: an historical inquiry” (2008) 19(1) *History of Psychiatry* 47, 49.

### ***v. Medical Immunity from Litigation***

Importantly, the 1945 Act went further than providing doctors with maximum discretion in the detention process but it also protected them from litigation arising from their conduct under the 1945 Act. Where a person wished to take civil proceedings against anybody involved in the operation of the 1945 Act, for example a doctor who carried out the examination, the person had to get permission from the High Court to do so. In granting this permission the High Court had to be satisfied that there were substantial grounds for contending that the person against whom the proceedings were to be brought acted in bad faith or without reasonable care.<sup>224</sup> The provision was worded in an expansive manner and covered all acts in respect of involuntary and voluntary patients. It was believed by those involved in the drafting of the 1945 Act, that due to the nature of the work carried out by the medical profession- detention of the mentally ill- they needed special protection from unfounded claims of unwarranted detention and similar issues to enable them to carry out their duties effectively.<sup>225</sup> The aim of the provision was to discourage “vexatious or frivolous action or one based on imaginary complaints”.<sup>226</sup> Nevertheless, it ensured that medical involvement in the detention process was protected not only from unfounded claims but possibly from well-founded claims also. This provision truly provided doctors with maximum discretion and authority as there was little chance of being held legally negligent for acts committed under the 1945 Act.

### **b. Influence of Medicalism in the Detention Specific Provisions of the Mental Treatment Act 1945**

This section considers the influence of medicalism in the detention specific provisions of the 1945 Act including the detention process and the provisions established to prevent arbitrary detention.

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<sup>224</sup> Mental Treatment Act 1945, s 260. See generally, Jarlath Spellman, “Section 260 of the Mental Treatment Act 1945 Reviewed” (1998) 4(1) *Medico-Legal Journal of Ireland* 20.

<sup>225</sup> Mental Treatment Bill, 1944- Second Stage, Dáil Debates, Volume 95, no. 8, 29 November 1944.

<sup>226</sup> *Murphy v Greene* [1990] 2 IR 566.

### **i. *The Detention Process***

Under the 1945 Act detained patients were divided into two categories: temporary patients and permanent patients. Temporary patients were diagnosed as “suffering from a mental illness” that was curable, permanent patients were diagnosed as “persons of unsound mind” whose condition was thought to be incurable.<sup>227</sup> In both cases applications for detention were normally made by a spouse or relative who had to be over 21 years of age, aside from this, different detention procedures applied to each category and were also dependent on whether the patient was public or private.<sup>228</sup> However, applications could also be made an authorised officer, a police officer or any other person over the age of 21. Where the application was not made by a spouse or relative, or a person authorised on their behalf, it had to include a statement of the reasons why it was not made by the spouse or relative, of the connection of the applicant with the proposed patient, and of the circumstances in which the application was made.<sup>229</sup>

#### *Temporary Detention*

Applications for the temporary detention of a relative would be made to the person in charge of the hospital. In the public mental hospitals this was always a psychiatrist-the resident medical superintendent. This application had to be accompanied by a medical recommendation from a doctor to the effect that, following their examination on a date not earlier than seven days, in his/her opinion the person was suffering from a mental illness requiring not more than six months treatment for recovery.<sup>230</sup> Temporary detention was for a specified period of time; six months, which could be extended by a maximum of eighteen months. An application for the extension of the temporary detention of both private and public patients had to be made to the Minister of Health after each six month period.<sup>231</sup>

#### *Permanent Detention*

Alternatively an application could be made by the same persons to any doctor (usually a GP) to have the person detained as a ‘person of unsound mind’, unlikely to recover within six months. The applicant must have seen the proposed patient within the previous fourteen days. The doctor had to then visit and examine the proposed patient within 24 hours and either

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<sup>227</sup> Mental Treatment Act, Part XIV.

<sup>228</sup> Patricia Casey & Ciaran Craven, *Psychiatry and the Law* (Oak Tree Press 1999) 457-489.

<sup>229</sup> Mental Treatment Act 1945, s 162, 177.

<sup>230</sup> Mental Treatment Act 1945, s 184.

<sup>231</sup> Mental Treatment Act 1945, s 189.

make a recommendation for detention or refuse to do so. Where the recommendation was made upon arrival at the mental hospital, the proposed patient would be examined by the medical superintendent.<sup>232</sup> Detention as a person of unsound mind was of indefinite duration. This contrasts sharply with the detention of temporary patients whereby extensions of detention had to be approved by the Minister of Health.

### *Private Patients*

For private patients, both temporary and permanent, given the fact that the hospital may not be run by a doctor, the application had to be accompanied by two medical recommendations.<sup>233</sup> The differing certification processes for private and public patients again attracted criticism on the grounds of class discrimination as public patients had less protection from arbitrary detention.<sup>234</sup> This provision was reflective of the belief that there was no benefit to gain from the detention of public patients. Alternatively, there was a belief that due to the financial benefit that could accrue to the owner of a private mental hospital, private patients required further protection from arbitrary detention. Consequently, the persons who could apply for private detention were restricted and could not include those who had any relationship with the person who owned or worked in the private mental hospital. No similar provisions existed for public detention.<sup>235</sup>

Detention based on medical recommendation(s) was seen as the most appropriate way to determine if a person required detention and is obviously an enunciation of medicalism by providing minimum legal control and maximising medical discretion in the detention process. Despite the fact that the requirement for two medical examinations for private patients was an attempt to control medical discretion and prevent arbitrary detention, in reality there was no sacrifice of medical power or discretion, rather, it was re-distributed to other doctors. Therefore this protection was consistent with medicalism. However, there are several reasons why the protective quality of the medical recommendation was diminished. Significantly, for temporary public patients there was only the requirement of one medical examination. A

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<sup>232</sup> Mental Treatment Act 1945, s 162, 177.

<sup>233</sup> Mental Treatment Act 1945, s 177 & 178 for persons of unsound mind. Mental Treatment Act 1945, s 185: for temporary patients.

<sup>234</sup> Faye Boland and Judith M Laing, "Out of Sight and Out of Mind? A Feminist Perspective on Civil Commitment in Britain and Ireland" (1999/2000) 4(3) *Contemporary Issues in Law* 257.

<sup>235</sup> Mental Treatment Act 1945, s 179: The following persons could not apply to have a person detained: a member of the governing body of or the person carrying on or in charge of the institution; any person interested in the payments (if any) to be made on account of the taking care of the person proposed to be received; any registered medical practitioner who is a regular medical attendant at the institution; or any relative of the above mentioned persons.

number of detentions therefore would have been on the basis of one medical examination alone. There was also no definition of examination for the purposes of the 1945 Act. Therefore the type, duration and method of examination varied from case to case based on the subjective criteria applied by each doctor, an issue which was to come to the fore in the case law. Reluctance to provide a definition of examination was also reflective of medicalism and the minimum control of and maximisation of medical judgement. Similarly, there was no requirement for recourse to any judicial consideration of the case as required previously under the 1867 Act, now medical recommendation was sufficient in itself. Furthermore, any defects in a detention order could be remedied within twenty one days with the consent of the Minister for Health, an obvious rejection of legalism.<sup>236</sup>

## ***ii. Protections against Arbitrary Detention***

Several provisions were included in the 1945 Act to protect against arbitrary detention. The 1945 Act stipulated that the doctors' recommendation for detention had to include a statement of the facts upon which the doctor had formed his/her opinion, distinguishing facts personally observed and facts communicated by others. This presumably was to ensure a person was not detained purely on the basis of second-hand information and is consistent with legalism in that it attempts to require the doctors to justify their decision to detain and ensure that they had observed the patient personally. If the doctor did not believe the proposed patient to be a person of unsound mind or suffering from a mental illness then they had to refuse to make the recommendation for detention.<sup>237</sup> If, following the refusal to make a recommendation for detention another request was made for the examination of a person, then the person requesting the examination had to disclose the fact that a prior request had been made and why it was refused.<sup>238</sup> Again, this resonates with legalism by attempting to prevent multiple applications to different doctors in cases where one refuses.

Once a person was detained the medical superintendent possessed the power, at any time during the detention to grant conditional leave<sup>239</sup> or discharge the patient completely.<sup>240</sup> Any relative or friend could apply to the medical superintendent in a mental hospital to allow them

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<sup>236</sup> Mental Treatment Act 1945, s 174.

<sup>237</sup> Mental Treatment Act 1945, s 163.

<sup>238</sup> Mental Treatment Act 1945, s 164.

<sup>239</sup> Mental Treatment Act 1945, s 203 & 204.

<sup>240</sup> Mental Treatment Act 1945, s 217 & 218.

to take care of the patient.<sup>241</sup> If the medical superintendent thought this proper he/she could discharge the patient, however, he/she reserved the right to refuse discharge if he/she considered the patient unfit thereto. Objections to this decision could be sent to the Minister, who could then order the Inspector of Mental Hospitals to examine whether the patient was fit to be discharged.<sup>242</sup> The President of the High Court also had the power to order and authorise the Inspector to visit and examine any person detained as a person of unsound mind and report to them on the condition of such person.<sup>243</sup>

Alternatively, any person could apply to the Minister for an examination of the detained patient. This examination had to be carried out by two independent physicians. If they both certified that the patient was fit for discharge, the Minister could direct an order to this effect.<sup>244</sup> The only option the patient had to seek a review of their detention under the 1945 Act was to send an unopened letter to the Inspector of Mental Hospitals or the Minister for Health (or whomever he/she wanted) concerning matters to do with their care, treatment or detention. The Inspector of Mental Hospitals also had a duty to examine every temporary patient received since their last visit and a duty to visit each mental hospital at least once a year.<sup>245</sup> If the Inspector felt that a patient was fit for discharge he/she reported this to the Minister who could then take appropriate steps.<sup>246</sup> The Inspector also had a general duty to see every patient who he/she had been requested to examine or whose detention was in doubt.<sup>247</sup>

Therefore, once a person was detained, their detention and options to seek release were dominated by medicalism. The medical superintendent had maximum discretion in determining when a person should be released, but even where this judgement was challenged, it would be reviewed by other psychiatrists or physicians, further maximising medical discretion. Moreover, the detention of persons of unsound mind under the 1945 Act significantly restricted the rights of those detained; significantly, detention could be indefinite and was not subject to any automatic, personal or in-depth review. While the Inspector of Mental Hospitals was required to provide an annual review of all mental hospital patients, it

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<sup>241</sup> Mental Treatment Act 1945, s 220 (as amended by Mental Treatment Act 1961, s 30). Private patients may be discharged on direction of the person who made the last payment and this is approved of by the resident medical superintendent; see: s 215 of the 1945 Act (as amended by Mental Treatment Act 1945, s 26).

<sup>242</sup> Mental Treatment Act 1945, s 221.

<sup>243</sup> Mental Treatment Act 1945, s 241.

<sup>244</sup> Mental Treatment Act 1945, s 222.

<sup>245</sup> Mental Treatment Act 1945, s 236.

<sup>246</sup> Mental Treatment Act 1945, s 226 & 227.

<sup>247</sup> Mental Treatment Act 1945, s 237 (as amended by Mental Treatment Act 1961, s33).

would not have been possible to provide a personal or detailed review of each patient's case. The only provisions provided under the 1945 Act for the patient to seek a review of their detention was to send an unopened letter to the Inspector of Mental Hospitals or the Minister for Health but this often did not happen as there was no obligation under the 1945 Act to inform the patient or anyone else that this right existed.<sup>248</sup> The only right to information concerned extensions of temporary detention orders. Here, the patient or the applicant had to be told they could make an objection to the Inspector of Mental Hospitals and the Minister for Health. An investigation could then be carried out by the former and a recommendation would be made thereon.<sup>249</sup>

### **c. Conclusion**

The provisions included in the 1945 Act bear analogy to the therapeutic rules described by Bean, the primary object of which is to help or treat the patient.<sup>250</sup> In re-casting rules in this manner, particular features emerge, all of which were evident in the 1945 Act. Firstly, as highlighted, there was minimum control of and a maximisation of psychiatric judgement. There were also no secondary rules to inhibit professional decisions. Therefore, psychiatrists could rely on whatever information they thought appropriate and there was no cross examination or rules of evidence. This allowed for wide variation in medical practice and legitimised the use of different styles of examination or interview. Furthermore, physicians were rarely questioned about the criteria they used to admit persons. Even where this was questioned they were provided with immunity from suit. Importantly, the usual legal rights of the citizen were absent. Thus, the right of access to the Courts was curtailed. There was no formal cautioning or provision of information regarding, for example, patient rights or even the length of stay. Where detention documentation was flawed this could be amended within 21 days. In this way, cumulatively, the 1945 Act was an espousal of medicalism.

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<sup>248</sup> Mental Treatment Act 1945, s266.

<sup>249</sup> Mental Treatment Act 1945, s221.

<sup>250</sup> Philip Bean, "The Mental Health Act 1959: Some Issues Concerning Rule Enforcement" (1975) 2(2) *British Journal of Law and Society* 225, 228.

### **3.04 Influence of Medicalism in the Operation & Interpretation of the Mental Treatment Act 1945**

Despite the fact that medicalism was enshrined in the 1945 Act, the operation of the 1945 Act by doctors and others or the judicial interpretation and application of the 1945 Act could reduce the impact of this medicalism. This section necessarily considers these issues.

#### **a. Operation of the Mental Treatment Act 1945 from 1945 to 1980**

In the aftermath of the 1945 Act's enactment several issues came to be highlighted by those entrusted with its operation, and some of them were subsequently amended.

##### **i. Defining Mental Illness**

The 1945 Act had provided for the detention of a wide variety of persons and correlatively provided for the control a variety of social issues. There was some concern expressed in the psychiatric literature about detaining alcoholics and addicts.<sup>251</sup> Treatment of the 'underlying psychopathic state' was difficult and it was believed that the six months temporary detention was really to the benefit of the patient's family rather than the cure of the patient. In detaining such persons, there was heavy reliance on the evidence of the applicant, usually a family member. It was recognised that this could permit possible abuse whereby the family could mislead doctors and convince them that the patient needed treatment, so that an unwanted or inconvenient relative was removed while perhaps some financial or property readjustment was made in their absence.<sup>252</sup> Despite the fact that doctors had the power to release patients where they felt that the patient no longer suffered from a mental disorder, it seems that they felt constrained not to.<sup>253</sup>

As the criteria for detention were so loose, mental hospitals also came to be used as a substitute for the lack of provision of appropriate services elsewhere. In this manner the elderly were regularly admitted, in 1960 20% of all admissions were over the age of 65.<sup>254</sup> Some of these persons were transferred from poor law and other institutions; alternatively they were admitted not because of mental illness, but rather, their poor living conditions.<sup>255</sup>

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<sup>251</sup> HJ Eustace, "Addiction under the Mental Treatment Act, Eire, 1945" (1945) 95 *British Journal of Psychiatry* 693.

<sup>252</sup> *Ibid.*

<sup>253</sup> *Ibid.*

<sup>254</sup> Dermot Walsh & Antoinette Daly, *Mental Illness in Ireland 1750-2002* (Health Research Board 2004) 33.

<sup>255</sup> Report of the Inspector of Mental Hospitals 1953 as quoted in Pdraig O'Morain, *The Health of the Nation* (Gill and Macmillan 2007) 69.



Furthermore, in 1958 11% of people in mental hospitals did not have a mental illness but had intellectual disabilities. Anecdotal reports from medical superintendents confirmed that these people were being referred from a variety of sources, often at very young ages.<sup>256</sup> The population of the mental hospitals also included persons who were inconvenient, defiant or deviant and in this manner admissions came from homes for unmarried mothers and other similar institutions.<sup>257</sup> Those detained in the mental hospitals thus came to include children, unmarried mothers, the elderly, the intellectually disabled and the socially marginalised with no other options. The lack of specific definitions of mental illness and the wide discretion provided to the psychiatric profession in determining who could be detained enabled the development of this situation.

## **ii. *Inspector of Mental Hospitals***

Despite the Inspectors role in considering the legal propriety of detention in the mental hospitals the Annual Reports do not contain any consideration of these issues. In general they primarily focused on: the number of admissions, discharges and deaths; expenditure; and the general conditions of the institutions. In this respect the Reports continued to draw attention to overcrowding and the poor quality of accommodation in the mental hospitals.<sup>258</sup>

## **iii. *Amendments***

The 1945 Act had provided that detention orders could only be signed by the person in charge of the hospital, in the case of public hospitals this was the resident medical superintendent. However, given the large populations of the institutions and the wide range of duties assigned to the medical superintendent, it had become regular practice that some of these duties would be assigned to medical officers other than the person in charge.<sup>259</sup> The Mental Treatment Act 1953 was introduced in the wake of a High Court decision which held that a temporary detention order was invalid where it had been signed by a medical officer who was not the resident mental superintendent.<sup>260</sup> The 1953 Act was therefore enacted to:

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<sup>256</sup> Dermot Walsh & Antoinette Daly, *Mental Illness in Ireland 1750-2002* (Health Research Board 2004) 33.

<sup>257</sup> Department of Justice, *Report of the Inter-Departmental Committee to establish the facts of State involvement with the Magdalen Laundries* (2013) 434-521.

<sup>258</sup> See generally, *Report of the Inspector of Mental Hospitals* 1945 to 2003.

<sup>259</sup> Mental Treatment Bill, 1953- Second and Subsequent Stages, Dáil Debates, Volume 143, no. 14, 16 December 1953, 2457.

<sup>260</sup> *In re J Donnelly* [1954] 1 IR 124.

*“correct technical omissions in the Mental Treatment Act, 1945, which have created serious difficulties in the machinery for the provision of institutional treatment for mental patients.”*<sup>261</sup>

It provided that any a power or duty under the 1945 Act of the resident medical superintendent, the chief medical officer or the person in charge of a district mental hospital may be exercised or performed by any other medical officer of the institution authorised on that behalf by the mental hospital authority maintaining the institution. However, as the power of detention could now be operated by any medical officer it was believed that there needed to be some control of this discretion.<sup>262</sup> The 1953 Act thus also provided that the person the subject of a temporary public detention order may request a second medical examination, however, this was not automatic.<sup>263</sup> This amendment further enshrines medicalism. The initial purpose of the provision was an attempt to ensure only the most senior psychiatrist in the mental hospital could approve detention, as a result of the 1953 Act this was broadened to any of the medical officers in the hospital and significantly increased the discretion of those tasked with its operation.

A further amendment to the 1945 Act was made as a result of another administrative burden that had been created by requiring the Minister of Health to approve extensions to temporary detention orders. The Mental Treatment Act 1961 amended this and provided that such extension would be made rather by the medical superintendent.<sup>264</sup> When considering whether this would be a subjugation of the previous safeguard, it was concluded that the Minister was responsible for extending over 3,000 detention orders annually and was already relying on advisors who in turn were relying on chief medical officers to do this.<sup>265</sup> Thus, in reality this protection that was consistent with legalism, had never really provided the intended protection against unwarranted detention for patients and its removal was consistent with medicalism.

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<sup>261</sup> Minister for Health, Dr Ryan, Mental Treatment Bill, 1953- Second and Subsequent Stages, Dáil Debates, Volume 143, no. 14, 16 December 1953, 2457.

<sup>262</sup> Mental Treatment Bill, 1953- Second and Subsequent Stages, Dáil Debates, Volume 43, no. 4, 17 December 1953, 351.

<sup>263</sup> Mental Treatment Act 1953, s 5(3)(i).

<sup>264</sup> Mental Treatment Act 1961, s 18.

<sup>265</sup> Mental Treatment Bill, 1960- Second Stage, Dáil Debates, Volume 186, no. 1, 8 February 1961, 87.

## **b. Influence of Medicalism on the Judicial Interpretation of the Mental Treatment Act 1945 from 1945 to 1980**

Given the significant powers of detention provided to doctors under the 1945 Act one might assume that such detention would have been readily challengeable in the courts. The 1937 Constitution reinforced the personal rights of the Irish citizen under Article 40, including the right to liberty under Article 40.4. Indeed, these personal rights represented one of the most unique developments of the 1937 Constitution by comparison with that of the 1922 Constitution which devoted little space to such rights and in reality played almost no part on the maintenance of those rights.<sup>266</sup> The right to liberty was expanded under the 1937 Constitution and a legal process by which persons could challenge the lawfulness of their detention was established. The *habeas corpus* provision in Article 40.4.2<sup>0</sup> provides that a complaint may be made by or on behalf of any person to the High Court alleging that such person is being unlawfully detained. The Court is required to directly enquire into the complaint and order the release of such person from detention unless satisfied that he or she is being detained in accordance with the law.<sup>267</sup> Alternatively, if the High Court finds that said person is detained in accordance with the law but that the law is unconstitutional it must refer the case to the Supreme Court and allow the person to be at liberty in accordance with such conditions of the High Court, until the Supreme Court has determined the question referred to it.<sup>268</sup>

### **i. Challenging Detention by way of Habeas Corpus**

Consequently, aside from the provisions in the 1945 Act the primary method by which one could challenge the legality of their detention was through the use of the *habeas corpus* provision under Article 40.4.2<sup>0</sup> of the 1937 Constitution. Indeed within five years of the enactment of the 1945 Act, the significant provisions of detention were challenged in a *habeas corpus* application in *In Re Philip Clarke*.<sup>269</sup> Philip Clarke challenged the constitutionality of Section 165 of the 1945 Act which allowed a police officer to detain a person at a police station where the officer was of the opinion that the person was of unsound mind and should be detained for their personal or public safety. The police officer must then contact an authorised medical officer who was required to examine the person and make a

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<sup>266</sup> G Hogan & G Whyte, *J.M. Kelly: The Irish Constitution* (4<sup>th</sup> Ed, Butterworths 2003) 1245.

<sup>267</sup> See generally, K Costello, *The Law of Habeas Corpus in Ireland* (Four Courts Press 2006); G Hogan & G Whyte, *J.M. Kelly: The Irish Constitution* (4<sup>th</sup> Ed, Butterworths 2003) 1677-1706.

<sup>268</sup> The Irish Constitution 1937, Art 40.4.

<sup>269</sup> *In re Philip Clarke* [1950] IR 235.

recommendation for detention if he/she believed the person was of unsound mind. Philip Clarke challenged the constitutionality of this provision on the basis that there were insufficient safeguards in the 1945 Act to protect the right to liberty. Comparison was made to the previous legislation where there was an element of judicial review or examination prior to detention. The argument was a plea for increased legalism.

Significantly, the Supreme Court rejected the argument that the 1945 Act failed to protect the patient from unlawful detention and held that the requirement that a person alleged to be of unsound mind must be examined by two medical professionals with the least possible delay satisfied every reasonable requirement of legality under the Constitution and provided sufficient safeguards. Moreover, O’Byrne J stated:

*“the impugned legislation is 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.”*<sup>270</sup>

The judicial interpretation of the 1945 Act in the first case challenging its constitutionality was representative of the judiciary’s adherence and endorsement of medicalism. In a similar vein to the legislature, the judiciary was of the belief that the solution to the problem of mental illness in the country was psychiatric treatment. In this manner the Supreme Court held that when persons were detained under it, their rights were not restricted but vindicated.<sup>271</sup> The 1945 Act provided citizens with the treatment they needed and protected them from harm: it was paternalistic in nature. The Court believed that as detention under the 1945 Act was not an administration of justice there was no need for judicial intervention. Furthermore, the constitutional rights of those detained were adequately upheld by the periodical review of their medical condition by the medical professionals responsible for their initial detention and subsequent care. Thus, there was an absence of any notion that such medical decision making could be incorrect or even arbitrary at times. This case, as decided by the Supreme Court, was to have a determinative effect on the manner in which other cases were decided on the 1945 Act from this point to date.<sup>272</sup>

Significantly, there were no other cases which challenged the constitutionality of the 1945 Act until 1994, meaning there were only two constitutional challenges in a 50 year period.

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<sup>270</sup> *In re Philip Clarke* [1950] IR 235 at 247.

<sup>271</sup> *In re Philip Clarke* [1950] IR 235 at 248.

<sup>272</sup> [1950] IR 235.

This is significant given the vast powers of detention under the 1945 Act, the extent to which they curtailed the constitutional right to liberty and the number of people detained thereunder. Between 1950 and 1980 there was also only one other written decision concerning a *habeas corpus* application challenging detention on a specific procedural violation (rather than constitutionality) under the 1945 Act; *In re J Donnelly*.<sup>273</sup> In this case, however, the High Court held that the applicant's detention was unlawful as it was signed by a medical officer who was not the superintendent of the hospital and this resulted in the 1953 amendment of the 1945 Act. The High Court held that the provision requiring the reception order to be made by the resident medical superintendent was clear and unambiguous. The Court disregarded the argument that the lack of a provision that would allow for another consultant psychiatrist on the staff of a district hospital to make such reception order where the resident medical superintendent was unable to was an oversight of the legislature. Davitt P stated that it was of no relevance to the Court whether the lack of such a provision was an oversight or a deliberate policy, but he was of the opinion that the omission was most likely deliberate. The reception order in this case was accordingly made without any statutory authority and was legally void and of no effect. The detention of Donnelly thereunder was, therefore, illegal.<sup>274</sup> It is interesting that the High Court found the detention unlawful in this case and one can only postulate as to the reasons; perhaps the Court was more comfortable with finding detention unlawful based on the clear failure to comply with a specific provision of the 1945 Act. In this case there was no challenge to the constitutionality of the 1945 Act and the Court was not drawn into a consideration of the purpose of the 1945 Act or the lack of adequate safeguards for those detained. Nevertheless, it is significant that the Court found the detention unlawful on this ground and is a clear enunciation of legalism.

Keys conducted research into unreported *habeas corpus* applications. She has found that between 1923 and 1999 only 111 *habeas corpus* applications were made by or on behalf of psychiatric patients.<sup>275</sup> This compares with 113 *habeas corpus* applications made between

<sup>273</sup> *In re J Donnelly* [1954] 1 IR 124.

<sup>274</sup> *In re J Donnelly* [1954] 1 IR 124, at 126-127.

<sup>275</sup> Mary Keys, "Challenging the Lawfulness of Psychiatric Detention under Habeas Corpus in Ireland" (2002) 1 *Dublin University Law Journal* 26. It has not been possible to get a further breakdown of the figures per year. There are less than 20 published judgements of civil cases where the Mental Treatment Act 1945 was impugned, seven of these were *habeas corpus* applications; *In re Philip Clarke* [1950] IR 235; *In re J Donnelly* [1954] 1 IR 124; *Croke v Smith* [1994] 3 IR 525; *RT v Central Mental Hospital* [1995] 2 IR 65; *Croke v Smith (No 2)* [1998] 1 IR 101; *Gooden v St Otteran's Hospital* [2001] IESC 14; *Orton v St John of Gods Hospital* [2004] 11 JIC 1505. Following consultation with Dr Mary Keys she further explained that "On the *habeas corpus* applications,

1998 and 1999 by prisoners. During this time period no *habeas corpus* applications were received from over 60% of the mental hospitals in the country.<sup>276</sup> The higher numbers of *habeas corpus* applications from prisons has been attributed to a certain “rights culture” in the criminal justice system. Moreover, prisoners have lawyers who have defended them at trial and this goes some way to explaining the fact that 44% of the prison applications had legal representation compared with 31% of the applicants in psychiatric detention. To substantiate the point further, 63% of the psychiatric detention applications came from the Central Mental Hospital: 75% of the population in the Central Mental Hospital had come through the criminal justice system, having been found not guilty by reason of insanity or unfit for trial. These patients would have had access to legal representation. Furthermore, patients detained in mental hospitals may not have been aware of their right to make an application, they may not have had family or friends who could make an application on their behalf or they may not have had the ability to initiate the necessary written or verbal communications required to begin such a process. The failure to provide sufficient information about options to challenge one’s detention under the 1945 Act could be considered as a barrier to patients’ access to the courts.<sup>277</sup>

The lack of cases must be considered within the courts’ overall approach to the personal rights in the 1937 Constitution. In the first 25 years of the Constitution’s existence there was almost no exploration of the general phrase ‘personal rights’.<sup>278</sup> Indeed, *In re Philip Clarke*, was one of the only cases that considered personal rights in general prior to 1980 and the Supreme Court had stated that:

*“The [impugned] section cannot, in our opinion, be construed as an attack upon the personal rights of the citizen. On the contrary it seems to us to be designed for the protection of the citizen and for the promotion of the common good.”*<sup>279</sup>

It is likely that, in light of this strong ruling by the Supreme Court, lawyers were reluctant to make claims about the lack of legal protections under the 1945 Act as they were likely to be

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most applications came from the CMH so the 1945 Act was unlikely to have had an influence although it may have had in relation to the small numbers transferred from ordinary psychiatric hospitals...it was miniscule. Most occurred after the 1970s when information on rights etc was growing The major finding was the greater awareness of rights and representation due to being involved in the criminal justice system”.

<sup>276</sup> Mary Keys, “Challenging the Lawfulness of Psychiatric Detention under Habeas Corpus in Ireland” (2002) 1 *Dublin University Law Journal* 26.

<sup>277</sup> *Ibid.*

<sup>278</sup> G Hogan & G Whyte, *J.M. Kelly: The Irish Constitution* (4<sup>th</sup> Ed, Butterworths 2003) 1389-1390.

<sup>279</sup> *In re Philip Clarke* [1950] IR 235 at 248.

unsuccessful. When *Re Philip Clarke* was decided in 1951, there was no real rights consciousness or rights culture and therefore there was no belief on the part of the Supreme Court that legislation in general could restrict the rights of Irish citizens.

### c. Conclusion

Between 1945 and 1980, the operation of the 1945 Act was consistent with medicalism and, based on the lack of legal controls on medical discretion, a wide range of persons came to be detained in mental hospitals. Similarly, where amendments were made to the 1945 Act, these increased medical power in the detention process. In terms of the judicial interpretation of the 1945 Act only two cases were heard during this period. In the seminal *In re Philip Clarke*<sup>280</sup> case, the Supreme Court's interpretation of the powers of detention, consistent with medicalism, came to have an overarching influence on subsequent jurisprudence. Interestingly, however, the only other case during this period was *In re J Donnelly*<sup>281</sup> concerning procedural violation and this was decided in line with legalism. Such precedents were to have an influence on subsequent case law after the 1980s.

### 3.05 Challenges to the Dominance of Medicalism

Despite the complete acceptance of medicalism in the 1945 Act, between the 1950s and the 1970s dissatisfaction with psychiatry's role in the detention of the mentally ill emerged out of simultaneous developments in a number of disciplines internationally. While the development of psychiatry's legal powers of detention were initially considered as reforms, as a result of these developments, psychiatry's powers of detention came to be dominated by a social control interpretation that asserted that the state used welfare agencies, institutions and various reform measures to control and direct the control of society.<sup>282</sup> It is necessary to

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<sup>280</sup> [1950] IR 235.

<sup>281</sup> *In re J Donnelly* [1954] 1 IR 124.

<sup>282</sup> From an academic perspective the history of psychiatry has had a contentious evolution. Initially the field comprised clinicians and historians who had traditionally upheld the psychiatric professions espousal of 'reforms' in the treatment of the mentally ill see generally Gregory Zilboorg & George William Henry, *A History of Medical Psychology* (WW Norton 1973); F Alexander & S Selesnick, *The History of Psychiatry* (Allen and Unwin 1967); Richard Hunter & Ida MacAlpine, *Psychiatry for the Poor* (Dawsons 1973). By the 1960s the altruistic profession of psychiatry was questioned and the reality of mental illness contested, significantly by dissident psychiatrists such as Thomas Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (Harper and Row 1960); RD Laing, *The Divided Self: An Existential Study in Sanity and Madness* (Penguin 1960); RD Laing & A Esterson, *Sanity, Madness, and the Family* (Basic Books 1965); RD Laing, *Self and Others* (Pantheon 1969) and sociologists such as Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Anchor 1961); Thomas Scheff, *Being Mentally Ill, A Sociological Theory* (Aldine 1966). During the 1970s and 1980s the role of psychiatry in social control came to the fore with works such as Michael Foucault, *Madness and Civilisation: A History of Insanity in the Age of Reason* (Plon 1961, Pantheon 1965); Andrew Scull, *Museums of Madness: The Social Organization of*

examine these developments and determine the extent to which they affected the operation of the 1945 Act.

### **a. Anti-Psychiatry Movement**

The academic literature concerning the role of psychiatry in the detention of the mentally ill has had a contentious evolution. Initially the field comprised clinicians and historians who had traditionally upheld psychiatry's expanding role in the detention of the mentally ill as 'reforms'.<sup>283</sup> By the 1960s, however, the altruistic nature of the psychiatric profession came under significant scrutiny. The resulting 'anti-psychiatry' movement questioned the very basis of psychiatry: the claim that mental disorder is an illness. Significantly, it was instigated by dissident psychiatrists such as Szasz in the US and Laing and Cooper in Britain.<sup>284</sup> As the movement evolved, psychiatry's role in the detention and treatment of the mentally ill was recast in terms of its social control and moral regulation of society.<sup>285</sup>

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*Insanity in Nineteenth Century England* (Allen Lane 1979); Talcott Parsons, *The Social System* (Free Press 1951); Edwin Lemert, *Human Deviance, Social Problems and Social Control* (2nd Ed, Prentice Hall 1972); *Social Pathology* (McGraw Hill 1951); Howard S Becker, *Outsiders, Studies in the Sociology of Deviance* (The Free Press 1963); Thomas Scheff, *Being Mentally Ill, A Sociological Theory* (Aldine 1966); M Janowitz, "Sociological Theory and Social Control" (1975) 81(1) *American Journal of Sociology* 82. For a comprehensive overview see Andrew Scull, *The Insanity of Place/The Place of Insanity, Essays on the History of Psychiatry* (Routledge 2006) 38-54, 107-129 and Stanley Cohen & Andrew Scull (eds), *Social Control and the State: Historical and Comparative Essays* (Martin Robinson & Company Ltd 1983) 1-39.

<sup>283</sup> See generally Gregory Zilboorg & George William Henry, *A History of Medical Psychology* (WW Norton 1973); F Alexander & S Selesnick, *The History of Psychiatry* (Allen and Unwin 1967); Richard Hunter & Ida MacAlpine, *Psychiatry for the Poor* (Dawsons 1973).

<sup>284</sup> See generally Thomas Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (Harper and Row 1960); RD Laing, *The Divided Self: An Existential Study in Sanity and Madness* (Penguin 1960); RD Laing & A Esterson, *Sanity, Madness, and the Family* (Basic Books 1965); RD Laing, *Self and Others* (Pantheon 1969); David Cooper, *Psychiatry and Anti-Psychiatry* (Tavistock 1968). See also Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Anchor 1961); Thomas Scheff, *Being Mentally Ill, A Sociological Theory* (Aldine 1966); Nicholas N Kittrie, *The Right to Be Different: Deviance and Enforced Therapy* (Johns Hopkins University Press 1971); David Ingleby, 'Understanding Mental Illness' in David Ingleby (ed), *Critical Psychiatry: The Politics of Mental Health* (Penguin 1981); Geoff Baruch and Andrew Treacher, *Psychiatry Observed* (Routledge and Kegan Paul 1978); Geoff Baruch and Andrew Treacher, 'Towards a Critical History of the Psychiatric Profession' in David Ingleby (ed), *Critical Psychiatry: The Politics of Mental Health* (Penguin 1981); Philip Bean, *Compulsory Admissions to Mental Hospitals* (John Wiley & Sons 1980); Andrew Scull, "From Madness to Mental Illness: Medical Men as Moral Entrepreneurs" (1975) 16(2) *European Journal of Sociology* 218; Peter Conrad & Joseph W Schneider, *Deviance and Medicalization: From Badness to Sickness* (Temple University Press 1980).

<sup>285</sup> See generally Michael Foucault, *Madness and Civilisation: A History of Insanity in the Age of Reason* (Plon 1961, Pantheon 1965); Andrew Scull, *Museums of Madness: The Social Organization of Insanity in Nineteenth Century England* (Allen Lane 1979); Talcott Parsons, *The Social System* (Free Press 1951); Edwin Lemert, *Human Deviance, Social Problems and Social Control* (2nd Ed, Prentice Hall 1972); *Social Pathology* (McGraw Hill 1951); Howard S Becker, *Outsiders, Studies in the Sociology of Deviance* (The Free Press 1963); Irving Zola, "Medicine as an Institution of Social Control" (1972) 20(4) *The Sociological Review* 487; Thomas Scheff, *Being Mentally Ill, A Sociological Theory* (Aldine 1966); M Janowitz, "Sociological Theory and Social Control" (1975) 81(1) *American Journal of Sociology* 82; For a comprehensive overview see Andrew Scull, *The Insanity of Place/The Place of Insanity, Essays on the History of Psychiatry* (Routledge 2006) 38-54, 107-129



## b. De-Institutionalisation Movement

This anti-psychiatry work influenced and coincided with the deinstitutionalisation movement which launched a sustained analysis and critique of the mental hospital system during the 1950s and 1960s.<sup>286</sup> During this time growing concern was publicly expressed about the conditions of large public mental hospitals. Notably, Goffman's work analysed the adverse effects of detention in mental hospitals which had the effect of institutionalising both patients and staff.<sup>287</sup> Mental hospitals were dehumanising places whereby the 'inmate' experienced obvious abuses such as unwarranted or disproportionate detention, forced treatment and degrading living conditions. Less obvious but equally affecting were the power imbalances, the lack of pleasure and comfort, the monotony of everyday scheduled life and the increased inability to live an independent life outside the mental hospital.<sup>288</sup> Other studies into the effects of mental hospitals reinforced Goffman's theory of institutionalisation.<sup>289</sup> Wing highlighted the social withdrawal and passivity of patients that was unconnected to their particular diagnosis but correlated to their length of stay in mental hospital.<sup>290</sup> The impacts of institutionalisation continued to be studied throughout the latter half of the twentieth century and to this day remain relevant.<sup>291</sup>

Simultaneously, in England revelations of serious institutional malpractice in a series of inquiries into abuses in psychiatric hospitals were emerging.<sup>292</sup> These inquiries found that patients were neglected, severely ill-treated and provided with inadequate medical and nursing care by incompetent staff. There was poor administration, defective management and a suppression of complaints. Allegations of cruelty and the issue of consent to

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and Stanley Cohen & Andrew Scull (eds), *Social Control and the State: Historical and Comparative Essays* (Martin Robinson & Company Ltd 1983) 1-39.

