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MENTAL HEALTH TRIBUNALS: A SIGNIFICANT MEDICO-LEGAL CHANGE

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After lengthy delays and protracted debates, the Mental Health Act 2001[1] was finally enacted and commencement of its substantive sections appears to be imminent. One crucial cornerstone of the new regime introduced by the Act will be automatic periodic reviews of patients' detentions by Mental Health Tribunals. This article will focus on the background to the new Tribunal system, the statutory rules for its operation, and case-law of relevance from Strasbourg and England.

Background

The Mental Treatment Act 1945 provided for detention of indefinite duration for 'persons of unsound mind' and, alternatively, temporary detention for periods of six months at a time (for a maximum of two years.) Patients had various rights of review of their detention, such as a habeas corpus application[2] or correspondence with the Minister for Health, but these rights were rarely invoked and appeared to be weak and relatively ineffective. While the Inspector of Mental Hospitals was required to report on conditions in mental hospitals, this was of little direct assistance to individual patients.[3] Nevertheless, when the constitutionality of the 1945 Act system was challenged in 1949[4] and again in 1996[5], the Supreme Court found on each occasion that it did not infringe the constitutional right to liberty. There were, however, strong

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1 See generally Mary Keys, 'The Mental Health Act 2001', Irish Current Law Statutes Annotated; Simon Mills, 'The Mental Health Act 2001: Involuntary Psychiatric Treatment and Detention' (2003) 8 Bar Rev. 42. For the debates preceding the Act, see Mary Keys, 'Issues for the New Mental Health Act' (1997) 3 MLJI 96; Ubaldus de Vries, 'Mental Treatment: The Need for Change' (1997) 15 ILT 114; Owen McIntyre, 'Mental Health: The Case for Reform' (1999) 5 MLJI 53; Ubaldus de Vries, 'The New Mental Health Bill - Failing to be Progressive' (2000) 6 MLJI 19; Mary Keys, 'Guarded Welcome for Mental Health Bill' (2000) 6 MLJI 28; G. J. Calvert, 'Comments on An Bille Meabhair-Sláinte 1999 (Mental Health Bill 1999) (2000) 24 Psych.Bull. 278

2 See Mary Keys, 'Challenging the Lawfulness of Psychiatric Detention under Habeas Corpus in Ireland' (2002) 24 DULJ 26

3 Faye Boland, 'Improving Conditions in Irish Psychiatric Hospitals' (2001) 7 MLJI 5.

4 *In Re Philip Clarke* [1950] IR 235.

5 *Croke v Smith (No.2)* [1998] 1 IR 101.

judicial views to the contrary[6] and Human Rights case-law, notably the *Winterwerp* case of 1979,[7] pointing in the opposite direction.[8] The Irish courts occasionally gave permission for court proceedings where procedures under the 1945 Act had been breached[9] and at European level some 'friendly settlements' were reached.[10]

Proposals for reform were contained in the Report of the Commission of Inquiry into Mental Illness, 1966, the Health (Mental Services) Act 1981,[11] the Green Paper of 1992[12] and the White Paper of 1995.[13] In the latter two documents, the Government conceded that our law was out of line with international human rights standards and required major change. Regrettably, the new Act was not finally enacted until 2001 and, at time of writing, it appears that the substantive provisions may be commenced in late 2004 or early 2005, 25 years after the *Winterwerp* case and 12 years after the Green Paper. Parallel proposals to reform mental health law concerning criminal cases have been published in the form of the Criminal Law (Insanity) Bill 2002, which is slowly making its way through the Oireachtas.[14]

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6 See Costello P. in *R.T. v Director of Central Mental Hospital* [1995] 2 IR 65; Budd J's High Court judgment in *Croke v Smith (No.2)*, 27 and 31 July 1995 (reversed by Supreme Court: [1998] 1 IR 101.)

7 *Winterwerp v The Netherlands* (1979-80) 2 EHRR 387.

8 *Winterwerp v The Netherlands* (1979-80) 2 EHRR 387 (holding that the decision to detain must be supported by objective medical expertise, the mental disorder must be serious enough to warrant compulsory confinement, and the validity of confinement must be based on the persistence of the disorder); *X v United Kingdom* (1981) 4 EHRR 188 (holding that mental health review tribunals which had advisory functions only were not sufficient to protect patients' rights to liberty under Article 5(4)); *Megyeri v Germany* (1993) 15 EHRR 584 (confirming the right to take proceedings at periodic intervals to put in issue the lawfulness of detention.)

