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**National Survey of Psychiatrists' Responses to Implementation of the Mental  
Health Act 2001 in Ireland**

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**Conflict of interest**

None

## **Abstract**

*Background* Ireland's Mental Health Act 2001 resulted in substantial changes to mental health services and the process of involuntary admission.

*Aims* To determine the views of Irish psychiatrists regarding the new legislation one year after full implementation.

*Methods* We sent questionnaires to all 735 members of the Royal College of Psychiatrists in Ireland.

*Results* The response rate was 43.7%. Eighty-four percent of respondents reported satisfaction with training; 69.1% reported increased workloads; 26.8% reported decreased time with service-users; 40.7% reported changes relationships with service-users (e.g. increased empathy, but more legalistic, conflicted relationships). Almost one-in-three (27.4%) stated it was not feasible to implement the Mental Health Act. Negative comments highlighted the adversarial nature of mental health tribunals, effects on therapeutic relationships and issues related to children.

*Conclusions* The implementation of the Mental Health Act 2001 has resulted in increased workloads, more conflicted relationships with service-users and adversarial mental health tribunals.

## **Keywords**

Legislation, medical

Mental health services

Psychiatric hospitals

Health resources

Health care reform

Ireland

## **Introduction**

The Mental Health Act 2001 was implemented on a phased basis following its enactment by the Irish Houses of Oireachtas (parliament) on 8 July 2001. The new legislation has resulted in multiple changes to the governance of mental health services (e.g. establishment of the Mental Health Commission in 2002) and to the process of involuntary admission to approved psychiatric centres (Kelly, 2007). More specifically, full implementation of the final provisions of the Mental Health Act, on 1 November 2006, introduced automatic reviews of involuntary admission orders by mental health tribunals within 21 days of involuntary admission.

Prior to full implementation of the Mental Health Act, psychiatrists expressed concerns regarding the resource implications of the new legislation (Ganter, 2005). More specifically, psychiatrists were concerned that the new legislation would increase workloads (93.0%), change relationships with service-users (51.6%), increase levels of administrative activity (60.0%) and decrease resources for other areas of mental health services (over 80%) (Kelly & Lenihan, 2006). Overall, 80% of respondents felt it was less than 'moderately feasible' to implement the Mental Health Act at current resource levels.

One year after full implementation of the final provisions of the new legislation, we performed another survey to determine the views of Irish psychiatrists in relation to the effects of the Mental Health Act on specific aspects of psychiatric practices and services in Ireland.

## **Methods**

We sent questionnaires to all 735 members of the Royal College of Psychiatrists (i.e. individuals with MRCPsych) on the membership list of the Irish College of Psychiatrists. The questionnaire comprised eight questions:

1. What grade are you (consultant psychiatrist, senior or specialist registrar, registrar)?
2. Was your training in the Mental Health Act good, adequate or poor?
3. Was the training of allied mental health workers good, adequate or poor?
4. Was the geographical accessibility of training good, adequate or poor?
5. Has the Mental Health Act changed your overall workload (increased, no change, decreased)?
6. Has the Mental Health Act changed the amount of time you spend with service-users (increased, no change decreased)?
7. Has the Mental Health Act changed your relationship with service-users (yes/no)?
8. Overall, was it feasible to introduce the Mental Health Act (yes/no)?

Respondents were also provided with a 'free-text' area in which to provide details about how the Mental Health Act changed their relationship with service-users, if at all. Many respondents also provided additional comments at the end of the questionnaire.

## **Results**

We received responses from 321 (43.7%) psychiatrists, of whom 4 declined to complete the questionnaire owing to retirement (n=2), working in another jurisdiction (n=1) or no reason given (n=1). The remaining 317 respondents comprised 208 (65.6%) consultant psychiatrists, 45 (14.2%) senior registrars and 64 (20.2%) registrars.

The majority of respondents reported that training in the Mental Health Act for themselves and allied mental health workers was either 'good' or 'adequate', although a significant minority (27.7%) felt training for allied mental health workers was 'poor' (Table 1). Two-hundred and nineteen respondents (69.1%) stated that the Mental Health Act had increased their workload; 86 (27.1%) stated it had no effect; 6 (1.9%) stated it had decreased their workload; and 6 (1.9%) did not reply to this question. Eighty-five respondents (26.8%) stated that the Mental Health Act decreased the amount of time they spent with service-users; 161 (50.8%) stated it had no effect; 64 (20.2%) stated it increased the time they spent with service-users; and 7 (2.2%) did not reply to this question.

One-hundred and twenty-nine respondents (40.7%) stated that the Mental Health Act changed their relationship with service-users; 182 (57.4%) stated it did not; and 6 (1.9%) did not reply to this question. Positive comments in this section referred to increased emphasis on issues of consent and increased empathy with service-users. Negative comments referred to the effects of adversarial mental health tribunals and the perception that relationships with service-users have become more legalistic, more conflicted, less trusting and less collaborative.

Two-hundred and thirteen respondents (67.2%) stated that they felt it was feasible to implement the Mental Health Act at this time; 87 (27.4%) stated it was not feasible; and 17 (5.4%) did not reply to this question. One-hundred and eight respondents (34.1%) provided additional comments of which 19 (17.6%) were 'positive'; 13 (12.0%) were 'neutral'; and 76 (70.3%) were 'negative.' The most common negative themes included the adversarial nature of mental health tribunals, effects of mental health tribunals on the therapeutic relationship, increased workloads and issues related to children and adolescents. Other positive and negative themes are listed in Box 1.

