Mental Health Acts – Perspectives from Mental Health and Law in Ireland and in Portugal

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Abstract: Mental Health legislation is a cornerstone to ensure that individuals with severe mental illness access proper care and treatment. Each country establishes their own legislation. We aimed to compare the Portuguese and Irish Mental Health Acts (MHAs). We reviewed the respective MHA and the literature. While the definition of mental disorder is similar in general, who, where, when and how one can be detained differ. Judges decide on detentions in Portugal, while consultant psychiatrists may do so in Ireland. Community-based compulsory treatment is possible and used in Portugal while it is not possible in Ireland. Pros and cons of each approach are discussed with a reflection on the protection of human rights. Further theoretical and empirical studies comparing systems in different jurisdictions would be helpful to deepen our understanding of the legislation and guide on how to better serve individuals with severe mental illness.

Keywords: Mental Health Act; Law; Forensic Psychiatry; Capacity; Jurisdiction

1. Introduction

Throughout Europe, countries acknowledge the need for principles regulating the compulsory admission of patients with severe mental illness. Mental illness is highly prevalent worldwide and often underreported. It is estimated that one in eight people have a mental health

disorder.[1] Moreover, psychiatric disorders are amongst the main causes of disability.[2] A number of factors affect incidence and prevalence of mental disorders, including cultural differences, poverty indexes, and societal inequalities, among others.[3] Recently, a systematic review and meta-analysis published during the COVID-19 pandemic found that the prevalence of mental disorders increased since the pandemic started.[4] The impairment caused by mental illness is also correlated with high societal burden.[5] However, evidence notes that proper treatment could, at least partially, prevent this burden.[6] Furthermore, specific factors may be associated with compulsory admissions, as reflected in a study that has been conducted in Portugal.[7] One study in England found that 28 out of 59 patients who had been detained recognised that the coercive measure was important in their recovery, while 19 had negative views and 12 were ambivalent.[8] It is everyone's role to ensure involuntary treatment is justified,[9] fair, and respectful of the highest dignity of the detainee. Individuals with a mental illness are often perceived as different, unpredictable and dangerous,[10] even by law enforcement agents.[11] Together we must move towards a world with less stigmatization and appropriate integration of individuals in the community.[12]

At United Nations level, a significant landmark has been achieved in this respect with the Convention on the Rights of Persons with Disabilities (CRPD). The CRPD acknowledged a shift

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[1] World Health Organization, 'Mental Disorders', 8 June 2022, https://www.who.int/news-room/fact-sheets/detail/mental-disorders. Retrieved 25 September 2023.

[2] J.C. de Almeida, 'Portuguese National Mental Health Plan (2007-2016) Executive Summary', *Mental Health in Family Medicine* 6(4) (2009) 233.

[3] M. Hodes, M. Vasquez, D. Anagnostopoulos, K. Triantafyllou, D. Abdelhady, K. Weiss, … & N. Skokauskas, 'Refugees in Europe: National Overviews from Key Countries with a Special Focus on Child and Adolescent Mental Health', *European Child & Adolescent Psychiatry* 27(4), (2018) 389-399; C. Lund, 'Poverty and Mental Health: Towards a Research Agenda for Low And Middle-Income Countries. Commentary on Tampubolon and Hanandita (2014)', *Social Science & Medicine* 111 (2014) 134-136; U. Niaz & S. Hassan, 'Culture and Mental Health of Women in South-East Asia', *World Psychiatry* 5(2) (2006) 118.

[4] S. Nochaiwong, C. Ruengorn, K. Thavorn, B. Hutton, R. Awiphan, C. Phosuya, … & T. Wongpakaran, 'Global Prevalence of Mental Health Issues Among the General Population During the Coronavirus Disease-2019 Pandemic: A Systematic Review and Meta-Analysis', *Scientific Reports* 11 (2021) 10173.

[5] D. Levinson, M. Lakoma, M. Petukhova, M. Schoenbaum, A. M. Zaslavsky, M. Angermeyer, … & R.C. Kessler, 'Associations of Serious Mental Illness with Earnings: Results from the WHO World Mental Health surveys', *British Journal of Psychiatry* 197(2) (2010) 114-121.

[6] R. Kessler, S. Aguilar-Gaxiola, J. Alonso, S. Chatterji, S. Lee, J. Ormel, … & P. Wang, 'The Global Burden of Mental Disorders: An Update from the WHO World Mental Health (WMH) Surveys', *Epidemiology and Psychiatric Sciences* 18(1) (2009) 23-33.

[7] S. Brissos, A. Carita, & F. Vieira, 'Compulsory Admission to a Portuguese Psychiatric Hospital: Retrospective Study of 497 Involuntary Admissions', *BMC Psychiatry* 7(1) (2007) 1.

[8] C. Katsakou, D. Rose, T. Amos, L. Bowers, R. McCabe, D. Oliver, … & S. Priebe, 'Psychiatric Patients' Views on Why Their Involuntary Hospitalisation was Right or Wrong: A Qualitative Study', *Social Psychiatry and Psychiatric Epidemiology* 47 (2012) 1169–79.

[9] A. Molodynski, Y. Khazaal & F. Callard, 'Coercion in Mental Healthcare: Time for a Change in Direction', *BJPsych International* 13 (2016) 1-3.

[10] S. Levey, K. Howells & S. Levey, 'Dangerousness, Unpredictability and the Fear of People with Schizophrenia', *Journal of Forensic Psychiatry* 6(1) (1995) 19-39.

[11] R. Soares & M. Pinto da Costa, 'Experiences and Perceptions of Police Officers Concerning their Interactions with People with Serious Mental Disorders for Compulsory Treatment', *Frontiers in Psychiatry* 10 (2019) 187.