9 *Bailey v Gallagher* [1996] 2 ILRM 433; *Melly v Moran*, Supreme Court, 28 May 1998; *Kiernan v Harris*, O'Higgins J., High Court, 12 May 1998; Jarlath Spellman, 'Section 260 of the Mental Treatment Act 1945 Reviewed' (1998) 4 MLJI 20.

10 *O'Reilly v Ireland*, Application No. 24196/94, European Commission of Human Rights (1996) DR 84-A p.72 and Friendly Settlement of 3 December 1996; *Croke v Ireland*, Application No. 33267/96, European Court of Human Rights, 21 December 2000.

11 This Act has not been commenced.

12 Department of Health, *Green Paper on Mental Health* (Dublin, 1992).

13 Department of Health, *A New Mental Health Act: White Paper* (Dublin, 1995).

14 Simon Mills, 'Criminal Law (Insanity) Bill 2002: Putting the Sanity Back into Insanity?' (2003) 8 Bar Rev. 101; Mental Health Commission, *Response to the Criminal Law (Insanity) Bill 2002* (March 2003), available at www.mhcirl.ie (accessed 14 September 2004).

In 2003, there were 2,349 involuntary admissions to mental hospitals and psychiatric units in Ireland.[15] If similar numbers are being detained at present, this will translate into the need for roughly 2,000 reviews by Mental Health Tribunals each year.[16] Large numbers of patients, psychiatrists, lawyers and others are about to participate in a tribunal system of a comparable scale to the Refugee Appeals Tribunal, the Equality Tribunal or the Employment Appeals Tribunal. In a few years time, there will possibly have been a number of High Court decisions clarifying the procedures to be followed, and those with extensive experience of the tribunal system will meet to discuss the finer points of the operation of certain aspects of the system. An examination of the Irish legislation and consideration of relevant case-law from outside Ireland will provide some indications of possible future developments.

The Statutory Provisions on Mental Health Tribunals

The 2001 Act contains the basic rules for the operation of the tribunals, but these will probably be supplemented by guidance to be produced by the Mental Health Commission, and possibly by Statutory Instruments.[17] As there has been a mental health tribunal system in England and Wales for decades, helpful comparisons may be drawn with the legislation there.[18]

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[15] *Report of the Inspector of Mental Hospitals 2003* (Dublin, 2004), p.1. This represents 10% of a total of 23,234 admissions. In 2002, there was an involuntary detention rate of 89.7 per 100,000 population – Antoinette Daly & Dermot Walsh, *Activities of Irish Psychiatric Services 2002* (Health Research Board, Dublin, 2003), p.17.

[16] It is difficult to calculate the number of reviews. Some patients will be discharged within 21 days and therefore in most of those cases a review will not take place. On the other hand, the cases of those who remain longer than 21 days will need to be reviewed at various statutory intervals specified in the Act. An estimate of 2,000 completed reviews per year was made by Minister Mary Hanafin on 23 May 2001 – vol. 536 Dáil Debates.

[17] See s.5, Mental Health Act 2001.

[18] See Mental Health Act 1959, now replaced by Mental Health Act 1983 as amended; Peter Bartlett & Ralph Sandland, *Mental Health Law: Policy and Practice*, 2nd ed. (Oxford University Press, 2003); Richard Jones, *Mental Health Act Manual*, 8th ed. (Sweet & Maxwell, London, 2003); Brenda Hoggett, *Mental Health Law*, 4th ed. (Sweet & Maxwell, London, 1996); Anselm Eldergill, *Mental Health Review Tribunals: Law and Practice* (Sweet & Maxwell, London, 1998). Reforms have been proposed in the Mental Health Bill 2002, now superseded by the Mental Health Bill 2004. In this article, discussion will focus on standard admissions for treatment of non-restricted patients made under s.3 of the Mental Health Act 1983.