<sup>286</sup> Anne Rogers & David Pilgrim, *A Sociology of Mental Health and Illness* (3<sup>rd</sup> Ed, Open University Press 2005) 172.

<sup>287</sup> Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Aldine Transaction 1961).

<sup>288</sup> Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Aldine Transaction 1961).

<sup>289</sup> JK Wing & RK Freudenberg, "The Response of Severely Ill Chronic Schizophrenic Patients to Social Stimulation" (1961) 118(4) *American Journal of Psychiatry* 311; GW Brown, "Experiences of Discharged Chronic Schizophrenic Patients in Various Types of Living Group" (1959) 37(2) *Milbank Memorial Fund Quarterly* 105; GW Brown & JK Wing, "A Comparative Clinical and Social Survey of Three Mental Hospitals" (1962) 5(S1) *The Sociological Review* 145.

<sup>290</sup> JK Wing, "Institutionalism in Mental Hospital" (1962) 1(1) *British Journal of Social and Clinical Psychology* 38.

<sup>291</sup> RD Scott, "The Treatment Barrier, Part 1" (1973) 46(1) *British Journal of Medical Psychology* 45; BM Braginsky, DD Braginsky & K Ring, *Methods of Madness: The Mental Hospital as a Last Resort* (Holt, Rinehart and Winston 1973); James Purdon Martin, *Hospitals in Trouble* (Blackwell 1985).

<sup>292</sup> Anne Rogers & David Pilgrim, *A Sociology of Mental Health and Illness* (3<sup>rd</sup> Ed, Open University Press 2005) 174.

electroconvulsive therapy were the focus of one inquiry. In another, the report on the Normansfield Hospital, described the consultant psychiatrist there as intolerant, abusive and tyrannical.<sup>293</sup> Martin reviewed the failures of caring in British mental institutions during this period and attributed it to the isolation that is associated with institutionalisation.<sup>294</sup>

The critique of mental hospitals as total institutions began to impact upon psychiatric ideology and thus began the deinstitutionalisation movement, starting in the US in the 1960s. Significantly, the legal sphere changed to accommodate this deinstitutionalisation. American President John F. Kennedy signed the Community Mental Health Centres Act in 1963 as a means of facilitating the transition from inpatient psychiatric care to community care. In 1966 it was held by the US Supreme Court in *Lake v Cameron*<sup>295</sup> that all psychiatric treatment must be carried out in the least restrictive setting possible. What initially began in the US then spread to Europe about a decade later. The most successful of these movements was in Italy. Here Basaglia, an Italian psychiatrist, became the main proponent of a very successful anti-psychiatry movement that culminated in the 1978 Italian National Reform Bill that banned all asylums and compulsory admissions and established community hospital psychiatric units, which were restricted to 15 beds.

At the same time there was a revolution in pharmacology in the 1950s with the discovery of major tranquillisers that facilitated the treatment of psychotic disorders outside of the mental hospital system.<sup>296</sup> The theory that the pharmacological revolution instigated the deinstitutionalisation of the mental hospitals has been contested on numerous grounds. A number of studies demonstrate that an increased level of discharges occurred prior to the widespread use of tranquillisers and the introduction of psychotropic drugs did not appear to accelerate the rate of discharges.<sup>297</sup> While the pharmacological revolution may not have instigated the de-institutionalisation movement, according to Scull it did help manage deviance post-deinstitutionalisation through the control of symptoms.<sup>298</sup> Importantly, however, the development and use of psychotropic drugs allowed psychiatry to maintain their

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<sup>293</sup> J R Hamilton, "The Mental Health Act 1983" (1983) 286 (6379) *British Medical Journal* 1720, 1721.

<sup>294</sup> See generally James Purdon Martin, *Hospitals in Trouble* (Blackwell 1985).

<sup>295</sup> 64 F.2d 657 (1966).

<sup>296</sup> Phil Fennell, *Treatment Without Consent; Law, Psychiatry and the Treatment of Mentally Disordered People since 1845* (Routledge 1996) 148-167.

<sup>297</sup> Anne Rogers & David Pilgrim, *A Sociology of Mental Health and Illness* (3<sup>rd</sup> Ed, Open University Press 2005) 177.

<sup>298</sup> Andrew Scull, *Decarceration: Community Treatment and the Deviant-A Radical View* (Prentice-Hall 1977).

control in the treatment of mental illness and therefore the shift to community care did not undermine their jurisdiction.<sup>299</sup>

### c. Mental Health Rights Movement

The anti-psychiatry and de-institutionalisation movements provided an ideological platform for the rejection of medicalism and the emergence of legalism. A significant contributing factor to the development of legalism was that this sociological work emerged at a time when mass civil rights movements saw a worldwide resistance to all forms of political, racial and sexual oppression in the 1960s. In the US, alliances were formed between anti-psychiatry and gay activists. In 1970 and 1971 they prevented psychiatrists from entering the American Psychiatric Association's (APA) annual meeting on account of its classification of homosexuality as a psychiatric disorder. In 1973 homosexuality was removed from the DSM manual as a mental illness by the APA.<sup>300</sup> By the 1980s the international human rights sphere had significantly developed since the initial creation of the Universal Declaration of Human Rights in 1948 and the European Convention on Human Rights (ECHR) in 1950.<sup>301</sup>

It was against this backdrop that Gostin, the legal director of MIND, a voluntary organisation situated in England published two books; *A Human Condition Vols I and II*.<sup>302</sup> In these books he criticised the operation of the English Mental Health Act 1959 which was seen as overly paternalistic in that it conferred wide discretionary power on doctors and state authorities to treat the mentally ill. Gostin, an American lawyer, was influenced by the recent sociological thought<sup>303</sup> and came to play a prominent role in what was termed the pendulum swing between medicalism and legalism.<sup>304</sup> He urged the introduction of more effective procedural

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<sup>299</sup> Abbey Hyde, Maria Lohan and Orla McDonnell, *Sociology for Health Professionals in Ireland* (Institute of Public Administration 2004) 192.

<sup>300</sup> D Rissmiller & J Rissmiller, "Evolution of the Antipsychiatry Movement into Mental Health Consumerism" (2006) 57(6) *Psychiatric Services* 864.

<sup>301</sup> On international human rights see generally: P Alston & H Steiner, *International Human Rights in Context* (Oxford University Press 2000); Ian Brownlie, *Basic Documents on Human Rights* (4<sup>th</sup> Ed Oxford University Press 2002); A Cassese, *International Law* (2nd Ed, Oxford University Press 2005); M Ishay, *The History of Human Rights* (University of California Press 2004). On the European Convention on Human Rights see generally; DJ Harris, M O'Boyle & C Warbrick, *Law of the European Convention on Human Rights* (2<sup>nd</sup> Ed, Oxford University Press 2009); Jacobs, White & Ovey, *The European Convention on Human Rights* (5<sup>th</sup> Ed, Oxford University Press 2010). P Van Dijk & GJH Van Hoof (eds), *Theory and Practice of the European Convention on Human Rights* (4<sup>th</sup> Ed, Hart Publishing 2006); Ed Bates, *The Evolution of the European Convention on Human Rights* (Oxford University Press 2010).

<sup>302</sup> Lawrence O Gostin, *A Human Condition Vols I and II* (National Association for Mental Health 1977).

<sup>303</sup> Lawrence O Gostin, "From Civil Libertarian to a Santiarian" (2007) 34(4) *Journal of Law and Society* 597.

<sup>304</sup> Kathleen Jones, *Lunacy, Law and Conscience 1744-1845* (Routledge and Kegan Paul 1955); Kathleen Jones "The Limitations of the Legal Approach to Mental Health" (1980) 3(1) *International Journal of Law and Psychiatry* 1.

safeguards and regulation of psychiatry, describing reform proposals which he had drafted for MIND as based on a 'new legalism'.<sup>305</sup> Gostin's new legalism was built on a rights based approach and drew heavily from the ECHR.<sup>306</sup>

### ***i. The Council of Europe and the Legal Powers of Detention***

At the same time the Council of Europe was moving towards a view of mental health detention that was consistent with legalism. The Council of Europe is the continent's leading human rights organisation and provides a framework of rules and widespread guarantees on the subject of human rights in general.<sup>307</sup> Given what was occurring via the anti-psychiatry and de-institutionalisation movements in the 1970s, the Committee of Ministers of the Council of Europe turned their attention to the situation of persons in psychiatric detention in Recommendation 818 (1977); Relating to the situation of the mentally ill (12<sup>th</sup> Meeting, October 8, 1977) and Recommendation No R (83) 2; On the legal protection for people suffering mental illnesses and admitted as involuntary patients (356<sup>th</sup> Meeting, February 1983).<sup>308</sup> The Recommendations represent an overwhelming acceptance of legalism. Reference is made to how profound changes have taken place in Europe in attitudes towards mental illness from both the medical and social points of view. Subsequently, the Recommendations suggest that member states' mental health legislation should be re-cast in terms of rights protection. Mental health detention should restrict rights for as short a time period as possible and in the least restrictive manner. Significantly, the Recommendations, suggest removing sole authority in the detention process from psychiatry and transferring this

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<sup>305</sup> Larry Gostin, "Contemporary Social Historical Perspectives on Mental Health Reforms" (1983) 10(1) *Journal of Law and Society* 47; and 'The Ideology of Entitlement: The Application of Contemporary Legal Approaches to Psychiatry' in Philip Bean (ed), *Mental Illness: Changes and Trends* (Wiley 1983).

<sup>306</sup> Phil Fennell, 'Institutionalising the Community: The Codification of Clinical Authority and the Limits of Rights-Based Approaches' in Bernadette McSherry & Penelope Weller (eds), *Rethinking Rights-Based Mental Health Laws* (Hart Publishing 2010) 16.

<sup>307</sup> Council of Europe, 'Council of Europe in Brief'

<http://www.coe.int/aboutCoe/index.asp?page=quisommesnous&l=en> accessed 1 June 2014.

<sup>308</sup> Parliamentary Assembly, *Recommendation 818 (1977); Relating to the situation of the mentally ill* (12<sup>th</sup> Meeting, October 8, 1977); Committee of Ministers, *Recommendation No R (83) 2; On the legal protection for people suffering mental illnesses and admitted as involuntary patients* (356<sup>th</sup> Meeting, February 1983). One of the ways the Council of Europe attempts to establish human rights standards is through recommendations. These recommendations are adopted by the Committee of Ministers of the Council of Europe and addressed to the governments of the Council of Europe member states. Although they are not legally-binding, recommendations do represent important standard setting documents. The ECtHR has drawn on such documents for inspiration in interpreting ambiguous provisions of the ECHR; See G Quinn, "Civil Commitment and the Right to Treatment under the European Convention on Human Rights" (1992) 5(1) *Harvard Human Rights Journal* (1992) 13.

to the courts in addition to introducing external oversight through independent tribunals or courts.<sup>309</sup>

## **ii. European Court of Human Rights & the Legal Powers of Detention**

There was also an increase in cases brought to the ECtHR concerning mental health detention and it becomes apparent that when deciding these cases the ECtHR was similarly influenced by the movements. Unlike the Committee of Ministers Recommendations, ECtHR decisions are legally binding and therefore have greater weight. While in some countries ECHR law cannot be relied on in domestic courts, citizens can sue the State through the ECtHR. It is a breach of the State's international obligations if a violation of the ECHR is found. Since the late 1970s decisions of the ECtHR on cases concerning the psychiatric detention of persons have defined member states' obligations in line with legalism.<sup>310</sup>

In these cases the ECtHR developed features of legalism similar to those outlined in the Recommendations by introducing specific requirements for psychiatric detention. The principal instrument for these developments was Article 5 of the ECHR. Article 5 expressly allows the lawful detention of 'persons of unsound mind' yet sets out safeguards for persons who have been detained.<sup>311</sup> It states that no one can be detained except by a procedure defined by law and that a person must be informed of the reasons for the detention and must be able to appeal against the lawfulness of detention. Article 5(4) specifically outlines the right of detained persons to take proceedings by which the lawfulness of the detention shall

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<sup>309</sup> Parliamentary Assembly, *Recommendation 818 (1977); Relating to the situation of the mentally ill* (12<sup>th</sup> Meeting, October 8, 1977); Committee of Ministers, *Recommendation No R (83) 2; On the legal protection for people suffering mental illnesses and admitted as involuntary patients* (356<sup>th</sup> Meeting, February 1983).

<sup>310</sup> On mental health and the European Convention on Human Rights see generally; Lawrence Gostin et al, *Principles of Mental Health Law and Policy* (Oxford University Press 2010) 103-167; Peter Bartlett, Oliver Lewis & O Thorold, *Mental Disability and the European Convention on Human Rights* (Martinus Nijhoff 2007); Lawrence O Gostin & Lance Gable, "The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health" (2004) 63 *Maryland Law Review* 20; LO Gostin, "Human Rights of Persons with Mental Disabilities" (2000) 23(2) *International Journal of Law and Psychiatry* 125; Oliver Lewis, "Protecting the Rights of People with Mental Disabilities: the European Convention on Human Rights" (2002) 9(4) *European Journal of Health Law* 293; Johan Legemaate, "Involuntary Admission to a Psychiatric Hospital: Recent European Developments" (1995) 2(1) *European Journal of Health Law* 15; Oliver Thorold, "The Implications of the European Convention on Human Rights for United Kingdom Mental Health Legislation" (1996) 6 *European Human Rights Law Review* 619; G Richardson, "The European Convention and Mental Health Law in England and Wales: Moving Beyond Process?" (2005) 28(2) *International Journal of Law and Psychiatry* 127; Jim Murdoch "Safeguarding the Liberty of the Person: Recent Strasbourg Jurisprudence" (1993) 42(3) *International and Comparative Law Quarterly* 494; Kris Gledhill, "Human Rights Instruments and Mental Health Law: The English Experience of the Incorporation of the European Convention on Human Rights" (2006-2007) 34(2) *Syracuse Journal of International Law and Commerce* 358; G Niveau & J Materi, "Psychiatric Commitment: over 50 years of case law from the European Court of Human Rights" (2006) 22(7) *European Psychiatry* 427; Alasatir Mowbray, *Cases and Materials on the European Convention on Human Rights* (Oxford University Press 2011) 245-344.

<sup>311</sup> European Convention on Human Rights and Fundamental Freedoms, Article 5(1)(e).

be decided speedily by a court, and his or her release ordered if the detention is held not to be lawful.

The ECtHR has continued to build on the terms of Article 5 to create a number of clear requirements for lawful detention that are in line with legalism. In the cases concerning psychiatric detention the ECtHR has established that the detention process should not be one which is based on arbitrary decisions and therefore mental health detention must be in accordance with a specific procedure prescribed in law.<sup>312</sup> Domestic law must also be sufficiently accessible and precise to ensure the law itself is foreseeable in its application<sup>313</sup> and to avoid all risk of arbitrariness.<sup>314</sup> Furthermore, these domestic legal procedures must conform with the ECHR<sup>315</sup> and there is a positive obligation on states to protect the liberty of its citizens, including those detained in private institutions.<sup>316</sup> The legal regulation of the detention process is a primary tenet of legalism whereby legal controls are required to limit medical discretion in the process and protect the rights of those detained. All legal and administrative processes outlined in this legislation must be adhered to and any discrepancies render the detention unlawful.

Given that the role of psychiatry in the detention process was no longer unquestioned the ECtHR further refined the grounds upon which a person could be detained. It held that having a mental disorder is not enough in itself to warrant detention, rather the nature or degree of the mental disorder must be such as to justify the deprivation of liberty and continued detention is only valid so long as the disorder persists. The approach to the severity question is normally based on an individual's dangerousness, or his or her need for treatment, or both.<sup>317</sup> A detailed definition of mental disorder was not provided by the ECtHR on the grounds that it is a term that is constantly evolving with medical science.<sup>318</sup> However, it did outline that Article 5(1)(e) cannot be used to detain an individual just because his view or

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<sup>312</sup> *Winterwerp v Netherlands* (1979) 2 EHRR; *Van der Leer v Netherlands* (1990) 12 EHRR 567 at 23; *Kawka v Poland* (2001) App No 25874/94 ECHR at 49; *HL v the United Kingdom* (2005) 40 EHRR 32.

<sup>313</sup> *Kawka v Poland* (2001) App No 25874/94 ECHR at 49.

<sup>314</sup> *Amuur v France* (1996) 22 EHRR 533 at 50.

<sup>315</sup> *Winterwerp v Netherlands* (1979) 2 EHRR 387 at 45.

<sup>316</sup> *Stork v Germany* (2006) 43 EHRR 96 at 100-108.

<sup>317</sup> *Winterwerp v Netherlands* (1979) 2 EHRR 387; *Hutchison Reid v United Kingdom* (2003) 37 EHRR 9; The ECtHR has provided some justification for the detention of the groups listed under Article 5(1)(e) based upon the dangerousness and treatment grounds. 'The reason why the Convention allows [persons of unsound mind, alcoholics, and drug addicts] to be deprived of their liberty is not only that they have to be considered as occasionally dangerous for public safety but also that their own interests may necessitate their detention'. *Winterwerp v Netherlands* (1979) 2 EHRR 387; *Guzzardi v Italy* (1980) 3 EHRR 333 at 336; *Hutchison Reid v United Kingdom* (2003) 37 EHRR 9. See Lawrence Gostin et al, *Principles of Mental Health Law and Policy* (Oxford University Press 2010) 130.

<sup>318</sup> *Winterwerp v Netherlands* (1979) 2 EHRR 387 at 37.

behaviour deviates from the norms prevailing in a particular society.<sup>319</sup> Reflective of legalism this requirement was aimed at ensuring psychiatric detention was not used as a form of social control, a real life example of which was seen in the USSR.<sup>320</sup> Similarly, as detention is such a serious infringement on rights, in order to ensure the patient's rights are protected, such detention is only justified where other less severe measures have been considered and found to be insufficient to safeguard the individual or public interest.<sup>321</sup> However, when a person is detained on these grounds to ensure the protection of their rights the detention must take place in a caring and therapeutic rather than punishing environment such as a hospital, clinic or other appropriate institution for the mentally ill.<sup>322</sup>

One of the most important articulations of legalism is the manner in which the ECtHR built on the right under Article 5(4) to have the lawfulness of one's detention reviewed speedily by a court.<sup>323</sup> Furthermore, as mental illness is subject to amelioration or cure, to ensure that the continuing decision to detain is valid, the patient also has the right to have this reviewed periodically by an independent court.<sup>324</sup> The attributes of such a court are discussed in further detail in Chapter 5.<sup>325</sup> It was in this manner that Gostin and MIND utilised the ECHR and brought a series of test cases before the European Commission and the ECtHR, highlighting

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<sup>319</sup> *Ibid.*

<sup>320</sup> See R van Voren, "Political Abuse of Psychiatry—An Historical Overview" (2010) 36(1) *Schizophrenia Bulletin* 33.

<sup>321</sup> *Witold Litwa v Poland* (2001) 33 EHRR 53, the applicant who was blind went to his post office to collect his post. On arrival he found his box open and empty of his post. He complained to the staff who contacted the police alleging he was drunk and abusive. He was detained in a sobering up centre for 5-6 hours. The Court found that the lawful detention of alcoholics is permitted on both medical and social grounds. However, it did not believe that the applicant was an alcoholic or that he posed a threat to himself or the public. Here the detention was found to be unlawful as less severe measures could be used which were provided for in the Polish legislation.

<sup>322</sup> *Ashingdane v United Kingdom* (1985) 7 EHRR 528; *Aerts v Belgium* (1998) 29 EHRR 50.

<sup>323</sup> The ECtHR has not definitively stated how quickly the review of the decision to detain must take place as each case concerning this issue has been decided on its own facts. The ECtHRs jurisprudence on the issue of the 'speediness of the review' has found breaches of Article 5(4) where there have been delays of 24 days in *LR v France* (2002) App No 33395/96 ECHR; 35 days in *Laidin v France* (2002) App No 43291/98 ECHR; 56 days in *E v Norway* (1990) 17 EHRR 30; and 150 days in *Van der Leer v Netherlands* (1990) 12 EHRR 567. However in determining the urgency of cases the ECtHR has also drawn a distinction between first time patients and those applying for subsequent reviews of their detention. In the latter situation less urgency is required, *Koendjibiharie v Netherlands* (1990) 13 EHRR 820.

<sup>324</sup> *Winterwerp v Netherlands* (1979) 2 EHRR 387 at 39. In determining the urgency of cases the ECtHR has also drawn a distinction between first time patients and those applying for subsequent reviews of their detention. In the latter situation less urgency is required as per *Koendjibiharie v Netherlands* (1990) 13 EHRR 820. The ECtHR has not yet definitively stated how often a person is entitled to exercise the right to 'periodic review' under Article 5(4). However, in *Herczegfalvy v Austria* (1992) 15 EHRR 437 the ECtHR considered three intervals, the first fifteen months, the second two years, and the third nine months. It decided that the first two were excessive and the last acceptable. The ECtHR was therefore tolerant of an annual right.

<sup>325</sup> See pages 109-112.

the absence of possibilities for legal review of detention for many patients.<sup>326</sup> The most successful case brought was *X v United Kingdom*.<sup>327</sup> The ECtHR held that the independent review of detention must not be a mere formality, but must provide a serious examination of the merits of the case. Moreover, review by way of *habeas corpus* was not sufficient to fulfil the requirements of the ECHR.<sup>328</sup> As a result of the work of Gostin and MIND and the *X v United Kingdom* case, the Mental Health Act 1983 was enacted in England and Wales. The 1983 Act represented Gostin's new legalism and established procedural safeguards and external reviews that were to protect civil rights and limit psychiatric discretion in the detention of the mentally ill.<sup>329</sup> In time, the 1983 Act and the ECtHR decision in *X v United Kingdom*, were to have a significant impact on the legal powers to detain in Ireland.<sup>330</sup>

Cumulatively, in terms of mental health detention it can be said that the ECtHR's approach enshrined legalism and as a result of these developments it is interesting to note the number of countries in which mental health legislation was enacted or amended; Switzerland (1980), Scotland (1984), Northern Ireland (1986), the Former USSR (1988), Denmark (1989), Belgium (1990) and France (1990). However, once we stray from the specific procedural aspects of mental health detention and review, the case becomes less clear and it cannot be said that the ECtHR accepted legalism completely. In an influential case concerning psychiatric detention and treatment, the applicant argued that he had been unnecessarily and involuntarily given sedatives, force-fed, and restrained with handcuffs to a hospital bed for weeks which amount to torture and inhuman and degrading treatment under Article 3 of the ECHR. The ECtHR rejected this argument and held where such psychiatric treatment is in line with:

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<sup>326</sup> *A v United Kingdom* (1981) 3 EHRR 131; *Ball v United Kingdom* (1983) App No 9292/81 ECHR; *Barclay-Maguire v United Kingdom* (1981) App No 911/80 ECHR; *Medway v United Kingdom* (1983) App No 7699/76 ECHR; *O'Brien v The Prudential Assurance Co. Ltd.* (1979) IRLR 140; *X v United Kingdom* (1981) 1 BMLR 98; *X v United Kingdom X v United Kingdom* (1981) 4 EHRR 188; *X v United Kingdom* (1983) 5 EHRR 192.

<sup>327</sup> *X v United Kingdom* (1981) 4 EHRR 188.

<sup>328</sup> *X v United Kingdom* (1981) 4 EHRR 188 at 52.

<sup>329</sup> Gostin estimated that approximately two-thirds of the provisions of the Mental Health (Amendment) Act 1982 derived from proposals of MIND and contained in his book *A Human Condition Vols I and II* (London, National Association for Mental Health, 1977), see Larry Gostin, "Contemporary Social Historical Perspectives on Mental Health Reforms" (1983) 10(1) *Journal of Law and Society* 47, 67. For an analysis of the legalism inherent in the 1983 Act see generally Phil Fennell, "Law and Society: The Legal Constitution of the Psychiatric System" (1986) 13(1) *Journal of Law and Psychiatry* 35; Clive Unsworth, *The Politics of Mental Health Legislation* (Oxford University Press 1987); Nikolas Rose, "Unreasonable Rights, Mental Illness and the Limits of the Law" (1985) 12(2) *Journal of Law and Psychiatry* 199.

<sup>330</sup> *X v the United Kingdom* (1981) 4 EHRR 188.



*“established principles of medicine...as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading.”*<sup>331</sup>

Furthermore, while member states are required to meet the standards established by the ECHR, the ECtHR allows them a ‘margin of appreciation’ as to how they do so. It must also be remembered that the ECtHR prescribes minimum criteria. Individual member states have the ultimate responsibility for regulating this area through domestic legislation and may prescribe in greater detail the requirements for lawful psychiatric detention and treatment.

#### **d. Conclusion**

By the 1980s, at the international level, the anti-psychiatry and de-institutionalisation movements had initiated the significant shift in the approach to legal powers of detention from medicalism to legalism that continued to dominate mental health detention through to the twenty first century.

### **3.06 Impact of Challenges to the Dominance of Medicalism in Ireland 1980 to 2001**

Given the significance of these developments it is necessary to consider their impact in the Irish context in terms of their influence on the operation of the 1945 Act, mental health policy and legislation and the interpretation of the 1945 by the judiciary from the 1980s to 2001.

#### **a. Impact on Operation of the Mental Treatment Act 1945**

The 1945 Act had been introduced on a wave of optimism that predicted reduction in the use of mental hospitals through the treatment and cure of mental illness by psychiatry. By the 1960s, however, despite the fact that the numbers in detention were slowly starting to decline, Ireland’s mental hospital system remained in a state of crisis. Relative to the size of its population, Ireland had the highest number of persons detained in mental hospitals in the world. In Ireland, approximately 7.3 psychiatric beds were provided per 1,000 of the population compared with 4.5 in Northern Ireland, 4.6 in England and Wales, 4.3 in Scotland, 2.1 in France and 4.3 in U.S.A in 1961.<sup>332</sup> The 1945 Act had ensured that once a person was directed towards a mental hospital, no bar to treatment or admission was to be put in their way. Notably, senior staff members were remunerated in accordance with the number of beds

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<sup>331</sup> *Herczegfalvy v Austria* (1992) App No 10533/83 ECHR at 82.

<sup>332</sup> Department of Health, *Report of the Commission of Inquiry on Mental Illness* (Stationary Office 1966) 24.

under their control; therefore it became essential in larger hospitals that this number did not dip below 1,000.<sup>333</sup>

As a result, a Commission of Inquiry on Mental Illness was established in 1961.<sup>334</sup> The Commission's Report found that there was little or no alternative to hospitalisation for patients. The Report recommended a policy shift from institutionalised, custodial care to community-based treatment and the establishment of smaller psychiatric units in general hospitals. The Commission suggested that if its recommendations were implemented the number of beds necessary to deal with mental illness would fall by over half to 8,000 in 1981. The Report did not advise how these new policies might be implemented and the result was that no formal processes for implementation were introduced. Nevertheless some individual initiatives appeared sporadically and geographically unevenly throughout the country and community care and outpatient treatment did increase. From the 1960s onwards, hostels, group homes, day hospitals, day centres, sheltered workshops, rehabilitation and retraining centres were developed. Outpatient clinics were also provided in some general hospitals and health centres. In 1965, the first psychiatric unit in a general hospital was opened in Ardkeen Hospital in Waterford.<sup>335</sup> However, the extent to which these developments took place varied greatly from area to area throughout the country.<sup>336</sup> Therefore, contrary to the forecast, the number of psychiatric beds in use in 1981 was approximately twice the projected 8,000 and the mental hospital was far from redundant.

As a result a further Commission was established in 1981 with the aim of examining the components of both institutional and community care in Ireland and making recommendations for the future.<sup>337</sup> The Commission's 1984 Report similarly recommended an overhaul of the psychiatric services that should be community oriented. Where in-patient treatment was required this should be provided in psychiatric units in general hospitals. All long stay patients were to be rehabilitated with the view to relocation in the

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<sup>333</sup> Dermot Walsh, 'Mental Health Care in Ireland 1945-1997' in Joseph Robins, *Reflections on Health, Commemorating Fifty Year of the Department of Health 1947-1997* (Department of Health 1997) 128.

<sup>334</sup> Department of Health, *Report of the Commission of Inquiry on Mental Illness* (Stationary Office 1966).

<sup>335</sup> Dermot Walsh, 'Mental Health Care in Ireland 1945-1997' in Joseph Robins, *Reflections on Health, Commemorating Fifty Year of the Department of Health 1947-1997* (Department of Health 1997) 131.

<sup>336</sup> Department of Health, Report of a Study Group on the Development of the Psychiatric Services, *The Psychiatric Services- Planning for the Future* (Stationary Office 1984) 3; Department of Health, *Report of the Commission of Inquiry on Mental Illness* (Stationary Office 1966) 22.

<sup>337</sup> Department of Health, Report of a Study Group on the Development of the Psychiatric Services, *The Psychiatric Services- Planning for the Future* (Stationary Office 1984).

community.<sup>338</sup> The Report had some success and the network of out-patient services increased, as too did the number of psychiatric units in general hospitals.<sup>339</sup> Furthermore, the numbers of voluntary patients steadily increased and this category came to be the predominant mode of admission to mental hospitals. The numbers in detention accordingly decreased from a high of 21,720 in 1956 to 4,321 in 2001.<sup>340</sup> By 2001, 83% of mental hospital residents were voluntary patients.<sup>341</sup> In this manner the institutional approach remained the primary approach to mental health care.

A significant obstacle to the creation of a comprehensive community care service was that there was no legal backing for it; such legal backing has been seen to be an integral part of the development of the mental health services.<sup>342</sup> In this manner the move to community care in Britain had been provided for in the Mental Treatment Act 1959. This move was also facilitated by the expansion of the welfare state.<sup>343</sup> However, the late development of a welfare system in Ireland meant that the mental hospital system based on detention in large institutions was retained for a longer period and similar levels of community care were never realised. Even considering the increase in outpatient treatment, numbers in detention remained high and patients continued to be detained in aging and dilapidated institutions.<sup>344</sup>

## **b. Impact on Mental Health Legislation**

While the de-institutionalisation movement was limited in Ireland, the legislature were influenced by the anti-psychiatry movement and sought to provide for this in legislation.<sup>345</sup> The resulting Health (Mental Services) Act 1981 saw a move towards legalism. It provided specific legal controls to limit medical discretion and protect patient's rights. It provided new criteria for detention and new detention processes. It also established a form of appeal against detention and an automatic review of long term detention by an independent and multi-disciplinary tribunal. Despite its passing the 1981 Act was not brought into force

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<sup>338</sup> Department of Health, Report of a Study Group on the Development of the Psychiatric Services, *The Psychiatric Services- Planning for the Future* (Stationary Office 1984).

<sup>339</sup> Dermot Walsh, "Mental Health Care in Ireland" (1987) 16(1-2) *International Journal of Mental Health* 115.

<sup>340</sup> Damien Brennan, *Irish Insanity; 1800-2000* (Routledge 2014) 125-126.

<sup>341</sup> Dermot Walsh & Antoinette Daly, *The Irish psychiatric Hospitals and Units Census 2001* (Health Research Board 2002) 31.

<sup>342</sup> Clive Unsworth, *The Politics of Mental Health Legislation* (Oxford University Press 1987) 14.

<sup>343</sup> *Ibid.*

<sup>344</sup> Damien Brennan, *Irish Insanity; 1800-2000* (Routledge 2014) 99-104.

<sup>345</sup> In the summer of 1977, the Irish political party Fianna Fáil promised in their election manifesto to undertake a complete re-organisation of the mental health service and to undertake a comprehensive national programme for the mentally handicapped. The subsequent Health (Mental Services) Act 1981 sought to give effect to these two ambitions. See Health (Mental Services) Bill, 1980- Second Stage, Dáil Debates, Volume 323, no. 2, 16 October 1980.

for two reasons. Firstly, the general purpose of the 1981 Act failed to provide a legal framework for developing community care services advocated by the Commission of Inquiry in 1966 and restated in 1984.<sup>346</sup> Secondly, the 1981 Act was overtaken by developments in the ECtHR which required states to provide an independent judicial review of the decision to detain. The review boards established under the 1981 Act were not intended to do this in every case and furthermore their decisions could be appealed to the Minister for Health. This meant that decisions could be overturned by the executive, thereby failing one of the primary tenets of independence as established by the ECtHR.<sup>347</sup> No further attempts were made by the legislature during the period to amend the 1945 Act and therefore the medicalism enshrined therein monopolised the legal powers of detention until 2001 when new legislation was enacted.

### **c. Impact on Judicial Interpretation 1980 to 2006<sup>348</sup>**

Prior to 1980 there was a dearth of cases challenging detention under the 1945 Act. As stated, when *In re Philip Clarke*<sup>349</sup> was decided the Courts approach to personal rights was extremely conservative. However, the period between 1965 and 1980 was the most fruitful era of judicial activism in the history of the Constitution and the Courts recognised a panoply of unenumerated rights under Article 40.<sup>350</sup> Thereafter, the rate of expansion slowed down but three new rights were established in the 1980s and another three during the 1990s.<sup>351</sup> This judicial activism and newfound rights consciousness may explain the modest increase in cases challenging detention under the 1945 Act. However, most of these cases were brought in the 1990s and as stated the period of judicial activism had subsided. Nevertheless, the detention provisions came under scrutiny in thirteen (six of these were initiated by the same person) High Court cases which considered whether to grant leave to persons seeking to institute civil proceedings in respect of an act purporting to have been done in pursuance of

<sup>346</sup> Department of Health, *Report of the Commission of Inquiry on Mental Illness* (Stationary Office 1966); Department of Health, *The Psychiatric Services: Planning for the Future Report of a Study Group on the Development of the Psychiatric Services* (1984).

<sup>347</sup> Department of Health, *The Psychiatric Services: Planning for the Future Report of a Study Group on the Development of the Psychiatric Services* (1984).

<sup>348</sup> The period 2006 is used here because the Mental Health Act 2001 was not commenced until 2006 and therefore cases considered up to this date related to persons detained under the 1945 Act.

<sup>349</sup> [1950] IR 235.

<sup>350</sup> G Hogan & G Whyte, *J.M. Kelly: The Irish Constitution* (4<sup>th</sup> Ed, Butterworths 2003) 1417. The rights recognised included: the right to bodily integrity; right to work and earn a livelihood; the right of access to the courts; the right to fair procedures; the right to travel; the right to marry; the rights of unmarried mothers and of their children arising out of their mutual relationship; and the right to state-funded legal representation.

<sup>351</sup> These rights included: the right to communicate, right to beget children and the right to individual privacy; the right to independent domicile; the right to maintenance; and the right to know the identity of one's natural mother.

the 1945 Act.<sup>352</sup> During this period six *habeas corpus* applications were also made challenging the lawfulness of detention under the 1945 Act.<sup>353</sup>

### **i. Judicial Interpretation of Medical Examination & Diagnosis of Mental Illness**

One of the ways by which detention under the 1945 Act came under judicial scrutiny was in the cases where leave was sought to initiate civil proceedings against those involved in the detention process.<sup>354</sup> In order to do so the High Court had to be satisfied that there were substantial grounds for contending that the person against whom the proceedings are to be brought acted in bad faith or without reasonable care. The aim of this requirement was to discourage vexatious or frivolous action or one based on imaginary complaints and thus the requirement placed the burden of proof on the person bringing the claim, requiring him or her to show substantial grounds for it.<sup>355</sup> The Supreme Court did recognise that the requirement imposed a limitation on the constitutional right of access to the courts and therefore must be strictly construed.<sup>356</sup> However, it held that because the 1945 Act was dealing with the mentally ill, there was a greater risk that those working with them would be subject to imagined complaints. According to the Court it was an unfortunate feature of mental illness that those afflicted resent treatment because, like children, they do not know what is for their own good and can have delusional obsessions about their unlawful detention.<sup>357</sup> In 1985 the ECtHR held in *Ashingdane v United Kingdom* that the then English version of this provision did not breach the ECHR Article 6(1) right to a fair trial.<sup>358</sup> The ECtHR held the right of access to the courts is not absolute but may be subject to limitations and Member States enjoy a certain margin of appreciation in this regard. Despite this, any limitations must not impair the essence of the right and they must be proportionate.<sup>359</sup>

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<sup>352</sup> *O'Dowd v North Western Health Board* [1983] IRLM 186; *Murphy v Greene* [1990] 2 IR 566; *O'Reilly v Moroney* [1992] 2 IR 145; *Bailey v Gallagher* [1996] 2 IRLM 433; *Melly v Moran* [1997] IEHC 101; *Kiernan v Harris* [1998] IEHC 71; *Blehein v Murphy* [1999] IEHC 183; *Blehein v St John of God Hospital* [2000] IEHC 133; *Blehein v Murphy* [2000] IESC 1; *Blehein v Murphy (No 2)* [2000] IESC 65; 3 IR 359; *Blehein v St John of God Hospital* [2001] IESC 73; *Blehein v Murphy* [2002] IESC 43; *Dervan v Moran* [2002] 6 JIC 2503.