[12] K. Sugiura, F. Mahomed, S. Saxena & V. Patel, 'An End to Coercion: Rights and Decision-Making in Mental Health Care', *Bulletin of the World Health Organization* 98(1) (2020) 52; D. Wasserman, G. Apter, C. Baeken, & S. Bailey, 'Compulsory Admissions of Patients with Mental Disorders: State of the Art on Ethical and Legislative Aspects in 40 European Countries', *European Psychiatry* 63(1) (2020) e82.

in the way persons with disabilities are to be viewed, from the traditional objectification to a more active stance as subjects of rights enjoying all fundamental freedoms. The CRPD's first general principle is "Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons" (article 3(a)). Given the wide number of ratifications of this convention (184 States have ratified this convention; it was ratified by Portugal in 2009 and by Ireland in 2018), this is a widely binding principle and a part of the large number of States Parties' legal systems. There is extensive literature on the relationship between the CRPD and mental health law.[13]

More recently, some authors have queried the role of preventive detention in psychiatry and inequalities between different medical specialties advocating for a reformulation of the mental law and a generalization of the law.[14] The CRPD Committee has stated that every signatory to the Rights of Persons with Disabilities (CRPD) should abolish compulsory treatment in healthcare.[15] The World Health Organization (WHO) has pushed towards the end of coercion.[16] However, several researchers have highlighted the need for a MHA system as it promotes allocation of funding to help those with severe mental health issues.[17]

Principles concerning mental health legislation differ from country to country and throughout time. Moreover, countries throughout the world have different legal systems that may have an impact on the understanding of the law.[18] Even when we focus on Europe, countries have different legal systems. However, a role for the European Union in global health has been suggested;[19] in working jointly towards better mental health and, thus, human rights.[20] In 2002 the EU published a report on the legislation and practice of compulsory admissions in the member states.[21]

Portugal is a civil law jurisdiction while Ireland is a common law jurisdiction. In Portugal the *Lei de Saúde Mental* (herein defined as the Portuguese MHA) is a Law the title of which could be freely translated to the Mental Health Law (MHL), which we will refer to as the Portuguese MHA. The designation of MHA applied to the Portuguese legislation has also been used

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[13] P. Bartlett, 'The United Nations Convention on the Rights of Persons with Disabilities and Mental Health Law', *Modern Law Review* 75 (2012) 752-778; B. McSherry, 'Mental Health Laws: Where to from Here?', *Monash University Law Review* 40 (2014) 175; A. Nilsson, 'Objective and Reasonable? Scrutinising Compulsory Mental Health Interventions from a Non-discrimination Perspective', *Human Rights Law Review* 14 (2014) 459; S. Doyle Guilloud, 'The Right to Liberty of Persons with Psychosocial Disabilities at the United Nations: A Tale of Two Interpretations', *International Journal of Law and Psychiatry* 66 (2019) 101497.

[14] G. Szmukler & S. Weich, 'Maudsley Debate: Has the Mental Health Act Had its Day?', *BMJ* 359 (2017) j5248.

[15] United Nations, *United Nations Committee for the Protection of Rights of Persons with Disabilities. Concluding observations on the initial report of the United Kingdom of Great Britain and Northern Ireland (CRPD/C/GBR/CO/1)* (Geneva, 2017).

[16] M. Freeman, & A. Pathare. *WHO Resource Book on Mental Health, Human Rights and Legislation* (Geneva: World Health Organization, 2005); R. Duffy & B. Kelly, 'Rights, Laws and Tensions: A Comparative Analysis of the Convention on the Rights of Persons with Disabilities and the WHO Resource Book on Mental Health, Human Rights and Legislation', *International Journal of Law and Psychiatry* 54 (2017) 26-35.

[17] Szmukler & Weich, *supra* note 14.

[18] A. Moreira, C. Miguel, J. Ferreira, & M. Colón 'Assessing NGRI and Dangerousness: Perspectives from Forensic Reports in Portugal', *International Journal of Law and Psychiatry* 58 (2018) 171-177.

[19] I. Kickbusch & A. de Ruijter, 'How a European Health Union Can Strengthen Global Health', *The Lancet Regional Health - Europe* 1 (2021) 100025.

[20] A. P. McCann, 'A Human Rights Emergency in Mental Health: Can 'New Governance' Mechanisms in the EU Make a Difference?', *European Journal of Comparative Law and Governance* 6(4) (2019) 333-338.

[21] H. Salize, H. Dreßing & M. Peitz, *Compulsory Admission and Involuntary Treatment of Mentally Ill Patients: Legislation and Practice in EU Member States* (Mannheim: Central Institute of Mental Health Research, 2002).

before.[22] In Ireland, the Mental Health Act (herein referred to as the Irish MHA) sets the rules to legally detain individuals covered by it. In Portugal the latest MHA is from 1998 while in Ireland the latest MHA is from 2001 and has been amended on a number of occasions since then.[23] These MHAs have established the practice in each of these countries for more than 20 years. The Irish MHA is currently under review and the Government has published Heads of a Bill with a view to its reform.[24] In this paper, we will deal with the Irish legislation as it currently stands.

1.1. Aims

Irish and Portuguese jurisdictions have both ratified the European Convention of Human Rights. Patients with severe mental illness and doctors can move between both countries and an understanding of both systems is of relevance in such instances.

It is not the role of this paper to argue against or in favor of one or the other approach regarding involuntary admissions. However, in order to move forward, one must have a good knowledge of the current legislation and practices throughout the world, including Europe, and how they affect individuals. The authors aim to compare the main differences and similarities of each – Portuguese and Irish - MHA in order to foment a better and more comprehensive understanding of current practices and guide future directions.

The first author of the current manuscript has had experience as a psychiatrist in Portugal and in Ireland, two of the authors are currently in Portugal and two are currently in Ireland, two of the authors are psychiatrists and two Professors in Law schools.

There is a general lack of literature in English on mental health law in civil law countries such as Portugal. We believe it is important to share knowledge about legal developments in mental health law in different European countries, to fill the gaps in literature. Comparing and contrasting the law in different legal systems generates knowledge progression.[25] In comparative law methodology,[26] it is common practice that authors will conduct research on legal systems in which they have expertise and appropriate linguistic knowledge.

2. Material and methods

The authors examined the current legislation and practices in Ireland and Portugal.

A review of the literature and current practices was also undertaken. We searched Google Scholar for: Irish OR Portuguese OR Europe AND Mental Health Law; epidemiology of mental illness world; comparative forensic psychiatry and reviewed each article's references of interest. First, we aimed to compare: the main purpose of the MHA; the reasons for detention or not under

[22] Ibid.

[23] M. Keys, 'Annotation of the Mental Health Act 2001', *Irish Current Law Statutes Annotated* (2001); D. Whelan, *Mental Health Law and Practice: Civil and Criminal Aspects* (Dublin: Round Hall, 2009); A.M. O'Neill, *Irish Mental Health Law* (Dublin: First Law, 2005); T. Cronin, P. Gouda, C. McDonald, & B. Hallahan, 'A Comparison of Mental Health Legislation in Five Developed Countries: A Narrative Review', *Irish Journal of Psychological Medicine* 34(4) (2017) 261-269.