Members of Mental Health Tribunals (MHTs) in Ireland will be appointed by the Mental Health Commission for up to three years.[19] Each MHT will have three members: a lawyer who acts as Chairperson,[20] a consultant psychiatrist[21] and another person.[22] In England and Wales, a judge may act as the legal member of the tribunal[23] and slightly more specific criteria are laid down for the appointment of the third member.[24]

The main function performed by the MHTs will be the automatic review of detention of those patients detained involuntarily, although they will also have a role in decisions concerning psycho-surgery[25] and transfers to the Central Mental Hospital.[26] After a psychiatrist makes an admission order or a renewal order, he or she must send a copy of the order to the Mental Health Commission and give notice of the making of the order to the patient.[27] The written notice to the patient must include seven items of information, one of which is a statement that the patient will have his or her detention reviewed by a MHT.[28] Once the Commission receives the copy of the order, it refers the case to a Tribunal, assigns a legal representative to the patient and directs an independent psychiatrist to examine the patient.[29] The MHT must review the patient's detention and make its decision within 21 days of the making of the order.[30] This 21-day period may be extended by two further periods of 14 days.[31]

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19 s.48, Mental Health Act, 2001

20 This person must be a practising barrister or solicitor who has at least 7 years' experience as a practising barrister or solicitor immediately before his or her appointment – s.48(3)(b).

21 This includes a person who was employed as a consultant psychiatrist by a Health Board or an approved centre not more than 7 years before his or her appointment to the Tribunal – s.48(12).

22 This person must *not* be a psychiatrist, a lawyer qualified to act as Chairperson, a registered medical practitioner or a registered nurse – s.48(c).

23 A circuit judge acts as the legal member of the vast majority of English tribunals – Department of Health, *Mental Health Review Tribunals for England and Wales Annual Report 1996* (London, 1997), appendix 1.

24 The third member must be a person "with experience in administration … knowledge of social services or such other suitable qualifications and experience as the Lord Chancellor considers suitable" - Mental Health Act 1983, schedule 2, para. 1(c).

25 s.58, Mental Health Act, 2001.

26 s.21(2).

27 s.16(1). These two tasks must be carried out within 24 hours of the order.

28 s.16(2)(e).

29 s.17.

30 s.18(2).

In England and Wales, the Mental Health Review Tribunals (MHRTs) do not automatically review involuntary detentions; the patient must generally take the initiative of applying for a tribunal review within certain time limits.[32] If the patient or his or her 'nearest relative' does not make an application, then hospital managers are required to refer the case to a tribunal.[33] The patient can appoint his or her own medical expert.[34] The medical member of the MHRT examines the patient beforehand.[35] Legal representatives are not automatically assigned to patients; instead the patient may appoint any person as his or her authorised representative (AR).[36] A number of weeks may elapse between the application for review and the Tribunal hearing.[37]

Reviews in Ireland must take the form of Tribunal sittings at which submissions and evidence are received.[38] The MHTs have extensive powers to facilitate their work, such as directing witnesses to appear and ordering the production of documents.[39] A Tribunal will determine its own procedure and it must enable examination and cross-examination of witnesses, administration of oaths in appropriate cases and admission of written statements with the patient's consent.[40] Sittings must be held in private and the patient will not be required to attend if, in the tribunal's opinion, such attendance might prejudice his or her health.[41]

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[31] The first extension may be made either of the tribunal's own motion or at the request of the patient; the second may only be made on application of the patient if the tribunal is satisfied that it is in the interest of the patient – s.18(4).

[32] For example, the patient may apply for a review within six months of admission for treatment – s.66 Mental Health Act 1983; see Bartlett & Sandland, op.cit., pp.435 ff.

[33] s.68(5) Mental Health Act 1983.

[34] s.76 Mental Health Act 1983.

[35] Rule 11, Mental Health Review Tribunal Rules 1983, S.I. 1983/942. This aspect of the English and Welsh system has been problematic (see Bartlett & Sandland, op.cit., pp.444-5) and it is likely that this rule will be changed and replaced with a pre-hearing examination by a psychiatrist who would not be a member of the tribunal.

[36] s.78 Mental Health Act 1983. Most applicants appoint a lawyer as their AR.

[37] For example, in December 2000 the average wait for non-restricted patients varied regionally from 7.5 to 9.4 weeks – Bartlett & Sandland, op.cit., p.448.

[38] s.49(1).

[39] s.49(2).

[40] s.49(6).

[41] s.49(9) and (11).