<sup>353</sup> *Croke v Smith* [1994] 3 IR 525; *RT v Central Mental Hospital* [1995] 2 IR 65; *Croke v Smith (No 2)* [1998] 1 IR 101; *Gooden v St Otteran's Hospital* [2001] IESC 14; *Orton v St John of Gods Hospital* [2004] 11 JIC 1505; *LK v Clinical Director of Lakeview Unit, Naas General Hospital* [2006] IEHC 196.

<sup>354</sup> Jarlath Spellman, "Section 260 of the Mental Treatment Act 1945 Reviewed" (1998) 4(1) *Medico-Legal Journal of Ireland* 20.

<sup>355</sup> *Murphy v Greene* [1990] 2 IR 566.

<sup>356</sup> *Ibid.*

<sup>357</sup> Griffin J quoting Denning LJ in *Richardson v London County Council*, [1957] 1 WLR 751 in *O'Dowd v North Western Health Board* [1983] IRLM 186 at 195 and per Henchy J *O'Dowd v North Western Health Board* [1983] IRLM 186 at 196.

<sup>358</sup> *Ashingdane v United Kingdom* (1985) 7 EHRR 528.

<sup>359</sup> *Ashingdane v United Kingdom* (1985) 7 EHRR 528 at 57.

Thirteen section 260 cases were brought in the lifetime of the 1945 Act.<sup>360</sup> In only three cases leave was granted and was either because a time limit had been breached,<sup>361</sup> a doctor did not examine the plaintiff at all, or a relative who applied for a recommendation for admission had failed to notify the plaintiff of the nature of the detention and the right to a second medical examination.<sup>362</sup> The primary issues in the remaining cases concerned the medical examination and diagnosis of mental illness.

In these cases no, or indeed a very brief initial medical examination had been carried out prior to the recommendation for detention.<sup>363</sup> From this case law, an examination in the form of an observation from a car at a 12-15 yard distance sufficed, similarly, reliance on medical history and second-hand information in the absence of any examination was found acceptable.<sup>364</sup> The Supreme Court held that while these examinations might be criticised for being too general, this was to be excused because when a doctor is called on to deal with these situations the law does not require a standard of precision such as might be appropriate to other aspects of medical practice. Due to the urgency and the danger to others, protection must be afforded to doctors working under the 1945 Act.<sup>365</sup> Where the validity of the diagnosis was challenged, on the basis that the plaintiff was released very shortly after they were detained,<sup>366</sup> it was held that psychiatrists especially were not to be found negligent if they made a wrong diagnosis and they were entitled to rely on second-hand information. This

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<sup>360</sup> *O'Dowd v North Western Health Board* [1983] ILRM 186; *Murphy v Greene* [1990] 2 IR 566; *O'Reilly v Moroney* [1992] 2 IR 145; *Bailey v Gallagher* [1996] 2 ILRM 433; *Melly v Moran* [1997] IEHC 101; *Kiernan v Harris* [1998] IEHC 71; *Blehein v Murphy* [1999] IEHC 183; *Blehein v St John of God Hospital* [2000] IEHC 133; *Blehein v Murphy* [2000] IESC 1; *Blehein v Murphy (No 2)* [2000] IESC 65; 3 IR 359; *Blehein v St John of God Hospital* [2001] IESC 73; *Blehein v Murphy* [2002] IESC 43; *Dervan v Moran* [2002] 6 JIC 2503.

<sup>361</sup> *Bailey v Gallagher* [1996] 2 ILRM 433 (more than seven days elapsed between the doctor's examination and the plaintiff's detention); *Melly v Moran* [1997] IEHC 101 (more than 24 hours elapsed between examination by the doctor and his completion of a recommendation for admission).

<sup>362</sup> The latter two circumstances applied in *Kiernan v Harris* [1998] IEHC 71.

<sup>363</sup> See for example *Murphy v Greene* [1990] 2 IR 566 wherein Murphy refused to submit to an examination and Dr Greene relied on medical records and information from his wife to make the recommendation order; and *O'Reilly v Moroney* [1992] 2 IR 145 where Dr Moroney had signed a certificate for detention having neither examined O'Reilly nor questioned her for the purpose of obtaining direct evidence as to her mental well-being.

<sup>364</sup> *O'Reilly v Moroney* [1992] 2 IR 145; *Murphy v Greene* [1990] 2 IR 566.

<sup>365</sup> *Murphy v Greene* [1990] 2 IR 566 at 581.

<sup>366</sup> See *O'Dowd v North Western Health Board* [1983] 1 ILRM 186 where O'Dowd was detained as a person of unsound mind that was unlikely to recover within six months. O'Dowd claimed that because he was released after six days the doctor acted without reasonable care in making such diagnosis. Furthermore, O'Dowd challenged the actions of a Dr Geraghty who had signed the admission order despite the fact that it was another doctor who examined him.

was because the human psyche is so complex and susceptible to different interpretations and clinical tests are so apt to mislead.<sup>367</sup>

To substantiate the issue concerning the subjugation of patients' rights further, a peculiar feature of this case law is that in five of the thirteen cases, marital or family discord was a prominent factor.<sup>368</sup> Boland has therefore seriously questioned the extent to which GPs and the initial medical examination actually provided protection against unlawful detention.<sup>369</sup> By 1996, however, the Supreme Court was aware of the controversy surrounding such detentions. In *Bailey v Gallagher*<sup>370</sup> leave was granted to allow Bailey bring a civil case against a GP who had made a recommendation for detention outside of the permitted time limit. As the detention was:

*“taking place against a background of marital discord...[it] 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”.*<sup>371</sup>

Cumulatively, this provision created a significant obstacle for those wishing to bring a case against those who they believed acted in bad faith or without reasonable care in their detention. From the case law it appears to have been almost impossible to show that the doctors acted in bad faith or without reasonable care if they had made any attempt to comply with the provisions of the 1945 Act, even if they were seriously sub-standard. The absence of any definition for examination and mental illness in the 1945 Act meant that there could be huge discretion and variation which may have led to inconsistency in the application of the law by doctors. The lack of definition for examination meant that the responsibility was upon the courts to determine the extent to which such examination could act as a protection for those the subject of a detention order. This it failed to do by deferring to the medical profession and protecting their interests over the interests of those detained. In concluding

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<sup>367</sup> *O'Dowd v North Western Health Board* [1983] 1 ILRM 186 at 198; See also *Murphy v Greene* [1990] 2 IR 566; *O'Reilly v Moroney* [1992] 2 IR 145.

<sup>368</sup> *Murphy v Greene* [1990] 2 IR 566; *O'Reilly v Moroney* [1992] 2 IR 145; *Bailey v Gallagher* [1996] 2 ILRM 433; *Kiernan v Harris* [1998] IEHC 71; *Dervan v Moran* [2002] 6 JIC 2503. See *RTE Guide* 10 April 1992 6, *Woman's Way* 17 July 1992 18, *Irish Press* 5 May 1992; Department of Health, *Green Paper on Mental Illness* (1992) 82; Carey et al, "Involuntary Admissions to a new District Mental Health Service-Implications for a new Mental Treatment Act 1945" (1993) 10 *Irish Journal of Psychological Medicine* 139; Faye Boland, "Compulsory detention and the general practitioner in Irish mental health law: armour or weapon in wrongful committals?" (2001) 52(2) *Northern Ireland Legal Quarterly* 205.

<sup>369</sup> Faye Boland, "Compulsory detention and the general practitioner in Irish mental health law: armour or weapon in wrongful committals?" (2001) 52(2) *Northern Ireland Legal Quarterly* 205.

<sup>370</sup> *Bailey v Gallagher* [1996] 2 ILRM 433.

<sup>371</sup> [1996] 2 ILRM 433 at 436.

that such tenuous forms of examination and diagnosis were valid the Courts unquestionably endorsed medicalism; medical diagnosis was unquestioned, variation of practice was accepted, subjugation of patient's rights was endorsed and the profession were insulated from legal challenge. In 2004 this provision was found unconstitutional, the Supreme Court held that while the aim of the 1945 Act was legitimate, the limitation of the rights of the plaintiff should not be overbroad, should be proportionate and should be necessary to secure the legitimate aim. By prescribing only two grounds (that the person acted in bad faith or without reasonable care) the provision was not proportionate, was arbitrary and hence unfair.<sup>372</sup>

## ii. *Challenging the Legality of Detention*

Between the period of 1980 and 2006, only one of the six *habeas corpus* cases challenging the lawfulness of detention under the 1945 Act resulted in a finding of unlawful detention.<sup>373</sup> In cases where the Courts were required to examine straight-forward procedural violations in the detention process, the cases were decided in line with legalism. In these cases the primary concern of the Courts was whether the legislation had been complied with not whether detention was required for the treatment of the patient. Therefore in *Croke v Smith* an expired detention order resulted in unlawful detention.<sup>374</sup> Where the Courts found in two similar cases that there was evidence that the provisions had been complied and the patients had been informed of their right to a second medical opinion prior to detention the detention was found lawful.<sup>375</sup>

However, where the Courts were asked to decide upon cases where the violation was less straight-forward, they relied on medicalism. Therefore, in *Gooden v St Otteran's Hospital*<sup>376</sup> the operation of the legal powers of detention by psychiatrists involved in the detention of a patient were called into question. Here a voluntary patient gave written notice that he wished to leave hospital, the medical evidence provided to the Court was that the applicant remained seriously ill and not fit for discharge. The doctors involved changed his status to involuntary, in circumstances where he had never left the hospital and thus was not strictly provided for in the legislation. Consistent with medicalism, despite the failure to comply with the law the Supreme Court deferred to the medical staff in their attempt to care for the patient in his best

<sup>372</sup> *Blehein v Minister for Health and Children* [2008] IESC 40 at 18.

<sup>373</sup> *Croke v Smith* [1994] 3 IR 525.

<sup>374</sup> *Croke v Smith* [1994] 3 IR 525.

<sup>375</sup> In both cases the patients had actually had two medical examinations prior to detention *Orton v St John of Gods Hospital* [2004] IEHC 361; *LK v Clinical Director of Lakeview Unit, Naas General Hospital* [2006] IEHC 196.

<sup>376</sup> *Gooden v St Otteran's Hospital* [2001] IESC 14.



interests and used a purposive interpretation to find the detention lawful. In doing so Hardiman J opined:

*“I do not know that I would have been prepared to go as far as we have in this direction were it not for the essentially paternal character of the legislation in question here, as outlined in In re Philip Clarke. The nature of the legislation, perhaps, renders less complicated the application of a purposive construction than would be the case with a statute affecting the right to personal freedom in another context.”*<sup>377</sup>

The remaining two *habeas corpus* applications challenged the legality of the powers of detention and the absence of any non-medical review on legalism grounds. In *RT v Central Mental Hospital*<sup>378</sup> it was argued that section 207, which provided that based on the Inspector of Mental Hospitals recommendation a person could be transferred from a district mental hospital to the Central Mental Hospital, was unconstitutional as there were no procedures for patients to review the Inspector’s opinion, to procure their re-transfer or release or to review their continued detention.<sup>379</sup> Significantly, Costello P held that the section was unconstitutional because the 1945 Act did not contain adequate protections against abuse and error in the interests of those whose welfare the legislation is designed to support. Furthermore, the State’s duty to protect the citizen’s rights was more exacting in the case of weak and vulnerable citizens such as those suffering from mental disorder. Once the High Court found section 207 unconstitutional it was required to refer the question of the validity of the section to the Supreme Court by way of case stated. However, by the time the case reached the Supreme Court, the patient had been transferred back to a district mental hospital. The case stated lapsed and therefore section 207 remained on the statute books until the new legislation came into effect in 2006.

In *Croke v Smith (No 2)* the legal powers of detention were again at issue.<sup>380</sup> Consistent with legalism it was argued that the provisions under section 172 were unconstitutional as they granted powers of indefinite detention without sufficient safeguards in the absence of any judicial adjudication or the opportunity to challenge before a court or tribunal the diagnosis of

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<sup>377</sup> *Gooden v St Otteran’s Hospital* [2001] IESC 14 at 639-640.

<sup>378</sup> *RT v Central Mental Hospital* [1995] 2 IR 65.

<sup>379</sup> Section 207 provided that the Minister for Health and Children could order the Inspector of Mental hospitals to visit the person and report on their condition. After this, the Minister made the decision whether to make the transfer to the Central Mental Hospital. In the criminal case of *State (O) v Daly* [1977] 1 IR 312, 316 the Supreme Court held that this process was eminently fair and designed to serve the common good and needs of those afflicted with mental illness.

<sup>380</sup> *Croke v Smith (No 2)* [1995] IEHC 6.

mental illness or the legality of the detention. The High Court concurred and found section 172 unconstitutional. Significantly, Budd J's decision was consistent with legalism. He referenced the ECHR and the UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (adopted by the General Assembly, 17 December, 1991)<sup>381</sup> and opined that:

*"The certainties implicit in the judgement in Clarke's case in 1949 may be diluted by now with increasing knowledge about psyche, changing patterns of behaviour, conflicts between psychiatrists as to the nature of mental illness and awareness of the abuses of psychiatric treatment in other countries".*<sup>382</sup>

On appeal, the Supreme Court reversed this decision. The Supreme Court relied heavily on the paternal nature of the 1945 Act as espoused in *In re Philip Clarke*.<sup>383</sup> Significantly it pointed out that section 172 of the 1945 Act enjoyed a presumption of constitutionality and that the doctors and others who issue decisions under the 1945 Act will act in accordance with constitutional justice. In addition, it held that there were sufficient protections in the 1945 Act to prevent unlawful detention. These protections were viewed uncritically without any regard to the possibility that they might be of little use in practice, for example for a person that did not have the capacity to make a *habeas corpus* application or write a letter to the Minister for Health or the Inspector of Mental Hospitals.<sup>384</sup> It further stated that there was no need for periodic review because the doctors involved were required to consistently review the medical condition of the patient and release them if they were no longer suffering from a mental illness.<sup>385</sup>

The adherence of the Supreme Court to the paternalistic nature of the 1945 Act right up to 2006 is evidence of the strength of medicalism.<sup>386</sup> The judiciary continued to believe that doctors should have ultimate discretion and authority in detaining and treating persons with mental illness. Restrictions on this power were unnecessary and unhelpful in ensuring persons received the treatment they needed. As opposed to finding that patient's rights were

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<sup>381</sup> *Croke v Smith (No 2)* [1995] IEHC 6 at 103.

<sup>382</sup> *Croke v Smith (No 2)* [1995] IEHC 6 at 124.

<sup>383</sup> *In re Philip Clarke* [1950] IR 235; *Croke v Smith (No 2)* [1995] IEHC 6 at 119-120.

<sup>384</sup> *Croke v Smith (No 2)* [1995] IEHC 6.

<sup>385</sup> *Croke v Smith (No 2)* [1995] IEHC 6 at 114.

<sup>386</sup> See *Gooden v St Otteran's Hospital* [2001] IESC 14 where the Supreme Court relied on the paternalistic intent of the legislation as espoused in *In re Philip Clarke* [1950] IR 235 to interpret the detention of voluntary patients under section 184 and 194 of the 1945 Act.

restricted the Courts actually found that they were vindicated as it enabled persons with mental illness to receive the care and treatment they needed.

#### **d. Conclusion**

The anti-psychiatry and deinstitutionalisation movements had little impact in the Irish context. While there was some movement to community care, the full migration from institutionalised detention was frustrated by the lack of legislative provision for such. This was proffered as one of the reasons the 1981 Act was not commenced and as such the legislative transition from medicalism to legalism was never realised. Additionally, judicial support for this transition was lacking and aside from the two High Court cases<sup>387</sup> mentioned, which were ultimately overruled or lapsed, and the cases which concerned clear cut procedural violations of the law there was a continued adherence to medicalism.

#### **3.07 Conclusion**

The 1945 Act was an overwhelming espousal of medicalism in that it provided minimum legal control over the medical profession and permitted the maximum use of discretion upon therapeutic and social responsibilities and expectations, principally for the treatment of the patient. Treatment and cure of mental illness was the priority, if necessary at the expense of other considerations, such as the civil rights of the patient or the procedural requirements of law. The subjugation of patient rights and weakening of protections was borne out in the case law under the 1945 Act whereby the Courts refused to find the vast powers of detention granted to the medical profession under the 1945 Act unconstitutional or render detention unlawful where doctors failed to comply with legislative provisions.

The end of the twentieth century had witnessed a radical shift in the perception of psychiatry's role in the detention of the mentally ill. The anti-psychiatry, deinstitutionalisation and mental health rights movements had tarnished the altruistic image of mental health legislation that endorsed medicalism. A critical and questioning approach to psychiatry had emerged and this resulted in the transition to legalism. This shift had occurred in Britain and the burgeoning legalism was evident in the Mental Health Act 1983. The shift to legalism in Britain had drawn from the ECHR. At this international level too a shift had occurred; legalism pervaded the Council of Europe Recommendations and the case law decided by the ECtHR. Although there were some developments in Ireland that entertained

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<sup>387</sup> *RT v Central Mental Hospital* [1995] 2 IR 65 at 79; *Croke v Smith (No 2)* [1995] IEHC 6.

such a transition towards legalism ultimately these developments amounted to nothing and therefore had little impact in the Irish context or on the medicalism enshrined in the 1945 Act. A core strength of these movements in Britain, that was absent in Ireland, was the alliance between academics, mental health service users and the voluntary sector, reinforced by members of the psychiatric profession. Most of the voluntary bodies working in mental health in Ireland were actually led by medical professionals<sup>388</sup> and there were no other bodies or individuals, on par with Gostin for example, advocating any change.

In the meantime the jurisprudence of the ECtHR continued to endorse legalism and expand the legal requirements for detaining persons suffering from mental illness. However, due to the dualistic nature of the Irish Constitution, the ECHR had limited affect in Ireland. However, under the ECHR Irish citizens could take a case to the ECtHR if they believed their rights had been infringed, having first exhausted all domestic remedies.<sup>389</sup> It was in this manner that a case was brought against Ireland concerning the legality of detention under the 1945 Act which resulted in a seismic shift in the legislation.<sup>390</sup> This is discussed in Chapter 4.

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<sup>388</sup> Damien Brennan, *Irish Insanity; 1800-2000* (Routledge 2014) 107.

<sup>389</sup> This option was exercised by *O'Reilly v Ireland* (1996) App No 24196/94 ECHR concerning the arbitrary deprivation of liberty under Article 5(1)(e) of the ECHR and *Croke v Ireland* (2000) App No 3326/96 ECHR concerning the sufficiency of the safeguards against illegal detention and the requirements under Article 5(4). In both cases friendly settlements were reached with the applicants.

<sup>390</sup> *Croke v Ireland* (2000) App No 3326/96 ECHR. This case is further discussed in Chapter 4, 80.

## CHAPTER 4

# INFLUENCE OF LEGALISM IN THE MENTAL HEALTH ACT 2001

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### 4.01 Introduction

By 2001 the case law of the ECtHR concerning the right to liberty of persons detained in mental hospitals had evolved significantly and had established numerous requirements for the lawful detention of the mentally ill in Council of Europe Member States. This jurisprudence and the anti-psychiatry, deinstitutionalisation and mental health rights movements discussed in the previous chapter were to play a pivotal role in the twentieth first century when new mental health legislation was considered in Ireland.

The subsequent analysis of the 2001 Act measures the influence of legalism in the creation, operation and interpretation of the 2001 Act by the legislature, psychiatry and the judiciary. In examining the operation of the 2001 Act the chapter relies on three significant reports conducted by the Department of Health and the Mental Health Commission (MHC),<sup>391</sup> in addition to Annual Reports of the MHC and the Inspector of Mental Services and academic literature produced by those tasked with its operation- psychiatrists. In determining the judicial response to legalism the chapter provides an analysis of the case law concerning detention under the 2001 Act to date. The operation of the provisions concerning the MHT is discussed in Chapter 5 and is therefore excluded from more than a cursory analysis in this chapter.

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<sup>391</sup> Department of Health and Children, *Review of the Operation of the Mental Health Act 2001; Findings and* (2007); Mental Health Commission, *Report on the Operation of Part 2 of the Mental Health Act 2001* (2008); and the Department of Health and Children, *Interim Report of the Steering Group on the Review of the Mental Health Act 2001* (2012).

## 4.02 The Influence of Legalism on the Mental Health Act 2001

The 2001 Act was passed following a protracted legal and political process which included the drafting of a Green Paper in 1992 and a White Paper in 1995 on a new Mental Health Act.<sup>392</sup> In the Green and White Papers it was noted how the 1981 Act was intended to give patients greater protection against unnecessary detention in psychiatric hospitals and that this must now be incorporated in new mental health legislation.<sup>393</sup> The government highlighted how:

*“As involuntary admission restricts the liberty of the patient it is important that there are safeguards in law to protect the person’s interests.”*<sup>394</sup>

It is evident from the Green and White Papers that the Irish government was also very aware of its international legal and political obligations concerning mental health detention. Frequently, the Papers referred to Ireland’s obligations under the Council of Europe Recommendations, the UN Principles for the Protection of Persons with Mental Illness<sup>395</sup> and the case law of the ECtHR. They also regularly noted how the current 1945 Act failed to meet these obligations and how it failed to safeguard the rights of those detained.<sup>396</sup> The manner by which the resulting 2001 Act protects these rights is discussed below.

### a. Legalism in the General Provisions

The legal powers of detention are the focal point of the thesis, however, the provisions concerning detention do not exist in isolation and therefore it is necessary to analyse the general provisions of the 2001 Act to determine the extent to which they bolster legalism. Therefore, this section considers the influence of legalism in the aim of the 2001 Act, the guiding principle of best interests, the definition of mental disorder, the establishment of the MHC and the Inspector of Mental Services and the provision of medical immunity from suit.

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<sup>392</sup> Department of Health, *Green Paper on Mental Health* (1992); Department of Health, *White Paper: A New Mental Health Act* (1995).

<sup>393</sup> See generally Department of Health, *Green Paper on Mental Health* (1992); Department of Health, *White Paper; A New Mental Health Act* (1995).

<sup>394</sup> Department of Health, *White Paper; A New Mental Health Act* (1995) 51.

<sup>395</sup> UN General Assembly, Resolution 46/119 “The protection of persons with mental illness and the improvement of mental health care”. These principles lay down provisions to promote the rights of mentally disabled persons in health care. There are specific provisions on the procedures for involuntary admission to mental health care facilities, rights of those in psychiatric detention, review of detention and anti-discrimination on the ground of mental disability. It was adopted by General Assembly resolution 46/119 of 17 December 1991.

<sup>396</sup> Department of Health, *Green Paper on Mental Health* (1992) 71-75; Department of Health, *White Paper; A New Mental Health Act* (1995) 5-11.

### **i. Aim of the Mental Health Act 2001**

The purpose of the 2001 Act was to provide protections for the rights of those subject to mental health detention.<sup>397</sup> Upon introducing the Mental Health Bill, the Minister for Health and Children at the time, Mícheál Martin stated:

*“The Bill will bring our legislation on the detention of mentally disordered patients into conformity with the European Convention on the Protection of Human Rights and Fundamental Freedoms... At the core of the Bill is the need to address the civil and human rights of persons receiving care and treatment in our psychiatric services. The Bill focuses on: improving and modernising the criteria and mechanisms for the involuntary detention of persons for psychiatric care and treatment; establishing a system of automatic and independent review of all detentions, including the provision of legal aid to all those who are detained; and putting in place a framework by which the standards of care and treatment provided in our in-patient mental health facilities can be supervised and regulated.”*<sup>398</sup>

However, from the publication of the Green Paper it took nine years for the Mental Health Act 2001 to be put on the statute books and it was not until 2006 that the 2001 Act came into force. Ultimately, the Bill and subsequently the 2001 Act primarily focused on the involuntary detention procedure and the establishment of a MHC. It was argued that while the Bill addressed the position of 10% of those who are detained every year, it did nothing for the 90% who are voluntary psychiatric patients. It was highlighted that the Bill missed the opportunity to address the totality of the psychiatric service in the context of the obligations of the State and the prescription of patients' rights and failed to regulate mental health services in a comprehensive manner. Certainly, there was no legislative provision for the establishment of a comprehensive system of community care that had been a major focus of the Commissions established in 1961 and 1981 and the Green Paper.<sup>399</sup> Other issues,

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<sup>397</sup> Anselm Eldergill, “The Best is the Enemy of the Good: The Mental Health Act 2001” (May 2008) 21 *Journal of Mental Health Law* 21; Darius Whelan, *Mental Health Law and Practice* (Roundhall 2009); Claire Murray, “Reinforcing Paternalism within the Irish mental health law-Contrasting the decision in *EH v St. Vincent’s and Others* and *SM v The Mental Health Commission and Others*” (2010) 17(1) *Dublin University Law Journal* 273; BD Kelly, “Human Rights and the Mental Health Act 2001, Part 1” (2012) 1(1) *Psychiatry Professional* 11-13; A Ni Mhaoláin & BD Kelly, “Ireland’s Mental Health Act 2001: Where are we now?” (2009) 33(5) *Psychiatric Bulletin* 161; H Ramsey, E Roche & B Donoghue “Five years after implementation: A review of the Irish Mental Health Act 2001” (2013) 36 *International Journal of Law and Psychiatry* 83.

<sup>398</sup> Mícheál Martin, Mental Health Bill, 1999- Second Stage, Dáil Debates, Volume 517, no. 5, 6 April 2000, 997.

<sup>399</sup> Department of Health, *Report of the Commission of Inquiry on Mental Illness* (Stationary Office 1966); Department of Health, *Report of a Study Group on the Development of the Psychiatric Services*, *The*

including some that had been highlighted in the White Paper were omitted from the Bill, such as funding for multidisciplinary community care teams, provisions regarding the capacity and consent of voluntary patients, provisions concerning the needs of mentally disordered offenders and provisions concerning community treatment orders.<sup>400</sup>

The resulting focus of the 2001 Act on detention procedures has been attributed to the fact that the Irish government was forced to produce a Bill following a case brought against it to the ECtHR for a violation of an individual's rights as a result of its failure to put in place protections for mental health detention; namely a review of the decision to detain by an independent body. There was a friendly settlement in the case, part of which the Irish government pledged to enact legislation that would ensure compliance with the ECHR provisions concerning the review of the detention.<sup>401</sup> In introducing the Mental Health Bill 1999, the Minister for Health and Children, Micheál Martin outlined how,

*“the necessity to provide urgently for a reform of our legislation regarding detention, in order to bring this country into line with the European Convention on Human Rights, has resulted in my bringing forward a Bill which is shorter than originally envisaged.”*<sup>402</sup>

According to Alan Shatter TD (member of parliament) the other proposals were omitted *“for no reason other than the work and preparation had not been done properly over the period of the Government's term of office”*.<sup>403</sup>

Given the haste with which the 2001 Act was enacted, included in its provisions is a requirement that the Minister for Health reviews the operation of the Act and makes a report on it no later than five years after its commencement.<sup>404</sup> This provision demonstrates the awareness on the part of the government that the significant transformation of the legal powers of detention, which the 2001 Act sought to enshrine, would be challenging and the Act may have some difficulties in the early years of its operation. Therefore, in order to ensure the successful transition to legalism the government provided for this review.

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*Psychiatric Services- Planning for the Future* (Stationary Office 1984); Department of Health, *Green Paper on Mental Health* (1992) 11-20.

<sup>400</sup> Alan Shatter, Mental Health Bill, 1999- Second Stage, Dáil Debates, Volume 517, no. 5, 6 April 2000, 1005-1013; Also see generally Department of Health, *White Paper; A New Mental Health Act* (1995).

<sup>401</sup> *Croke v Ireland* (2000) App No 3326/96 ECHR at 680.

<sup>402</sup> Micheál Martin, Minister for Health and Children, Mental Health Bill, 1999- Second Stage, Dáil Debates, Volume 517, no. 5, 6 April 2000, 1004. Martin was referring to the fact that the 1999 Bill did not deal with a number of the issues that had been discussed in the White Paper 1995.

<sup>403</sup> Alan Shatter, Mental Health Bill, 1999- Second Stage, Dáil Debates, Volume 517, no. 5, 6 April 2000, 1009.

<sup>404</sup> Mental Health Act 2001, s 75.



## ii. Defining Mental Disorder

The term mental disorder is used throughout the 2001 Act and includes ‘mental illness, severe dementia and significant intellectual disability’.<sup>405</sup> The 2001 Act also introduces dangerousness and treatment grounds that are necessary for detention. Thus, the existence of a mental disorder is not enough, in order to detain the person there must be a serious likelihood of the person concerned causing immediate and serious harm to him or herself or to other persons. Alternatively, persons can be detained if failure to do so would be likely to lead to a serious deterioration in their condition or would prevent the administration of appropriate treatment that could only be given in detention and this detention and treatment would be likely to benefit or alleviate the condition of that person to a material extent.<sup>406</sup>

Defining ‘mental disorder’ in more specificity was a significant legislative choice, reflective of legalism and an attempt to limit psychiatry’s discretion in determining who could be detained. Given that the decision to detain a person can often be based on subjective psychiatric diagnosis, the legal definition of mental disorder aims to circumscribe psychiatry’s discretion in making this determination. Specifically, the definition of mental illness refers to *serious* impairment, the dangerousness ground requires a *serious* likelihood of *immediate and serious* harm and the treatment ground refers to a *serious* deterioration in the person’s condition if not admitted (emphasis added).<sup>407</sup> The exclusion of personality disorders, addictions to drugs or intoxicants and social deviance also narrow the scope of detention. There was much debate and lack of consensus over the inclusion or exclusion of personality disorder in the Green Paper and it was ultimately removed in the White Paper.<sup>408</sup> It is significant that it was excluded in an attempt to further narrow the categories of persons subject to detention. This was especially so considering personality disorder is specifically provided for in England’s Mental Health Act 1983.<sup>409</sup>

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<sup>405</sup> These terms are further defined in the Mental Health Act 2001, s 3. Mental illness is defined as ‘a state of mind of a person which affects the person’s thinking, perceiving, emotion or judgement and which seriously impairs the mental function of the person to the extent that he or she requires care of medical treatment in his or her own interest or in the interest of other persons’. Severe dementia is defined as a ‘deterioration of the brain of a person which significantly impairs the intellectual function of the person thereby affecting thought, comprehension and memory and which includes severe psychiatric or behavioural symptoms such as physical aggression’. Significant intellectual disability is defined as ‘a state of arrested or incomplete development of mind of a person which includes significant impairment of intelligence and social functioning and abnormally aggressive or seriously irresponsible conduct on the part of the person’.

<sup>406</sup> Mental Health Act 2001, s 3.

<sup>407</sup> Darius Whelan, *Mental Health Law and Practice* (Round Hall 2009) 79.

<sup>408</sup> Department of Health, *White Paper on a New Mental Health Act* (1995) 23.

<sup>409</sup> Mental Health Act 1983, s 1(3).

### **iii. Guiding Principle of Best Interests**

Despite the stated purpose of the 2001 Act in terms of providing rights protection, specific provisions of the Act created significant obstacles for legalism, in particular the best interests provision. The 2001 Act provides in its guiding principles that in making a decision under this Act concerning the detention, care or treatment of a person, the best interests of the person shall be the paramount consideration. The section further states that in establishing the best interests of a person due regard shall be given to the need to respect the personal right to dignity, bodily integrity, privacy and autonomy.<sup>410</sup> At the same time however, the 2001 Act states that in doing this due regard must also be given to the interests of other persons who may be at risk of serious harm if the decision is not made. The term best interests was not defined in the 2001 Act, thus, it was left to the Courts to balance best interests with the rights outlined. The best interests standard is widely used in a medical context,<sup>411</sup> therefore its incorporation in the 2001 Act is representative of a continued adherence medicalism and allowed for a significant weakening of the rights protection that was the driving force behind the 2001 Act's creation, and for the rejection of legalism. The extent to which this has occurred will be discussed further when considering the Courts interpretation of the 2001 Act.

### **iv. Mental Health Commission & the Inspector of Mental Health Services**

Another attempt to safeguard the rights of those detained and limit the discretion of psychiatry in line with legalism was the establishment of the MHC which the 2001 Act stated was to be independent of the government in exercising its functions. The MHC is composed of a multi-disciplinary board which includes physicians, nurses, a barrister, a social worker and persons representing relevant voluntary groups including two who have or have had mental illness. Its principal function is to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and take all reasonable steps to protect the interests of persons detained in approved centres.<sup>412</sup> More specifically it appoints persons to serve on MHTs; establishes a panel of psychiatrists to perform independent examinations; assists in organising legal aid for those detained; undertakes research on mental health services; and prepares and reviews a code of

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<sup>410</sup> Mental Health Act 2001, s 4.

<sup>411</sup> Mary Donnelly, "Best Interests, Patient Participation and the Mental Capacity Act 2005" (2009 17(1) *Medical Law Review* 1.

<sup>412</sup> Mental Health Act 2001, s 32-35.

practice and rules for the guidance of persons working in the mental health services.<sup>413</sup> The MHC has issued six codes of practice concerning: admission of children; notification of deaths; admission, transfer and discharge to and from approved centres; use of ECT for voluntary patients; and use of physical restraint.<sup>414</sup> It has also issued two sets of statutory rules concerning the use of seclusion and the use of ECT.<sup>415</sup>

The MHC is also responsible for the appointment of a consultant psychiatrist to act as the Inspector of Mental Health Services, and any Assistant Inspectors and other staff as it considers necessary to assist the Inspector.<sup>416</sup> The Inspector inspects every approved unit at least once a year and these visits can be both scheduled and unannounced to ensure appropriate standards in care and treatment are being upheld. They must assess the degree and extent to which the approved centre complies with the 2001 Act; the Mental Health Act (Approved Centres) Regulations 2006, which contain legal requirements that set out the minimum standards that all approved centres must adhere to;<sup>417</sup> MHC rules; and MHC codes of practice. They are also required to see every patient whom they have been requested to see, either by the patient themselves or any other person. The Inspector is required to see every patient the propriety of whose detention they have reason to doubt.<sup>418</sup>

In comparison with the Inspector of Mental Hospitals under the 1945 Act, the MHC and the Inspector of Mental Services' functions are more specific and detailed; they provide a more thorough oversight of approved centres' compliance with the law, regulations and rules concerning the detention, treatment and care of patients under the 2001 Act in a considerable strengthening of legalism.

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<sup>413</sup> Mental Health Act 2001, s 33(3) states that the MHC shall "prepare and review periodically, after consultation with such bodies as it considers appropriate, a code or codes of practice for the guidance of persons working in the mental health services". See generally Claire Murray, "The role of the Mental Health Commission in Irish mental health law: interrogating the effectiveness of the statutory functions of the Commission" (2011) 17(2) *Medico-Legal Journal of Ireland* 93.

<sup>414</sup> Mental Health Commission, *Mental Health Act 2001; Codes of Practice* [http://www.mhcirl.ie/Mental\\_Health\\_Act\\_2001/Mental\\_Health\\_Commission\\_Codes\\_of\\_Practice/](http://www.mhcirl.ie/Mental_Health_Act_2001/Mental_Health_Commission_Codes_of_Practice/) accessed 29 June 2014.

<sup>415</sup> Mental Health Commission, *Mental Health Act 2001; Rules* [http://www.mhcirl.ie/Mental\\_Health\\_Act\\_2001/Mental\\_Health\\_Commission\\_Rules/](http://www.mhcirl.ie/Mental_Health_Act_2001/Mental_Health_Commission_Rules/) accessed 29 June 2014.

<sup>416</sup> Mental Health Act 2001, s 39(2) & s 54.

<sup>417</sup> Mental Health Act (Approved Centre Regulations) 2006, SI 2006/551. The Regulations contain 32 Articles concerning for example: individual care plans; health; food; safety; staffing; and maintenance of records.

<sup>418</sup> Mental Health Act 2001, s 50-55.