[24] Department of Health, *Mental Health (Amendment) Bill 202X: Draft Heads of Bill to Amend the Mental Health Act 2001* (Dublin: Department of Health, 2021); C. O'Mahony & F. Morrissey, *A Human Rights Analysis of the Draft Heads of a Bill to Amend the Mental Health Act 2001* (Dublin: Mental Health Reform, 2021).

[25] G. Samuel, *An Introduction to Comparative Law Theory and Method* (Oxford: Hart, 2014).

[26] See M.-L. Paris, 'The Comparative Method in Legal Research: The Art of Justifying Choices' in: L. Cahillane & J. Schweppe (eds.), *Legal Research Methods: Principles and Practicalities* (Dublin: Clarus Press, 2016).

the MHA in each jurisdiction; parties involved, particularly in enforcing the law; the review process of the detention; age constraints; the end of the detention. Second, we critically examine the main similarities and differences. Third, we propose suggestions for future directions. Since the article is theoretical in nature no Ethical Approval was required for this study.

3. Theory

3.1. Purpose of the Mental Health Act

"The fundamental aim of mental health legislation is to protect, promote and improve the lives and mental well-being of citizens", in order for the Law to be applicable it must be realistic and attainable.[27] It is acknowledged that the rights of psychiatric patients continue to be violated in European countries[28] and there is a need to continuously strive to improve human rights for people with mental health conditions. There are debates about whether enforcing treatment is appropriate in any community, but we must recognize we have come a long way since the days when individuals with a severe mental illness were informally detained and did not have a clear guidance on their duties and rights under the law.

When someone is involuntarily admitted, several disciplines are involved in ensuring that individuals are being offered appropriate treatment. Psychiatrists, lawyers, police officers/the Gardaí, and others have potential roles when it comes to involuntary admission of individuals with a severe mental illness. Once an involuntary admission is started, the community is depriving one of its members of their liberty but, at the same time, is acknowledging that there is the need to have resources available to ensure that that same individual gets the care they need. If there is to be involuntary admission, there must be transparency regarding the process and we must ensure it abides by the best practices and models available.

3.2.Principles of the Mental Health Act

3.2.1. Principles of the Irish Mental Health Law

The Irish MHA sets out three principles at the outset in section 4. The first principle is that, in making a decision concerning admission, care or treatment of a person, the best interests of the person shall be the principal consideration, with due regard being given to the interests of other persons who may be at risk of serious harm if a decision is not made. This "best interests" principle has been interpreted in a paternalistic manner by the courts.[29] The second principle is that, where it is proposed to make a recommendation or an admission order in respect of a person, or to administer treatment to a person, the person shall be notified of the proposal and be entitled to make representations in relation to it. The third principle is that, in making a decision regarding admission, care or treatment of a person, due regard shall be given to the need to respect the right of the person to dignity, bodily integrity, privacy and autonomy.

3.2.2. Principles of the Portuguese Mental Health Law

The Portuguese Mental Health Law (Lei n.º 36/98, 24th July) establishes the meaning and purpose of mental health protection (article 2.º), stating that it must contribute to ensure or re-

[27] Freeman & Pathare, *supra* note 16.
[28] See for example *Aggerholm v. Denmark* (2020) European Court of Human Rights, application no. 45439/18; *Miranda Magro v. Portugal* (2024) European Court of Human Rights, application no. 30138/21.
[29] D. Whelan, 'Application of the Paternalism Principle to Constitutional Rights: Mental Health Case-Law in Ireland', *European Journal of Health Law* 28 (2021) 223.

establish the individual's mental stability, to promote the development of those capacities necessary for building personality and to promote the person's crucial integration in their social environment.

The general principles applicable to mental health policy clearly aim to eliminate stigma around mental health treatment. The first principle establishes that mental health care is promoted at community level, to ensure the patients will not be removed from their usual environment and to facilitate their rehabilitation and social integration (article 3.º/1/a). Also, patients should receive health care treatments in the least restrictive environment possible (article 3.º/1/b), in general hospitals when possible (3.º/1/c) and, in the case of patients who need mostly psychosocial rehabilitation, treatment should occur in residential structures, day-care centres and training and professional rehabilitation institutions (3.º/1/d). There is also a clear commitment to the social rehabilitation of mental health patients in the definition of multidisciplinary teams to ensure treatment comprising professionals qualified to respond in a co-ordinated manner at the medical, psychological, social, nursing and rehabilitation levels (article 3.º/3).

3.3.Compulsory admissions – when and why

Compulsory admissions are considered both in Portuguese and Irish MHA when individuals have a severe mental illness that either puts them at risk to themselves or to the public or of a significant deterioration in their state (specific wording of the law can be found in each Act, respectively). In the Irish MHA the concept of mental disorder is paramount to the detention of an individual in an Approved Centre. In Portugal people with a 'severe psyche anomaly' (freely translated from the original '*anomalia psíquica grave'*) may be admitted involuntarily to a department of psychiatry if they meet criteria for such under the Portuguese MHA and a judge determines they may be so admitted. Both systems acknowledge that measures must be proportionate and must ensure the appropriate treatment of the individual.[30]

While it is not explicit in the Portuguese MHA, lawyers have annotated the law and exclusion criteria are, for the most part, consistent: personality disorders, substance use disorders, mental illness secondary to an organic cause. According to the Irish MHA (Section 9), a person may not be detained by reason *only* of the fact that the person "is suffering from a personality disorder, is socially deviant, or is addicted to drugs or intoxicants".

Furthermore, regarding age, the Irish MHA clearly distinguishes legal procedures for children (under the age of 18) and adults whereas the Portuguese MHA is applied without special requirements to individuals over the age of 14 years old. In individuals that cannot consent or under the age of 14 the legal representative decides.[31]

3.4.Compulsory admissions – who and how

In Portugal, several individuals can request a compulsory admission, but it is the role of the court to decide whether individuals are detained under the MHA. There are in general three ways by which the individual can have the process started: 1) a direct request to the court (if not urgent, the court requests a report to two psychiatrists and decides considering that report); 2) a request to a Public Health doctor (the Public Health doctor decides whether there are grounds or not to have the individual transported to the Psychiatric Emergency Room for assessment or to

[30] T. Almeida & A. Molodynski, 'Compulsory Admission and Involuntary Treatment in Portugal', *BJPsych International* 13(1) (2016) 17-19.