In conducting a review of an admission or renewal order, the Tribunal must either affirm or revoke the order.[42] To affirm the order, the MHT must be satisfied that the patient is "suffering from a mental disorder" and that certain procedures[43] 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."[44] The question of whether the patient is "suffering from a mental disorder" involves both a consideration of the patient's diagnosis[45] and the necessity for his or her detention.[46] If the MHT affirms the order, it does not have a statutory power to make recommendations concerning the patient.[47]

English and Welsh legislation formerly placed the burden of proof on patients by requiring those seeking discharge to demonstrate to the Tribunal that they did not meet the standard for confinement.[48] This was held to be incompatible with Articles 5(1) and 5(4)[49] of the European Convention on Human Rights in *R v MHRT, North & East London, ex parte H.*[50] Amending legislation was passed to remedy the situation.[51] The new provision states that it is for those opposing the discharge to prove, or the Tribunal to be satisfied, that the patient is suffering from mental disorder.

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[42] s.18(1).

[43] The Tribunal must be satisfied "that the provisions of sections 9, 10, 12, 14, 15 and 16, where applicable, have been complied with."

[44] s.18(1)(a).

[45] "Mental illness" means mental illness, severe dementia or significant intellectual disability, each of which is defined in s.3 of the Act. A person may not de detained by reason only of the fact he or she (a) is suffering from a personality disorder, (b) is socially deviant, or (c) is addicted to drugs or intoxicants (s.8(1)).

[46] Detention may be based either on a serious likelihood of harm to self or others, or a finding that failure to admit will lead to deterioration of the patient's condition or prevent administration of appropriate treatment (s.3(1)).

[47] Compare s.72(3) Mental Health Act 1983. If a recommendation is not complied with, the case will go back to the Tribunal.

[48] s.72(1)(b) Mental Health Act 1983.

[49] Article 5(1) provides that everyone has the right to liberty except in certain exceptional cases, including the lawful detention of persons of unsound mind; Article 5(4) states that everyone deprived of liberty is entitled to take proceedings by which the lawfulness of the detention shall be decided speedily by a court and release ordered if the detention is not lawful.

[50] [2001] EWCA Civ 415; [2002] QB 1. This case concerned the statutory provision concerning restricted patients, but would apply equally to non-restricted patients.

[51] Mental Health Act 1983 (Remedial) Order 2001, S.I. 2001/3712.

If the MHT decides to revoke the admission or renewal order, it must direct that the patient be discharged.[52] There is no statutory power to make a conditional discharge,[53] defer a discharge, or direct that a patient's disorder be reclassified.[54]

If a Tribunal confirms the initial 21-day admission order, subsequent tribunal reviews will take place each time the patient's detention is renewed, i.e. for a further three months, then six months and finally at 12-monthly intervals.[55] Under English and Welsh legislation, the renewals operate at different intervals[56] and the patient can choose to apply for a tribunal review at any stage between renewals, provided he or she only applies once during a period of renewal.[57]

The patient may appeal to the Circuit Court against the decision to affirm an admission or renewal order within 14 days of receipt of notice of a MHT decision.[58] This appeal may only be based on one ground – that the patient argues that he or she is not "suffering from a mental disorder."[59] The burden of proof is on the patient in these appeals:

> On appeal to it under subsection (1), the Circuit Court shall –
> (a) unless it is shown by the patient to the satisfaction of the Court that he or she is not suffering from a mental disorder, by order affirm the order, or
> (b) if it so shown as aforesaid, by order revoke the order.[60]

The Circuit Court decision may be appealed to the High Court, but only on a point of law.[61]

The provision placing the burden of proof on the patient in Circuit Court appeals might not withstand a challenge based on the ECHR, if a court were to adopt the persuasive reasoning in the *ex parte H.* case.[62]

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[52] s.18(1)(b).

[53] Compare s.73(2) Mental Health Act 1983, which applies to restricted patients.

[54] Compare s.72(5) Mental Health Act 1983. See *R v Ashworth Hospital, ex parte B.* [2003] EWCA Civ 547.

[55] s.15.

[56] The first renewal is for six months and subsequent renewals are for 12 months.

[57] s.66, Mental Health Act 1983.

[58] s.19.

[59] s.19(1). As was noted earlier, the question of whether the patient is "suffering from a mental disorder" involves both a consideration of the patient's diagnosis and the necessity for his or her detention.

[60] s.19(4).

[61] s.19(16).