There were significant differences between responses of consultant psychiatrists (n=208) and non-consultant hospital doctors (n=109) for certain variables. More consultants than non-consultant hospital doctors rated their training in the Mental Health Act as "good" (47.7% and 34.9%, respectively; Chi Square 8.145, p=0.017). However, a greater proportion of consultant than non-consultant hospital doctors reported increased workloads (75.5% and 56.9%, respectively; Chi Square 15.149, p=0.002), decreased time spent with service-users (32.7% and 15.6%, respectively; Chi Square 12.712, p=0.005) and a belief that implementing the Mental Health Act was not feasible (33.7% and 15.6%, respectively; Chi Square 12.624, p=0.002). In addition, a greater proportion of consultants provided negative additional comments about the Act (29.3% and 13.8%, respectively; Chi Square 10.493, p=0.015).

## **Discussion**



While a majority of respondents in this survey were satisfied with their training in the Mental Health Act 2001, our results show that implementation of the new legislation has resulted in increased workloads, more conflicted relationships with service-users and adversarial mental health tribunals. A wide range of themes underlie negative perceptions of the Act amongst psychiatrists; these include difficulties with mental health tribunals (e.g. delays, duration, adversarial nature, effects on therapeutic relationship, health and safety), involuntary admissions processes (e.g. assisted admissions, involuntary patients in general hospitals), resource issues (e.g. in intellectual disability services), stigma (e.g. media reporting, lack of public understanding) and the legal position of children and adolescents (Box 1).

The comparison of responses of consultant and non-consultant hospital doctors indicated that a greater proportion of consultants reported increased workloads, decreased time spent with service-users, a belief that implementing the Mental Health Act was not feasible, and various other negative observations about the Act. These differences may be related to the fact that consultants are responsible for most of the additional workload associated with the Mental Health Act. These differences may also relate to a lack of training in the new legislation amongst non-consultant hospital doctors: in our study, fewer non-consultant hospital doctors than consultants reported their training in the Mental Health Act as “good” (34.9% and 47.7%, respectively; Chi Square 8.145,  $p=0.017$ ). On this basis, there may be a need for greater education about the Mental Health Act amongst non-consultant hospital doctors.

The limitations of this survey include (a) the response rate (43.7%), although this is significantly higher than the response rate achieved by Kelly and Lenihan (2006)

(26.0%); (b) the small number of specific questions in the questionnaire (8), although this was designed to optimize the response rate; and (c) the fact that this survey was performed just one year after full implementation of the Mental Health Act when some of the long-term effects of the new legislation may not yet have become apparent. The strengths of this survey include (a) the inclusion of questions about multiple areas related to the Mental Health Act (e.g. training, workload, time with service-users, relationships with service-users, etc.); (b) the inclusion of space for 'free-text' comments; and (c) the inclusion of different grades of respondents (e.g. consultant psychiatrists, senior registrars, registrars).

Overall, this survey indicated significant concerns amongst psychiatrists about multiple aspects of the implementation of the Mental Health Act, many of which were related to the conduct of mental health tribunals and resource implications of the new legislation. There is already strong evidence that mental health services in Ireland are inequitably distributed, with particular deficiencies in areas of greatest need (O'Neill et al, 2002; O'Keane et al, 2004). Our findings indicate that the implementation of the Mental Health Act has further intensified psychiatrists' concerns about these resource deficiencies in mental health services in Ireland.

### **Acknowledgements**

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**Table 1: Psychiatrists' Views of Training in the Mental Health Act 2001**

	<i>Good</i>	<i>Adequate</i>	<i>Poor</i>
Was your training in the Mental Health Act good, adequate or poor? (n=317)	137 (43.2%)	130 (41.0%)	50 (15.8%)
Was the training of allied mental health workers good, adequate or poor? (n=289)	69 (23.9%)	140 (48.4%)	80 (27.7%)
Was the geographical accessibility of training good, adequate or poor?	134 (43.0%)	113 (36.2%)	65 (20.8%)

**Box 1: Central Themes in Psychiatrists' Comments about the Mental Health Act  
2001**

*Positive themes*

- Increased emphasis on service-users' rights
- Increased emphasis on comprehensive risk assessments
- Involvement of some excellent solicitors at mental health tribunals
- Increased clarity about involuntary admission of individuals with substance misuse problems

*Negative themes*

- Deficiencies in training for junior doctors, general practitioners and others
- Increased workload
- The position of individuals who lack capacity to consent
- Difficulties with assisted admissions
- Complexity of the involuntary admission process
- Difficulties with involuntary treatment in general hospitals
- Reduced time available to spend with service-users and staff
- Decrease in time available for voluntary service-users
- Effect on other duties of consultants and clinical directors
- The negative effects of mental health tribunals on the therapeutic relationship
- The adversarial nature of some mental health tribunals

- Delays in holding mental health tribunals
- Duration of mental health tribunals
- Health and safety issues at mental health tribunals (e.g. risk of assault)
- The perception that mental health tribunals do not act in the best interests of service-users
- Deterioration in mental health of service-users around the time of mental health tribunals
- Multiple issues related to solicitors (e.g. adversarial approach, involvement with clinical issues)
- Concern about the functioning of the Mental Health Commission
- Lack of resources and facilities for implementation
- Lack of facilities for individuals with intellectual disabilities
- Multiple issues related to children and adolescents (e.g. resources, legal position of adolescents)
- Difficulties providing adequate, appropriate care to the elderly
- Issues related to recruitment and retention of staff
- Level of remuneration for psychiatrists on mental health tribunals
- Increased burden on families
- Lack of public understanding of the new legislation
- Increased stigma
- Poor media reporting
- Poor value for money

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