[31] Almeida & Molodynski, ibid.; Mental Health Commission. *Code of Practice relating to Admission of Children under the Mental Health Act* (Dublin: Mental Health Commission 2006).

make a request to the Court); 3) a direct presentation of the individual to the Psychiatric Emergency Room either by themselves or brought by the police[32] (the psychiatric doctor in the Emergency Department assesses and, if warranted, sends a report to the court). If patients are already hospitalized (in a psychiatric or any other unit) and warrant a compulsory admission, the doctor may request the Clinical Director to start the process.

In Portugal, police officers may be involved.[33] However, in Portugal, contrary to Ireland, police officers cannot force entrance to a patient's home and the individual must remain in hospital until the individual is assessed by a doctor to enforce the "deprivation" of their liberty until they are either detained or their liberty is restored.[34] Police officers can, however, force entrance to a patient's home if a judge of law so determines or, exceptionally, if urgency and danger in delay do not allow for a warrant to be issued (article 23.º PMHA). Under the Portuguese MHA, police forces must enact the judicial warrant with the accompaniment of the health service the patient is to be presented to, whenever possible (article 23., n.º2 PMHA), In either case, judicial guarantees assist the patient, particularly *habeas corpus* and the right to appeal the decision on *habeas corpus* (articles 31.º and 32.º PMHA).

In Ireland, several individuals can also request a compulsory admission by completing an application (Forms 1 to 4). A Registered Medical Practitioner (usually, but not always, the General Practitioner) then decides whether the recommendation (Form 5) should be filled out and, if it is, the patient is brought to an approved centre where a Consultant Psychiatrist decides whether criteria are satisfied to detain the individual or not (completing Form 6) . If the individual is already in an Approved Centre (a psychiatric unit that the Mental Health Commission has deemed to have the requisites for patients to be detained if necessary) and wishes to leave it, the Consultant Psychiatrist may decide whether the individual satisfies the criteria or not to be detained. If the psychiatrist decides that the individual satisfies the criteria, he or she may complete the first part of Form 13 and request an independent Consultant Psychiatrist to assess the person and, subsequently, determine whether the person should be detained.

In Portugal, the court has the final say in the decision to detain individuals; i.e. a patient is not involuntarily admitted before a court approves the involuntary admission. If they have entered through the Emergency Department route this happens within hours: the law allows the patient to be held for assessment and admission, but requires immediate communication to the competent court in case the patient opposes to be admitted, in which case the court's decision must be delivered in 48 hours; if not, the patient must be released. However, the decision must be substantiated. This is one of the main differences compared to the Irish MHA, where Consultant Psychiatrists can directly detain individuals, i.e. before the decision is reviewed by a Mental Health Tribunal within 21 days.

3.5.Compulsory admissions – where and for how long

In Portugal, it is the court that reviews the detention. In Ireland, it is the Mental Health Tribunal (MHT) that does so. Joint sessions in Portuguese courts are attended by the patient, his or her solicitor, the applicant and the public prosecutor, but the judge can request the attendance of any other persons, including the treating doctor (art. 18.º, n.º1 and n.º 2 Portuguese MHA). There is no established time frame for these joint sessions.

[32] R. Soares & M. Pinto da Costa, *supra* note 11.
[33] Ibid.
[34] Ibid.

MHTs are attended by the tribunal members (the chair who is a solicitor/barrister, a psychiatrist, a lay member), the treating consultant, the solicitor of the patient and the patient. The first MHT is organized within 21 days of the order of admission. In each MHT the order can be either affirmed or revoked. In between Tribunals a consultant can also revoke the order. Treatment with medications without consent must be confirmed every three months by an independent psychiatrist. ECT without consent must be approved by an independent psychiatrist. Restraint and seclusion are guided by Mental Health Commission regulations.[35] Patients may appeal to the Circuit Court regarding a decision of the MHT to affirm the order (section 19). Patients may also bring habeas corpus or judicial review applications to the High Court.

3.6.Community-based compulsory care – pros and cons

The Portuguese MHA provides for community-based compulsory care while the Irish MHA does not. In Portuguese legislation after a patient admitted under the MHA is discharged there is a joint session in Court. At least a Judge, a Prosecutor, the patient, the patient's lawyer and the responsible psychiatrist attend the session. After hearing all parties, the Judge ultimately decides whether the patient is to continue under compulsory treatment (in the community) or not. If the patient continues under compulsory treatment, he or she is obliged to do the treatment, which usually consists of medication and outpatient appointments. It is often the case that there is an obligation to accept an injection. If patients miss their injection the Court may request the help of the police to enforce the administration of medication. While at a first glance this system may seem much more coercive than the Irish one it may well be the case that it prevents (long) admissions to a psychiatric unit and, thus, actually favours less coercive measures. On the other hand, a 2014 meta-analysis found that community treatment orders may not lead to significant differences in readmission, social functioning, or symptomatology, compared with standard care.[36]

3.7.Beyond the Mental Health Act

The Mental Health Acts are not the only laws applying to individuals with mental illnesses.[37] In Portugal the Mental Health Act falls under the Criminal Law. In Ireland, it has its own scope. In both countries, however, specific legislation exists regarding Capacity. In Ireland, the Assisted Decision-Making (Capacity) Act 2015, commenced in April 2023, is transforming practice around capacity. In Portugal, the former law has recently been replaced by the Lei n.º 49/2018, de 14 de agosto – Regime jurídico do maior acompanhado. While a deeper understanding of the similarities and differences between both is out of the scope of this article, they do carry an impact for those in the field of Mental Health and the Law.

4. Results

[35] Cronin, Gouda, McDonald & Hallahan, *supra* note 23.
[36] S. Kisely & K. Hall, 'An Updated Meta-Analysis of Randomized Controlled Evidence for the Effectiveness of Community Treatment Orders', *Can J Psychiatry* 59(10) (2014) 561-564.
[37] G. Gulati, D. Whelan, V. Murphy, C. Dunne, & B. Kelly, 'The Inherent Jurisdiction of the Irish High Court: Interface with Psychiatry', *International Journal of Law and Psychiatry* 69 (2020) 101533; B. D. Kelly, 'Mental Health Legislation and Human Rights in England, Wales and the Republic of Ireland', *International Journal of Law and Psychiatry* 34 (2011) 439–454.