[62] *R v MHRT, North & East London, ex p. H* [2001] EWCA Civ 415; [2002] QB 1. See annotation of s.19 of the Irish Act by Mary Keys.

English and Strasbourg Case-law

It is axiomatic that any Strasbourg case-law concerning detention of mental patients is now of immense importance in Ireland, given the recent enactment of the European Convention on Human Rights Act 2003.[63] English case-law referring to the Convention will also be instructive, as will English case-law interpreting legislative provisions similar to provisions in the new Irish Act, or applying principles of administrative law to the tribunals.[64] Presumably patients who wish to challenge MHT procedures in Ireland will not be confined to the statutory Circuit Court appeal option, but may also bring judicial review proceedings[65], habeas corpus applications, or applications for declarations of unconstitutionality or incompatibility with the European Convention. These options would also be open to health boards who wish to challenge tribunal decisions.

It has been held by the House of Lords that MHRTs must comply with the rules of natural justice.[66] At High Court level, Stanley Burnton J. has stated that tribunals are properly seen as more inquisitorial and less adversarial.[67]

In a number of English cases, the importance of proper, adequate reasons for their decisions being given by Tribunals has been stressed. For example, in *R v MHRT, ex parte Clatworthy*,[68] the tribunal reached a contrary decision to the opinions of two doctors and it was held that the tribunal should have explained why. In another case, the Court of Appeal emphasised that it is not enough, where there are disputes of fact, to simply record that one

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[63] See Ursula Kilkelly (ed.), *The ECHR and Irish Law* (Jordan's, Bristol, 2004.)

[64] The English and Irish courts apply similar principles of administrative law – see generally Gerard Hogan & David Gwynn Morgan, *Administrative Law in Ireland*, 3rd ed. (Round Hall Sweet & Maxwell, Dublin, 1998).

[65] In England, it has been held that a patient need not apply for leave from the courts under the equivalent of s.73 of the Irish 2001 Act before initiating a judicial review – *R v Hallstrom, ex parte W.* [1986] QB 1090.

[66] *Campbell v Secretary of State for the Home Department* [1988] 1 AC 120 (holding that in a case concerning a restricted patient the Home Secretary must be notified of the tribunal hearing.)

[67] *R v MHRT for West Midlands and North West Regions, ex parte Ashworth Hospital* [2001] EWHC Admin 901 at para. 16. The Irish College of Psychiatrists has expressed concern that adversarial or contentious language would be used in tribunal hearings which would damage therapeutic relationships – *First Submission to the Mental Health Commission on the Code of Practice for the Mental Health Act 2001* (January 2003), p.25.

[68] [1985] 3 All ER 699.

witness was preferred over another; the tribunal must state why it accepted the evidence in question over conflicting evidence.[69]

If a health authority disagrees with a tribunal decision to discharge a patient, it might bring judicial review proceedings to quash the tribunal decision. Alternatively, in some cases, a new admission for treatment might be made soon after the patient's discharge by the tribunal. Such a practice was approved in a 1994 English case, provided the admissions team is acting objectively and bona fide.[70] More recently, the Court of Appeal has held in the *Von Brandenburg* case that the team must have some objective basis upon which to disagree with the tribunal's decision.[71]

The European Court of Human Rights has held that it is permissible for conditions, such as a condition that the patient take certain medication, to be attached to release of mental patients.[72] A condition that a patient live in a supervised hospital environment is also permissible, but release must not be unreasonably delayed while such accommodation is being found.[73]

As Article 5(4) refers to a patient's right to take proceedings by which the lawfulness of detention may be decided "speedily", the Strasbourg court has found breaches of the Convention where there have been delays of eight weeks[74] and five months.[75]

In England, there have been delays in tribunal hearings for various reasons, such as increasing case-loads, shortages of tribunal members and the low number of staff at the MHRT Secretariat.[76] The English courts have now begun to find breaches of the Human

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[69] *R v Ashworth Hospital Authority, ex parte H.* [2002] EWCA Civ 923; [2003] 1 WLR 127.

[70] *R v South Western Hospital Managers, ex parte M.* [1993] QB 683. Laws J. said that an approved social worker (ASW), in applying for an admission order, is not fettered in any way by a recent tribunal decision.