## ***v. Medical Immunity from Litigation***

As with the 1945 Act, the 2001 Act requires the leave of the High Court before proceedings can be commenced in respect of an act purporting to have been done in pursuance of the 2001 Act.<sup>419</sup> The main change from the 1945 Act is that instead of proving ‘substantial grounds’ for the claim that the person acted in bad faith or without reasonable care, the 2001 Act requires ‘reasonable grounds’ stating that leave shall not be refused unless the court is satisfied either (a) that the proceedings are frivolous and vexatious or (b) that there are no reasonable grounds for contending that the defendant acted in bad faith or without reasonable care.<sup>420</sup> Although this provision is not as restrictive as that that went before it remains consistent with medicalism, albeit somewhat weakened. This provision continues to limit the rights of patients in terms of their access to court. In line with medicalism it significantly protects the medical profession from challenge in the detention process.

## **b. Legalism in the Detention Provisions of the Mental Health Act 2001**

This section considers the influence of legalism in the detention provisions of the 2001 Act, including the detention process and the independent review of detention.

### ***i. The Detention Process***

Applications for detention can be made by a spouse or relative of the person, an authorised officer, or a member of the Garda Síochána.<sup>421</sup> For the purpose of making an application for involuntary detention, the term spouse ‘does not include a spouse of a person who is living separately and apart from the person or in respect of whom an application or order has been made under the Domestic Violence Act 1996’.<sup>422</sup> This provision was included as a result of the considerable public concern that had developed relating to the role of the spouse and relatives in such applications under the 1945 Act.<sup>423</sup> The application can also be made by any other person over the age of 18 but must include a statement of why the application is being

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<sup>419</sup> Mental Treatment Act 1945, s 260; Mental Health Act, s 73.

<sup>420</sup> Mental Health Act, s 73(1).

<sup>421</sup> Mental Health Act 2001, s 9(2).

<sup>422</sup> Mental Health Act 2001, s 9(8).

<sup>423</sup> Department of Health, *Green Paper on Mental Health* (1992) 81-82; Department of Health, *White Paper; A New Mental Health Act* (1995) 34-35.

made, of the connection of the applicant with the proposed patient, and of the circumstances in which the application was made.<sup>424</sup>

This application is made to a doctor, usually a GP, who is required to examine the proposed patient within 24 hours and if they make a ‘recommendation’ for detention it will remain in force for seven days.<sup>425</sup> Examination is defined in the 2001 Act as a personal examination of the process and content of thought, the mood and the behaviour of the person concerned.<sup>426</sup> This definition was included as a result of a number of cases under the 1945 Act where it was found that there was no physical examination of the person detained.<sup>427</sup> The doctor must also inform the person of the ‘purpose of the examination unless in his or her view the provision of such information might be prejudicial to the person’s mental health, well-being or emotional condition’.<sup>428</sup> The prescription of the form of examination is again consistent with legalism.

The person responsible for making the application is required to transport the proposed patient to an approved centre within 7 days, if they are unable to do so the doctor can arrange appropriate transportation. Once the person arrives at the approved centre they must be examined by a consultant psychiatrist within 24 hours and a detention order can be made. If a detention order is made it remains in force for 21 days which can subsequently be extended by periods of 3, 6 and 12 months. The patient must be provided with information about any and all detention orders. This is provided in the Patient Notification Form which includes information about the grounds for detention, the proposed treatment and the patient’s rights.<sup>429</sup>

Significantly, if a voluntary patient whom a psychiatrist, doctor or nurse believes is suffering from a mental disorder indicates a wish to leave the approved centre, they may be detained

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<sup>424</sup> Mental Health Act 2001, s 9(2) states that: “The following persons shall be disqualified for making an application in respect of a person (a) under the age of 18 years, (b) an authorised officer or a member of the Garda Síochána who is a relative of the person or of the spouse of the person, (c) a member of the governing body, or the staff, or the person in charge, of the approved centre concerned, (d) any persons with an interests in the payments (if any) to be made in respect of the taking care of the person concerned in the approved centre concerned, (e) any registered medical practitioner who provides a regular medical service at the approved centre concerned, (f) the spouse, parent, grandparent, brother, sister, uncle or aunt of any of the persons mentioned in the foregoing paragraphs (b) to (e), whether of the whole blood, of the half blood or by affinity.

<sup>425</sup> Mental Health Act 2001, s 10.

<sup>426</sup> Mental Health Act 2001, s 2.

<sup>427</sup> *Murphy v Greene* [1990] 2 IR 566 and *O’Reilly v Moroney* [1992] 2 IR 145; see generally Chapter 3, 72-75.

<sup>428</sup> Mental Health Act 2001, s 10.

<sup>429</sup> Mental Health Commission, Patient Notification Form, available at [http://www.mhcirl.ie/Mental\\_Health\\_Act\\_2001/Forms\\_under\\_Mental\\_Health\\_Act\\_2001/Patient\\_Notification\\_Form/](http://www.mhcirl.ie/Mental_Health_Act_2001/Forms_under_Mental_Health_Act_2001/Patient_Notification_Form/)

for 24 hours.<sup>430</sup> During this time the treating psychiatrist can either discharge them or arrange for another psychiatrist to examine them and, subsequently, if the second psychiatrist is of the opinion that the person is suffering from a mental disorder a detention order can be made.<sup>431</sup> Despite the fact that a MHT is then organised in the normal manner, the process of detaining a voluntary patient contains significantly fewer protections than the process of detaining a person who is not a voluntary patient. Furthermore, Fennell has questioned for whom the second opinion doctor acts as a safeguard-patients or physicians who desire a ‘flak jacket’ against potential legal liability.<sup>432</sup>

In the aggregate, however, the 2001 Act has provided stricter procedural requirements in the detention process and significantly shorter periods of detention than the 1945 Act. As such, it further reduced medical discretion and through these legal controls was consistent with legalism.

## **ii. Independent Review of Detention**

One of the central functions of the MHC is to appoint MHTs. The primary role of the MHT is to review the detention of persons involuntarily detained in approved centres under the 2001 Act. It has been stated that the establishment of the MHT represents a “significant medico-legal change”.<sup>433</sup> These MHTs represent the first time that lawyers, doctors and others have sat together in three-person tribunals to issue legally binding decisions concerning medico-legal issues. In line with legalism they introduce a multidisciplinary oversight of the medical decision to detain. Notably, after the enactment of the 2001 Act there was a five year delay until the commencement of all its provisions in 2006. This delay has been attributed mostly to the psychiatric profession who refused to work on the MHTs which they believed were under-resourced, operationally and logistically unmanageable and would place too many demands on the limited number of psychiatrists in the country.<sup>434</sup> From the outset this delay serves to highlight the continuing power of the psychiatric profession in Ireland.

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<sup>430</sup> Mental Health Act 2001, s 23.

<sup>431</sup> Mental Health Act 2001, s 24.

<sup>432</sup> Phil Fennell, ‘Institutionalising the Community: The Codification of Clinical Authority and the Limits of Rights-Based Approaches’ in Bernadette McSherry & Penelope Weller (eds), *Rethinking Rights-Based Mental Health Laws* (Hart Publishing 2010) 34.

<sup>433</sup> Darius Whelan, “Mental health tribunals: a significant medico-legal change” (2010) 10 *Medico-Legal Journal of Ireland* 84.

<sup>434</sup> K Ganter, I Daly & J Owens, “Implementing the Mental Health Act 2001: What should be done? What can be done?” (2005) 22(3) *Irish Journal of Psychological Medicine* 291.

Nevertheless, the MHTs became operational in 2006 and the process by which they review a detention order is outlined presently.

Following the making of a detention order, the consultant psychiatrist must inform the MHC. It will then (a) refer the matter to a MHT; (b) assign a legal representative to the person, unless they propose to engage one; and (c) direct an independent psychiatrist to examine the person, interview their consultant psychiatrist and review their records. Within 21 days the MHT shall review the detention of the person and, if satisfied that the person is suffering from a mental disorder and that the procedural requirements of detention have been followed, shall affirm the order. Significantly, however, the 2001 Act allows the MHT to ignore failures to comply with the procedural aspects of detention where it does not affect the substance of the order or cause injustice to the patient.<sup>435</sup> The 2001 Act does not define the type of procedural failures that would affect the substance of the order or cause an injustice and therefore it has been left to the Courts to determine what is required for a lawful detention. The inclusion of this provision in the 2001 Act has created a hierarchy of importance in determining the legality of detention. As a result it is a significant weakening of legalism by providing a mechanism by which failures to comply with the legal procedures of detention will not invalidate a detention. Furthermore, where the MHT upholds the detention, the patient may only appeal the decision to the Circuit Court on the grounds that they have a mental disorder, again reinforcing this hierarchy.<sup>436</sup>

### **c. Conclusion**

Many of the general provisions of the 2001 Act are consistent with legalism. However, as outlined, there remain some provisions where the adherence to legalism is questionable, in particular, the best interests principle and the MHT's power to ignore procedural irregularities in the detention. The application and interpretation of these provisions could undermine the legalism which the 2001 Act sought to enshrine. The next two sections assess the extent to which this has happened.

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<sup>435</sup> Mental Health Act 2001, s 18.

<sup>436</sup> Mental Health Act 2001, s 19(1).

### 4.03 Influence of Legalism in the Operation of the Mental Health Act 2001

The 2001 Act has been in operation for eight years and therefore it could be said that it is still in the early stages of its development. Nevertheless it is possible to determine at this point the extent to which the operation of most of the provisions of the 2001 Act are consistent with legalism. In doing so this section relies on three substantial reports conducted on the operation of the 2001 Act. The Department of Health and Children, *Review of the Operation of the Mental Health Act 2001; Findings and Conclusions* was published in 2007. Since then, two further reviews of the 2001 Act have been conducted in 2008 and 2012.<sup>437</sup> In addition to an examination of these Reports, this section relies on material from the Annual Reports of the MHC and the Inspector and academic literature on the operation of various aspects of the 2001 Act.

#### a. Defining Mental Disorder

Notwithstanding the narrowing of the detention criteria in the 2001 Act, the MHC has reported that the diagnoses of those detained involuntarily have not changed significantly since its enactment with the two most common diagnoses being primary psychotic disorders and bipolar affective disorder/schizoaffective disorder.<sup>438</sup> Other research examining involuntary detention under the 2001 Act also did not find any change in the demographic and clinical characteristics of those admitted compared with the previous legislation, the 1945 Act.<sup>439</sup> Other than an increase in the mean age of individuals admitted since 2006, there was no difference in gender, employment status, nationality, diagnosis or the dangerousness/treatment ground for detention since the implementation of the 2001 Act.<sup>440</sup>

Furthermore despite the specific exclusion of persons with personality disorder or addiction in the 2001 Act, persons with these diagnoses continue to be detained involuntarily, making

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<sup>437</sup> Mental Health Commission, *Report on the Operation of Part 2 of the Mental Health Act 2001* (2008); and the Department of Health and Children, *Interim Report of the Steering Group on the Review of the Mental Health Act 2001* (2012).

<sup>438</sup> I Murray, B Hallahan & C McDonald, "Has the Irish Mental health Act 2001 altered the clinical profile of involuntary admissions?" (2009) 26(4) *Irish Journal of Psychological Medicine* 179

<sup>439</sup> M Clancy, M Clarke & A Lane, "A comparison of involuntary admissions to an independent psychiatric hospital before and after the implementation of the 2001 Mental Health Act" (2008) Poster Presentation College of Psychiatry Ireland; I Murray, B Hallahan & C McDonald, "Has the Irish Mental health Act 2001 altered the clinical profile of involuntary admissions?" (2009) 26(4) *Irish Journal of Psychological Medicine* 179; I Nwachukwu, N Crumlish, EA Heron & M Gill, "Irish Mental Health Act 2001: Impact on involuntary admissions in a community mental health service in Dublin" (2010) 34(10) *The Psychiatrist* 436.

<sup>440</sup> M Clancy, M Clarke & A Lane, "A comparison of involuntary admissions to an independent psychiatric hospital before and after the implementation of the 2001 Mental Health Act" (2008) Poster Presentation College of Psychiatry Ireland.



up almost 6% of involuntary detentions in 2012.<sup>441</sup> In a survey of consultant psychiatrists 78% agreed that individuals should not be involuntarily detained solely on the grounds that they suffer from personality disorder or substance addiction. However, 58% felt this led to a risk that such persons would not be admitted in situations where it was clinically necessary. The authors of this survey state that this highlights the complex area of risk and responsibility faced by consultant psychiatrists in dealing with such persons. They also hypothesise that there may be higher rates of persons being detained on these grounds but with a diagnosis of psychiatric illness of an acute nature, such as “adjustment disorders” or “brief depressive episode”.<sup>442</sup>

While the provisions attempt to narrow the grounds on which persons can be detained, this in reality is an extremely difficult task. It is an attempt to circumscribe a subjective judgement, a judgement that can alter to suit its parameters of operation. Rose has also cast doubt on the extent to which such definitions provide a safeguard for those detained. The grounds for detention tend to be defined ambiguously, and the terms on which detention must be justified—the interests of the persons own health or safety or for the protection of others—allows enormous scope for discretionary judgment.<sup>443</sup> Bean has found that the added requirement that the person must be a danger to themselves does not necessarily add anything to the definition. He found that doctors will automatically assume that a danger exists if the mental disorder is severe. In this manner they can rely on a medical definition in order to cover any additional social requirements.<sup>444</sup> Therefore, while the definition of the mental disorder in the 2001 Act is an articulation of legalism, the extent to which it has been successful in circumscribing psychiatry’s power in determining who to detain is unproven.

## **b. Guiding Principle of Best Interests**

From the outset the term best interests has caused difficulties in the operation of the 2001 Act. In this manner, in the 2007 Report, the Minister of Health stated that best interests is a difficult concept to define.<sup>445</sup> Since 2007 the difficulty in defining best interests has come to

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<sup>441</sup> There are similar figures for each year since 2007. Mental Health Commission, *Annual Report; Including the Report of the Inspector of Mental Health Services* (2007 to 2013).

<sup>442</sup> B O’Donoghue & P Moran, “Consultant psychiatrists’ experiences and attitudes following the introduction the Mental Health Act 2001: A national survey” (2009) 26(1) *Irish Journal of Psychological Medicine* 23.

<sup>443</sup> Nikolas Rose, “Unreasonable Rights: Mental Illness and the Limits of the Law” (1985) 12 (2) *Journal of Law and Society* 199, 207.

<sup>444</sup> Philip Bean, “The Mental Health Act 1959: Some Issues concerning Rule Enforcement” (1975) 2(2) *British Journal of Law and Society* 225, 227.

<sup>445</sup> Department of Health and Children, *Review of the Operation of the Mental Health Act 2001; Findings and Conclusions* (2007) 8.

the fore and the 2012 Report stated that the inclusion of the principle and the failure to define it has resulted in an:

*“undermining of the significant advances in mental health law which the 2001 Act intended to enshrine and has given rise to concerns that the human rights aspects of the legislation have been diluted and diminished.”*<sup>446</sup>

Both the 2008 and the 2012 Reports highlighted how the Courts have come to interpret best interests as medical best interests and in this manner they have incorporated a paternalistic approach to detention under 2001 Act that was evident under the 1945 Act (this is discussed further below).<sup>447</sup> The 2012 Report recommended that the guiding principles of the 2001 Act should be revised and should focus on human rights and refocused away from best interests. Furthermore, there should be a hierarchy of rights upon which to guide decision-making under the 2001 Act.<sup>448</sup> Therefore, the inclusion of the best interests principle has resulted in a significant undermining of legalism and a perpetuation of medicalism in all aspects of the 2001 Act, and in particular the legal powers of detention.

### **c. Mental Health Commission & the Inspector of Mental Health Services**

The MHC has actually established an Inspectorate, which is comprised of a multi-disciplinary team including a psychiatrist (the Inspector), an occupational therapist, a clinical psychologist, a social worker, a nurse and a service user to assist the Inspector in the carrying out of their functions. This is a significant difference from the Inspector established under the 1945 Act, whom was only assisted by other psychiatrists in the exercise of his functions. Such a move has greatly assisted the Inspector in its role as is evidenced by the vast improvement in the standard of the Annual Report compiled by the office. In comparison with the Annual Reports published by the Inspector under the 1945 Act, the Reports published since 2003 are more exacting, specific, detailed and in a way, more considered; they are also nearly twice as long as before. The Reports detail the specifics of compliance with the law, regulations, rules and codes of practice. In doing so the most recent Annual Report of the Inspector found that only 6% (4 out of the 63) of the approved centres were

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<sup>446</sup> Department of Health and Children, *Interim Report of the Steering Group on the Review of the Mental Health Act 2001* (2012) 9.

<sup>447</sup> Kris Gledhill, ‘External Commentary on the Legislation’ in Mental Health Commission, *Report on the Operation of Part 2 of the Mental Health Act 2001* (2008) 18-19; Department of Health and Children, *Interim Report of the Steering Group on the Review of the Mental Health Act 2001* (2012) 9.

<sup>448</sup> Department of Health and Children, *Interim Report of the Steering Group on the Review of the Mental Health Act 2001* (2012) 9-11.

fully compliant with the 2006 Regulations and the MHC Rules and Codes of Practice. In particular, there was only 30% compliance with the Code of Practice concerning admission, transfer and discharge to and from approved centres. Given the low levels of compliance, the Inspector has recently established a follow up procedure with approved centres in an attempt to increase compliance on specific issues in a structured manner.<sup>449</sup> The Reports also provide detailed statistics concerning admissions, discharges and reviews to name but a few. Interestingly, however, the Reports go much further than detailing specifics; they offer a critical commentary on the state and future of Irish mental health services as a whole, including commentary on the roles of those tasked with its operation and the barriers to compliance, rights protection and an adequate mental health system for the country. In the aggregate the work of the MHC and the Inspectorate of Mental Health Services is consistent with legalism. Firstly, in terms of its composition it removes the exclusivity of doctors in the inspection of mental health services. Secondly, the Inspectorate provides a comprehensive examination of approved centres compliance with the legal requirements, in doing so their Reports are thorough and often critical of practice in different centres. However, in a similar manner to the Reports under the 1945 Act there is no discussion about specific cases where the Inspectorate questioned the propriety of a patient's detention. It is likely, however, that this role has been subsumed by the operation of the MHTs. Nevertheless, for some persons in long term detention, their case may only be reviewed by a MHT once a year and therefore the Inspector would be an important protection.

#### **d. The Detention Process**

Since 2007 there has been a gradual change in the identity of applicants in the detention process, with spouses and relatives having fallen from 69% to 57% of applications and Garda Síochána having risen from 16% to 19%. The use of an authorised officer has remained constant at 7-8%.<sup>450</sup> This is in line with the study by Murray et al., who found the proportion of family applicants for involuntary admission to their service had fallen from 85% to 54% following the implementation of the 2001 Act. One can hypothesise that if there are fewer applications from relatives or spouses there are probably less applications for detention on the basis of family disharmony. This is a positive effect of the legalism in operation. However,

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<sup>449</sup> Mental Health Commission, *Annual Report 2013; Including the Report of the Inspector of Mental Health Services* (2014) 18-25.

<sup>450</sup> Ibid 42.

the increase in applications by the Garda Síochána is less positive and is reminiscent of the process that had great stigma attached to it and which the 1945 Act sought to remedy.<sup>451</sup>

The views of GPs on the legislative changes were assessed by Jabbar et al.<sup>452</sup> They found that 53% of GPs were experiencing difficulties with the 2001 Act; 85% reported an increase in workload and 63% reported that the legislation was not user friendly.<sup>453</sup> GPs also complained that those receiving patients were more concerned with correct paperwork than with patient wellbeing.<sup>454</sup> On this point, an audit in the Longford and Westmeath catchment area found that involuntary detention orders were sometimes not concluded due to incorrectly completed forms.<sup>455</sup> Another audit in Dublin found that approximately 30% of persons referred for involuntary detention did not have their order concluded when they reached the approved psychiatric centre.<sup>456</sup> The failure to complete paperwork correctly and the subsequent refusal of approved psychiatric centres to detain persons based on this faulty paperwork raises several issues. The level of incorrect detention orders is concerning, one can only hypothesise as to the reasoning. Perhaps, as one study has shown there is not enough training for GPs in the 2001 Act, fewer GPs with training seemed to have difficulties with its operation.<sup>457</sup> This also raises the question as to whether medical practitioners without specialist knowledge of psychiatry should be the first port of call for detention. In line with medicalism, it allows for broad medical discretion. Another possible reason for the high level of incorrect form filling by GPs is that there is now a realisation within the psychiatric profession that an incorrectly completed detention order may lead to the discharge of a patient by a MHT or a court case being brought against them. However, this same realisation may not have occurred within the broader medical profession as they are not dealing with these issues on a daily basis. Nevertheless, legalism appears to be having an effect and there is evidence that where paperwork is flawed, psychiatrists will refuse to detain.

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<sup>451</sup> See Chapter 3, 42-43.

<sup>452</sup> F Jabbar, AM Doherty, M Aziz & BD Kelly, "Implementing the Mental health Act 2007 in British general practice: Lessons from Ireland" (2011) 34(6) *International Journal of Law and Psychiatry* 414.

<sup>453</sup> *Ibid.*

<sup>454</sup> M Kelly, K O'Sullivan, P Finnegan, J Moran & C Bradley, "Assisted admissions? A national survey of general practitioner experience of involuntary admissions" (2001) 104(9) *Irish Medical Journal* 273.

<sup>455</sup> A Rafiq & S O'Hanlon, "An audit of incomplete involuntary admissions to an approved Irish centre" (2010) 13(4) *Irish Journal of Psychological Medicine* 143.

<sup>456</sup> S Murphy, D Smith, S Barry & L Feeney, "Mental Health Act 2001: Where Form 6 is not completed – Need for Monitoring of Practice" (2009) *College of Psychiatry of Ireland Conference*.

<sup>457</sup> F Jabbar, AM Doherty, M Aziz & BD Kelly, "Implementing the Mental health Act 2007 in British general practice: Lessons from Ireland" (2011) 34(6) *International Journal of Law and Psychiatry* 414.

## **e. Conclusion**

In many ways the operation of the specific provisions of the 2001 Act is consistent with legalism and there is a belief among a majority of the stake-holders in mental health services (service users, service providers and others) that the introduction of the 2001 Act has supported the protection of human rights.<sup>458</sup> Despite this, the best interests principle is undermining legalism in the 2001 Act.

### **4.04 The Influence of Legalism on the Judicial Interpretation of the Mental Health Act 2001**

The fact that the impact of legalism is dependent on those operating it aptly demonstrates how law does not exist in a vacuum. It is therefore also necessary to look beyond the mere statutory provisions and to consider the role of those charged with interpreting legislation- the judiciary. This is so important because the judiciary's interpretation of the 2001 Act will also affect the MHTs interpretation of the 2001 Act. Following the enactment of the 2001 Act, but before the commencement of its substantive provisions, the ECHR was incorporated into Irish law in the European Convention on Human Rights Act 2003. Gledhill believed that the 2003 Act would further the protections enshrined in the 2001 Act by emphasising the need for public bodies to live up to the requirements of the ECHR.<sup>459</sup> In reality however, the 2003 Act has had less of an impact on Irish litigation and on the legal processes of the State than Gledhill and others might have anticipated or hoped for.<sup>460</sup> Furthermore, the extent to which it has advanced the human rights aspects of the 2001 Act has been negligible, as will become apparent in the following analysis.

## **a. Interpretation of the Purpose of the 2001 Act**

### **i. Purpose & Best Interests**

When introducing the 2001 Act, the government stated that its purpose was to provide for the protection of the rights of those detained and ensure that Irish legislation was compliant with the ECHR, consistent with legalism. Therefore in its guiding principles, the 2001 Act states

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<sup>458</sup> B O'Donoghue & P Moran, "Consultant psychiatrists' experiences and attitudes following the introduction the Mental Health Act 2001: A national survey" (2009) 26(1) *Irish Journal of Psychological Medicine* 23; Mental Health Commission, *Report on the Operation of Part 2 of the Mental Health Act 2001* (2008).

<sup>459</sup> Kris Gledhill, 'External Commentary on the Legislation' in Mental Health Commission, *Report on the Operation of Part 2 of the Mental Health Act 2001* (2008) 27.

<sup>460</sup> See generally, Fiona de Londras & Cliona Kelly, *European Convention on Human Rights Act: Operation, Impact and Analysis* (Roundhall 2010).

that when making decisions due regard should be had to the rights to dignity, autonomy, bodily integrity and privacy. It has been surmised that the articulation of these rights sought to introduce a human rights ethos into the legislation and that the introduction of statutory ‘best interests’ would lead to a new emphasis on the rights of the patient.<sup>461</sup> The interpretation of the 2001 Act by the Irish Courts, however, have endorsed medicalism by determining that the primary purpose of the 2001 Act is the paternalistic care and treatment of the mentally ill, similar to that established under the Mental Treatment Act 1945.<sup>462</sup> The High Court has made this explicit:

*“... having regard to the nature and purpose of the Act of 2001 as expressed in its preamble and indeed throughout its provisions, it is appropriate that it is regarded in the same way as the Mental Treatment Act 1945, as of a paternal character, clearly intended for the care and custody of persons suffering from mental disorder”.*<sup>463</sup>

The Supreme Court has endorsed this interpretation and in *EH v St Vincent’s Hospital*<sup>464</sup> Kearns J approved the judgement in the *Gooden v Otteran’s* case,<sup>465</sup> and stated that:

*“I do not see why any different approach should be adopted in relation to the Mental Health Act 2001, nor, having regard to the Convention, do I believe that any different approach is mandated or required by Article 5”.*<sup>466</sup>

In interpreting the 2001 Act in this manner, the Courts have used the best interests principle to provide a purposive interpretation which is consistent with medicalism.<sup>467</sup> Thus, in the

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<sup>461</sup> Department of Health, *Interim Report of the Steering Group on the Review of the Mental Health Act 2001* (2012) 9.

<sup>462</sup> Darius Whelan, *Mental Health Law and Practice: Civil and Criminal Aspects* (Round Hall 2009) 21-36; Claire Murray, “Moving towards rights-based mental health law: the limits of legislative reform” (2013) 49 *Irish Jurist* 161; Anne-Marie Brennan, “The Mental Health Act 2001 and the Best Interests Principle: A Revolutionary Step in the Improvement of Mental Health Law in Ireland?” (2010) 28 *Irish Law Times* 290; Ciaran Craven, “Signs of a paternalist approach to the mentally ill persist” *The Irish Times* (Dublin, 27 July 2009); Brendan Kelly, “Human Rights and the Mental Health Act 2001: Part 4” (2012) 1(4) *Psychiatry and the Law* 9; Claire Murray, “Reinforcing paternalism within Irish mental health law - contrasting the decisions in *EH v St. Vincent’s Hospital and Others* and *SM v The Mental Health Commission and Others*” (2010) 32(1) *Dublin University Law Journal* 273; Darius Whelan “Can the Right to Personal Liberty be Interpreted in a Paternalistic Manner?: Cases on the Mental Health Act 2001” *Irish Human Rights Law Review* 2011 Available at: [http://works.bepress.com/darius\\_whelan/2](http://works.bepress.com/darius_whelan/2).

<sup>463</sup> *MR v Byrne and Flynn* [2007] IEHC 73; see also *JH v Lawlor, Clinical Director of Jonathan Swift Clinic, St James’ Hospital* [2007] IEHC 225 at 487.

<sup>464</sup> *EH v St Vincent’s Hospital and Ors* [2009] IESC 46.

<sup>465</sup> *Gooden v St Otteran’s Hospital* [2001] IESC 14.

<sup>466</sup> *EH v St Vincent’s Hospital and Ors* [2009] IESC 46 at 788-790.

above Supreme Court case, Kearns J held that the paternalistic intent of the 2001 Act is exemplified by the best interests principle.<sup>468</sup> In *MR v Byrne and Flynn*, O'Neill J found that:

*“Section 4 of the Act ... in my opinion gives statutory expression to the kind of paternalistic approach mandated in the case of Philip Clarke and approved in the case of Croke v Smith...”*<sup>469</sup>

From the jurisprudence that has developed it is clear that the term ‘best interests’ has come to mean medical best interests.<sup>470</sup> For example, in a recent case, *GF v Tallaght Hospital*, the High Court stated that the continuing detention of a person was lawful and in his best interests based on his mental condition as determined by the MHT who had heard the evidence of the treating psychiatrist and seen the report by the independent psychiatrist.<sup>471</sup> In another case it was stated that doctors must be permitted a wide margin of appreciation in how they might consider that the best interests of the patient are served.<sup>472</sup>

Additionally, the Courts regularly defer to the psychiatrists involved in the cases and attribute great weight and respect to their opinions.<sup>473</sup> In *MX v HSE*, for example, MacMenamin J opined that *“In this jurisdiction, we are fortunate that we can place a high degree of trust in our doctors. This is based on both tradition and modern day experience”*. He continued by stating that *“It is important to remember that it is doctors, not lawyers, who can cure patients”*.<sup>474</sup> Psychiatrists and the medical staff involved in detaining and subsequently treating persons are routinely congratulated on the manner in which they care for and treat

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<sup>467</sup> See generally *XY, a minor: HSE v JM and RP* [2013] IEHC 12; *MX v HSE* [2013] IEHC 491; *MX v HSE* [2011] IEHC 326; *F v Our Lady's Hospital* [2010] IEHC 243; *EH v St. Vincent's Hospital and Ors* [2009] IESC 46; *AR v St Brendan's Hospital* [2009] IEHC 143; *MM v Central Mental Hospital* [2008] IEHC 44; *B v Our Lady's Hospital* [2007] IEHC 403; *MR v Byrne and Flynn* [2007] IEHC 73; *JH v Lawlor, Clinical Director of Jonathan Swift Clinic, St James' Hospital* [2007] IEHC 225.

<sup>468</sup> *EH v St. Vincent's Hospital and Ors* [2009] IESC 46 at 788-789.

<sup>469</sup> *MR v Byrne and Flynn* [2007] IEHC 73.

<sup>470</sup> A Brennan, “The Mental Health Act 2001 and the Best Interests Principle: A Revolutionary Step in the Improvement of Mental Health Law in Ireland?” *Irish Law Times*, 2010 (28), pp290-300.

<sup>471</sup> *GF v Tallaght Hospital* [2013] IEHC 309. See also *F v Our Lady's Hospital* where it was stated that decisions must be made in the best interests of a person detained as determined by medical personnel; *C v St Patrick's Hospital* [2009] IEHC 47 where it was held that a MHT should not inhibit a psychiatrist from acting in a patient's best interests, in this case, re-detaining them after a MHT had revoked the detention order.

<sup>472</sup> *L v St Patricks Hospital* [2012] IEHC 15 at 54.

<sup>473</sup> See *L v St Patricks Hospital* [2012] IEHC 15 at 54; *SC v St Brigid's Hospital* [2009] IEHC 100; *C v St Patrick's Hospital* [2009] IEHC 47; *FW v James Memorial Connolly Hospital* [2008] IEHC 283; *L v St Brendan's Hospital* [2008] IEHC 11; Anne-Marie Brennan, “The Mental Health Act 2001 and the Best Interests Principle: A Revolutionary Step in the Improvement of Mental Health Law in Ireland?” (2010) 28 *Irish Law Times* 290-300.

<sup>474</sup> *MX v HSE* [2011] IEHC 326 at 3-5.

their patients to ensure that their best interests, that being medical best interests, are protected.<sup>475</sup>

The interpretation of best interests in this manner and the deference to the medical profession suggests that the judiciary have not accepted the legislature's move to legalism which advocates the establishment of legal controls on the medical power of detention and the limitation and overview of medical discretion in the process.

## **b. Protection against Arbitrary Detention**

### **i. Defining Mental Disorder**

The Courts have rarely had occasion to interpret the substantive requirements for detention. In the only case considering this issue, O'Neill J opined that the harm criterion and the need for treatment criterion are not to be considered only as alternatives but that both grounds can exist simultaneously.<sup>476</sup> He stated that the threshold for detention under the harm ground is set high, as there must be a serious likelihood of the person causing *immediate and serious* harm to themselves or others.<sup>477</sup> Furthermore, the standard of 'serious likelihood' was higher than the ordinary standard of proof in civil actions, namely the balance of probability, but somewhat short of certainty.<sup>478</sup> Various statutory forms were subsequently amended and current versions specifically permit it to be certified that a person either satisfies the danger ground or the treatment ground, or both.

However, in analysing the criteria for detention O'Neill J was keen to state that he was merely setting out the legal framework of the operation of the statutory provisions. In a conspicuous adherence to medicalism, O'Neill J emphasised that on a daily basis these provisions will have to be operated by 'clinical experts' who within the broad framework set out have to make clinical judgements and it was not intended in this judgement to interfere in the proper realm of clinical judgement or to cut down or limit the proper scope of clinical judgement.<sup>479</sup>

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<sup>475</sup> See *L v St Patrick's Hospital* [2012] IEHC 15 at 54; *SC v St Brigid's Hospital* [2009] IEHC 100; *C v St Patrick's Hospital* [2009] IEHC 47; *FW v James Memorial Connolly Hospital* [2008] IEHC 283; *L v St Brendan's Hospital* [2008] IEHC 11.

<sup>476</sup> *MR v Byrne* [2007] IEHC 73.

<sup>477</sup> *MR v Byrne* [2007] IEHC 73 at 222.

<sup>478</sup> *Ibid.*

<sup>479</sup> *MR v Byrne* [2007] IEHC 73 at 224.



## **ii. Medical Examinations**

The 2001 Act defines examination for the purpose of detention as a personal examination of the process and content of thought and the mood and behaviour of the person. In deciding these cases, the Courts have failed to endorse legalism and in a similar manner to the case law decided under the 1945 Act concerning the issue of examination they have endorsed medicalism. In doing so, they have found that a brief conversation without disclosing the purposes of that conversation or discussing the mental state of the person concerned, sufficed as an examination, so too did an observation without any personal conversation with the person.<sup>480</sup> The only instance where detention was found unlawful on the basis of an examination was where no attempt at all was made to examine or observe the person; the doctor had simply signed the recommendation for detention when presented with it by a family member without having seen the person at all.<sup>481</sup>

## **iii. Procedural Requirements for Lawful Detention**

There is a lot of paperwork connected with detention that requires various individuals to fill out specific forms in a precise manner, especially when compared with the previous detention process under the 1945 Act.<sup>482</sup> Furthermore there are specific time limits for the carrying out of examinations, the making of recommendations, the dating of detention orders and the review of the decision to detain by the MHT. In the initial years following the commencement of the 2001 Act, these issues were heard before the courts quite regularly and have continued to arise sporadically.

Cases which relate to procedural irregularities have generally been interpreted in a literal or a purposive manner. Where the Court decides to use a literal interpretation, they have found that the procedures laid down in the 2001 Act must be followed correctly or the detention will be found unlawful, in line with legalism. Thus, in *AM v Kennedy*, Peart J stated that:

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<sup>480</sup> *Z v Khattak and Another* [2008] IEHC 262; *XY v Clinical Director of St Patrick's Hospital* [2012] IEHC 224.

<sup>481</sup> *SO v Clinical Director of the Adelaide and Meath Hospital of Tallaght* [2013] IEHC 132.

<sup>482</sup> In order to have a person detained in a psychiatric hospital an application was made in the prescribed form, known colloquially as the “pink form” for temporary patients, the “white form” for persons of unsound mind or the “blue form” for voluntary patients. Patricia Casey & Ciaran Craven, *Psychiatry and the Law* (Oak Tree Press 1999) 462. There are in excess of 20 forms relating to different aspects of the detention of a person under the 2001 Act. Mental Health Commission, ‘Forms under the Mental Health Act 2001’ <[http://www.mhcirl.ie/Mental\\_Health\\_Act\\_2001/Forms\\_under\\_Mental\\_Health\\_Act\\_2001/](http://www.mhcirl.ie/Mental_Health_Act_2001/Forms_under_Mental_Health_Act_2001/)> accessed 01 June 2014.

*“The greatest care must be taken to ensure that procedures are properly followed, and it ill-serves those whose liberty is involved to say that the formalities laid down by statute do not matter and need not be scrupulously observed.”*<sup>483</sup>

Alternatively, where the Courts use a purposive interpretation of the 2001 Act, consistent with medicalism, they have been willing to permit procedural irregularities. Peart J opined in *PMcG v Medical Director of the Mater Hospital*:

*“It cannot have been the intention of the Oireachtas when it enacted this piece of legislation that its provisions would have to be acted upon in such a literal way that the best interests of the patient would take second place.”*<sup>484</sup>

The fact that the same judge came to two different conclusions about procedural irregularities serves to highlight the complexity of the area and the lack of a consensus in the case law.

Matters are further complicated by the fact that MHTs are given the express power in the 2001 Act to ignore procedural irregularities, and this has also led to conflicting case law. The 2001 Act provides that the MHT must be satisfied that certain procedures have been complied with or if there has been a failure to comply with these procedures, that the failure does not affect the substance of the order and does not cause an injustice.<sup>485</sup>

In 2007, Gledhill believed that the case law from the High Court on what procedural irregularities a MHT could cure ensured that there was no arbitrariness in the detention and that this was compliant with the ECHR.<sup>486</sup> Since then the Irish Courts have had further opportunity to consider what procedural irregularities result in unlawful detention. From the case law two different viewpoints have developed. The first viewpoint, in line with legalism, is that the MHT can only be used to excuse minor failures of an insubstantial nature.<sup>487</sup> The second viewpoint, in line with medicalism, is that the Section 18 can excuse nearly any procedural defect, unless it is in reckless disregard of the legislation.<sup>488</sup>

These cases have focused primarily on the manner in which detention orders are completed. At issue has been compliance with time limits in conjunction with the proper dating of the

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<sup>483</sup> *AM v Kennedy, Clinical Director of the Central Mental Hospital* [2007] IEHC 136 at 676.