We have summarized the proceedings in the two jurisdictions in Figures 1 and 2. There are a number of similarities and differences between the Portuguese and the Irish system that we have summarized in Table 1. In the Portuguese system data relating to involuntary admissions is scarce, with studies suggesting most people directly accessing emergency departments with eventual subsequent admission.[38]

In the Irish system there is no separation of urgent and routine involuntary admissions; they follow the same procedures.

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<Insert Figure 2 here>

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5. Discussion

The similarities between the Portuguese and the Irish MHA are obvious. The two MHAs aim to regulate the compulsory admission of individuals with mental illness. They establish the principles and procedures that guide the practice in both countries. In both cases only individuals with a severe mental illness that are at risk of harming themselves or others or of further deterioration should they not be offered appropriate treatment that can alleviate their suffering to a material extent can be admitted involuntarily. In Portugal, the court requests a report from two doctors five days and then every two months after the compulsory admission or community-based treatment. In Ireland a Tribunal is held within 21 days of the Order of Admission and then, if affirmed, after another 21 days, and then then this period gets longer as the durations of the Renewal Orders increase.

The main differences the authors have found are regarding who detains the individuals and whether the system permits compulsory community care or not. In Portugal, psychiatrists cannot detain individuals while in Ireland they can. Psychiatrists in Portugal complete reports that substantiate the decision of the court, whether the individual is in the emergency department and needs an urgent involuntary admission or the court has requested a report of two psychiatrists so the court can then make the decision to detain the individual or not. The psychiatrists can only advise if the individual meets the criteria for an involuntary admission or not based on their expert opinion. In Ireland, however, consultant psychiatrists can detain individuals if they are satisfied that they meet the criteria to be so detained. Moreover, in Ireland, independent psychiatrists must issue reports (under section 17) that Tribunals can use to decide whether they will affirm or revoke the order; in our opinion, this further ensures the fairness of the process as

[38] D. O. Aluh, M. Santos-Dias, M. Silva, B. Pedrosa, U. Grigaitė, R. C. Silva, M. Mousinho, Maria Ferreira, J. P. Antunes, M. Remelhe, G. Cardoso, & J. M. Caldas-de-Almeida, 'Contextual Factors Influencing the Use of Coercive Measures in Portuguese Mental Health Care', *International Journal of Law and Psychiatry* 90 (2023) 101918. https://doi.org/10.1016/j.ijlp.2023.101918; J. Ramos, J. Santos, S. Jorge, T. Maia & G. Cardoso, 'Pathways to Care for First Psychiatric Admissions in Lisbon', *Psychiatric Services* 66(8) (2015) 888–891; M. Silva, A. Antunes, S. Azeredo-Lopes, A. Loureiro, B. Saraceno, J. M. Caldas-de-Almeida, & G. Cardoso, 'Factors associated with Involuntary Psychiatric Hospitalization in Portugal', *International Journal of Mental Health Systems* 15(1) (2021) 37.

opposed to using in-house psychiatrists only. One could argue that the Portuguese MHA protects the therapeutic relationship more, although psychiatrists also inform the court as to whether the individual meets the criteria or not according to their technical expertise. Since, in Portugal, psychiatry trainees in the Emergency Department can themselves issue a report to the court, one could also argue that they do not have enough qualifications to do so. However, the court makes the decision and within less than five days the court requests another report from two different doctors (neither can be the same that assessed the person in the emergency department).[39] One could further argue that in Portugal the courts base their decisions on reports and they do not know the person. However, the technical knowledge regarding who meets criteria of having a severe mental illness is with psychiatrists. And it is important, given that a person is being deprived of their liberty, that the decision be scrutinised by a court or tribunal.

Compulsory community care is possible in Portugal but not in Ireland. When a patient is discharged to a compulsory community-based regime in Portugal, they must sign a written document whereby they accept this treatment instead of remaining in hospital. At least some psychiatrists in Portugal question the reasonableness of the patient signing such a document to leave hospital since, while they are gaining more liberty, they are acknowledging they will still accept coercive treatment. Furthermore, it is sometimes queried if the patient could sometimes move directly from a voluntary to an involuntary community treatment without having to be admitted to hospital. On this issue, article 33 of the Portuguese MHA seems difficult to interpret, giving Judges the last word on whether a change from voluntary to involuntary status might be without or must be with a prior admission to hospital. Nonetheless, the conditional discharge of patients may be a compromise to consider between continuing enforcing treatment while permitting the individual who meets criteria to be under a compulsory regime to be in a less restrictive environment.[40] The length of the hospital admissions in countries with and without community treatment orders should be further studied.[41] The authors note that there are involuntary patients in hospital in Ireland receiving long-acting injections frequently administered monthly that could be given in the community if there was a system to ensure it. However, we recognise that there are risks with introducing such a system and there would need to be detailed consideration of the consequences of such a major change.

In Portugal there are also two different pathways: routine and urgent, while in Ireland the procedures are the same albeit Section 3 distinguishes risk to self/others and deterioration in mental health. Recent empirical studies are necessary to establish whether or not most compulsory admissions to hospital in Portugal are through an urgent route.

The two systems also acknowledge differences between children and adults. Generally, under Portuguese law, civil legal capacity is established at 18 years old (article 123.º, Civil Code;

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[39] H. Prata-Ribeiro, 'The Portuguese Mental Health Law: The criteria for Compulsory Internment', *European Psychiatry* 33(S1) (2016) S489; Salize, Dreßing, & Peitz, *supra* note 21.

[40] M. Monden & J. Duindam, 'Conditional Discharge of Three Committed Psychiatric Patients: The Ambulatory Practice', *Nederlands Tijdschrift voor Geneeskunde* 144(32) (2000) 1548-1551; R. Durst, A. Teitelbaum, Y. Bar-El, & M. Shlafman, 'Compulsory, Ambulatory Psychiatric Treatment', *Harefuah* 133(12) (1997) 597-602.