[71] *R v East London and the City Mental Health NHS Trust, ex parte Von Brandenburg* [2001] EWCA Civ 239; [2002] QB 683. The Court of Appeal disagreed with Laws J's view in *ex parte M.* that an ASW is not fettered by a tribunal decision.

[72] *L v Sweden* (1986) 8 EHRR 269; *W v Sweden* (1988) 59 DR 158.

[73] *Johnson v UK* (1999) 27 EHRR 296. The court was willing to permit a short deferral of release while accommodation was being found, but this needed to be done with all reasonable expedition, which had not happened in this case. Johnson had been waiting for a hostel place for three years.

[74] *E v Norway* (1994) 17 EHRR 30.

[75] *Van der Leer v The Netherlands* (1990) 12 EHRR 567.

[76] Bartlett & Sandland, op.cit., pp.448-450.

Rights Act 1998 in such cases. In the *ex parte C.* case,[77] the Court of Appeal held that an eight week delay was too long when it was for purely administrative reasons. Lord Phillips MR cited Strasbourg case-law[78] to the effect that regard would not be had to any alleged constraint of resources, as it is the responsibility of the Contracting State sufficiently to resource its tribunal system so as to enable Convention compliance. This principle has been applied in subsequent cases such as *KB,*[79] in which damages of between £750 and £4,000 were awarded to seven patients for the delays in their hearings coming before tribunals. The damages were based on the patients' loss of liberty, frustration, distress and damage to mental health.

English Studies and Commentaries on the Tribunal System

A number of academics have studied the English MHRTs in action and made observations which suggest that the tribunal system does not operate strictly in accordance with legal principles. In her 1989 study,[80] Jill Peay found that the decision-making process in tribunals was sometimes back-to-front: the members determined the outcome they preferred and then selected the evidence to accord with that view. She found that decisions of the MHRTs were frequently dictated by the psychiatrist in the hospital – the RMO (Responsible Medical Officer.)[81] RMOs were not impressed by the legal criteria for detention and were known to reduce patients' medication before a hearing to demonstrate the need for detention.

Another study by Dolan et al[82] which surveyed the experiences of patients found that only 9% of them accurately understood the powers of MHRTs.[83] The majority of the patients (64%) were happy with their legal representation and 56% believed that the tribunal format was too

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[77] *R v MHRT London South & West Region ex parte C.* [2001] EWCA Civ 1110; [2002] 1 WLR 176.

[78] *Bezicheri v Italy* (1989) 12 EHRR 210.

[79] *R v MHRT ex parte KB* [2002] EWHC Admin 639; [2003] EWHC Admin 193.

[80] Jill Peay, *Tribunals on Trial: A Study of Decision-Making under the Mental Health Act 1983* (Clarendon Press, Oxford, 1989).

[81] In 84% of their decisions, tribunals agreed with the recommendation made by the RMO. See also a similar finding of a high level of agreement in Damian Mohan, Kevin Murray, Penny Steed & Mark A. Mellee, 'Mental Health Review Tribunal Decisions in Restricted Hospital Order Cases at One Medium Secure Unit' (1998) 8 Crim. Behav. & Ment. H. 57.

[82] Mairead Dolan, Robert Gibb & Placid Coorey, 'Mental Health Review Tribunals: A Survey of Special Hospital Patients' Opinions' (1999) 10 J. Forensic Psychiatry 264. This study was conducted at Ashworth Hospital in Liverpool, a "Special Hospital", i.e. a high-security hospital.

[83] The authors suggested that information sheets for patients not only inform them of their right to apply to a tribunal, but also set out the powers of the tribunal (ibid., p.271.)

formal. Ferencz and McGuire[84] observed that Tribunal hearings were alienating experiences for patients. Patients were given little opportunity to speak and Tribunals were uninterested in the patient's side of the story. They argued that Tribunal hearings have a therapeutic quality, and that Tribunals need to be more sensitive to these implications.