<sup>484</sup> *PMcG v Medical Director of the Mater Hospital* [2007] IEHC 401 at 339.

<sup>485</sup> Mental Health Act 2001, s 18.

<sup>486</sup> Kris Gledhill, ‘External Commentary on the Legislation’ in Mental Health Commission, *Report on the Operation of Part 2 of the Mental Health Act 2001* (2008) 23.

<sup>487</sup> *AMC v St Lukes Hospital Clonmel* [2007] IEHC 65; *WQ v Mental Health Commission* [2007] IEHC 154.

<sup>488</sup> *T OD v Kennedy, Clinical Director of Central Mental Hospital* [2007] IEHC 129; *AR v Clinical Director of St Brendan’s Hospital* [2009] IEHC 143.

orders,<sup>489</sup> the completion and signature of the orders by the appropriate person<sup>490</sup> and the ticking of the box which indicates the grounds upon which a person is detained.<sup>491</sup> A related issue here is that the Courts have repeatedly held that a previous flaw in a detention order will not have a domino effect on subsequent properly made detention orders and will not result in unlawful detention. Therefore, if there is unlawfulness at an earlier stage of detention it may be “cured” by a subsequent lawful detention.<sup>492</sup>

However, in *EH v St Vincent’s Hospital* in the Supreme Court, Kearns J stated that a legal challenge to a patient’s detention is only warranted where their best interests, appearing to mean medical best interests, so demand.<sup>493</sup> In this case Kearns J opined that the proceedings that resulted from an incorrect date on a renewal order, were initiated and maintained on:

*“purely technical and unmeritorious grounds [and that,] mere technical defects, without more, in a patient’s detention should not give rise to a rush to court, notably where any such defect can be, or has been, cured - as in the present case.”*<sup>494</sup>

Kearns J went on to state that it was difficult to see in what way the case advanced the interests of the applicant who was “*patently in need of psychiatric care.*”<sup>495</sup> This is a significant judgement and one which considerably undermines legalism. It seems to imply that only where the person is not suffering from a mental illness or where there has been a gross abuse of the legislation should a legal representative challenge the legality of the detention. This approach would require a legal representative to consider whether release is appropriate, not whether it is legal or not. Ultimately, if legal representatives feel they are required to act in their client’s best interests, the extent to which they can question the legality of such detention will be reduced. Consequently, this would significantly increase medical discretion in detention and fail to comply with legalism. Darius Whelan hoped that the statement was meant merely to advise legal representatives to exercise constraint when

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<sup>489</sup> *AMC v St Lukes Hospital Clonmel* [2007] IEHC 65; *AM v Central Mental Hospital* [2007] IEHC 136; *T OD v Kennedy, Central Mental Hospital* [2007] IEHC 129; *WQ v Mental Health Commission* [2007] IEHC 154; *JH v Lawlor, Jonathan Swift Clinic* [2007] IEHC 225; *PD v Connolly Hospital* [2014] IEHC 58.

<sup>490</sup> *WQ v Mental Health Commission* [2007] IEHC 154; *JB v Central Mental Hospital (No.2)* [2007] IEHC 201.

<sup>491</sup> *AR v St Brendan’s Hospital* [2009] IEHC 143; *GF v Tallaght Hospital & Ors* [2013] IEHC 309.

<sup>492</sup> *RL v Clinical Director of St Brendan’s Hospital*, Supreme Court (*ex tempore*), February 15, 2008; *SC v Clinical Director of St Brigid’s Hospital* [2009] IEHC 100.

<sup>493</sup> *EH v St Vincent’s Hospital* [2009] IESC 46 at 50.

<sup>494</sup> *Ibid.*

<sup>495</sup> *Ibid.*

bringing cases where there is settled law to the effect that the case is likely fail.<sup>496</sup> However, given the lack of consistency in the case law, it would be difficult for any legal representative to determine whether an issue has been settled by the Courts or not.<sup>497</sup>

Thus, the most recent case considering this issue is *PD v Connolly Hospital*, where it was held that the wrong section filled out on a detention order in conjunction with an incorrect date thereon, caused the detention to be unlawful.<sup>498</sup> In the High Court, Hogan J opined that such flaws affected the substance of the detention because the detention order failed on its face to recite clearly either the proper legal basis for the detention or the correct date on which the renewal order will expire. This he held could potentially have further implications for when one's detention was reviewed.<sup>499</sup> This case has ramifications for the other issues upon which cases have been brought to date. The case law up to this point has yet to find that the failure to tick the box indicating the grounds on which a person is detained (for treatment or risk, or both) will result in unlawful detention. In terms of whom signs forms the Courts have decided several cases on this issue. In *WQ v Mental Health Commission* it was held that a MHT could not affirm a renewal order where it was made by "the wrong person"-a psychiatrist who was not involved in the treatment and was from a different hospital.<sup>500</sup> Subsequent cases have upheld this decision yet relaxed it depending on the level of involvement in the patient's care and treatment.<sup>501</sup> In light of *PD v Connolly Hospital*, similar cases in future may yield different results. Despite the *PD v Connolly Hospital* judgement the case law may continue to be divided as has been seen with the cases concerning time limits and the dating of orders.<sup>502</sup>

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<sup>496</sup> Darius Whelan, *Mental Health Law and Practice: Civil and Criminal Aspects* (Thomson Round Hall 2009) 243.

<sup>497</sup> *PD v Connolly Hospital* [2014] IEHC 58 at 15.

<sup>498</sup> *Ibid.*

<sup>499</sup> *Ibid.*

<sup>500</sup> *WQ v Mental Health Commission* [2007] IEHC 154, 35 where the incorrect signature was held to be a fundamental defect, however, the issue had not been raised at the MHT hearing and a renewal order had been affirmed by a second MHT, therefore the service user's current detention was lawful.

<sup>501</sup> See generally *JB v Central Mental Hospital (No 2)* [2007] IEHC 201; *MM v Clinical Director of the Central Mental Hospital* [2008] IEHC 44 & [2008] IESC 31; *B v Our Lady's Hospital Navan* [2007] IEHC 403; *JH v Lawlor, Jonathan Swift Clinic* [2007] IEHC 225; *D v Health Service Executive and Mental Health Commission* [2009] IEHC 488.

<sup>502</sup> Cases concerning the meaning of s18 with respect to time limits and dating of orders can be separated into two schools of thought: those which follow *WQ v Mental Health Commission* [2007] IEHC 154 and hold that only insubstantial failures may be excused; and those which follow *T OD v Kennedy, Central Mental Hospital* [2007] IEHC 129 which hold that more substantial flaws may be excused.

The High Court has held that procedural flaws may in some cases result in leave being granted to initiate civil proceedings against those involved in the detention.<sup>503</sup> In two out of four cases where leave was granted the High Court held that reasonable care does not just relate to medical matters but that those involved in detention are required to ensure the procedural requirements are also fulfilled.<sup>504</sup> So in *AM v Kennedy*<sup>505</sup>, the Court allowed leave on the basis that three separate renewal orders had actually been sent to the MHC, all with different dates thereon which had subsequently led to a finding of unlawful detention.<sup>506</sup> The other case where leave was granted was a case wherein the MHC had failed to organise a MHT which resulted in the patient's detention not being reviewed for six months. The Court held that both the MHC and the physicians involved in the patient's care should have realised that there had been no review and therefore there was a want of reasonable care.<sup>507</sup> From the few cases that have sought leave to initiate proceedings under Section 73, there seems to be more willingness from the High Court to grant such leave when compared with the situation under Section 260 of the 1945 Act. Therefore, despite the medicalist nature of the provision, the Court has interpreted the provision in a legalist manner and granted leave to initiate proceedings where there is any evidence of a lack of reasonable care.

### c. Conclusion

When the cases concerning procedural irregularities are considered chronologically it can be seen that there is no definitive position of the Courts on this issue. However, both in terms of chronology and quantity, the Courts have tended towards finding that anything more than an insubstantial flaw will result in unlawful detention. Given the most recent case on the issue, it is unclear what these minor flaws could include as the wrong date, which the court stated was an easy mistake to make (the order was made at the start of a new year and the previous year was written), was held to affect the substance of the detention. A strict interpretation like this where only minor failures that do not cause any injustice to the person being detained remains consistent with legalism, alternatively a broad interpretation would not as it would dilute the protections provided in the 2001 Act. Having said that, in almost half of the cases

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<sup>503</sup> Mental Health Act 2001, s 73.

<sup>504</sup> Leave was refused in *MP v Attorney General, HSE and Casey* [2010] IEHC 473 who had previously been refused leave in a similar action in *MP v HSE, Minister for Justice, Equality and Law Reform and Casey* [2010] IEHC 161. The Court found no evidence to support the claims that those involved acted negligently or with proper care in the detention of the applicant. Leave was granted in *AM v Kennedy* [2007] IEHC 136 and *AM v Kennedy* [2013] IEHC 55.

<sup>505</sup> *AM v Kennedy* [2013] IEHC 55.

<sup>506</sup> *AM v Kennedy* [2007] IEHC 136.

<sup>507</sup> *AL v Clinical Director of St. Patrick's Hospital* [2010] IEHC 62.

concerning procedural irregularities the Courts, and in particular the Supreme Court has, consistent with medicalism, used a purposive interpretation to find that, in line with medicalism, the flaw does not affect the substance of the detention because this detention is needed in the best interests of the patient. Although not directly relevant to detention, it must also be highlighted that the Courts have more recently heard cases concerning the treatment of persons lacking capacity detained under the 2001 Act. In these cases too, the Courts have relied on a purposive interpretation of best interests and found that in line with medicalism, if such treatment is determined to be therapeutically necessary, it will not be unlawful.<sup>508</sup> Therefore, when the case law is considered in its totality and not restricted to the detention cases, the Courts paternalistic interpretation of best interests has ensured the perpetuation of medicalism in the 2001 Act.

#### 4.05 Conclusion

The 2001 Act had the potential to enshrine legalism in the legal powers of detention, however, the extent to which this has occurred is questionable. While the 2001 Act reflects the weakened credibility of the medical profession in the detention of the mentally ill, it does not really threaten its hegemony. Doctors remain involved in every aspect of the detention process, from examination and diagnosis to second opinion safeguards and the MHT review of the decision to detain. Furthermore, through the best interests principle, the 2001 Act has actually ensured that what is deemed optimally therapeutic by medical professionals will take priority in decisions concerning detention.

The existing research also shows that there has been little change in the types of persons being detained. However, the numbers in detention have continued to decline since the introduction of the 2001 Act; in 2001 there were 4,321 people in detention,<sup>509</sup> in 2013 there were 2,132.<sup>510</sup> Significantly, however, there is evidence that there is non-compliance with aspects of the 2001 Act with respect to detention. Some of this has been attributed to the fact that doctors are operating in conditions where administrative staff has been reduced and some

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<sup>508</sup> *MX v HSE* [2013] IEHC 491 and *MX v HSE* [2011] IEHC 326. See also *XY, a minor: HSE v JM and RP* [2013] IEHC 12 where the High Court held that a purposive construction of the 2001 Act is appropriate having regard to the paternalistic intent of the legislation.

<sup>509</sup> Antoinette Daly & Dermot Walsh, *HRB Statistics Series 12; Irish Psychiatric Units and Hospitals Census 2010* (2011) 28.

<sup>510</sup> Mental Health Commission, *Annual Report 2013; Including the Report of the Inspector of Mental Health Services* (2014) 40.

have failed to proactively ensure that their legal responsibilities are met.<sup>511</sup> In other areas there seems to be a lack of knowledge of the 2001 Act on the part of those charged with its implementation, this is particularly true for GPs.

In the aggregate, the judiciary's approach to the 2001 Act has been mixed and has provided interpretations that are consistent with both legalism and medicalism in different cases. However, there is a strong line of case law from both the High and Supreme Court where legalism has been rejected and medicalism has been endorsed. In conclusion, any further move to enshrine legalism may require an amendment to the best interests principle and the power of the MHT to ignore procedural flaws in detention, but this will also require acceptance by the judiciary and those responsible for the 2001 Act's operation. This has not yet occurred.

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<sup>511</sup> Mental Health Commission, *Annual Report 2012; Including the Report of the Inspector of Mental Health Services* (2013).

## CHAPTER 5

# THE NATURE OF MENTAL HEALTH TRIBUNAL OPERATION: MEDICALISM OR LEGALISM?

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### 5.01 Introduction

The imposition of a legal requirement that provides an independent non-medical review of the medical decision to detain a person on the grounds of mental illness is a clear articulation of legalism. In line with this the ECtHR has built on the terms of Article 5(4) of the ECHR and held that for mental health detention to be lawful there must be an independent review by a court of the medical decision to detain. Consequently, in Ireland, the 2001 Act was enacted to provide for this independent review and ensure compliance with the ECHR. The 2001 Act established MHTs for this purpose.

However, the previous chapter concluded that there is a discrepancy between the aim and the operation and interpretation of the 2001 Act in Ireland. In particular, the Irish Courts' interpretation of the 2001 Act has maintained the medicalism that was apparent in the 1945 Act, which it is claimed is frustrating the purpose of the 2001 Act. Yet, the Irish Courts have heard no more than 60 of such detention cases. When this is compared with approximately 13,400 MHT hearings, the ramifications of the MHTs acting in a similar manner are put in perspective.

The first part of this chapter analyses the manner by which the ECtHR has incorporated legalism in the requirements for reviewing mental health detention. The 2001 Act is subsequently analysed to determine the extent to which the MHT provisions and their interpretation by the Courts endorse legalism and the framework designed by the ECtHR. The second part of this chapter examines the operation of the MHTs utilising academic literature, material from several reviews on the operation of the 2001 Act<sup>512</sup> and original interviews with treating psychiatrists and service users whom have had experience of MHTs. A tentative

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<sup>512</sup> Department of Health and Children, *Review of the Operation of the Mental Health Act 2001; Findings and Conclusions* (2007); Mental Health Commission, *Report on the Operation of Part 2 of the Mental Health Act 2001* (2008); Department of Health and Children, *Interim Report of the Steering Group on the Review of the Mental Health Act 2001* (2012).



conclusion as to the prevalence of medicalism and legalism in the legal structure and operation of the MHTs is provided.

## **5.02 Legalism & Reviewing the Decision to Detain under the European Convention on Human Rights**

Article 5(4) of the ECHR states that:

*Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.*

In its interpretation of the ECHR, the ECtHR has built on the terms of Article 5(4) and created a number of clear requirements for the review of the detention of those detained on the grounds of mental illness.<sup>513</sup> Consistent with legalism this independent review is supposed to provide an essential check on psychiatry's power to detain people against their will. The ECtHR has therefore established that this must involve a substantive review of the grounds and reasons for detention.<sup>514</sup> The primary purpose of the review is to ensure no one should be dispossessed of his liberty in an arbitrary fashion.<sup>515</sup>

### **a. Independence & Impartiality**

In its case law the ECtHR has explained in more detail the attributes of this "court". Article 5(4) does not only signify a court of law of the classic kind that is integrated within the

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<sup>513</sup> On mental health and the European Convention see generally; Gostin et al, *Principles of Mental Health Law and Policy* (Oxford University Press 2010) 103-167; Lawrence Gostin & Lance Gable, "The Human Rights of Persons with Mental Disabilities: A Global Perspective on the Application of Human Rights Principles to Mental Health" (2004) 63(20) *Medical Law Review* 8; Lawrence Gostin, "Human Rights of Persons with Mental Disabilities" (2000) 23(2) *International Journal of Law and Psychiatry* 125; Oliver Lewis, "Protecting the Rights of People with Mental Disabilities: the European Convention on Human Rights" (2002) 9(4) *European Journal of Health Law* 293; Johan Legemaate, "Involuntary Admission to a Psychiatric Hospital: Recent European Developments" (1995) 2 *European Journal of Health Law* 15; Oliver Thorold, "The Implications of the European Convention on Human Rights for United Kingdom Mental Health Legislation" (1996) 6 *European Human Rights Law Review* 619; Genevra Richardson, "The European Convention and Mental Health Law in England and Wales: Moving Beyond Process?" (2005) 28(2) *International Journal of Law and Psychiatry* 127; Jim Murdoch, "Safeguarding the Liberty of the Person: Recent Strasbourg Jurisprudence" (1993) 42(3) *International and Comparative Law Quarterly* 494; Kris Gledhill, "Human Rights Instruments and Mental Health Law: The English Experience of the Incorporation of the European Convention on Human Rights" (2006-2007) 34(2) *Syracuse Journal of International Law and Commerce* 358; G Niveau & J Materi, "Psychiatric Commitment: over 50 years of case law from the European Court of Human Rights" (2006) 21(7) *European Psychiatry* 427; Alastair Mowbray, *Cases and Materials on the European Convention on Human Rights* (Oxford University Press 2011) 245-344.

<sup>514</sup> *X v United Kingdom* (1982) 4 EHRR 188 at 13

<sup>515</sup> *Winterwerp v Netherlands* (1979) 2 EHRR 387 at 37. For a discussion of the requirements of a lawful detention, including the establishment of mental disorder by objective medical expertise Chapter 3, 64-68.

judicial arm of the country. Rather it must be a body with a judicial character that affords procedural guarantees to the parties.<sup>516</sup> Despite the fact that Article 5(4) does not mention the requirement of independence or impartiality and thus differs from Article 6(1) which requires an independent and impartial review, the ECtHR has held that it would be inconceivable that Article 5(4) of the ECHR, relating to such a sensitive issue as the deprivation of liberty of ‘persons of unsound mind’ within the meaning of Article 5(1)(e), should not equally envisage, as a fundamental requisite, the impartiality of that court.<sup>517</sup> Therefore, the court must be independent from the executive and the parties involved to ensure there are no conflicts of interest.<sup>518</sup> As the executive branch of government is responsible for the detention of persons, the court must reside within either the judicial branch of government or it may be independent of both the executive and the judicial branches.

## **b. Procedural Fairness**

In the first case considering mental health detention, *Winterwerp v Netherlands*, the ECtHR outlined the essential requirements of such a review under Article 5(4):

*“The judicial proceeding referred to in Article 5(4) need not, it is true, always be attended by the same guarantees as those required under Article 6(1) for civil or criminal litigation. Nonetheless, it is essential that the person concerned should have access to a court and the opportunity to be heard in person or, where necessary, through some form of representation, failing which he will not have been afforded the ‘fundamental guarantees of procedure applied in matters of deprivation of liberty.’”*<sup>519</sup>

The ECtHR has held that the court must follow a procedure of a judicial character and ensure adherence to ‘equality of arms’, which is a component of a fair hearing.<sup>520</sup> Equality of arms connotes the idea that in hearings concerning mental health detention, the detained person should be allowed the same opportunity to present their case under conditions that do not put them at a substantial disadvantage *vis- à- vis* their opponent, in this case the State.<sup>521</sup> Mental

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<sup>516</sup> Peter Bartlett, Oliver Lewis & Oliver Thorold, *Mental Disability and the European Convention on Human Rights* (Martinus Nijhoff 2007) 62.

<sup>517</sup> *DN v Switzerland* (2001) 37 EHRR 510 at 42.

<sup>518</sup> *De Wilde, Ooms, and Versyp v Belgium* (1971) 1 EHRR 373 at 78; See *DN v Switzerland* (2001) 37 EHRR 510 at 42-56 where it was held that a psychiatrist may only be on the review panel if they had not previously examined the patient.

<sup>519</sup> *Winterwerp v Netherlands* (1979) 2 EHRR 387 at 60.

<sup>520</sup> *De Wilde, Ooms, and Versyp v Belgium* (1971) 1 EHRR 373 at 78.

<sup>521</sup> See generally Eva Brems, “Conflicting Human Rights: An Exploration in the Context of a Right to a Fair Trial in the European Convention on Human Rights and Fundamental Freedoms” (2005) 27(1) *Human Rights Quarterly* 294.

disorder may entail restricting or modifying the manner of exercise of the right to review of detention but the essence of this right cannot be impaired and this is where the equality of arms concept comes into play.<sup>522</sup> In line with legalism and the protection of civil rights, special procedural safeguards may be necessary to protect the interests of persons who on account of mental illness are not fully capable of acting for themselves in the review. This may require the provision of legal representation by the government.<sup>523</sup> In certain instances, the failure to provide an applicant with legal representation may result in a breach of Article 5(4).<sup>524</sup> The ECtHR has explained that the importance of what is at stake for the applicant, personal liberty, taken with the fact that they may have diminished mental capacity means that they should receive legal assistance in proceedings relating to their detention.<sup>525</sup>

### **c. Powers of the Court**

The court must have the power to order the patient's release if the detention is not lawful. It therefore must not be a mere advisory body and must have the ultimate power to discharge the patient. The ECtHR in *X v United Kingdom* was prepared to regard a mental health review tribunal as a body with appropriate "court like" attributes, provided that it enjoys the necessary independence and offers sufficient procedural safeguards appropriate to the category of deprivation of liberty being dealt with and has the power to order release from detention.<sup>526</sup>

Detention must be in accordance with the law if it is to be free from arbitrariness. The ECtHR has held that the independent review of detention must firstly determine whether the authorities have complied fully with domestic law. Secondly, this domestic law must also be in line with the ECHR and therefore provide for the protection of the civil rights of those detained.<sup>527</sup> The ECtHR has given effect to legalism and held that failure to comply with the law will result in unlawful detention. This entails the adherence to the standards established by the ECtHR under Article 5, as discussed, but importantly includes the requirement that the person is suffering from mental disorder as determined by objective medical expertise.<sup>528</sup>

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<sup>522</sup> See page 117 for further discussion of natural justice principles.

<sup>523</sup> See *Winterwerp v The Netherlands* (1979) 2 EHRR 387 at 60.

<sup>524</sup> In *Megyeri v Germany* (1992) 15 EHRR 584, the applicant who had been declared incapable of conducting proceedings himself had sought to appeal his detention but did not arrange for legal representation. The failure to provide him with such representation was found to be a breach of Article 5(4).

<sup>525</sup> *Megyeri v Germany* (1992) 15 EHRR 584 at 23.

<sup>526</sup> *X v United Kingdom* (1982) 4 EHRR 188 at 61.

<sup>527</sup> *Winterwerp v Netherlands* (1979) 2 EHRR 387 at 45.

<sup>528</sup> *Winterwerp v Netherlands* (1979) 2 EHRR 387 at 39. See Chapter 3, 64-68.

Representative of legalism, Article 5(4) attempts to ensure a patient's rights are restricted for the shortest time possible by guaranteeing the right to a 'speedy' review and judicial decision on the legality of the detention, and its termination if it proves unlawful.<sup>529</sup> The ECtHR has further read into this provision the need for periodic review where there is continuing detention, on the ground that the original reasons justifying detention may change over time. As the review must be able to consider whether, on the facts, the criteria for lawful detention are still met, the patient must still be suffering from a mental disorder of a degree warranting detention at the time of the review. Mental disorder is subject to amelioration or cure and therefore reviews at reasonable intervals are necessary to ensure that the person's mental state continues to justify the detention.<sup>530</sup>

The ECtHR, however, has not yet definitively stated how frequently a patient must be able to exercise his 'periodic' right to review. The maximum permissible time remains undecided as each case concerning this issue has been decided on its own facts. The jurisprudence on this issue has found breaches of Article 5(4) where there have been delays of 24 days,<sup>531</sup> 5 weeks,<sup>532</sup> 8 weeks<sup>533</sup> and 5 months.<sup>534</sup> In determining the urgency of cases the ECtHR has also drawn a distinction between first time applicants and those applying for subsequent reviews of their detention. In the latter situation less urgency is required.<sup>535</sup> It has held that pre-trial detention in criminal cases should only be of "strictly limited duration", however, it noted that in other cases such as committals to mental hospitals, lengthier periods between reviews may be more appropriate.<sup>536</sup> Lengthy delays in a review or the making of a decision will only be excused in exceptional circumstances. Insufficient State resources, such as shortage of judicial manpower or judicial overload are not sufficient State excuses, even if the access or decision is as "speedy" as is possible in the particular circumstances.<sup>537</sup>

#### **d. Conclusion**

Cumulatively, the ECtHR's interpretation of Article 5(4) establishes a review of mental health detention that is consistent with legalism. The ECtHR's requirement that a court that is

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<sup>529</sup> *Musial v Poland* (1999) 31 EHRR 720 at 43.

<sup>530</sup> *Winterwerp v Netherlands* (1979) 2 EHRR 387 at 55.

<sup>531</sup> *LR v France* (2002) App No 33395/96.

<sup>532</sup> *Laidin v France* (2002) App No 43291/98.

<sup>533</sup> *E v Norway* (1990) 17 EHRR 30.

<sup>534</sup> *Van der Leer v Netherlands* (1990) 12 EHRR 567.

<sup>535</sup> *Koendjiharie v Netherlands* (1990) 13 EHRR 820.

<sup>536</sup> *Bezicheri v Italy* (1989) 12 EHRR 210.

<sup>537</sup> *E v Norway* (1990) 17 EHRR 30 at 66.

independent and has the power to review whether the person is suffering from a mental disorder and whether the legal processes concerning their detention have been complied with establishes a significant control over medical discretion. Furthermore, the primary purpose of this is to ensure the patient's civil rights as established under the ECHR are protected. Importantly, however, Article 5(4) and its interpretation by the ECtHR set down the minimum requirements for the review of mental health detention. It is open to States to provide greater protections than that established by the ECtHR which could enshrine a heightened version of legalism.

### **5.03 Mental Health Tribunal Review of Detention**

Based on this jurisprudence, from the early 1980s Ireland's 1945 Act had been in contravention of the ECHR.<sup>538</sup> When a case was taken to the ECtHR on this very issue, the Irish government agreed to a friendly settlement. The resulting settlement included a commitment to introduce legislation which gave effect to this type of independent review.<sup>539</sup> It is notable that the government chose to establish MHTs to provide this independent review instead of a court. It is necessary to determine why this is and the extent to which their development was influenced by legalism.

#### **a. The Evolution of the Irish Mental Health Tribunal**

The Health (Mental Services) Act 1981 provided for the establishment of a review board whose purpose was to safeguard the patient from unnecessary detention.<sup>540</sup> These boards largely followed the English model contained in the Mental Health Act 1959.<sup>541</sup> They were composed of a legal member, a medical member and a member who was not a legal or medical professional.<sup>542</sup> The Board would review the decision to detain on the basis of an application.<sup>543</sup> The grounds of the review of the detention were not specified, however, it could not discharge a patient unless it was satisfied that detention and treatment were no longer necessary in the interests of the patient's health or safety or for the protection of other persons or property.<sup>544</sup>

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<sup>538</sup> See Chapter 4, 64-68.

<sup>539</sup> *Croke v Ireland* (2000) App No 33267/96 ECHR.

<sup>540</sup> Dr Woods, Minister for Health, Health (Mental Services) Bill, 1980- Second Stage, Dáil Debates, Volume 323, no. 2, 16 October 1980, 164.

<sup>541</sup> Michael Keating, Minister for Health, Health (Mental Services) Bill, 1980- Second Stage, Dáil Debates, Volume 323, no. 2, 16 October 1980, 811.

<sup>542</sup> Health (Mental Services) Act 1981, s 37.

<sup>543</sup> *Ibid.*

<sup>544</sup> Health (Mental Services) Act 1981, s 39.

The 1981 Act was passed but never brought into operation and the next consideration of the review of detention came with the Green Paper 1992 and the White Paper on a New Mental Health 1995. Here, two options were considered: the involvement of the courts in the decision to detain or a review by an independent body of the decision to detain. The Green Paper subsequently surmised that the Irish courts were not well suited to the investigatory process needed to confirm the legality of a detention. Additionally, in light of the volume of initial detention orders -3,300 in 1990- judicial confirmation would involve a substantial additional workload for the courts. It is also likely that the government were highly influenced by the tribunals established under the Mental Health Act 1983 in England and Wales. On balance the Government favoured a procedure whereby the decision to detain was taken by a medical practitioner but with an independent review.<sup>545</sup> In line with legalism it was proposed that the Mental Health Review Board should have the “*necessary degree of independence to carry out its functions in an impartial way*”<sup>546</sup> and its membership should be “*competent to judge medico-legal issues involved in decisions to detain.*”<sup>547</sup> The White Paper proposed that a review of the procedural legality of a person's detention would take place within seven days. A more substantive review of whether the person was suffering from a mental disorder that warranted detention would not have occurred until the person was detained continuously for over a year.<sup>548</sup>

However, in June 1999 the ECtHR declared the admissibility of the *Croke v Ireland* case and found that it raised “serious issues under Article 5(1) and (4) of the Convention which require determination on the merits.”<sup>549</sup> As a result, the Government agreed to a friendly settlement. The resulting settlement included a commitment to introduce legislation which gave effect to an independent review.<sup>550</sup> The Government were consequently under significant pressure to ensure that this independent review was compliant with the ECHR and the jurisprudence on the review of detention.

The proposals in the White Paper did not comply with the ECtHR’s requirements as there would be no substantive review of the decision to detain until the patient was in detention for over a year. A new mental health tribunal (MHT) was put forward which would provide an

<sup>545</sup> Department of Health, *Green Paper on Mental Health* (1992) 88-93.

<sup>546</sup> Department of Health, *Green Paper on Mental Health* (1992) 90.

<sup>547</sup> Department of Health, *White Paper; A New Mental Health Act* (1995) 54.

<sup>548</sup> Department of Health, *White Paper; A New Mental Health Act* (1995) 55-59.

<sup>549</sup> *Croke v Ireland* (2000) App No 33267/97 ECHR at 16.

<sup>550</sup> *Croke v Ireland* (2000) App No 33267/96 ECHR.

automatic substantive review of the decision to detain within 28 days.<sup>551</sup> This time period was ultimately reduced as the 28 day period was seen as too long given that the majority of detained patients were released within a month, thus rendering such a review ineffective.<sup>552</sup> The composition of the MHT also changed over the course of the Bill's debate and passage into law. Initially, the Bill provided that there would only be a psychiatrist and a lawyer on the MHT; several TDs (Teachta Dála; Irish version of an MP) questioned this.<sup>553</sup> TD Liz McManus, in a clear articulation of legalism and her thinking concerning the professions, outlined the benefit of such lay representation:

*“It is not the role of politicians to perpetuate the power of the professions but to challenge it and to recognise the contribution of lay people. I urge the Minister not to become part of this potential conspiracy. If it is not challenged it will be perpetuated. The Courts Service is an example of how to do things right. The fact that lay people who are outside the judiciary participate in the new structures running our courts has improved the capability of the Courts Service in ways that would not have been dreamt of in the past. The Minister should move with the times and recognise the contribution of lay people. The lay perspective, the importance of which even professionals recognise, will be missing from the commission and from the decision making table.”*<sup>554</sup>

By the time the Bill was introduced the concept of a body that would provide an independent review of the decision to detain a person on the grounds of mental illness had been in circulation for twenty years.<sup>555</sup> It had also been recognised by the Government in the early 1990s that the 1945 Act failed to comply with international legal obligations in this regard.<sup>556</sup> Despite this, the introduction of the MHT under the 2001 Act was actually quite rushed as a result of the *Croke v Ireland* case.<sup>557</sup> Several key features of a review body had emerged during the course of the Bill's debate including that the review body had to be independent, impartial and competent in terms of expertise. Furthermore, it had to provide a speedy and

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<sup>551</sup> Micheál Martin, Minister for Health and Children, Mental Health Bill, 1999- Second Stage, Dáil Debates, Volume 517, no. 5, 6 April 2000, 999-1000.

<sup>552</sup> Liz McManus, Mental Health Bill, 1999- Second Stage, Dáil Debates, Volume 517, no. 5, 6 April 2000, 1015.

<sup>553</sup> Alan Shatter, Mental Health Bill, 1999- Second Stage, Dáil Debates, Volume 517, no. 5, 6 April 2000, 1012.

<sup>554</sup> Liz McManus, Mental Health Bill, 1999- Second Stage, Dáil Debates, Volume 517, no. 5, 6 April 2000, 1016.

<sup>555</sup> Health (Mental Services) Act 1981.

<sup>556</sup> It had been recognised since the Green Paper on Mental Health 1992 that new legislation was needed to comply with Ireland's international law obligations.

<sup>557</sup> *Croke v Ireland* (2000) App No 33267/96 ECHR.

substantive review of the decision to detain. The overriding purpose of these features was to ensure the human rights of those detained, as established in the ECHR were protected. Thus, from the outset the features of the MHT appeared to be consistent with legalism and the requirements under the ECHR. The final form of the MHT as established under the 2001 Act is discussed next.

## **b. Characteristics of a Tribunal**

Although the term tribunal is not subject to precise definition it can generally be considered as a body that is independent of the executive and the judicial arms of the government that takes decisions affecting individual rights, according to some precise legal guidelines and through a somewhat regular and established procedure.<sup>558</sup> Tribunals in general are thought to have several advantages over courts, especially in dealing with certain issues. These characteristics include their speed, economy, accessibility, flexibility, informality and expert knowledge of a particular subject.<sup>559</sup> Indeed, the first detailed scrutiny of tribunals in Britain stated that they should be “independent, accessible, prompt, expert, informal and cheap”.<sup>560</sup> Whether these alleged advantages are always delivered in practice has, of course, been called into question.<sup>561</sup> While tribunals are bound by some rules, to a large degree they are masters of their own procedure. They have considerable discretion concerning the conduct of the hearing, rules of evidence and the cross examination of witnesses. Another benefit is that many tribunals possess particular expertise. For example, having a medical expert as part of the tribunal panel is often seen as more advantageous than relying on the introduction of medical expertise through expert medical witnesses.<sup>562</sup> These characteristics in conjunction with, the hearing of disputes in private and a less formal setup are thought to make them a less intimidating experience than a court.<sup>563</sup> However, it is questionable whether these characteristics are consistent with legalism and this is discussed in relation to the Irish MHT below.

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<sup>558</sup> David Gwynn Morgan, Paul Daly, Gerard W Hogan, *Hogan and Morgan's Administrative Law* (4<sup>th</sup> Ed, Round Hall 2012) 160.

<sup>559</sup> Robin Creyke (ed), *Tribunals in the Common Law World* (The Federation Press 2009) x.

<sup>560</sup> Franks Committee, *Report of the Committee on Administrative Tribunals and Enquiries* (Cmnd 218, 1957).

<sup>561</sup> Michael Adler, “Lay tribunal members and administrative justice” (1999) 4 *Public Law* 616.

<sup>562</sup> David Gwynn Morgan, Paul Daly, Gerard W Hogan, *Hogan and Morgan's Administrative Law* (4<sup>th</sup> Ed, Round Hall 2012) 165.

<sup>563</sup> David Gwynn Morgan, Paul Daly, Gerard W Hogan, *Hogan and Morgan's Administrative Law* (4<sup>th</sup> Ed, Round Hall 2012) 164.



Despite their differences, one similarity between tribunals and courts that is consistent with legalism is that both must adhere to “natural justice”. Natural justice has two principles: the decision maker must not be biased (*nemo iudex in causa sua*); and anyone who may be adversely affected by the decision must be allowed to be heard and have the best possible chance to put their side of the case forward (*audi alteram partem*).<sup>564</sup> In Ireland the principle of natural justice is recognised as an unenumerated constitutional right.<sup>565</sup> The natural justice principle is so important that tribunals must practice it if they are to function at all.<sup>566</sup> This is especially true for MHTs reviewing the decision to detain a person on the grounds of mental illness.

#### **5.04 The Influence of Medicalism & Legalism in the MHT Provisions & Judicial Interpretation of the Provisions**

The 2001 Act provides that within 21 days of detention, a three person MHT consisting of a lawyer as chair, a consultant psychiatrist and a lay person must review this decision to detain. Prior to the independent review, a legal representative is appointed by the MHC to represent the patient at the MHT, unless s/he proposes to engage one. An independent medical examination by a consultant psychiatrist, appointed by the MHC, will also have been completed and provided to the MHT for consideration. If the MHT is satisfied that the person is suffering from a mental disorder and that the detention provisions have been followed it can approve the detention order. If the MHT is not satisfied it must revoke the detention order and direct that the person be discharged from the approved centre.

##### **a. Independence & Impartiality**

In order to fulfil its purpose it is necessary that the MHT is independent and impartial, thus also correlating with the first principle of natural justice which requires a non-biased review of the case (*nemo iudex in causa sua*) and as required by Article 5(4) of the ECHR as discussed above.<sup>567</sup> The MHC Procedural Guidance on MHT proceedings states that “the

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<sup>564</sup> David Kenny, “Fair Procedures in Irish Administrative Law: Toward a Constitutional Duty to Act Fairly in *Dellaway Investments v NAMA*” (2011) 34 *Dublin University Law Journal* 47.