[41] A.M.A. O'Brien & S. J. Farrell, 'Community Treatment Orders: Profile of a Canadian Experience', *Canadian Journal of Psychiatry* 50(1) (2005) 27-30; T. Burns, J. Rugkåsa, A. Molodynski, J. Dawson, K. Yeeles, M. Vazquez-Montes, … & S. Priebe, 'Community Treatment Orders for Patients with Psychosis (Octet): A Randomised Controlled Trial', *The Lancet* 381(9878) (2013) 1627-1633; S. P. Segal, N. Preston, S. Kisely & J. Xiao, 'Conditional Release in Western Australia: Effect on Hospital Length of Stay', *Psychiatric Services* 60(1) (2009) 94-99; P. Barnett, H. Matthews, B. Lloyd-Evans, E. Mackay, S. Pilling, & S. Johnson, 'Compulsory Community Treatment to Reduce Readmission to Hospital and Increase Engagement With Community Care in People With Mental Illness: A Systematic Review and Meta-Analysis', *The Lancet Psychiatry* 5(12) (2018) 1013-1022.

exceptionally, minors' legal capacity is acknowledged under article 127.º, Civil Code) and criminal liability is established at 16 years old (article 19.º Penal Code). The Portuguese MHA stipulates that minors over 14 years old are capable for giving consent (referring to voluntary admission, article 7.º/b). Having three different ages might increase difficulty to navigate the system for those involved. Child and Adolescent Mental Health Services (CAMHS) in Portugal serve people below the age of 18 years old while Adult Psychiatry and Mental Health Services serve people 18 years and older, except for the Emergency Department where specific exceptions may apply such as adult services observing people 16 years and older. The organization of services in Portugal is different from that in Ireland and not every region has a CAMHS, although this reality has profoundly changed in most recent years. Regarding children, the authors consider the Irish MHA clearer and easier to follow, while acknowledging that patients between the age of 16 and 18 in Ireland are from time to time admitted to Approved Centres in Adult Psychiatry Services, even though the Mental Health Commission has stated that this should only occur in exceptional circumstances.[42]

There are issues that are not addressed by both MHAs. Portuguese and Irish Laws are naturally different, but both acknowledge that in some circumstances the individual might be treated without consent even if they do not satisfy the criteria under the MHA. In Ireland, individuals can be temporarily detained if they lack capacity and are under an imminent and serious risk

Under Portuguese law, the consent of patients who do not have the capacity of self-determination is given by legal representatives, namely their legal guardians (article 142.º, Civil Code). In urgent cases where guardianship has not been established, treatment should be decided considering, when possible, the patient's presumed consent (articles 6.º and 9.º of the Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine, ratified by Portugal in 2001).[43] Patients with severe mental illness who cannot understand the meaning of consent can be committed if the lack of treatment contributes to the deterioration of their state (article 12.º MHA)

Furthermore, in both regimes, courts may decide on specific treatments under Capacity Laws (the *Regime Jurídico do Maior Acompanhado* in Portugal and the Wards of Court in Ireland, the latter changed in 2023). In Ireland, the Assisted Decision-Making (Capacity) Act 2015 may alleviate the use of the MHA 2021 in specific circumstances when the person has expressed their preference in advance; further studies will be warranted to ascertain its impact.

Another issue that emerges from our research is the value of training for those involved directly or indirectly with the MHA.[44] In Portugal, police officers would welcome further training.[45]. In Ireland, training is usually mandatory for staff (including Assisted Admissions, nursing staff, doctors, tribunal members and legal representatives)[46] and psychiatrist trainees and

[42] Mental Health Commission, *Addendum to Code of Practice Relating to Admission of Children under the Mental Health Act 2001* (Dublin: Mental Health Commission, 2009).
[43] A. Sousa Pinheiro & D. de Freitas, *Portugal. Country Thematic Report on the Fundamental Rights of Persons with Intellectual Disabilities and Persons with Mental Health Problems* (Vienna: EU Fundamental Rights Agency, 2009).
[44] I. Nwachukwu, N. Crumlish, E. Heron, & M. Gill, 'Irish Mental Health Act 2001: Impact on Involuntary Admissions in a Community Mental Health Service in Dublin', *The Psychiatrist* 34 (2010) 436–440.
[45] Soares & Pinto da Costa, *supra* note 11.
[46] R. Murphy, D. McGuinness, E. Bainbridge, L. Brosnan, et al., 'Service Users' Experiences of Involuntary Hospital Admission under the Mental Health Act 2001 in the Republic of Ireland', *Psychiatric Services* 68(11)

psychiatrists in general find their training in the MHA to be good.[47] In the two countries, efforts are made to inform individuals of their rights under the MHAs. Detainees under the MHAs have their own solicitor and are offered guidance on the process in both countries.

The aim of mental health care is to have better care closer to the individual's own community.[48] The MHA is a living document that changes throughout the years. Mental health legislation is not the only player in moving towards improving citizens' mental health and reducing its burden in the community. There are several contributing factors. Many of these must be acted upon a long time before considering the option of detaining an individual. In 2011 Portugal was under austerity measures. There was a lesser investment in mental health. Among the identified consequences was an increase in compulsory admissions in at least one of the populated regions in Portugal, Odivelas.[49] There have been several measures proposed to improve the efficiency of the services in Portugal,[50] some of these may well have an impact in reducing the need to contemplate restrictive measures. The COVID-19 pandemic has also imprinted its mark on the need for mental health support and treatment. Several articles demonstrate an impact in the vulnerability to mental illness[51] and at least some studies suggest an increased number of detentions since the Covid-19 pandemic has begun and that there were several restrictions that further imposed limitations of liberty particularly for those detained in hospital.[52] While before the pandemic patients could, in justified circumstances, be granted leave,[53] they were exceptionally allowed to leave the units during certain periods of the pandemic. While this seemed to be one of the restrictions most reported by patients, it was far from the only one.[54] When considering changes to the law, as proposed by WHO, those must be

(2017) 1127-1135; Mental Health Commission, *Mental Health Commission News: Volume 1, Issue 3* (Dublin: Mental Health Commission, 2005).

[47] F. Jabbar, B. Kelly, & P. Casey, 'National Survey of Psychiatrists' Responses to Implementation of the Mental Health Act 2001 in Ireland', *Irish Journal of Medical Science* 179(2) (2010) 291-294.

[48] De Almeida, *supra* note 2.

[49] M. Gil, D. Lopes, C. Martinho, M. Pereira, L. Gomes, J. Machado, … & H. Esteves, 'Mental Illness Decompensation between 2007 and 2016 in a Portuguese Municipality', *European Journal of Public Health* 27(suppl_3) (2017) ckx187.133.

[50] A. Nunes & D. Ferreira, 'Reforms in the Portuguese Health Care Sector: Challenges and Proposals', *International Journal of Health Planning and Management* 34(1) (2019) e21-e33.