Richardson and Machin[85] found that the requirements of the Mental Health Act were discussed before the hearing in only one of fifty cases observed. The questions asked at the hearing demonstrated a clinical rather than a legal focus. Tribunals tended to be aware of and to comply with judicial rulings relating to interpretation of their specific powers, but compliance was lower on some other points, e.g. issues of procedural fairness concerning the medical member of the tribunal.[86] The reasons given by tribunals for their decisions were often inadequate,[87] the reasons did not reflect the issues in the hearing[88] and apparent compliance with the duty to give reasons was relatively easy to achieve.[89] Overall, the influence of judicial review on decision-making was patchy at best.[90]

Writing an opinion piece from the perspective of the psychiatric profession, Obomanu and Kennedy[91] pull no punches in their critique of the adversarial tactics employed by lawyers at

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[84] Nicola Ferencz & James McGuire, 'Mental Health Review Tribunals in the UK: Applying a Therapeutic Jurisprudence Perspective' (2000) 37 *Court Review: The Journal of the American Judges Association* 48, available at http://aja.ncsc.dni.us/courtrv/review.html (accessed 14 September 2004.) Their study is based on a very small sample – seventeen patients and ten tribunal members.

[85] Genevra Richardson & David Machin, 'Judicial Review and Tribunal Decision-Making: A Study of the Mental Health Review Tribunal' [2000] *Public Law* 494. The authors observed 50 tribunal hearings and conducted 38 interviews with patient representatives, tribunal members and members of tribunal staff.

[86] For example, the medical member did not express a direct clinical opinion at any hearing, even though this was required for fairness, especially where the member's view differs from that of a medical witness.

[87] See example given at p.510 of their article, in which there was no indication of the type of disorder which the patient had.

[88] For example, in 76% of hearings the emphasis was on risk rather than the presence of a disorder, while in relation to reasons the figure was only 32% (ibid., p.512.)

[89] The authors note that the record provided by the reasons given by the tribunal is partial and provides an inadequate basis on which to judge the legality of a tribunal's decision-making by means of judicial review (ibid., loc.cit.)

[90] Ibid., p.514.

[91] William Obomanu & Harry Kennedy, 'Juridogenic Harm: Statutory Principles for the New Mental Health Tribunals' (2001) 25 Psych. Bull. 331.

tribunals. They suggest that four principles should be written into the new English Mental Health Bill, including a principle that nothing should be said or done to undermine an existing or future therapeutic relationship.[92] Another principle they suggest is that Tribunals should give greater weight to opinions of clinicians who would take responsibility for the care and treatment of the patient following his or her move to a lower level of security.[93] Their article is a stark contrast to that of Richardson and Machin, and reading the two articles together provides a thought-provoking illustration of the difficult balancing act involved in tribunal decision-making.

Conclusion

Once it commences, the tribunal system will be here to stay and all interested parties will have no choice but to grapple with the hard questions which will need to be resolved in its operation. The system will be a significant milestone in medico-legal relationships, and represent the first time that lawyers, doctors and others will sit together in three-person tribunals to issue legally binding decisions concerning medico-legal issues. While legal principles will obviously be of paramount importance, tribunals will also need to take care to have regard to the therapeutic consequences of the manner in which the tribunal is conducted, and the decision which is reached.

Another valuable theme running through the case-law and literature is the requirement of procedural fairness, which not only serves a legal purpose but also may help to improve patient satisfaction with the tribunal system. While sometimes the courts are portrayed as unrealistically bureaucratic in overturning tribunal decisions on procedural grounds, it must be remembered that these procedural markers are laid down for sound reasons. Peay provides an excellent concrete suggestion along these lines by proposing that tribunals should be required to follow a set order of proceedings.[94] This might mean, for example, that evidence from the patient would be heard first and cross-examined, followed by evidence from the health authority. This proposal would not be difficult to implement, and would help to ensure that procedural fairness is maintained as "the order of proceedings can influence the weight given to the various elements of evidence that are presented, and so the chances of discharge."[95]

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[92] This principle is also cited by the Irish College of Psychiatrists in its 2003 submission (op.cit., p.25). The submission cites Obomanu and Kennedy's article with approval.

[93] The state that the opinion of "independent" experts can be less reliable because they are disconnected from responsibility and vulnerable to market pressures.

[94] Peay, op.cit., p.95.

[95] Bartlett & Sandland, op.cit., p.457.

The statutory framework is in place, the tribunal members will shortly be appointed and this new phase in Irish mental health law is about to begin. In the crucial first years of the tribunal system's operation, tribunal members and medical personnel will set the tone for its operation for decades to come. While there may be teething problems with these tribunals which operate in "the hinterland between law and medicine",[96] the patients whose liberty is at stake will rightly expect that lawyers and medical personnel will rise to the challenge.

[96] Richardson & Machin, op.cit., p.495.