<sup>565</sup> Bunreacht na hEireann, Article 40.3. The right to constitutional justice, the Irish form of natural justice, is recognised as one of the unenumerated rights embraced by Article 40.3 of the Constitution. It has been established since *Re Haughey* [1971] IR 217, the classical statement of constitutional justice, that any public inquiry impugning a citizen’s right to a good name is amenable to judicial review, and therefore attracts the rule against bias as well as the *audi alteram partem* (‘fair hearing’) rule. See generally David Gwynn Morgan, Paul Daly & Gerard W Hogan, *Hogan and Morgan’s Administrative Law* (4<sup>th</sup> Ed, Round Hall 2012) chps 13 & 14.

<sup>566</sup> Robin Creyke (ed), *Tribunals in the Common Law World* (The Federation Press 2009) x.

<sup>567</sup> *DN v Switzerland* (2003) 37 EHRR 21 at 42. See above pages 109-110.

right to a fair hearing is a basic human rights requirement and is dependent on the MHT being independent and free from influence by any party in its decision making.”<sup>568</sup> It also states that members of the MHT must take reasonable steps to avoid any potential conflict of interest in a particular case. Members are also required to report to the MHC as soon as possible, any involvement with a particular approved centre or a particular organisation or individual which could be seen to constitute a potential conflict of interest in a particular case and to refrain from taking part in such a case.<sup>569</sup>

## **b. Procedural Fairness**

### **i. MHT Procedure**

The 2001 Act sets out the powers of MHTs.<sup>570</sup> In a similar manner to a court the MHT has the power to hear submissions and any evidence it requires in order to make a decision.<sup>571</sup> In doing so it may direct any person to appear at a MHT to give evidence or direct any person to produce any documents relevant to the work of the MHT.<sup>572</sup> The MHT must enable the examination and cross examination of witnesses, administration of oaths and the admission of written statements with the patient’s consent.<sup>573</sup> Failure to co-operate with any of the requirements of a MHT is an offence and where false evidence is given before a MHT the person giving such false evidence shall be guilty of perjury as if the evidence were given before a court.<sup>574</sup> All witnesses, and the patient’s legal representative, shall have the same privileges and immunities as if they were appearing in a court.<sup>575</sup> The MHT is required to keep record of the MHT proceedings and it also produces a written decision, albeit one that is not made publically available.<sup>576</sup> These MHT procedures appear to comply with the ECHR and legalism to ensure there is a fair hearing which also correlates with natural justice.

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<sup>568</sup> Mental Health Commission, *Mental Health Tribunals: Procedural Guidance and Administrative Protocols* (2006) para 3.1.

<sup>569</sup> Mental Health Commission, *Mental Health Tribunals: Procedural Guidance and Administrative Protocols* (2006) para 3.7.

<sup>570</sup> Mental Health Act 2001, s 49.

<sup>571</sup> Mental Health Act 2001, s 18(3).

<sup>572</sup> Written statements may be admissible as evidence before the MHT but only with the consent of the service user or the service user’s legal representative.

<sup>573</sup> Mental Health Act 2001, s 49(6).

<sup>574</sup> Mental Health Act 2001, s 49(4) and (5).

<sup>575</sup> Mental Health Act 2001, s 49(7) and (8).

<sup>576</sup> Mental Health Act 2001, s 49(6)(j); Mental Health Commission, *Mental Health Tribunals: Procedural Guidance and Administrative Protocols* (2006) para 4.3; Mental Health Commission, *Form 8; Decision of the Mental Health Tribunal* (2007).

Other than these requirements, the MHTs are given the power to create their own procedures and give any directions for the purpose of proceedings that appear to it to be just and reasonable.<sup>577</sup> This flexibility allows the MHT to respond to the exigencies of each particular case and make it more accessible, less formal and at times less adversarial than a typical court setting. Such an adversarial approach has been deemed inappropriate for the MHTs.<sup>578</sup> In the adversarial system the judge plays the role of impartial arbiter between two identifiable parties with opposing interests. The two sides and their legal representatives play what has been described as a ‘mutually antagonistic role’.<sup>579</sup> By comparison with an inquisitorial system, there is often only one individual interest. On the other side is often the “public” or “community” interest, which may consist of divergent concerns, some of which may converge with those of the individual. In this system the court is involved in establishing facts, collecting evidence and questioning witness. Such an inquisitorial approach is often used by tribunals<sup>580</sup> and the MHC emphasises in its Procedural Guidelines that MHTs should not be conducted in an adversarial manner.<sup>581</sup>

## **ii. Privacy**

Significantly, however, unlike the courts, MHT hearings are held in private.<sup>582</sup> Kris Gledhill has raised an issue with respect to Article 6 of the ECHR which presumes that hearings relating to the determination of civil rights (including the right to liberty) should be in public. This is subject to the interests of the private lives of the parties, which would naturally include information as to someone’s mental health. However, the privacy right belongs to the patient and in cases where the patient would prefer to have a public hearing there is no provision for this in the legislation.<sup>583</sup> In terms of legalism this privacy may have an impact on the extent to which the MHTs act as a control on clinical discretion and protect the civil rights of the patient. The oft quoted aphorism ‘justice must not only be done; it must also be

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<sup>577</sup> Mental Health Act 2001, s 49.

<sup>578</sup> Mental Health Commission, *Mental Health Tribunals: Procedural Guidance and Administrative Protocols* (2006) 18.

<sup>579</sup> Byrne & McCutcheon, *The Irish legal System* (4<sup>th</sup> Ed, LexisNexis Butterworths 2005) 227-228.

<sup>580</sup> David Gwynn Morgan, Paul Daly, Gerard W Hogan, *Hogan and Morgan’s Administrative Law* (4<sup>th</sup> Ed, Round Hall 2012) 169.

<sup>581</sup> Mental Health Commission, *Mental Health Tribunals: Procedural Guidance and Administrative Protocols* (2006) 18.

<sup>582</sup> Mental Health Act 2001, s 49(9).

<sup>583</sup> Kris Gledhill ‘External Commentary on the Legislation’ in Mental Health Commission, *Report on the Operation of Part 2 of the Mental Health Act 2001* (2008) 21-22.

seen to be done' is apt here.<sup>584</sup> As MHTs are held in private and they do not publish judgements, the latter part of the aphorism is not fulfilled.

Given the nature of the issues being dealt with in the MHT a certain level of privacy is warranted, however, this should not be to the extent that it removes the MHT from any form of oversight or review. In the debating of the Mental Health Bill 1999, an amendment was proposed in relation to allowing "*bona fide* members of the press and such other persons (if any) as the [tribunal] may in its discretion permit to remain."<sup>585</sup> The amendment was proposed on the basis that MHTs should be responsible to society and not too secluded. However, it was subsequently withdrawn on the grounds that allowing members of the press or any other person to attend the MHT was seen to be an unwarranted intrusion of privacy.<sup>586</sup> However, this was a naïve and short-sighted conclusion; a simple legal provision in the 2001 Act could have controlled the attendance of persons for *bona fide* purposes such as research or audit. Such a provision could have required the consent of the patient before any such attendance, therefore negating the concern raised about an unwarranted invasion of privacy.

This provision has had an overarching impact on any research, review or oversight of the operation of the MHTs and as a result there has been no audit of their operation to date.<sup>587</sup> Even the MHC, whose responsibility it is to promote high standards in the delivery of mental health services and ensure the interests of those detained are protected, feel they are precluded from reviewing and auditing the operation of MHTs because of this privacy requirement. Indeed, the CEO of the MHC expressed concern at the fact that they have no idea what is going on within MHTs and how they are performing because of this.<sup>588</sup> Therefore, the extent to which this privacy furthers the protection of detained patients and correlatively whether it is consistent with legalism is questionable. A tentative answer to this question is provided in the consideration of the operation of the MHTs below.

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<sup>584</sup> As derived from Lord Hewart opining that "justice should not only be done, but should manifestly and undoubtedly be seen to be done." in *R v Sussex Justices, Ex parte McCarthy* (1924) 1 KB 256, 259.

<sup>585</sup> Dr Henry, Mental Health Bill, 1999- Committee Stage (Resumed), Seanad Eireann Debate, Volume 167, no. 2, 13 June 2001, 216.

<sup>586</sup> Dr Moffatt, Mental Health Bill, 1999- Committee Stage (Resumed), Seanad Eireann Debate, Volume 167, no.2, 13 June 2001, 216.

<sup>587</sup> The MHC did conduct a consultation on the protections offered in the 2001 Act, with key stakeholders including MHT members, TPs and service users. However, the information relating to the conduct of MHTs is very brief: Mental Health Commission, *Report on the Operation of Part 2 of the Mental Health Act 2001* (2008) 75.

<sup>588</sup> Hugh Kane, "Mental Health Commission – Strategic Agenda 2010–2012 and Key Current Issues" (2010) Mental Health Law Conference; University College Cork. Presentation available at <http://www.ucc.ie/en/lawsite/eventsandnews/pastevents/2010/mentalh2010/> accessed 11 June 2014. In personal contact with the MHC in 2013, it appears that the MHC still feel so constrained.

### **iii. Legal Representative**

The second principle of natural justice also requires that anyone who may be adversely affected by the decision must be allowed to be heard and have the best possible chance to put their side of the case forward (*audi alteram partem*). A related concept required by the ECtHR is equality of arms, which provides that in the review of mental health detention, the patient must have legal representation.<sup>589</sup> In furtherance of these principles, once the patient is detained under the 2001 Act they are provided with free legal representation for the MHT that is organised by the MHC. The provision of legal representation to each patient detained actually goes beyond the requirements of the ECtHR, which only requires the provision of legal representation to those that cannot afford it.<sup>590</sup> By contrast, the treating psychiatrist is not represented which some have claimed fails to meet the natural justice requirements.<sup>591</sup>

The courts have given mixed messages with respect to the role of the legal representative. The High Court has stated that the legal representative is supposed to advise the patient and act as an advocate on their behalf both at the MHT and in cases brought to the courts concerning their detention.<sup>592</sup> Moreover, given the vulnerability of the patient who may not be in a position to instruct their legal representative to apply to the court for release, there is a duty on legal representatives to do this where a breach of statutory procedure has occurred.<sup>593</sup> However, as discussed in the previous chapter, the Supreme Court has held that legal representatives should not bring cases concerning procedural flaws in the detention where it is not in the patient's medical best interests.<sup>594</sup>

### **iv. Independent Psychiatric Evidence**

In order to ensure that the MHT does not only rely on the evidence from the treating psychiatrist the 2001 Act established the position of the independent psychiatrist whose role it is to provide an independent opinion to the MHT on whether the patient is suffering from a mental disorder that requires detention or not.<sup>595</sup> In this manner the independent psychiatrist, consistent with legalism, is intended to be a form of control on the initial medical decision to detain. In practice, the independent psychiatrist is not called to give oral evidence at the MHT

<sup>589</sup> *Megyeri v Germany* (1992) 15 EHRR 584 at 23. See above pages 111 & 117.

<sup>590</sup> *Winterwerp v Netherlands* (1979) 2 EHRR 387 at 60.

<sup>591</sup> John W Coates, "Mental health review tribunals and legal representation – equality of arms?" (2004) 28(11) *Psychiatric Bulletin* 426.

<sup>592</sup> As per Peart J in *EJW v Watters*, [2008] IEHC 462 at 20.

<sup>593</sup> As per Peart J in *P McG v Mater Hospital* [2007] IEHC 401 at 13.

<sup>594</sup> *EH v St Vincent's Hospital* [2009] IESC 46 at 50 discussed at page 103.

<sup>595</sup> Mental Health Act 2001, s 17(1)(c).

hearing but they do provide it with a report on their findings, which is also disseminated to the patient's legal representative.<sup>596</sup> This report is based on a personal examination of the patient and a questioning of their treating psychiatrist and others that are involved in their care and treatment. The independent psychiatrist's report provides an account as to whether they believe the patient is suffering from a mental disorder or not and whether they require detention for their treatment, protection or both. It provides a clinical description of the patient's current mental condition, their history, any change in their condition since admission, their treatment and any side effects, the patient's attitude to treatment and likely compliance with it in the future and any risk factors to the patient or others.<sup>597</sup> Therefore, the report is only concerned with the medical aspects of the detention, not the patient's civil rights or compliance with the other legal detention provisions. The MHT is required to have regard to this report before making its decision.<sup>598</sup>

### **c. Powers of the Mental Health Tribunal**

The MHT is required to provide an automatic review of the legality of the substantive and procedural aspects of detention.<sup>599</sup> The 2001 Act makes provision for a MHT within 21 days of detention. The ECtHR has never explicitly ruled that automatic reviews are required and therefore the automatic review within 21 days is a heightened form of legalism in the 2001 Act than that established by the ECtHR. If a patient's legal status is changed to voluntary within this time period the MHT can proceed, but only at the request of the patient. This acts as a control on medical power and is thereby consistent with legalism, and the ECtHR which has also established that for detention to be lawful it must be compliant with domestic legislation.<sup>600</sup>

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<sup>596</sup> Darius Whelan, *Mental Health Law and Practice: Civil and Criminal Aspects* (Thomson Round Hall 2009) 223.

<sup>597</sup> Mental Health Act 2001, s 17 Report of Consultant Psychiatrist.

<sup>598</sup> Mental Health Act 2001, s 18(3).

<sup>599</sup> Mental Health Act 2001, s 18(1).

<sup>600</sup> *Winterwerp v Netherlands* (1979) 2 EHRR 387, 45.

### ***i. Power to Ignore Detention Irregularities***

Notwithstanding this, the 2001 Act also specifically provides that MHTs can cure failures to comply with specific provisions in the detention process and affirm the detention provided that such failure does not affect the substance of the order or cause an injustice.<sup>601</sup> These specific provisions include failures regarding: the persons who may apply for detention;<sup>602</sup> the making of a recommendation for detention by the first doctor;<sup>603</sup> the powers of the Gardaí to take a person believed to be suffering from a mental disorder into custody;<sup>604</sup> the admission order;<sup>605</sup> the duration and renewal of detention orders;<sup>606</sup> and the provision of information for persons detained.<sup>607</sup> As can be seen these powers are far reaching. Furthermore, the 2001 Act does not define what failure will or will not affect the substance of the order or cause an injustice. The ECtHR requires compliance with the law for detention to be lawful; however, the 2001 Act provides both specific detention provisions and a power in the MHT to waive compliance with these provisions if it does not cause an injustice. It is questionable as to whether this is ECHR compliant and is a significant weakening of legalism in the 2001 Act. Essentially, it establishes a hierarchy of importance in terms of the medical and procedural requirements for detention. Absence of a medical disorder will result in unlawful detention, yet in certain circumstances, failure to comply with the detention provisions will not. Moreover, as discussed in the previous chapter, the inconsistency of the case law in determining what flaws will result in unlawful detention, and the judgements that have held that the MHT can cure nearly any procedural flaw, has added to the subjugation of legalism which requires compliance with all aspects of the law.<sup>608</sup>

### ***ii. Appeal to the Circuit Court***

The patient can appeal the decision of the MHT to the Circuit Court. However, legalism is further reduced in that the patient can only appeal this decision on the grounds that they are not suffering from a mental disorder. The Circuit Court cannot consider whether the procedural aspects of the detention have been complied with and it cannot vary the order of

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<sup>601</sup> Mental Health Act 2001, s18(1)(a)(ii) states that the MHT must be satisfied that certain provisions (in s9, s10, s12, s14, s15 and s16 of the 2001 Act) have been complied with or “if there has been a failure to comply with these provisions, that the failure does not affect the substance of the order and does not cause an injustice.”

<sup>602</sup> Mental Health Act 2001, s 9.

<sup>603</sup> Mental Health Act 2001, s 10.

<sup>604</sup> Mental Health Act 2001, s 12.

<sup>605</sup> Mental Health Act 2001, s 14.

<sup>606</sup> Mental Health Act 2001, s 15.

<sup>607</sup> Mental Health Act 2001, s 16.

<sup>608</sup> See pages 100-106.

the MHT, it can only affirm or revoke the detention order.<sup>609</sup> In this manner the 2001 Act has reinforced the hierarchy between the medical and procedural aspects of the detention.

#### **d. Conclusion**

On its face the MHT provides an independent and speedy review of the medical decision to detain that is compliant with the ECHR and appears to be consistent with legalism. It is true that the provisions of the MHT do allow it to act as a control on medical discretion in the detention process by reviewing whether the person has a mental disorder. Furthermore, the MHT is also concerned with the patient's civil and statutory rights and must also determine whether they have been protected. However, upon analysis some of the provisions in the 2001 Act concerning the MHT significantly weaken the impact of legalism and provide the opportunity for medicalism to prevail. These include the MHT's privacy, the continuing medical dominance in the process and the MHT's power to cure flaws in the detention where it believes it does not cause an injustice to the patient. The extent to which legalism has been realised or medicalism has prevailed in the operation of the MHTs is the focus of the next section.

### **5.05 Influence of Medicalism & Legalism in the Operation of Mental Health Tribunals**

This section of the chapter focuses on the extent to which legalism or a perpetuation of medicalism has been realised in operation of the MHTs and the Courts interpretation of this. As with the previous section, the focus is on the extent to which the MHT provides an independent and fair review of the medical decision to detain. The following assessment of the extent to which legalism or medicalism are evident in the operation of the MHTs draws on information obtained in original interviews with treating psychiatrists and service users, findings from academic literature on the subject and research and data from the Department of Health and MHC Reports on the operation of the 2001 Act.<sup>610</sup>

#### **a. Difficulties with Conducting Qualitative Research on Irish MHTs**

As MHTs are held in private there were significant challenges in obtaining material to examine their operation. Following protracted consultation with the MHC which began in

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<sup>609</sup> *The Mental Health Tribunal v SP & Anor* [2014] IEHC 249 at 14.

<sup>610</sup> Department of Health and Children, *Review of the Operation of the Mental Health Act 2001; Findings and* (2007); Mental Health Commission, *Report on the Operation of Part 2 of the Mental Health Act 2001* (2008); and the Department of Health and Children, *Interim Report of the Steering Group on the Review of the Mental Health Act 2001* (2012).



2010, the MHC decided in late 2013 that it would not be possible to observe MHTs or interview or survey current or retired MHT members, independent psychiatrists or legal representatives on the basis that the 2001 Act requires MHTs to be held in private.<sup>611</sup> The result was disappointing, surprising and extremely guarded considering the MHC, itself, had conducted research on “stakeholders” views.<sup>612</sup> Their research involved inviting these stakeholders to make submissions by letter, email or fax on a guidance template which provided a range of questions to elicit responses on the operation of the legislation.<sup>613</sup>

## **b. Methodology**

As a result it was decided to conduct the research by interviewing consultant psychiatrists who had experience of MHTs in their capacity as the treating psychiatrist (TP) and service users (SUs) who had experience of MHTs. While the TP and the SU cannot provide information about the manner in which decisions are made by the MHT, they do have significant knowledge about how the MHT works, the roles of those involved and the issues that are considered; they can therefore provide some insight into the existence of legalism or medicalism. Furthermore, it is TPs who are charged with the operation of the 2001 Act and it is their medical discretion and professional judgement that the MHT is supposed to act as a control on, in line with legalism. Thus, it is essential to assess their attitudes towards this.

Tps that the researcher knew had experience of MHTs were contacted personally. The researcher also utilised snowballing sampling which involved asking TPs who had already been interviewed to identify other consultant psychiatrists who fit the selection criteria. As some sample participants were generated through existing ones, there was clearly the danger that the diversity of the sample could be compromised.<sup>614</sup> This was mitigated by contacting 45% independently and contacting 55% on the recommendation of another participant. A total of 11 interviews were conducted with TPs working in the Dublin region. Only one of these worked in the private sector. Cumulatively, the TPs had attended approximately 469 MHTs, ranging from 6MHTs for TP6 to 100 MHTs for TP2 and TP11.

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<sup>611</sup> See Appendix A, 1.

<sup>612</sup> The stakeholders encompassed service providers, all persons sitting on the MHT panels, professional bodies, representative bodies, and voluntary and public bodies active in the field of mental health or human rights. Notices for display were also forwarded to all approved centres. Mental Health Commission, *Report on the Operation of Part 2 of the Mental Health Act 2001* (2008) 65.

<sup>613</sup> Mental Health Commission, *Report on the Operation of Part 2 of the Mental Health Act 2001* (2008) 65-78.

<sup>614</sup> Jane Ritchie & Jane Lewis (eds), *Qualitative Research Practice, A Guide for Social Science Students and Researchers* (Sage Publications 2011).

It was decided to only interview SUs whom were no longer in in-patient care. This was because interviewing SUs in detention raised a host of problems that could not be resolved within the significant time constraints. These problems primarily revolved around the capacity of service users in detention to consent to such interviews and obtaining access to them through the approved centres and their legal representatives.<sup>615</sup> Ethical approval was subsequently granted by DCU Research Ethics Committee which also determined the manner by which service users were to be recruited.<sup>616</sup> Recruiting these service users was a more difficult task. Mr Paddy McGowan, Head of Service User, Family Member and Carer Engagement on the HSE National Mental Health Management Team, was contacted and agreed to inform service users about the research at the series of nationwide mental health public meetings held by the HSE. Mental health organisations operating in Ireland were contacted and asked to inform their members of the research being conducted.<sup>617</sup> Some organisations advertised the research on their websites or in their centres with an advertisement provided. The research was also presented at the members' meetings of several mental health organisations. This was done in an attempt to meet possible participants face to face and perhaps allay any anxieties concerning participation in the research. When discussing the research with service users, they were urged to bring along a person with whom they felt comfortable with to the interview if they so wished. Furthermore, the independence and confidentiality of the research was emphasised. A total of 4 interviews were conducted with SUs from the Dublin region. The low response rate is attributed to the sensitive nature of the subject to be discussed in the interviews, something which persons who are no longer in detention may not wish to recount with a relative stranger. Similar service user response rates were also seen in the MHC Consultation on the Operation of Part 2 of the 2001 Act.<sup>618</sup> This highlights the difficulty in recruiting SUs for this type of research; the MHC also has significantly better resources and access to service users to secure such recruitment than was available for this research.

Having provided informed consent, all participants underwent a semi-structured interview covering their knowledge of the purpose of the MHT, the MHT process, the roles of those

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<sup>615</sup> These were determinative issues for DCU Research Ethics Committee, who believed they could not provide ethical approval to interview service users in detention. This was despite the ethical approval proposal outlining that the UN Convention on Rights of Persons with Disabilities and the Irish Capacity Bill which provide that persons with mental disabilities enjoy legal capacity on an equal basis with others in all aspects of life.

<sup>616</sup> A copy of the Ethical Approval and its terms are contained in Appendix B, 2.

<sup>617</sup> See Appendix for list of organisations contacted, including the dates and responses.

<sup>618</sup> 5 service users responded to the Consultation on the Operation of Part 2 of the Mental Health Act 2001. Mental Health Commission, *Report on the Operation of Part 2 of the Mental Health Act 2001* (2008) 66.

involved, the evidence provided and the extent to which the MHT protects the SU's rights.<sup>619</sup> The following assessment of the extent to which legalism or medicalism is evident in the operation of the MHTs draws heavily from these interviews.

### **c. Introduction & Purpose of the Mental Health Tribunal**

TPs were initially asked about why the 2001 Act was introduced and what was its purpose in order to get an overview of their feelings and some sense of whether they were supportive of or opposed to legalism. TPs stated that the 2001 Act was introduced to ensure compliance with the ECHR and provide a review of their decision to detain the patient.<sup>620</sup> Many highlighted the inadequacies of the 1945 Act which they said was completely out of date and failed to protect the rights of those detained. Primarily, because many people were detained unnecessarily for long periods of time with no real right of appeal, except to the courts, and psychiatrists had no real oversight on what they did.<sup>621</sup> TP2 stated that in addition to providing the patient with a review, the 2001 Act served a societal purpose by introducing transparency into the system. Although not perfect, the 2001 Act was seen as a huge improvement on the 1945 Act.<sup>622</sup> However, a continuing issue that must be highlighted is that TP2 and TP8 believed that if there were more comprehensive community services, or more funding for supported housing, they would detain less people.<sup>623</sup> The 2001 Act, as highlighted, did not provide legislatively for this.

However, despite knowing that the 2001 Act was needed to comply with the ECHR, the extent to which TPs truly endorsed the MHTs role in the protection of patients' civil rights was variable. Overall, each TP stated that the MHT was a good thing.<sup>624</sup> While several TPs believed the MHT was in the best interests of the patient,<sup>625</sup> TP2 believed the MHT was in the legal best interests of the patient but remarked that the therapeutic effect was less clear. All of the TPs highlighted how the MHT was often a stressful and upsetting experience for patients, but could not think of a better way to do it. However, for TP1, the MHT was just a legal process needed to comply with the ECHR but not to the real benefit of or in the best interests of the patient.<sup>626</sup> Three of the SUs also appeared to believe that the MHT was more

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<sup>619</sup> A copy of the Interview Topic Guides is provided in Appendix H, 15-18 and Appendix J, 21-28.

<sup>620</sup> TP1, TP2, TP3, TP4, TP5, TP6, TP7, TP8, TP9, TP10, TP11.

<sup>621</sup> TP1, TP2, TP3, TP4, TP5, TP6, TP7, TP9.

<sup>622</sup> TP1, TP5.

<sup>623</sup> TP2, TP8.

<sup>624</sup> TP1, TP2, TP3, TP4, TP5, TP6, TP7, TP8, TP9, TP10, TP11.

<sup>625</sup> TP7, TP8, TP9, TP10, TP11.

<sup>626</sup> TP1.

of a ‘box ticking’ exercise, a formality, that did not protect their rights.<sup>627</sup> SU2, alternatively, was extremely positive about the MHT process and believed it was an essential human rights protection for those in detention.

Significantly, TPs believed the MHT was beneficial for them, as it often provided validation of their decision to detain.<sup>628</sup> This was especially important where there were societal pressures from family members or the Gardaí pushing for a person’s detention, but whom the TP did not believe satisfied the criteria of mental disorder.<sup>629</sup> TP7, particularly, highlighted how the 2001 Act prohibition on detaining alcoholics is essential in that it prevents families from having people detained where it is to no benefit in terms of their treatment. It also, in some cases, removes from the TP the risk attached to revoking a detention order where they are unsure whether to continue the detention.<sup>630</sup> Additionally, the MHT was seen in a positive light in that it “keeps you on your toes” and acts as a quality control in making detention decisions.<sup>631</sup>

Therefore, from the outset it is unclear the extent to which the TPs embraced the legalistic intention of the MHT which was to provide an independent control on the medical decision to detain, for the protection of the patient’s civil rights. While many accepted that this system did protect the rights of the patients, it was cumulatively seen as a body that often provided them with some protection and a validation of their decision to detain. This is perhaps an inescapable consequence of the MHT, and as such the extent to which it provides for the maximisation of medical discretion, consistent with medicalism, is examined presently.

#### **d. Revocation of Detention Prior to the Mental Health Tribunal Hearing**

A significant issue that must be highlighted at the outset is the high percentage of detention orders that are revoked prior to the MHT sitting. In cases where the detention order is revoked prior to a MHT hearing, the MHT hearing only proceeds at the request of the person who was detained. The MHT is usually held toward the end of the 21 days provided and concern has been expressed at government level of the high numbers of detention orders that are revoked prior to the MHT hearing resulting in no review of the decision to detain.<sup>632</sup>

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<sup>627</sup> SU1, SU3, SU4.

<sup>628</sup> TP2, TP4, TP8, TP10, TP11.

<sup>629</sup> TP2, TP4, TP7, TP10.

<sup>630</sup> TP4, TP10, TP11.

<sup>631</sup> TP8, TP11.

<sup>632</sup> Department of Health and Children, *Review of the Operation of the Mental Health Act 2001; Findings and Conclusions* (2007) 13-14, 21-22.

When asked about this some TPs believed 21 days was too long and questioned whether it complied with the speediness requirement under the ECHR.<sup>633</sup> They thought MHTs could probably be held earlier but that it was cheaper to have it this way, on the basis that many detention orders would be revoked.<sup>634</sup> Others thought 21 days was appropriate<sup>635</sup> and TP6 thought the MHTs should be as late as possible because patients should be given as long as they can to recover.

In 2013 only 56% of people who were detained and due to have a MHT review actually had one; 44% (1,455 of 3,325) of detention orders were revoked prior to the MHT hearing.<sup>636</sup> In 2007, 42% (1,444 of 3,244) of detention orders were revoked prior to detention and there were 16 requests for such a review; unfortunately there are no similar statistics for subsequent years.<sup>637</sup> Significantly, revoking the detention order does not mean the patient is released from the approved centre; it can mean that they are re-graded as voluntary patients.<sup>638</sup> Unfortunately, the MHC has not produced statistics on the frequency with which this happens. In a study of a mental health service in Galway, 68% of SUs had their status changed to voluntary prior to the review by the MHT and none of these requested their MHT to proceed.<sup>639</sup>

These statistics are compelling. The establishment of the MHT to review the medical decision to detain is a clear espousal of legalism. In practice however, only 56% of those who should have a review of this decision to detain actually have one. Of course, some of those who were initially detained may have recovered sufficiently to agree or want to stay in hospital on a voluntary basis by the time the MHT sits. Indeed, all of the TPs who were asked to explain the high number of revocations prior to a MHT hearing stated that this was the reason for the high rate of revocation.<sup>640</sup> Significantly, however, in a national study it was acknowledged by

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<sup>633</sup> TP2.

<sup>634</sup> TP2, TP4, TP7, TP9, TP10; See comments regarding MHC organising MHT later on basis of cost issues Department of Health and Children, *Review of the Operation of the Mental Health Act 2001: Findings and Conclusions* (2007) 13-16.

<sup>635</sup> TP3, TP5.

<sup>636</sup> Mental Health Commission, *Mental Health Tribunal Activity Statistics 2013*, accessible at [http://www.mhcirl.ie/Mental\\_Health\\_Tribunals/Involuntary\\_Admission\\_Activity/Activity-Statistics-2013/](http://www.mhcirl.ie/Mental_Health_Tribunals/Involuntary_Admission_Activity/Activity-Statistics-2013/); See also S Murphy, D Smith, S Barry & L Feeney, "Mental Health Act 2001: Where Form 6 is not completed – Need for Monitoring of Practice" (2009) *College of Psychiatry of Ireland Conference* where it was found that only 42% of those detained in an Approved Centre in Dublin had a review.

<sup>637</sup> Mental Health Commission, *Report on the Operation of Part 2 of the Mental Health Act 2001* (2008) 56.

<sup>638</sup> Mental Health Commission, *Annual Report 2012; Including the Report of the Inspector of Mental Health Services* (2013) 35.

<sup>639</sup> I Murray, B Hallahan & C McDonald, "Has the Mental Health Act 2001 altered the clinical profile of involuntary admissions?" (2009) 26(4) *Irish Journal of Psychological Medicine* 179.

<sup>640</sup> TP1, TP2, TP3, TP4, TP5, TP6, TP7, TP8, TP9, TP10, TP11.

consultant psychiatrists that detention orders may be revoked early to avoid a MHT.<sup>641</sup> Therefore consultant psychiatrists sometimes change a person's status in order to circumvent the process. If this is still the case then TPs are avoiding the review of their decision to detain and denying those who were detained an opportunity to have the legality of their detention assessed and in turn circumventing legalism.

## **e. Independence & Impartiality of the Mental Health Tribunal**

### **i. Roles of MHT Members**

The composition of the MHT was intended to provide a multi-disciplinary control on the medical decision to detain. Rose, however, has stated that there is no evidence that the involvement of legal and lay members on tribunals makes them more competent, objective or rational in making decisions concerning detention than psychiatrists are.<sup>642</sup> Information was gathered from the interviews to determine the extent to which the MHT does provide an independent, competent and fair review of the medical decision to detain.

The legal member in the MHT acts as the Chairperson. The legal member provides legal expertise to the MHT. In doing so they ensure that the legal processes for detention have been complied with.<sup>643</sup> Additionally, at the outset of the MHT hearing, they ask the legal representative, whether the forms have been completed correctly and if there are any anomalies with the detention.<sup>644</sup> The chairperson will also question the TP about the detention or for clarification on issues that were raised during the hearing.<sup>645</sup> Despite the fact that all MHT members have an equal vote, TP7 thought the chairperson was the most important member on the MHT and would have the deciding vote if there was no consensus. TP5 thought the chairperson, as a lawyer, would hold disproportionate weight with the MHT members:

*"Lawyers see themselves as the dominant figure – I'm just being realistic, there is a sense amongst the legal Chairs that they are the ones in charge and the rest are passengers."*<sup>646</sup>

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<sup>641</sup> Brian O'Donoghue & Paul Moran, "Consultant psychiatrists' experiences and attitudes following the introduction the Mental Health Act 2001: A national survey." (2009) 26(1) *Irish Journal of Psychological Medicine* 23.

<sup>642</sup> Nikolas Rose, "Unreasonable Rights: Mental Illness and the Limits of the Law" (1985) 12(2) *Journal of Law and Society* 199, 206.

<sup>643</sup> TP1, TP2, TP3, TP7, TP8, TP10, TP11.

<sup>644</sup> TP3, TP4, TP7, TP8, TP9, TP10, TP11.

<sup>645</sup> TP1, TP2, TP3, TP4, TP7, TP8, TP9, TP10, TP11.

<sup>646</sup> TP5.

The medical member forms their own medical opinion of the patient. This is based on the evidence provided by and questioning of the patient and the TP and an examination of the medical reports including the independent psychiatrist's report.<sup>647</sup> They will ask the TPs about the reasons for detention, the history, family involvement, GP involvement, diagnosis, medication, current situation, treatment plan and anything else they feel relevant.<sup>648</sup> It was also believed that the medical member was an information resource for the other MHT members and could explain to them the various aspects of the medical evidence.<sup>649</sup> For TP6, the medical member was the most important member, and the one that made him most nervous and as colleagues they may,

*"look at what you have done and say, this is a load of rubbish."*<sup>650</sup>

The lay member provides a common sense view of the case in conjunction with forming their own opinions about whether the patient suffers from a mental disorder that requires detention and whether the provisions concerning detention have been complied with.<sup>651</sup> The questions asked by lay members are quite variable and some ask a lot more questions than others, but they are always involved.<sup>652</sup> It is important that the process is transparent to the patient and the lay member plays an important role in this.<sup>653</sup> Therefore, they may seek clarification about something the TP has said about diagnosis or treatment. They also ask practical questions about where the patient would live if they were released, family involvement and supports.<sup>654</sup>

In terms of independence, the same MHT members do not usually sit on the same MHT together.<sup>655</sup> However, TP6 did have one patient whose detention was reviewed by the same legal member twice. This he found helpful as he did not have to go over his same concerns again and the chairperson knew what he was trying to achieve. However, with a different MHT panel each time *"you don't know what they think and what you can say to them."*<sup>656</sup> This raises questions about the independence of this review as it is unlikely that a legal member whom had previously upheld the detention would decide differently where no circumstances had changed. This might introduce some prejudice into the review. The usual

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<sup>647</sup> TP1, TP2, TP3, TP4, TP5, TP6, TP7, TP8, TP9.

<sup>648</sup> TP1, TP2, TP3, TP4, TP5, TP6, TP7, TP8, TP9.

<sup>649</sup> TP7, TP8, TP9.

<sup>650</sup> TP6

<sup>651</sup> TP1, TP2, TP3, TP4, TP5, TP6, TP7, TP8, TP9.

<sup>652</sup> TP3, TP4, TP5, TP6, TP7, TP8, TP9; SU1, SU2, SU4.

<sup>653</sup> TP1, TP7.

<sup>654</sup> TP1, TP2, TP3, TP5, TP6; SU2.

<sup>655</sup> TP1, TP2, TP3, TP4

<sup>656</sup> TP6

mixture of MHT members provides a greater control on the medical decision to detain and is consistent with legalism.

Cumulatively, from the interviews the MHTs do provide a comprehensive and seemingly independent review of the decision to detain. The review is not solely concerned with the medical issues and each member questions the TP and the patient from a legal, medical and lay perspective. It does not appear that the MHT members automatically accept what the TP decided and they were definitely not seen by TPs as somebody who merely accepted their decision to detain without question. In the aggregate, the composition of the MHT provides for a review of the medical decision to detain that is consistent with legalism.

## **ii. Familiarity of the Irish Psychiatric Profession**

Having said this, there are some factors that may affect the independence and impartiality of the MHT. Psychiatric familiarity is a serious issue for the MHT in Ireland and the independence of Irish psychiatrists in the process is questionable. In this small jurisdiction there are only 353 consultant psychiatrists working in the public sector,<sup>657</sup> therefore there is a distinct possibility that any of the psychiatrists may know the other psychiatrists involved in the process.<sup>658</sup> This was attested to in the interviews, where most of the TPs recognised that all Irish psychiatrists are colleagues and know each other, at least in passing and by name.<sup>659</sup> TP6 thought that this must cause an issue that would affect the Medical Member and Independent Psychiatrist's decision, as no psychiatrist is ever going to damn another. TP5 further stated Ireland is too small to effectively inspect or govern itself. Some thought that, while it could be a problem, they have never personally seen it cause an issue.<sup>660</sup> Others again did not think it was a problem at all because psychiatrists are required to be independent and objective and, in reality, regularly give second opinions and disagree with each other.<sup>661</sup> In practice the independent psychiatrist is not employed by the hospital in which the patient is detained. Whether this is enough to constitute independence is highly questionable.<sup>662</sup> There are some precedents which govern these situations. If two of the psychiatrists were in the

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<sup>657</sup> It has not been possible to determine the number of private consultant psychiatrists. This figure was obtained from a personal query directed to the Department of Health. Department of Health, *Personnel Census Data For Consultant Psychiatry in All Agencies Broken Down by Grade and Agency* (2013).