[51] J. Wirkner, H. Christiansen, C. Knaevelsrud, U. Lüken, S. Wurm, S. Schneider & E.-L. Brakemeier, 'Mental Health in Times of the COVID-19 Pandemic: Current Knowledge and Implications from a European Perspective', *European Psychologist* 26 (2022) 310-322; A. Werling, S. Walitza, S. Eliez, & R. Drechsler, 'The Impact of the COVID-19 Pandemic on Mental Health Care of Children and Adolescents in Switzerland: Results of a Survey among Mental Health Care Professionals after One Year of COVID-19', *International journal of Environmental Research and Public Health* 19(6) (2022) 3252.

[52] M. Balestrieri, P. Rucci, D. Amendola, M. Bonizzoni, G. Cerveri, C. Colli, F. Dragogna, G. Ducci, M. G. Elmo, L. Ghio, F. Grasso, C. Locatelli, C. Mencacci, L. Monaco, A. Nicotra, G. Piccinini, L. Pischiutta, M. Toscano, M. Vaggi, V. Villari, A. Vitalucci, G. Castelpietra, & E. Bondi, 'Emergency Psychiatric Consultations During and After the COVID-19 Lockdown in Italy: A Multicentre Study', *Frontiers in Psychiatry* 12 (2021) 929.

[53] A. Datta & J. Frewen, 'Mental Health Law Profile on the Republic of Ireland', *BJPsych International* 13(1) (2016) 15-17.

[54] B. D. Kelly, 'Emergency Mental Health Legislation in Response to the Covid-19 (Coronavirus) Pandemic in Ireland: Urgency, Necessity and Proportionality', *International Journal of Law and Psychiatry* 70 (2020) 101564.

realistic and attainable.[55] When law changes, adaptations must occur and they may take several years to implement,[56] nevertheless, these are warranted if in the right direction.[57]

Besides the ones already mentioned, strengths to the current study include the comparison of two MHAs in European countries that are sufficiently different to provide clear grounds for a critical discussion and the understanding of several factors at play when discussing changes to the current legislation. Previous studies have focused on comparing MHAs in different English-speaking countries,[58] but broadening our understanding to other jurisdictions may introduce different practices that could eventually be beneficial. There are also other factors that affect mental health legislation such as cultural differences, poverty indexes, and more recently COVID-19. The MHAs are dynamic rather than static documents, and the law has changed throughout the years, with a new Bill currently being discussed in both countries.

The current study has shortcomings that may be overcome with an increased focus in the area. The study compares the Portuguese and the Irish realities regarding the current MHAs. Even though the authors have chosen to focus on systems they are acquainted with, this study unveils several procedural differences which are notable when designing newer approaches. The authors would welcome further research in the field in order to have further clarity on how better we can provide for those with severe mental illness. We chose to focus on a theoretical introduction rather than show empirical data. Although this was the focus of our current study, we need empirical data to better clarify how differences and similarities in the Law may have a practical impact in the history of the illness and the quality of life of individuals with a severe mental illness. In addition, common law and civil law traditionally have different ways of approach to legal matters. In our understanding, purpose(s) and common grounds of the law are more relevant than their differences and the comparison can help us develop a better system in the future.

6. Conclusion

Mental Health Acts differ from country to country, but we can learn from each other in order to better serve those with severe mental illness. While there are established principles in place, the process is dynamic and newer principles will translate into different practices. A theoretical comparison of the similarities and differences between existing models in different countries may aid to a more comprehensive understanding and, subsequently, a better conceptualization and establishment of principles to guide future practice. Cultural differences may play a role when tailoring the law to each country, but we could benefit from additional comparison of existing models in different countries. Moreover, empirical studies would further increase our knowledge and lead to best practices on the frontier between Mental Health and the Law.

[55] Freeman & Pathare, *supra* note 16.
[56] B. D. Kelly, 'The Irish Mental Health Act 2001', *Psychiatric Bulletin* 31(1) (2007) 21-24; B. D. Kelly, 'Mental Health Law in Ireland 1945 to 2001: Reformation and Renewal', *Medico-Legal Journal* 76 (2008) 65-72.
[57] A. Ní Mhaoláin & B. Kelly, 'The Irish Mental Health Act 2001: Where are we Now?', *Psychiatric Bulletin* 33 (2009) 161-164.
[58] Cronin, Gouda, McDonald, & Hallahan, *supra* note 23.

Figure 1 – Explanatory flowchart of involuntary admissions and subsequent provisions in Portugal, adapted from Almeida & Molodynski, supra note 30.