<sup>658</sup> David Gwynn Morgan, Paul Daly, Gerard W Hogan, *Hogan and Morgan's Administrative Law* (4<sup>th</sup> Ed, Round Hall 2012) 165.

<sup>659</sup> TP1, TP2, TP3, TP4, TP5, TP6, TP7, TP10.

<sup>660</sup> TP4, TP5, TP10.

<sup>661</sup> TP3, TP4, TP7, TP8.

<sup>662</sup> TP2.



same class in university, this would not be an issue. However, if one of them is in a position of seniority over another then this would not be appropriate.<sup>663</sup>

Three of the four SUs did not see the independent psychiatrist as a safeguard or control on the decision to detain and believed that they simply agreed with the TP. In particular SU1 highlighted how she requested her legal representative to get a different independent psychiatrist to provide evidence, but the legal representative failed to do so. TP1 believed that many patients do not appreciate the role of the independent psychiatrist as a protection; they just see it as another psychiatrist coming to examine them.<sup>664</sup> This may have something to do with the way in which they are informed on the day about the independent exam. While some TPs inform them personally,<sup>665</sup> in other cases it would usually be ward staff informing them<sup>666</sup> and this may give the impression that it is simply another psychiatrist involved in their care.<sup>667</sup> For TPs 7 and 8 this was an issue because the independent psychiatrist should not only be independent but also be seen to be independent from the patients' perspective to ensure transparency and confidence in the system.

## **f. Fair Procedures**

For the MHT to provide a review of the decision to detain that is compliant with the ECHR and legalism it must ensure that there is fairness in the proceedings. Natural justice and equality of arms requires that the patient is able to put their side of the case forward and is not put at a disadvantage in the proceedings concerning their detention.

### **i. Mental Health Tribunal Format; Evidence & Cross-Examination**

Prior to a MHT taking place, in line with the requirement to provide patients with information, most TPs personally inform patient of MHT and the process when they are first detained. They will tell them what to expect about the process and what the TPs are likely to say during it.<sup>668</sup> Most TPs felt they had to prepare their patients for what they may have to say at the MHT, as it may be upsetting or stressful, in order to minimise the effect on the therapeutic relationship.<sup>669</sup> Where MHTs do occur they are generally quite formal in that that

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<sup>663</sup> Darius Whelan, *Mental Health Law and Practice: Civil and Criminal Aspects* (Thomson Round Hall 2009) 272.

<sup>664</sup> TP1.

<sup>665</sup> TP2, TP3, TP4, TP.

<sup>666</sup> TP4, TP5, TP6, TP10, TP11.

<sup>667</sup> SU1, SU3, SU4.

<sup>668</sup> TP2, TP3, TP4, TP5, TP6, TP7, TP8, TP9, TP11.

<sup>669</sup> TP2, TP4, TP6, TP7, TP8, TP9, TP11

are quiet, respectful, sensible and people are addressed by their titles and surnames.<sup>670</sup> There may be some variety in the format of the MHT hearing and this is dependent on the legal member who is at all times responsible for its orderly running.<sup>671</sup>

The MHT usually starts with the legal member asking the patient's legal representative if they have any submissions to make. This can concern procedural errors in terms of the paperwork. The MHT may then decide to use the s18 power to cure a failure in the detention process. Then the legal member usually gets the TP to summarise the case and why they believe the patient needs to be detained. This would usually require the TP to give account of the patient's past history, current position, the treatment plan and perhaps the individual care plan. It varies from this point but usually the legal representative is given the opportunity to present the patient's case and cross examine the TP. The patient is also given the opportunity to talk and question the TP. Thereafter the MHT members question the TP.<sup>672</sup> The length of the MHT hearing is extremely variable, they were much longer in the beginning but are now approximately 1-1.5 hours.<sup>673</sup>

## **ii. Legal Representation**

Consistent with legalism, the legal representative must ascertain the legality of the patient's detention. Therefore, it is necessary that they have adequate knowledge of the 2001 Act and can provide representation of a high quality. In this manner training is mandatory for legal representatives to ensure that a patient is not represented by a lawyer who knows very little about the 2001 Act.<sup>674</sup> TPs were asked what made a good or a bad legal representative; they believed that a good legal representative establishes the legal and factual circumstances of the case and the wishes of the patient.<sup>675</sup> All SUs stated that they had a good relationship with their legal representatives: they met with them prior to the MHT; were understanding and compassionate; took instructions; and represented the SU to their best ability.<sup>676</sup>

The legal representative determines whether the legal processes have been complied with through an examination of the paperwork and medical records attached to the detention and perhaps questioning of the patient and others involved in the detention. On this point all of

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<sup>670</sup> TP1, TP5

<sup>671</sup> TP1, TP2, TP3, TP4, TP5, TP6, TP7.

<sup>672</sup> TP2, TP3, TP4, TP5, TP6, TP7, TP8, TP10, TP11; SU2, SU4.

<sup>673</sup> TP4, TP6.

<sup>674</sup> Mental Health Legal Aid Scheme (2005), para 8.1(2).

<sup>675</sup> TP2, TP4, TP5, TP7, TP11.

<sup>676</sup> SU1, SU2, SU3, SU4.

the TPs said that the legal representative is consistently excellent at raising such procedural issues. Establishing the legality of detention also requires the legal representative to question the TP on the grounds upon which they are detaining the patient. From the interviews it appears that the legal representative will question the TP about the diagnosis, treatment, risk and continuing reasons for detention.<sup>677</sup> The legal representative's approach to the questioning of the TP during the MHT has often been highlighted by psychiatrists involved in the operation of the 2001 Act and the Department of Health and MHC Reports reviewing the 2001 Act.<sup>678</sup>

In general the approach to questioning seems to be inquisitorial, although several TPs indicated that they had experienced some adversarial approaches, more so in the early years of the MHT but still apparent.<sup>679</sup> Some TPs stated that legal representatives seemed to believe they had to win the case and get the patient out of hospital, without considering what was in the best interests of the patient.<sup>680</sup> While some recognised that the TP was required to take instructions from their client and do what they could to get them released if that is what they wanted.<sup>681</sup> TP1 stated that "the legal representatives are the ones that we have had issues with since it started and I think some of them had to be removed from the Panels... because they acted in a very adversarial way." Where there was adversarial questioning it seemed to make the TPs very uncomfortable. They did not want to be seen as a detainer who was restricting the rights of the patient and were averse to questioning that intimated that.<sup>682</sup> Some TPs referred to emotional legal arguments made by the legal representative about the repression of their client's rights. This they believed was unnecessary and somewhat ridiculous.<sup>683</sup> Rather, TPs emphasised their role in the treatment and care of the patient, they did not see themselves as being in opposition to the patient but instead 'on their side'. Therefore, they found an adversarial approach inappropriate. Furthermore, they thought it was unproductive

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<sup>677</sup> TP2, TP4, TP5, TP7, TP8, TP9.

<sup>678</sup> Department of Health and Children, *Review of the Operation of the Mental Health Act 2001; Findings and Conclusions* (2007) 24; Department of Health, *Interim Report of the Steering Group on the Review of the Mental Health Act 2001* (2012) 56; F Jabbar, B Kelly & P Casey, "National survey of psychiatrist's responses to implementation of the Mental Health Act 2001 in Ireland" (2010) 179(2) *Irish Journal of Psychological Medicine* 291; W Obomanu & H Kennedy, "Juridogenic Harm: Statutory Principles for the New Mental Health Tribunals" (2001) 25 *Psychiatric Bulletin* 331; Gary Lee, "Far from the Madding Crowd" (2008) July *Law Society Gazette* 40.

<sup>679</sup> TP1, TP3, TP4, TP5, TP7, TP8, TP9, TP10, TP11; Gary Lee, "Far from the Madding Crowd" (2008) July *Law Society Gazette* 40.

<sup>680</sup> TP1, TP3, TP5.

<sup>681</sup> TP7, TP11.

<sup>682</sup> TP1, TP5.

<sup>683</sup> TP3, TP5.

and at times detrimental to the therapeutic relationship as it undermined their credibility<sup>684</sup> or forced them to say things that were likely to humiliate, upset or anger their patients.<sup>685</sup> This damage to the therapeutic relationship by adversarial questioning has been highlighted in several studies.<sup>686</sup> Others thought it did not have an effect on the therapeutic relationship and, if it did, it was only short term.<sup>687</sup>

Adversarial approaches by the legal representatives are no longer as common and three TPs believed this was because they have become more accustomed to how mental health detention works whereby the psychiatrist should not be seen as a detainer who is trying to deprive the patient of their rights, rather they are trying to help the patient.<sup>688</sup> Despite this, and the possible effect on the therapeutic relationship, the role of the legal representative, consistent with legalism is to challenge the detention and have the patient released where it is not lawful. This remark seems to suggest that legal representatives may be taking into account the medical aspects of whether the patient requires detention as opposed to simply arguing the law. Two TPs mentioned how recently legal representatives have said “these are the instructions I have been given” and the TPs believed they were “dropping a hint” that they understood that release may not be in the patient’s best interests but they were obliged to represent their client’s wish.<sup>689</sup>

There is some evidence that legal representatives may feel constrained to consider the medical best interests of their clients which may result in a subjugation of legalism. In 2009, judicial review applications were filed by solicitors whose membership of the MHC’s legal representative panel was not renewed. According to an article in the Sunday Times, the MHC conducted interviews with its panel of solicitors and marked them out of 25. Some solicitors whom were considered well-respected experts on mental health were marked poorly for their interpretation of “best interests” and told that they had insufficient knowledge of the law.<sup>690</sup> However, in line with legalism, as a matter of statutory construction the best interests principle in the 2001 Act does not apply to legal representatives as it only applies to those

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<sup>684</sup> TP1, TP5.

<sup>685</sup> TP2, TP7, TP8, TP11.

<sup>686</sup> Department of Health, *Review of the Operation of the Mental Health Act 2001: Findings and Conclusions* (2007); F Jabbar, B Kelly & P Casey, “National survey of psychiatrist’s responses to implementation of the Mental Health Act 2001 in Ireland” (2010) 179(2) *Irish Journal of Psychological Medicine* 291; W Obomanu & H Kennedy, “Juridogenic Harm: Statutory Principles for the New Mental Health Tribunals” (2001) 25 *Psychiatric Bulletin* 331; Gary Lee, “Far from the Madding Crowd” (2008) July *Law Society Gazette* 40.

<sup>687</sup> TP3, TP4.

<sup>688</sup> TP1, TP3, TP5.

<sup>689</sup> TP 2, TP3.

<sup>690</sup> Mark Tighe, “Mental Health Lawyers Dropped” *Sunday Times* (Dublin, 23 August 2009).

involved in “in making a decision under the Act concerning the care or treatment of a person.”<sup>691</sup> Furthermore, the Law Society’s guidance for legal representatives states that it is the patient’s views or wishes that should be presented at the MHT. A legal representative should act in accordance with their instructions and act in their best interests in terms of legal representation.<sup>692</sup>

A lack of acceptance of legalism is highlighted in the belief of several of the TPs that some solicitors took too many High Court actions against detentions.<sup>693</sup> This point was raised several times in the interviews and it was believed that these cases were brought primarily for the financial gain to legal representatives as opposed to the interests of the patient.<sup>694</sup> One TP, whom has had experience of several such cases, explained that they had a significant impact on the patient in that they were told that their TP is in effect abusing their human rights. Where these cases are not successful it is the TP who has to pick up the pieces and the legal representative washes their hands of it.<sup>695</sup> While such motivations behind *habeas corpus* cases may be true, it must not be forgotten that the original wrong has been the failure of the TP to comply with the procedural requirements for a lawful detention. Legalism requires compliance with the law and these cases provide a greater potential for this. Therefore, the result of cases being brought on procedural issues is that now every effort is made to have the paperwork and the procedural aspects of the detention complied with fully and accurately.<sup>696</sup>

### **iii. Independent Psychiatric Evidence**

In line with legalism, the independent psychiatrist should provide an independent examination as to whether the TP’s decision to detain was medically warranted. TPs believed that the purpose of the independent psychiatrist’s exam is to empower the MHT by giving it access to clinically relevant information from an independent source.<sup>697</sup> However, an issue concerning the timing of the independent psychiatrist’s review was highlighted. If this is done early in the 21 days, it may be out of date by the time the MHT receives the report.<sup>698</sup> For

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<sup>691</sup> Darius Whelan, *Mental Health Law and Practice: Civil and Criminal Aspects* (Thomson Round Hall 2009) 241-242.

<sup>692</sup> Law Society of Ireland Mental Health and Capacity Task Force, “Practice Note: Representation at Mental Health Tribunals: Guidelines for Solicitors”, (2008) 102(6) *Law Society of Ireland Gazette* 58.

<sup>693</sup> TP5, TP8, TP9, TP10, TP11; See also Mark Tighe, “Mental Health Lawyers Dropped” *Sunday Times* (Dublin, 23 August 2009).

<sup>694</sup> TP5, TP8, TP9, TP10, TP11.

<sup>695</sup> TP5.

<sup>696</sup> TP1, TP2, TP3, TP4, TP5, TP9.

<sup>697</sup> TP5, TP6, TP7, TP9.

<sup>698</sup> TP10.

some TPs, the independent psychiatrist and the MHT also had an indirect quality control role in that it made them think more deeply about detaining a person as they knew this decision would be reviewed by psychiatric colleagues.<sup>699</sup> Importantly, in terms of independence, where a patient has multiple reviews it will usually always be a different independent psychiatrist examining them.<sup>700</sup> As outlined above, the independent psychiatrist carries out a comprehensive medical exam of the patient. SU2 stated that this exam was very thorough and the independent psychiatrist made sure he verified everything that was in the medical notes by questioning the SU about them.<sup>701</sup> The independent psychiatrist is also required to question the TP and they generally ask about the diagnosis, the treatment plan, current views about the detention and whether it remains relevant.<sup>702</sup>

However, there is the possibility that the independent psychiatrist may be deferential to the TP. There are no statistics available on the frequency with which the independent psychiatrist's opinion differs from TP's; the interviews indicate that it could occur approximately 15% of the time.<sup>703</sup> Significantly, TP6 stated that *"I'm very lucky here in that none of the Independent Psychiatrists have experience of learning disability. So they all agree with everything we say."*<sup>704</sup> Furthermore, TPs welcomed the independent examination as it provided some reassurance about their decision to detain and an opportunity for a collegial discussion about the patient, different approaches, other treatment options and any possible alternatives to detention.<sup>705</sup>

#### **g. Powers of MHT**

The MHT is required to review the substantive basis for detention and whether the procedural requirements have been complied with. However, as stated the provisions of the 2001 Act concerning the MHT's powers to review the legality of detention have actually provided a significant potential for the subjugation of legalism. It is therefore necessary to consider whether this has occurred in practice.

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<sup>699</sup> TP2, TP6, TP11.

<sup>700</sup> TP1, TP3, TP4, TP6, TP7.

<sup>701</sup> SU2.

<sup>702</sup> TP1, TP2, TP3, TP4, TP5, TP6, TP7, TP8.

<sup>703</sup> Out of 469 MHTs, the independent psychiatrist's report differed from the TP's opinion on 30 occasions.

<sup>704</sup> TP6.

<sup>705</sup> TP1, TP2, TP3, TP6, TP8, TP11

### **i. Review of the Decision to Detain**

As seen above the MHT hears evidence about the substantive basis for detention from the TP and this is subject to questioning from all those present. Also the legal representative will always highlight any procedural flaws in the detention. In reality, however, the MHT very rarely revokes a detention order: from the MHC statistics for the last four years less than 10% of detention orders were revoked. The first two years of the 2001 Act's operation saw a slightly higher number of detention orders revoked; 11%. In an analysis of the MHT revocations in 2007, it was seen that in 60% of the cases where the MHT revoked the detention order it was based on the substantive issue of whether the patient had a mental disorder. Only 39% of the revocations were based on a failure to comply with the detention provisions of the 2001 Act.<sup>706</sup> These statistics are somewhat surprising as it may have been assumed, based on the court cases, that the main issues arising at MHTs were procedural ones. Unfortunately, there are no similar statistics for the following years.<sup>707</sup> However, from the interviews TPs estimated that 77% of the revocations were on the basis of an absence of a mental disorder requiring detention.<sup>708</sup> TP2 remarked that he had never seen a MHT even come close to revoking detention on a procedural issue. The absence of any published judgements also means that there is no "case law" to guide MHT decisions which could lead to variations in approach and lack of consistency.<sup>709</sup> TP6 stated that, in general, there was very little consistency in MHT decisions whereby two MHTs can determine almost identical cases completely differently.<sup>710</sup> Such variance has also been found in other jurisdictions.<sup>711</sup>

### **ii. Medical Dominance & Deference to the Treating Psychiatrist**

Despite the composition of the MHT, the process remains heavily influenced by clinicians in the form of the medical member, the independent psychiatrist and the TP.<sup>712</sup> Additionally, the legal criteria for detention are defined in medical and therapeutic terms. The MHTs power to

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<sup>706</sup> Mental Health Commission, *Annual Report 2007* (2008), 42- Table 17.

<sup>707</sup> The Mental Health Commission was contacted on several occasions for further statistics but they failed to respond.

<sup>708</sup> 33 of the 43 revocations were on the basis that the person no longer satisfied the detention criteria in terms of mental diagnosis.

<sup>709</sup> Brendan Kelly, "Human Rights and the Mental Health Act 2001: Part 4" (2012) 1(4) *Psychiatry and the Law* 9, 10.

<sup>710</sup> TP6.

<sup>711</sup> See generally Jill Peay, *Tribunals on Trial: A study of decision making under the Mental Health Act 1983* (Clarendon Press 1989); Elizabeth Perkins, *Decision-Making in Mental Health Review Tribunals* (Policy Studies Institute 2000).

<sup>712</sup> For a discussion of the role of lay persons on tribunals see generally: Valerie P Hans & Neil Vidmar, *Judging the Jury* (Plenum 1986); Neil Vidmar (ed), *World Jury System* (Oxford University Press 2000); Neil Vidmar, 'The Jury Elsewhere in the World' in Neil Vidmar (ed), *World Jury Systems* (Oxford University Press 2000).

ignore procedural flaws in the detention also indicates a hierarchy in terms of the importance of medical and legal issues. Therefore, as highlighted by Rose, it is possible that the legal and lay members will defer to psychiatric expertise in determining whether the patient requires detention or not.<sup>713</sup>

There is a possibility that those involved in the MHT process may be over reliant on the opinion of the TP. There are understandable reasons as to why MHT members may be deferential to the TP. The TP has more knowledge of the patient and their particular case than anybody else involved in the MHT process. MHT members may also be conscious as to the potential realities of risk in revoking a detention order. While these factors can understandably result in deference to the TP, in line with legalism it is important that this is not excessive and is well founded. Compliance with legalism requires the MHT to go behind such assertions and critically assess whether the views formed by the TP are evidence-based and sound. SU1, SU3 and SU4 did not believe the MHT went beyond the assertions of the TP. SU4 thought this was because they did not want to bear that risk and would prefer to have the TP revoke the detention. However, SU4 had two MHTs, one of which revoked the detention order. When asked to explain how this correlated with the claim that the MHT members simply agreed with the TP, he could not. Without observing the MHTs it is difficult to determine the extent to which this happens, however, there is a feeling that, in the words of TP2 *“the MHT does not take my opinion as gospel but they do take it very seriously.”*<sup>714</sup>

In a study conducted in England it was found that discharge from detention was only successful in 13% of cases where the TP opposed it. However, 86% of applications for discharge were successful where the TP supported it. This suggests that tribunals may be “unduly passive”.<sup>715</sup> Another study has shown that tribunals agree with the opinion of the TP in 86% of cases and when they did conflict they usually provided a more cautious response and detention was recommended.<sup>716</sup>

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<sup>713</sup> Nikolas Rose, “Unreasonable Rights: Mental Illness and the Limits of the Law” (1985) 12(2) *Journal of Law and Society* 199, 207.

<sup>714</sup> TP2.

<sup>715</sup> D Mohan, K Murray, P Steed & MA Mullee “Mental health review tribunal decisions in restricted hospital order cases at one medium secure unit 1992–1996” (1998) 8 *Criminal Behaviour and Mental Health* 57.

<sup>716</sup> Jill Peay, “Mental Health Review Tribunals and the Mental Health (Amendment) Act” (1984) *Criminal Law Review* 794.



From the interviews with the TPs, the percentage of MHTs that revoked a detention order of one of their patients was quite low at approximately 9%.<sup>717</sup> This figure corresponds with statistics from the Mental Health Commission that show the percentage of detention orders that have been revoked by MHTs since 2007:<sup>718</sup>

Year	% of Detention Orders Revoked
2007	11.5
2008	11.7
2009	9
2010	8
2011	8.2
2012	7.9
2013	9.1
2014 (up to and including April)	7.9

### iii. *Power to Ignore Detention Irregularities*

The MHC also does not publish data on the frequency with which the MHT cures procedural flaws. From the interviews it appears that they do so in approximately 3.8% of cases.<sup>719</sup> At issue has been the incorrect completion of detention orders with respect to timing, dates, the spelling of names, addresses, dates of birth and the ticking of boxes.<sup>720</sup> In one case the patient was not properly notified of their detention in the prescribed form within the appropriate time limit.<sup>721</sup> When TPs were asked what they thought of the paperwork attached to a detention a minority thought it was excessive and complicated.<sup>722</sup> Others thought that while it could be repetitive and complicated, it was acceptable given the serious nature of detention, and that

<sup>717</sup> This figure is derived from a percentage of the summation of the MHTs that TPs said they had attended (469) and a summation of those that revoked the detention order (43). They are approximate figures provided from memory.

<sup>718</sup> Mental Health Commission, *Mental Health Tribunals; Involuntary Tribunal Statistics*

[http://www.mhcirl.ie/Mental\\_Health\\_Tribunals/Involuntary\\_Admission\\_Activity/](http://www.mhcirl.ie/Mental_Health_Tribunals/Involuntary_Admission_Activity/) accessed 9 June 2014.

<sup>719</sup> This figure is an approximate percentage of MHTs that the TPs attended (469) that used s18 to cure a flaw in detention order (18).

<sup>720</sup> TP1, TP2, TP4, TP5, TP7, TP8, TP9, TP10, TP11.

<sup>721</sup> TP11.

<sup>722</sup> TP1, TP3.

this must be documented.<sup>723</sup> In cases where there is a procedural flaw and the MHT does not feel it can cure it, the MHT will revoke the detention or the case may end up in the High Court.<sup>724</sup> As a result of these Court cases many TPs have refused to detain a person on faulty paperwork received from a GP or the Gardaí, as ultimately it would be they who were held responsible.<sup>725</sup> Thus, a positive aspect of legalism is that as a result of these cases many approved centres have established systems to check the paperwork prior to detention.<sup>726</sup> It was also noted that in many cases that while the TP is responsible for signing off on these detention orders, in many cases it is a GP or the Gardaí who have incorrectly filled them out.<sup>727</sup> There is no comprehensive training for GPs that is organised by the MHC despite the fact that they play a significant role in administering it.

#### **iv. Appeal to Circuit Court**

In 2013 there were 121 Circuit Court appeals, which compares to 116 in 2012. Some of these cases did not proceed as the orders detaining the persons were revoked by the responsible consultant psychiatrist prior to the hearing of the appeal or the person did not wish to proceed for whatever reason. In the 21 cases that did go to hearing, all of the detention orders were affirmed by the Circuit Court. Similarly, in previous years no Circuit Court appeal has been successful. The person detained can only appeal the medical diagnosis of mental disorder, not whether the other detention provisions under the 2001 Act have been complied with. If one wanted to do so they would have to take a judicial review or *habeas corpus* case to the High Court. The burden of proof is also on the person detained to show that they are not suffering from a mental disorder. In many cases, the patient does not have independent evidence that they are not suffering from a mental disorder. Thus, the expert evidence of the consultant psychiatrist responsible for the patient, while subject to cross-examination, is uncontested by an opposing expert.<sup>728</sup> This naturally puts them at a significant disadvantage and could potentially allow for medicalism to dominate.

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<sup>723</sup> TP2, TP4, TP5, TP6, TP7, TP8, TP9, TP10, TP11.

<sup>724</sup> TP3, TP9.

<sup>725</sup> TP1, TP2, TP3, TP4, TP7, TP8, TP9, TP10, TP11.

<sup>726</sup> TP1, TP2, TP3, TP4, TP5, TP7.

<sup>727</sup> TP1, TP2, TP3, TP4, TP7, TP8, TP9, TP10, TP11.

<sup>728</sup> Mental Health Commission, *Annual Report 2013; Including the Report of the Inspector of Mental Health Services* (2014) 11.

## **h. Conclusion**

Legalism requires a review of the medical decision to detain for the purposes of controlling medical discretion and promoting the patient's civil rights. Naturally when no MHT occurs, as happens in 44% of cases, this purpose is negated resulting in a significant subjugation of legalism in the detention process. However, where they do occur, overall it appears that psychiatrists believe the MHT does provide an independent review of the decision to detain. Factors which could affect this, including the MHT's privacy and the psychiatric familiarity in Ireland have been highlighted. From the outset the inclusion of three psychiatrists in the MHT process provides the possibility for the maximisation of medical discretion and circumscription of the legalism in the MHT process. This has not been definitively determined from the interviews. However, it is possible to highlight how the MHT might be deferential to the TP, although it is acknowledged that this deference can be understandable. The MHT revoked less than 8% of detention orders contrary to the wishes of TPs in 2013. Furthermore, from the interview statistics, 15% of independent psychiatrists disagreed with the need to detain patients; however, only 9% of the MHTs revoked the detention order. Unfortunately, such a claim is difficult to substantiate without further information.

Through the legal representative the patient is able to put their side of the case forward and is not put at a disadvantage in the proceedings concerning their detention. However, the TPs' issues with legal representatives acting in an adversarial manner and bringing cases to the High Court concerning procedural issues indicates a lack of acceptance of legalism and a continuing adherence to medicalism. The extent to which this objection impacts on the legal representatives has yet to be determined. It is possible that it could have the effect of weakening the protection of rights and compliance with the law in favour of a medicalist determination of illness and waiving of the law.

Additionally, the MHTs power to cure procedural flaws in the detention and the Courts inconsistent approach to this serves to weaken the impact of legalism by introducing uncertainty and diminishing the foreseeability in the application of the law. From the interviews it appears that the MHT uses this power relatively rarely, approximately 3.8%, yet legalism prescribes that for detention to be lawful there must be complete compliance with the law, which would include procedural requirements. Without further statistics a definitive conclusion as to whether MHTs act in a legalist or medicalist fashion cannot be determined.

## 5.06 Conclusion

From the outset, the MHT was intended to provide a control on the medical decision to detain that was consistent with legalism. Ultimately, however, some of the statutory provisions concerning the MHT in the 2001 Act had the power to undermine legalism and allow medicalism to prevail. In the examination of the operation of the MHT it is clear that this new system of review is still attempting to find its feet. Although in force for over seven years, the MHT review of the clinical decision to detain represents a momentous change from what went before, where TPs were rarely required to answer to anybody. The decision to have a MHT review detention, as opposed to a court, and the failure to define the roles of those involved -the MHT members and the legal representative- has resulted in some consternation. This consternation emanated from the TP interviews, yet it is possible that it might also exist within the legal representative panel also, although this cannot be determined without further research.

What is apparent is that it is difficult, at times, for the MHT to balance the competing aims of medicine and law. The black and white approach of law has a difficult task in trying to control what are often the many shades of grey of psychiatric discretion. TPs understandably do not want to be seen as detainers who restrict the rights of their patients and are hostile towards adversarial questioning from the legal representative that intimates this. However, despite the intentions of the TPs, the unpleasant result of the decision to detain is a restriction of their patients' rights. The legality of their decision must be challenged and different legal representatives will naturally have different approaches in how they represent clients. Thus, while all of the TPs thought the MHTs were a good thing, in reality, their support was often left waning in the face of an adversarial legal representative who challenged their diagnosis of a patient or a High Court case concerning a faulty detention order.

The power of the MHT to cure procedural flaws, the inconsistent approach of the Courts to this issue and the lack of information about the extent to which the MHT uses this power add to the uncertainty and consternation about the MHT process. These issues, in conjunction with the privacy of the MHT and the reliance on a small and exclusive psychiatric profession in Ireland, present significant challenges to legalism. In conclusion, the outright medicalism of the 1945 Act is no longer evident but remnants of it still remain in the 2001 Act provisions on the MHT and in its operation. Importantly, further research is needed on the MHTs to

determine how they operate and whether they are fulfilling the purpose for which they were created.

# CHAPTER 6

## CONCLUSION

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### 6.01 Embedded Medicalism

The law has played a definitive role in the development of the Irish mental health system as a whole. It was through an Act in 1817 that Ireland came to have one of the first public asylum systems in the world and subsequently one of the highest numbers of citizens in mental health detention in the world.<sup>729</sup> The large institutions that were established under the Lunacy (Ireland) Act 1821 during the nineteenth century came to be one of the most enduring sources of social provision in the State, not only for the mentally ill but for an expanded form of social problems. In this manner institutionalised care became integrated in Irish culture and society and the institutions were relied on by society as a whole to manage not only the mentally ill but a plethora of social issues caused by those that were deemed to be socially problematic including the elderly, the intellectually disabled, unmarried mothers and children. Mental health detention in large institutions and subsequently smaller institutions and units in general hospitals has since then remained the government's primary approach to mental illness. This has been reflected in the law which has never provided for the establishment of any comprehensive system of community care. However, the government were not alone in favouring this approach.

From the mid-1800s the psychiatric profession were entrusted with the detention, care and treatment of those in the institutions. Despite psychiatry's subjective role in establishing professional dominance over all issues concerning mental illness, Irish society willingly delegated this role and, in fact, ardently relied on psychiatry to manage the perceived social problem caused by mental illness. It was in this way that the psychiatric profession came to occupy a position of importance and expertise in Irish society and culture also. Therefore, since 1821 the legal powers of civil mental health detention have been solely entrusted to the psychiatric profession. Moreover, society's trust in psychiatry also explains why the legislation concerning mental health detention did not provide for any non-medical review of the decision to detain or continuing detention until 2006. As such, for close to two hundred

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<sup>729</sup> Markus Reuber, 'Moral Management and the Unseen Eye: Public Lunatic Asylums in Ireland, 1800-1845' in Greta Jones & Elizabeth Malcolm, *Medicine, Disease and the State in Ireland, 1650-1940* (Cork University Press 1998) 208.

years medicalism dominated civil mental health detention in Ireland and became embedded in Irish society and culture.

## **6.02 Challenges to Legalism**

The 2001 Act really came quite late in the day when compared to similar legislative provisions on the continent and again is demonstrative of the strength of medicalism.<sup>730</sup> By 2001 there was a wealth of information and research that contested and criticised the role of psychiatry in the detention of the mentally ill. Furthermore, there was well established international human rights law from the ECtHR that required Ireland to provide greater protections for the human rights of those in detention. Ultimately, it was the threat of being found in violation of the ECHR that finally forced the government to introduce legislation that would give effect to legalism. The resulting 2001 Act was definitely a move towards legalism, as seen in the various provisions that have been outlined throughout Chapters 4 and 5 of the thesis. However, there was also a recognition on the part of the government that this transformative approach to the legal powers of detention was not something that could be achieved instantaneously. Specifically, for over 50 years the judicial interpretation of the 1945 Act was avowedly medicalist, despite the developments that had occurred in terms of the anti-psychiatry movements and the ECtHR jurisprudence on mental health detention. Thus, the government included in the 2001 Act a requirement that the Minister for Health review its operation within five years of its establishment.<sup>731</sup>

While the provisions in the 2001 Act therefore represented a substantial transition towards legalism, consistent with Unsworth's analysis that legalism has become a mode of medical power, many of the safeguards introduced in the 2001 Act are medical in nature.<sup>732</sup> Medical discretion in the detention of patients is restricted, but it is restricted through the use of second or multiple medical opinions. Similarly, the mental health tribunal is dominated by psychiatrists. These new restrictions ensured that decisions would continue to be made in the medical best interests of the detained. Significantly, the 2001 Act specifically provided that best interests are to be guiding principle in detention decisions.<sup>733</sup>

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<sup>730</sup> In the wake of ECtHR cases concerning mental health detention new mental health legislation was enacted that gave effect to the rights of those in detention in the following countries with the corresponding date of enactment: Switzerland (1980); Scotland (1984); Northern Ireland (1986); the Former USSR (1988); Denmark (1989); Belgium (1990); and France (1990).

<sup>731</sup> Mental Health Act 2001, s 75.

<sup>732</sup> Clive Unsworth, *The Politics of Mental Health Legislation* (Clarendon Press 1987) 11-12.

<sup>733</sup> Mental Health Act 2001, s4.

When the 2001 Act was reviewed in 2007 there were problems with several of its provisions, in particular, the best interests principle, which the Minister said was a ‘difficult concept to define’.<sup>734</sup> Five years later when the 2001 Act was reviewed, again the same issues persisted, and instead of a maturation of legalism, medicalism has prevailed.<sup>735</sup> The 2012 Report has attributed this to the Irish Courts interpretation of the term best interests and claimed that this is frustrating the aim of the 2001 Act which was intended to protect the human rights of those detained.<sup>736</sup> This is no doubt a contributing factor, however, the specific safeguards established in the 2001 Act which are dominated by the medical profession have ensured that medicalism remains embedded in the Irish mental health system.

### **6.03 The Need for Further Research**

Significantly, while the judicial attitude towards the powers of detention can be ascertained, further research is required to establish the extent to which the MHTs operate in accordance with legalism. A significant obstacle in ensuring the MHTs do act in line with legalism and provide protections for the rights of those detained, is that there is very little transparency in the process. There has been no real attempt to establish the inner-workings of the MHTs or determine whether they are fulfilling their purpose. In what could be history repeating itself, a system that appears to comply with the legal requirements of the ECHR has been established, Irish society has presumed it is working and subsequently has relinquished its responsibility in the protection of the rights of those in detention. Thus, there is a serious need for an on-going and proper review of the MHTs operation as, despite the establishment of the MHT, there remains scant knowledge about how the review of detention is working and whether it provides an independent and impartial review of the decision to detain as required under the ECHR and in line with legalism.

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<sup>734</sup> Department of Health and Children, *Review of the Operation of the Mental Health Act 2001; Findings and Conclusions* (2007) 8.

<sup>735</sup> Department of Health and Children, *Interim Report of the Steering Group on the Review of the Mental Health Act 2001* (2012) 9-11.

<sup>736</sup> Department of Health and Children, *Interim Report of the Steering Group on the Review of the Mental Health Act 2001* (2012) 9-11.



## 6.04 Future Possibilities

### a. Legislative Amendment

Moving forward, the 2012 Report recommended that many of the issues which have resulted in a rejection of legalism could be resolved by legislative amendment to establish a hierarchy of rights and a clarification or removal of the best interests provision.<sup>737</sup> Added to these legislative amendments could be the requirement for greater transparency in the MHT process through a systematic review of their operation and perhaps the publication of anonymised written decisions to guide tribunals in decision making.

However, as outlined above it is questionable as to whether such amendments would have the desired effect, particularly, in altering judicial attitude toward the legal powers of detention and therefore their interpretation of mental health legislation. Nevertheless, it is a necessary start. Furthermore, it must be borne in mind that the 2001 Act has only been in force for seven years; the 1945 Act was in operation for over fifty years. Therefore, change in judicial attitude towards the legal powers of detention may take some time.

### b. The United Nations Convention on the Rights of Persons with Disabilities

A possible driving force for such societal and cultural change may be assisted by the UN Convention on the Rights of Persons with Disabilities (CRPD), which requires ratifying states to rethink their mental health laws and their legal powers of detention. The CRPD has been hailed as revolutionising the rights of persons with disabilities, including persons with psycho-social disabilities.<sup>738</sup> The CRPD seeks to change society's conceptualisation of disability and states that disability is actually caused by the society and structures we live in,

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<sup>737</sup> Department of Health and Children, *Interim Report of the Steering Group on the Review of the Mental Health Act 2001*(2012) 9-11.

<sup>738</sup> See generally: Rosemary Kayess & Philip French, "Out of the darkness into the light? Introducing the Convention on the Rights of Persons with Disabilities" (2008) 8(1) *Human Rights Law Review* 1; Frédéric Mégret, "The disabilities convention; Human rights of persons with disabilities or disability rights?" (2008) 30(2) *Human Rights Quarterly* 494; Aart Hendricks, "UN Convention on the Rights of Persons with Disabilities" (2007) 14 *European Journal of Health Law* 273; Arlene S Kanter, "Promise and Challenge of the United Nations Convention on the Rights of Persons with Disabilities" (2006) 34(2) *Syracuse Journal of International Law and Commerce* 287; Tina Minkowitz, "United Nations Convention on the Rights of Persons with Disabilities and the Right to be Free from Non Consensual Psychiatric Interventions" (2006) 34(2) *Syracuse Journal of International Law and Commerce* 405; Anna Lawson, "United Nations Convention on the Rights of Persons with Disabilities: New Era or false Dawn" (2006) 34(2) *Syracuse Journal of International Law and Commerce* 563; Peter Bartlett, "The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law" (2012) 75(5) *Modern Law Review* 769; Phil Fennell & Urfan Khaliq, "Conflicting or complementary obligations? The UN Disability Rights Convention, the European Convention on Human Rights and English law" (2011) 6 *European Human Rights Law Review* 662; Eilionoir Flynn, *From Rhetoric to Action; Implementing the UN Convention on the Rights of Persons with Disabilities* (Cambridge University Press 2011).

not by a particular impairment. Thus, people with disabilities should no longer be considered objects of charity, social protection or medical treatment but as subjects of human rights and active members of society. From the case law on mental health detention, it is obvious that the Irish judiciary do not subscribe to this interpretation of mental illness and continue to see the purpose of mental health law as a means of ensuring the mentally ill are cared for and provided with medical treatment. Ireland was among the first group of countries to sign the CRPD but it has not yet ratified it. The delay has been attributed to the need to introduce capacity legislation which would establish a legal paradigm to assist and support people who have difficulties in exercising their decision-making ability. The Assisted Decision-Making (Capacity) Bill was published in July 2013, but has yet to be put on the statute books. The government has stated that this is the final barrier to ratification of the CRPD.<sup>739</sup>

Ratification of the CRPD will not see an overnight change in Irish society or the judiciary's approach to mental health detention; however, it may assist in influencing a move away from the embedded medicalism and towards legalism. Furthermore, unlike before, where there was no collective alliance advocating reform, the formation of the Centre for Disability Law and Policy in NUI Galway under the Directorship of Professor Gerard Quinn is producing important research that is contributing to the implementation of the CRPD and reform of disability law on an international and Irish scale.

There are indications that this may be already having some effect in Ireland. In 2013 a novel argument regarding the direct effect of the CRPD under EU law was made in a case challenging the constitutionality of the provisions which provided for the treatment without consent of a patient under the 2001 Act.<sup>740</sup> The applicant claimed that her treatment without consent failed to have regard to her equal rights before the law as a citizen. She also claimed that she was entitled to have the decision that she lacked capacity to refuse treatment subject to an independent review by a tribunal or court.

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<sup>739</sup> Department of Justice and Equality, *Speech by Minister for Justice, Equality & Defence at the Assisted Decision – Making (Capacity) Bill 2013: Consultation Symposium* (25 September 2013) <http://www.justice.ie/en/JELR/Pages/SP13000341> accessed 2 July 2014. See also Eilionoir Flynn, *Assisted Decision Making (Capacity Bill) Finally Published* (17 July 2013) <http://humanrights.ie/mental-health-law-and-disability-law/assisted-decision-making-capacity-bill-2013-finally-published/> accessed 2 July 2014; Darius Whelan, *Ireland's Assisted Decision-Making (Capacity) Bill 2013* (1 August 2013) <http://irishlawblog.blogspot.ie/2013/08/irelands-capacity-bill-2013.html> accessed 2 July 2014.

<sup>740</sup> *MX v HSE* [2013] IEHC 491 para 60. Mental Health Act, s 57 was challenged which provides for the non-consensual treatment of an involuntary patient. Such treatment requires a determination by a consultant psychiatrist that the patient lacks capacity to consent to the treatment and that the treatment is clinically necessary.

The High Court did not find that the applicant's rights under the Constitution had been breached; however, it made important observations regarding the constitutional rights of persons in mental health detention and also about the applicability of the CRPD in Irish law. The Court held that the CRPD did not have direct effect in Ireland at this time, but that this did not mean it was immaterial. MacMenamin J opined that the CRPD is a guiding principle in the identification of standards of care and review of persons in mental health detention and that the judiciary must inform their thought and interpret the Constitution using prevailing ideas and concepts.<sup>741</sup> Although the Court did not find the current absence of legislative provision for assisted decision making unconstitutional it did state that persons subjected to treatment under the 2001 Act must have access to the court concerning issues regarding decision making and be included in the decision making process.<sup>742</sup> This decision represents a significant movement towards legalism whereby the High Court actually established further safeguards for the rights of those detained under the 2001 Act, that have not yet been provided for in legislation. Therefore, at this point it must be concluded that both medicalism and legalism are evident in the law concerning the legal powers of detention, its interpretation and its operation but going forward it is likely there will be an increased acceptance of legalism.

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<sup>741</sup> *MX v HSE* [2013] IEHC 491 at para 60.

<sup>742</sup> *MX v HSE* [2013] IEHC 491 at para 75 & 82.



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## APPENDICES

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## APPENDIX A

### LETTER FROM MHC

#### APPENDIX A

#### MENTAL HEALTH COMMISSION

#### CORRESPONDENCE



Ms. Jennifer Brown  
PhD Candidate  
School of Law and Government  
Dublin City University  
Dublin 9

26<sup>th</sup> September 2013

Dear Ms. Brown,

Thank you for your letter of the 16<sup>th</sup> inst.

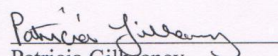
As you know, section 49 (10) of the Mental Health Act, 2001 provides that mental health tribunals shall be held in private. Furthermore, all information and documentation connected to the involuntary admission of a patient and the subsequent review of that detention at a tribunal is completely confidential and highly sensitive. The Mental Health Commission is under a duty to maintain such confidentiality.

The practical reality of your proposal is that the Commission would be obliged to conduct a large amount of work on your behalf as well as overseeing all of your research in order to ensure that such confidentiality was in fact maintained. Unfortunately, the Commission simply does not have sufficient resources at its disposal to provide such oversight at this time. This is notwithstanding the benefits which might accrue as a result of this kind of research.

As regards any research looking at service user perception of decision making in mental health tribunals you are free to contact approved centres directly if you so wish. However, the Commission is not in a position to assist or endorse such direct contact for the reasons set out above.

I trust this is in order and I wish you all the best with your studies.

Yours sincerely,

  
Patricia Gilheaney  
Chief Executive

## APPENDIX B

### ETHICAL APPROVAL

#### APPENDIX B

#### ETHICAL APPROVAL

Ollscoil Chathair Bhaile Átha Cliath  
Dublin City University



Ms. Jennifer Brown  
School of Law and Government

10<sup>th</sup> January 2014

**REC Reference:** DCUREC/2013/203

**Proposal Title:** **An analysis of the extent to which mental health tribunals protect the rights of persons detained under the Mental Health Act 2001**

**Applicants:** Ms. Jennifer Brown, Dr Adam McAuley

Dear Jennifer,

Further to review, the DCU Research Ethics Committee approves this research proposal. Materials used to recruit participants should note that ethical approval for this project has been obtained from the Dublin City University Research Ethics Committee. Should substantial modifications to the research protocol be required at a later stage, a further submission should be made to the REC.

Yours sincerely,

A handwritten signature in dark ink, reading 'Donal O'Mathuna'.

Dr. Donal O'Mathuna  
Chairperson  
DCU Research Ethics Committee



**Taighde & Nuálaíocht Tacaíocht**  
Ollscoil Chathair Bhaile Átha Cliath,  
Baile Átha Cliath, Éire

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**APPENDIX C**  
**CONCISE RESEARCH PROPOSAL**  
**SUBMITTED FOR ETHICAL APPROVAL**  
**8 NOVEMBER 2013**

**PROJECT TITLE:** An analysis of the extent to which mental health tribunals protect the rights of persons detained under the Mental Health Act 2001.

**PRINCIPLE INVESTIGATOR(S):** Jennifer Brown (PhD Student) & Dr Adam McAuley (PhD Supervisor)

**START DATE:** January 2014

**PROJECT OUTLINE:**

**Introduction**

The Mental Health Act 2001 significantly changed the process of mental health detention and sought to introduce safeguards for service users detained thereunder. The most radical change in the law was the introduction of mental health tribunals (MHTs) which are composed of a legal, lay and medical member. The purpose of the MHT is to provide an independent review of the decision to detain a person under the 2001 Act. In deciding to approve or revoke a detention order the MHT will rely on an independent psychiatric report of the service user, evidence from the treating psychiatrist and submissions from the appointed legal representative and the service user themselves. The MHTs have been in operation since 2006 with approximately 1,700 held each year.

The aim of the research is to examine the MHT process and hearing to determine how it affects the detention of the mentally ill. The MHT process was intended to provide safeguards for service users to protect them from unlawful detention. In furtherance of this purpose, the members of the MHT are supposed to provide an independent assessment of the service user's need for detention based on whether they believe the service user has a mental disorder and whether the legal requirements for lawful detention have been complied with. The project aims to assess the influences on the legal, medical and lay members and their



subsequent input on the conduct and decision making of the MHT. The independent psychiatrist and the legal representative are intended to provide safeguards for the service user and they also have the potential to influence MHT members. The research aims to determine the extent to which this happens.

Information on individual cases is not the object of the research, rather, general opinions on the whole MHT process and hearing is the purpose. The results will be used for the purposes of a PhD and possibly future academic articles on the topic. Participants will be informed as to the findings and results if they so wish.

## **Methodology**

Following consultation with the Mental Health Commission it is not possible to observe MHTs or interview MHT members due to the fact that the Mental Health Act 2001 requires MHTs to be held in private.

Therefore the research proposes to interview 30 treating psychiatrists who have experience of and have attended a MHT in the Dublin region. Treating psychiatrist that the researcher knows have experience of MHTs will be contacted personally. Snowballing sampling will subsequently be used to identify other consultant psychiatrists who fit the selection criteria and they will subsequently be contacted personally. Semi-structured interviews lasting approximately 40 minutes will be used to establish general opinions on the purpose and process of the MHT, the role of the various members and participants, the influence of evidence and the decision making therein.

It is also proposed to interview 30 service users over the age of 18 who are no longer in inpatient care and have previously had a detention order reviewed by a MHT under the Mental Health Act 2001. Mr Paddy McGowan, Head of Service User, Family Member and Carer Engagement on the HSE National Mental Health Management Team, has been contacted and agreed that once Ethical Approval has been obtained he will inform service users about the research at the series of nationwide mental health public meetings to be held by the HSE in 2014. A recruitment advertisement will be disseminated to voluntary mental health organisations operating in Ireland who will also be contacted personally and asked to inform their members of the research being conducted. Additionally, with the permission of mental health organisations, the researcher will present the research to the organisation's members in an attempt to meet possible participants face to face and perhaps relay some of

their fears concerning participation in the research. The interview should take approximately 40 minutes to conduct. All information concerning participants and information provided during the interview will be anonymised and kept completely confidential prior to its being disposed of.

### **Participants and Consent**

MHTs are held in private and deal with serious and sensitive issues. Discussion about the MHT has the potential to cause upset or distress for service users.

Informed consent will be sought from the service user first before the interview is carried out. They will be informed of the purpose of the interview, its benefits, their anonymity and how it will have no affect on their current status. Service users will be contacted initially by organisations with whom they are aware of and feel comfortable with. It is only after they have contacted me or agreed to take part in the study that I will obtain their informed consent.

Participants will be asked to bring a friend or family member (with whom they feel comfortable discussing the topics included in the interview questions) to the interview, unless to do so would make them feel uncomfortable. If at any point during the interview it becomes clear that the service user is upset, the interview will be terminated immediately. The service user will be directed to contact one of the mental health or counselling services in their region that I will provide a list of.

### **ANONYMITY OF THE PARTICIPANTS**

All information concerning participants involved in the interviews will be made anonymous and kept completely confidential. Any documentation relating to the research will be kept in a locked and secure unit in Dublin City University.

No names or identifying information will be used in the research or shared with any person or organisation. All participants involved in the interviews will be given false names when using information in relation to them. As soon as the interviews have been transcribed, with all identifying information anonymised, the original audio tapes and any documentation with identifying information will be disposed of.

## **AIMS OF AND JUSTIFICATION FOR THE RESEARCH**

Similar research has been commissioned by the Department of Health in the UK and used to inform reforms of the MHT process. No research has been conducted to date on the functioning of Irish MHTs, as such this research is now required for several reasons. In addition, it will have benefits for a range of actors including service users and legal representatives, the Mental Health Commission and MHT members and participants.

MHTs were introduced under the 2001 Act to reform the previous paternalistic legislation and ensure the rights of persons with psycho-social disabilities were protected. It is necessary to determine their impact and whether the aims behind the reforms have been achieved.

The Mental Health Commission is tasked with the promotion of high standards in the delivery of mental health services and ensuring the interests of those involuntarily detained. In pursuit of these standards the Commission has committed to utilise evidence based research. This research can assist the Commission in ascertaining how the MHT process operates, the conduct of MHT hearings and the factors that influence its decision making. This is necessary to ensure that the rights of the detained are protected and that the MHTs are conducted in a manner that promotes the highest standards possible. For example, this research could be essential in providing factual evidence of the role of the independent psychiatrist in the MHT process, a position that was questioned in the Interim Report of the Steering Group on the Review of the Mental Health Act 2001.

The advantages in gaining a clearer understanding of the real functioning of MHTs for service users, their legal representatives and others involved are obvious and essential. It is also important that MHT members are informed about the practices of their colleagues. Any individual member will have only limited knowledge as to how other MHT members or MHTs work as a whole. A shared understanding of how MHTs operate can provide the basis for the development of best practice and consistency in decision making.

Several decisions have been handed down by the High and Supreme Court which impact upon the operation of the MHT. These include decisions concerning the powers of MHTs. It is important to determine the impact, if any, of these decisions on the operation of MHTs.



## APPENDIX D

### ORGANISATIONS/PERSONS CONTACTED TO RECRUIT INTERVIEWEES

#### SERVICE USERS

ORGANISATION	DATE CONTACTED	FOLLOW UP CONTACT	OUTCOME
HSE National Mental Health Management Team	15/01/2014		Informed persons attending the nationwide meetings on mental health services organised by the HSE of the research.
National Service Users Executive	15/01/2014		Advertised research to members and on their website
Mental Health Reform	15/01/2014		Advertised research to members and on their website
Shine Online	15/01/2014		Advertised research to members and on their website.  Also presented research at members meeting on 9/04/14.
Mental Health Ireland	15/01/2014		Advertised research to members and on their website.
St Patrick's Consumer Council	15/01/2014		Members were informed of research by Ms Mary O'Hara at a members meeting.
HSE EVE	15/01/2014	30/01/2014 16/04/2014	Not in a position to advertise research.
Amnesty International	15/01/2014	30/01/2014	Not in a position to advertise research.

Inspire/Reachout	15/01/2014	30/01/2014 16/04/2014	No response.
Pieta House	15/01/2014		Not in a position to advertise research.
Aware	15/01/2014	30/01/2014 16/04/2014	No response.
Grow	15/01/2014	30/01/2014 16/04/2014	No response.
Refocus CPSYCHI	25/04/2014		Members were informed of research by Ms Sibéal Farrell at a members meeting.

## TREATING PSYCHIATRISTS

ORGANISATION/ PERSON	DATE CONTACTED	FOLLOW UP	OUTCOME
20 treating psychiatrists were contacted personally	Between 28/01/2014 and 09/06/2014	Of the treating psychiatrists who did not respond to the initial contact they were contacted on a further two occasions between 28/01/2014 and 09/06/2014.	11 interviews secured. 3 agreed to interview but failed to arrange interview after multiple attempts at organising this. 5 did not respond for interview. 1 did not meet the research criteria.
College of Psychiatrists Ireland	15/01/2014		Not in a position to advertise research.
Medico-Legal Society	15/01/2014		Not in a position to advertise research.
RCSI Department of Psychiatry	15/01/2014		Not in a position to advertise research.

## **APPENDIX E**

### **RECRUITMENT ADVERTISEMENT**

#### **HAVE YOU ATTENDED A MENTAL HEALTH TRIBUNAL?**

#### **WOULD YOU BE WILLING TO TALK ABOUT YOUR EXPERIENCES?**

Jennifer Brown from DCU is doing research on mental health tribunals and is looking for volunteers to talk about their experiences.

The aim of the research is to explore service users experience and opinions of mental health tribunals. Jennifer is seeking to interview volunteers who are over the age of 18, are no longer in inpatient care and have previously had a detention order reviewed by a mental health tribunal under the Mental Health Act 2001.

The interview will involve questions about the MHT process, its purpose, those involved, what is discussed and its general positives or negatives. The interview should take approximately 40 minutes to complete. All information concerning participants and information provided during the interview will be anonymised and kept completely confidential.

**For more information or to participate in the interview  
please contact Jennifer at:**

**Tel:** 087 3343 848

**Email:** mhtstudy@gmail.com

**Post:** Jennifer Brown, School of Law and Government, DCU,  
Glasnevin, Dublin 9.

**This research has obtained ethical approval from DCU Research Ethics Committee.**

**APPENDIX F**  
**PLAIN LANGUAGE STATEMENT**  
**SERVICE USERS**

**Researcher:**

*Jennifer Brown,*

*School of Law and Government*

*Dublin City University*

*Contact Details: [mhtstudy@gmail.com](mailto:mhtstudy@gmail.com) / 0873343848*

**Title:**

The Legal Powers to Detain the Mentally Ill in Ireland: Medicalism or Legalism?

**What is the research about?**

The aim of the research is to examine the MHT process and hearing to determine how it affects the detention of persons with mental illness. The purpose is to determine the extent to which the legal, lay and medical members provide an independent review of the need to detain the service user. The research will look at what influences the MHT members, including the independent psychiatrist and the legal representative. It will also assess the degree to which the independent psychiatrist and the legal representative protect the rights of the person detained.

**Why is this research being conducted?**

The research is being used as part of my PhD in Dublin City University.

**Independence of the Researcher**

I do not have any relationship with any of those involved in the mental health tribunal hearings, the Mental Health Commission, voluntary mental health organisations or the hospital in which you were resident. As a researcher I have no influence on your particular case. Therefore participating in the research study will do you no good or no harm. It will have no effect on your situation.

Voluntary mental health organisations have been contacted solely for the purpose of advertising the research I am conducting. They have no influence on or connection with the research.

**Who is funding the research?**

The research is being funded by the School of Law and Government, Dublin City University.

**How will the information gathered be used and subsequently disposed of?**

The information will be used in my PhD and possibly future academic articles about the topic.

As soon as the interviews have been transcribed, with all identifying information anonymised, the original audio tapes and any documentation with identifying information will be disposed of.

**What will happen if you decide to participate in the research study?**

Being included in the research study will require you to sign a form saying that you understand the purpose of the research, the independence of the researcher and you agree to answer honestly the questions that you are asked to the best of your ability.

You will then be asked approximately 30 questions about the mental health tribunal process and hearing by the researcher. The interview should take about 40 minutes to complete.

**How will your privacy be protected?**

All information concerning you and others involved in the mental health tribunal process will be made anonymous and kept completely confidential. Any documentation relating to the research will be kept in a locked and secure unit in Dublin City University that only the researcher will have access to.

No names or identifying information will be used in the research or shared with any person or organisation. You and all others mentioned in the interviews will be given false names when using information in relation to mental health tribunals which you participated in.

**What are the legal limitations to data confidentiality?**

In a similar manner to the doctor-patient relationship in very limited circumstances, disclosure of your information may be required by law. For example this could happen when

ordered by a judge in a court. If this were to happen you would be informed of the disclosure and the reasons for it.

**What are the benefits of taking part in the research study?**

There may be some future indirect benefits to participants.

The research will provide information on the conduct and operation of mental health tribunals in general which may improve the operation of mental health tribunals and have an impact on the development of best practices and encourage consistency in their operation. In addition, this information could be used to help service users to understand what to expect from the mental health tribunal hearing. This information may also assist legal representatives in the preparation of service user's cases.

**What are the risks of taking part in this research study?**

Taking part in the study will require you to recall events that occurred during your mental health tribunal process and hearing. Recalling such events may cause you some distress or upset.

**Can participants change their mind at any stage and withdraw from the study?**

Yes, you may withdraw from the research study at any point.

**How will participants find out what happens with the project?**

At the time of the interview you will be asked whether you want to find out the results of the research study. When the study is completed you will be contacted and informed of the results if you have agreed to this.

**Contact details for further information:**

Jennifer Brown; [mhtstudy@gmail.com](mailto:mhtstudy@gmail.com)/ 087 3343 848

If participants have concerns about this study and wish to contact an independent person, please contact:

The Secretary, Dublin City University Research Ethics Committee, c/o Research and Innovation Support, Dublin City University, Dublin 9. Tel 01-7008000

**APPENDIX G**  
**INFORMED CONSENT FORM**  
**SERVICE USER**

**Researcher:**

*Jennifer Brown,*  
*School of Law and Government*  
*Dublin City University*  
*Contact Details: [mhtstudy@gmail.com](mailto:mhtstudy@gmail.com) / 087 3343848*

**Title and Purpose:**

The Legal Powers to Detain the Mentally Ill in Ireland: Medicalism or Legalism?

The aim of the research is to examine the MHT process and hearing to determine how it affects the detention of the mentally ill. The purpose is to determine the extent to which the legal, lay and medical members provide an independent review of the need to detain the service user. The research will look at what influences the MHT members, including the independent psychiatrist and the legal representative. It will also assess the degree to which the independent psychiatrist and the legal representative protect the rights of the person detained.

**Privacy and Confidentiality**

All information concerning you and others involved in the MHT hearings will be made anonymous and kept completely confidential. Any documentation relating to the research will be kept in a locked and secure unit in Dublin City University that only the researcher will have access to.

No names or identifying information will be used in the research or shared with any person or organisation. You and all others mentioned in the interviews will be given false names when using information in relation to MHTs which you participated in.

## **Independence**

The research is to be used as part of my PhD. I do not have any relationship with any of those involved in the mental health tribunal hearings, the Mental Health Commission or any other organisation involved in the provision of mental health services.

As a researcher I have no influence on your situation. Therefore participating in the research study will neither do you good nor harm. It will have no effect on your position.

### **Participant – please complete the following (Circle Yes or No for each question)**

<i>I have read the Plain Language Statement (or had it read to me)</i>	<i>Yes/No</i>
<i>I understand the information provided</i>	<i>Yes/No</i>
<i>I understand that this research study will have no impact on my situation</i>	<i>Yes/No</i>
<i>I have had an opportunity to ask questions and discuss this study</i>	<i>Yes/No</i>
<i>I have received satisfactory answers to all my questions</i>	<i>Yes/No</i>
<i>I am aware that all information about me will be kept confidential and anonymous</i>	<i>Yes/No</i>
<i>I am aware that I may withdraw from the research study at any point</i>	<i>Yes/No</i>

**Signature:** I have read and understood the information in this form. My questions and concerns have been answered by the researchers, and I have a copy of this consent form. Therefore, I consent to take part in this research project

Participants Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**APPENDIX H**  
**INTERVIEW TOPIC GUIDE**  
**SERVICE USERS**

**Identifier**

**Date**

**Time**

- 1. Basic information:**
  - a. Gender
  - b. Can you estimate the number of MHT hearings you have attended in?

**PURPOSE OF MHT**

- 2. In your opinion what is the purpose of the MHT process and hearing?**
  - a. Has any person ever explained the purpose of the MHT?
    - i. Who explained the purpose of the MHT?
  - b. What powers does the MHT have?

**PRE HEARING PROCESS**

**INDEPENDENT PSYCHIATRIST**

- 3. Who informs you that you will be examined by an independent psychiatrist?**
- 4. What is the purpose of the independent psychiatrist's examination?**
- 5. Has anybody explained the purpose to you?**
  - a. Who?
- 6. What is the difference between the independent psychiatrist and the treating psychiatrist?**
- 7. What does the examination by the independent psychiatrist entail?**
- 8. Would you normally see the report compiled by the independent psychiatrist?**
  - a. Did you understand what it said?
  - b. What does it say?

**LEGAL REPRESENTATIVE**

9. **Have you had the same legal representative for each MHT?**
10. **Approximately how many times would you usually meet your legal representative?**
  - a. Before your hearing
  - b. After your hearing
11. **In the meetings prior to the hearing what is discussed?**
12. **Are you shown any documents prior to the MHT by your legal representative?**
  - a. Medical reports
  - b. Independent psychiatrist's report
  - c. Admission/renewal orders
  - d. Other
13. **Can you answer the following questions about your legal representative?**
  - a. Did they explain the MHT process and hearing to you?
  - b. Did you understand what they explained to you?
  - c. Did they keep you informed of developments in the MHT process and hearing?
  - d. Did they represent your interests?
  - e. Did they take instructions from you?

### **MHT HEARING**

#### **PARTICIPANTS & ROLES**

14. **Can you list the people who usually participate in the MHT hearing?**
15. **Can you explain the role of each participant you identified?**
  - a. If not mentioned ask about the following participants:
    - i. Chairperson of MHT
    - ii. Medical member of MHT
    - iii. Lay member of MHT
    - iv. Treating psychiatrist
    - v. Independent psychiatrist
    - vi. Legal representative
    - vii. You
    - viii. Other
16. **Have the roles of each participant been explained to you?**
  - a. Who explained the role of each participant to you?

#### **MHT ORDER OF BUSINESS & EVIDENCE**

17. **Could you explain the process at the MHT hearing?**
  - a. Does the MHT Chairman introduce people? How are they introduced- first names and surnames or by titles?
  - b. Does the legal representative make initial submissions?
18. **Does the treating psychiatrist provide any information at the MHT hearing?**
  - a. What information does he/she provide?
    - i. Do you understand what information he/she provides?
  - b. Does this generally agree or disagree with what the independent psychiatrist has said in their report?
  - c. How do you feel about what the treating psychiatrist says in the MHT?
    - i. Do you discuss this prior to or after the MHT?
  - d. Does the MHT medical member question the treating psychiatrist?
    - i. What do they ask?
  - e. Does the MHT Chairman question the treating psychiatrist?
    - i. What do they ask?
  - f. Does the MHT lay member question the treating psychiatrist?
    - i. What do they ask?
  - g. Does your legal representative question the treating psychiatrist?
    - i. What do they ask?
19. **Legal evidence**
  - a. Does your legal representative present your case?
    - i. What do they say generally?
20. **Do you understand the circumstances which can affect the validity of your detention under the Mental Health Act 2001?**
  - a. Diagnosis of mental disorder
  - b. Persons who may apply for detention
  - c. Medical examinations
  - d. Time limits (for exams and duration of detention orders)
  - e. Gardai powers of detention
  - f. Provision of information to service user
21. **Is the validity of your detention (as outlined above) ever raised in the MHT?**
  - a. What issue is raised?
  - b. Who highlights the issue?
  - c. Was there any discussion about it?
    - i. Who discussed this?
    - ii. What happened?
22. **Are you questioned during the MHT hearing?**

- a. By whom?
  - b. What are you asked?
- 23. Do you feel you can participate to the best of your ability in the MHT hearing?
  - a. If no, why?
- 24. Does any other participant speak during the MHT hearing?
- 25. How long are the hearings usually?
  - a. When do you find out the decision of the MHT?

#### **MHT DECISION**

- 26. Have you ever had a MHT decision that upholds the order detaining you?
  - a. Are you informed of the reasons for its decision?
  - b. What were the reasons for its decision?
- 27. Have you ever had a MHT hearing where it has not upheld the detention order?
  - a. Are you informed of the reasons for its decision?
  - b. What were the reasons for its decision?

#### **MHT & SERVICE USER FEELINGS**

- 28. How does the MHT process and hearing make you feel?
- 29. Do you think the MHT process and hearing protects your rights?
  - a. If yes, why?
  - b. If no, why?
- 30. Do you think the MHT process and hearing fulfils its purpose?
- 31. If you were to change the MHT process, how would you do so?

**APPENDIX I**  
**INFORMED CONSENT FORM**  
**TREATING PSYCHIATRIST**

**Researcher:**

*Jennifer Brown,*

*School of Law and Government*

*Dublin City University*

*Contact Details: [mhtstudy@gmail.com](mailto:mhtstudy@gmail.com) / 087 3343848*

**Title and Purpose:**

The Legal Powers to Detain the Mentally Ill in Ireland: Medicalism or Legalism?

The aim of the research is to examine the MHT process and hearing to determine how it affects the detention of the mentally ill. The purpose is to determine the extent to which the legal, lay and medical members provide an independent review of the need to detain the service user. The research will look at what influences the MHT members, including the independent psychiatrist and the legal representative. It will also assess the degree to which the independent psychiatrist and the legal representative protect the rights of the person detained.

**Privacy and Confidentiality**

All information concerning you and others involved in the MHT hearings will be made anonymous and kept completely confidential. Any documentation relating to the research will be kept in a locked and secure unit in Dublin City University that only the researcher will have access to.

No names or identifying information will be used in the research or shared with any person or organisation. You and all others mentioned in the interviews will be given false names when using information in relation to MHTs which you participated in.

## **Independence**

The research is to be used as part of my PhD. I do not have any relationship with any of those involved in the mental health tribunal hearings, the Mental Health Commission or any other organisation involved in the provision of mental health services.

As a researcher I have no influence on your performance or your employment. Therefore participating in the research study will neither do you good nor harm. It will have no effect on your position.

## **Treating Psychiatrists– please complete the following (Circle Yes or No for each question)**

<i>I have read the Plain Language Statement (or had it read to me)</i>	<i>Yes/No</i>
<i>I understand the information provided</i>	<i>Yes/No</i>
<i>I understand that this research study will have no impact on my position or employment</i>	<i>Yes/No</i>
<i>I have had an opportunity to ask questions and discuss this study</i>	<i>Yes/No</i>
<i>I have received satisfactory answers to all my questions</i>	<i>Yes/No</i>
<i>I am aware that all information about me will be kept confidential and anonymous</i>	<i>Yes/No</i>
<i>I am aware that I may withdraw from the research study at any point</i>	<i>Yes/No</i>

## **Signature:**

I have read and understood the information in this form. My questions and concerns have been answered by the researchers, and I have a copy of this consent form. Therefore, I consent to take part in this research project

Participants Signature: \_\_\_\_\_

Name in Block Capitals: \_\_\_\_\_

Date: \_\_\_\_\_

**APPENDIX J**

**INTERVIEW TOPIC GUIDE**

**TREATING PSYCHIATRIST**

**Identifier**

**Date**

**Time**

**1. Basic information:**

- a. Approximately how many MHTs have you attended?**

**PURPOSE OF MHT**

- 2. Why do you think MHTs were introduced?**
- 3. What is the purpose of the MHT?**

**TRAINING**

- 4. What does the training provided by the Mental Health Commission entail for consultant psychiatrists?**
  - a. Legal requirements for lawful detention**
    - i. Admission/renewal orders**
    - ii. Time limits**
- 5. Is there similar training for GPs?**
- 6. Have you ever refused to admit a person? Why?**
  - a. Do not meet the criteria for detention**
  - b. Reason? Faulty paperwork?**

**PRE HEARING PROCESS**

**RELATIONSHIP WITH SERVICE USER**

- 7. In your interactions with the service user do you ever discuss the MHT hearing?**
- 8. What is discussed about them?**

**9. Who explains the MHT process and hearing to the service user?**

- a. What is explained?
- b. Do you think they understand the MHT process?

**10. Do you show the service user any documents prior to the MHT hearing?/ Do you know if the legal representative shows the service user any documents?**

- a. Medical reports
- b. Section 17 independent psychiatrist's report
- c. Admission/renewal orders
- d. Other

**11. A significant percentage of detention orders are revoked prior to the hearing, why is this?**

- a. Where they are revoked in order to avoid a MHT, why is this?

#### **INDEPENDENT PSYCHIATRIST**

**12. Who informs the service user that they will be examined by an independent psychiatrist?**

**13. What is the purpose of the independent psychiatrist's examination?**

**14. What is the difference between the independent psychiatrist and the treating psychiatrist?**

**15. What does the examination by the independent psychiatrist entail?**

**16. What does the independent psychiatrist ask you?**

**17. Would you normally see the report compiled by the independent psychiatrist?**

- a. Could you provide an average percentage of how often the report complements your own medical opinion?
- b. On what facts could the report differ?



## **MHT HEARING**

### **PARTICIPANTS & ROLES**

**18. Can you list the people who usually participate in the MHT hearing?**

**19. What is the role of each participant you identified?**

**a.** If not mentioned ask about the following participants:

- i.** Chairperson of MHT
- ii.** Medical member of MHT
- iii.** Lay member of MHT
- iv.** Treating psychiatrist
- v.** Independent psychiatrist
- vi.** Legal representative
- vii.** You
- viii.** Other

### **MHT ORDER OF BUSINESS AND EVIDENCE**

**20. Could you explain the process at the MHT hearing?**

- a.** Does the MHT Chairman introduce people? How are they introduced- first names and surnames or by titles?
- b.** Who makes the initial submissions?
- c.** Then what happens?

**21. What information do you provide at the MHT hearing?**

- a.** Does this generally agree or disagree with what the independent psychiatrist has said in their report?
  - i.** Percentage

**b.** Does the MHT medical member question you?

**i.** What do they ask?

**c.** Does the MHT Chairman question you?

**i.** What do they ask?

**d.** Does the MHT lay member question you?

**i.** What do they ask?

**22. When does the legal representative present the service user's case?**

**a.** What do they say generally?

**i.** Do they outline the legal requirements for detention under the 2001 Act?

**ii.** Do they question the medical diagnosis of mental disorder?

**b.** What makes a good or bad legal representative?

**23. Does the legal representative question you?**

**a.** What do they ask?

**b.** Is this questioning generally inquisitorial or adversarial?

**i.** What is the effect of adversarial questioning? Positive/negative?

**24. Is the service user usually questioned during the MHT hearing?**

**a.** By whom?

**b.** What are they asked?

**25. What evidence if any does the service user provide?**

**26. Does any other participant speak during the MHT hearing?**

**27. Does the MHT ever consider what would happen if a service user was released, regarding their housing, employment or social security situation?**

**28. How long are the hearings usually?**

- a. When do you find out the decision of the MHT?

**MHT INDEPENDENCE**

**29. In your experience do the same MHT members usually sit on the same MHTs together or are there different members for each MHT constituted?**

**30. In your experience does the service user have the same legal representative, where they have more than one review?**

**31. In your experience does the service user have the same independent psychiatrist, where they have more than one review?**

**32. MHT rules refer to conflict of interest-what do you think constitutes a conflict of interest?**

- a. Have you ever been involved in a MHT where you believe there could have been a conflict of interest?
  - i. What was this conflict of interest?
- b. Do you think that being involved in a MHT where an independent psychiatrist or medical member is a colleague constitutes a conflict of interest?
  - i. Why?

**33. Do you think the small number of psychiatrists working in Ireland and the even smaller number working in Dublin, poses a problem for the operation of MHTs?**

**MEDICAL OPINION**

**34. Have you ever experienced a MHT where there is differing medical opinion as to illness or need for detention?**

- a. Who had the different opinion?
- b. What did the difference of opinion concern?
  - i. Diagnosis

- ii. Treatment
- iii. Prognosis
- iv. Need for detention
  - 1. Dangerousness
  - 2. Benefit of treatment

c. Was the service user's detention revoked or approved in this case?

## **MHT POWERS**

**35. How do you feel about the paperwork attached to a detention?**

**36. Have you ever experienced a hearing where the MHT has considered using the powers which allow it to cure failures to comply with the legal requirements of detention where they do not affect the substance of the order and do not cause an injustice to the service user (section 18)?**

- a. What was in issue?
  - i. Persons who may apply for detention
  - ii. Medical examinations
  - iii. Time limits (for exams and duration of detention orders)
  - iv. Admission/ renewal order form filling
  - v. Gardai powers of detention
  - vi. Provision of information to service user
- b. Who highlighted these?
- c. Who discussed these?

**37. Was the flaw capable of being resolved by the MHT?**

- a. Did this happen?

**38. If it could not be resolved, what happened?**

**39. Is there anything about the tribunal powers you would like to see changed?**

- a. If yes, what?

#### **MHT DECISION**

**40. Generally in cases where the MHT upholds the detention, on what basis does it do this?**

- a. Diagnosis of mental disorder and
  - i. Need for treatment
  - ii. Danger
  - iii. Both

**41. In cases where the MHT does not approve the detention, on what basis does it usually do this?**

- a. No existence of a mental disorder
- b. Existence of a mental disorder but no need for treatment
- c. Existence of a mental disorder but not a danger
- d. Existence of a mental disorder but no need for treatment and not a danger
- e. Legal flaw in the detention that is not capable of being resolved (by section 18).

**42. There are a percentage of detentions based on a diagnosis of personality disorder or addiction, which are prohibited by the MHA 2001, what happens in the MHT in these cases?**

**43. Have you ever readmitted a person after the MHT has ordered the revocation of their detention order?**

- a. Why did you re-detain them?

#### **MHT AND SERVICE USER**

**44. Do MHTs act in the best interests of the service user?**

**45. In your opinion what does the term ‘best interests’ mean?**

**46. Do they have a positive or negative effect on the mental health of the service user?**

## **RESOURCING**

**47. Do inadequate resources affect the operation of MHTs, or rather just the rest of your practice?**