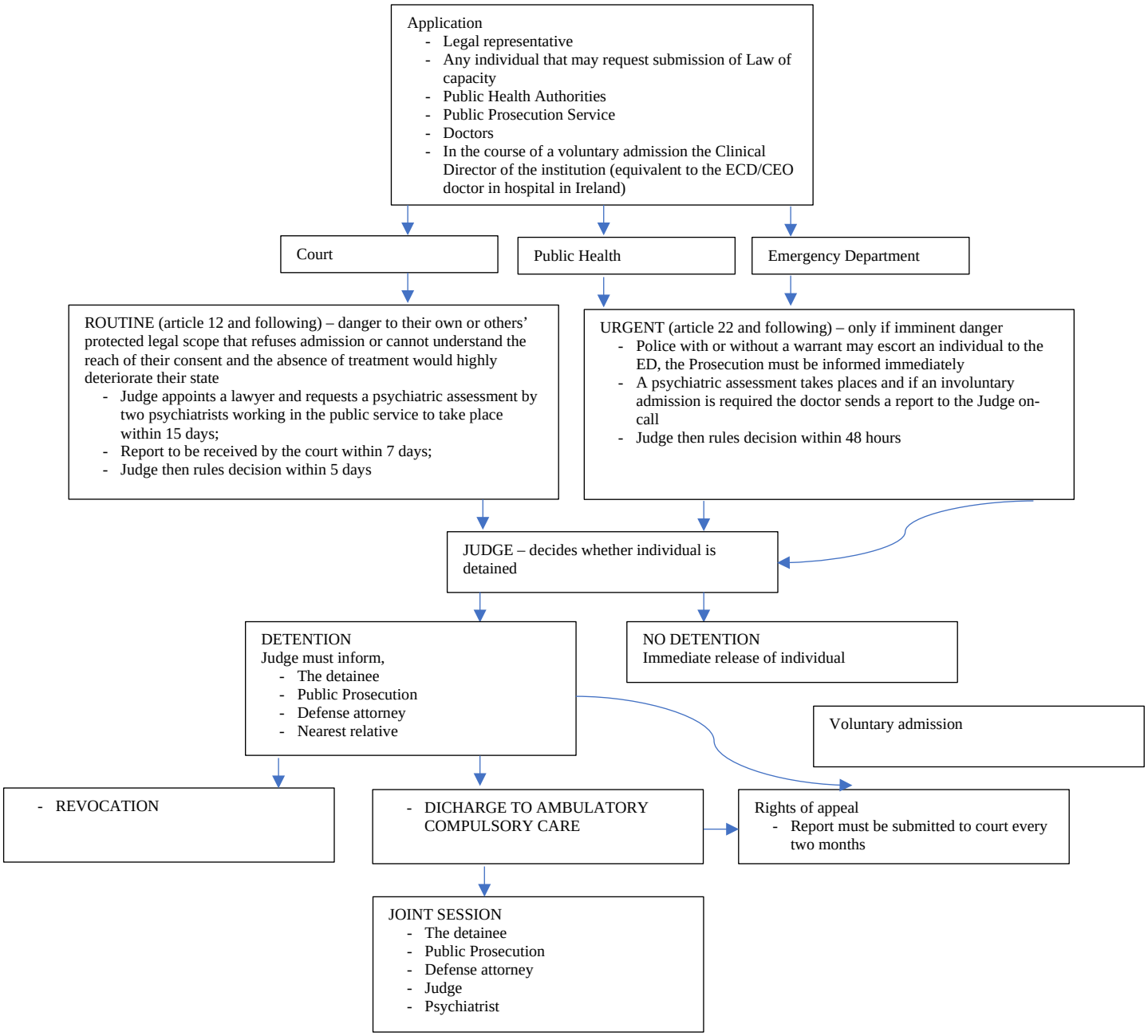

Figure 2 – Explanatory flowchart of involuntary admissions and subsequent provisions in Ireland. We highlighted commonly used forms in Approved Centres, for an exhaustive list please refer to https://www.mhcirl.ie/what-we-do/mental-health-tribunals/statutory-forms, last consulted 25/09/2023. List of acronyms: PICU - Psychiatric Intensive Care Unit. CMH - Central Mental Hospital.

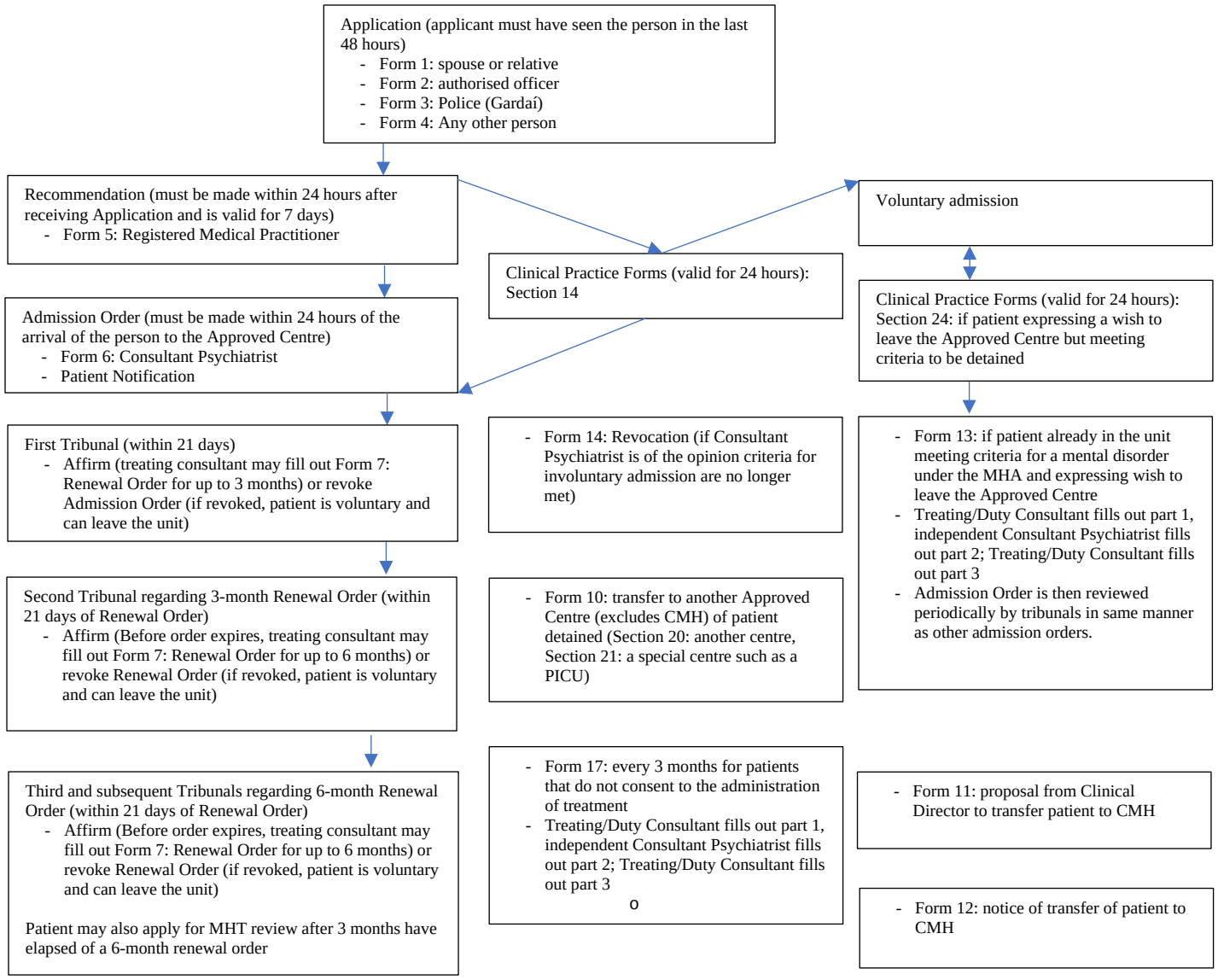

Table 1 – Similarities and differences between the Portuguese and the Irish MHA.

	Portugal	Ireland
Last Approved MHA	Law n.º 36/98, of 24th of July, note also Law n.º 49/2018, of 14/08	Mental Health Act 2001 Revised, Updated to 26 April 2023
New system under discussion?	Yes	Yes, may be enacted in 2024 or 2025
Age differences	The Portuguese MHA applies to those over 14 years old	The Irish MHA recognizes differences for individuals younger and older than 18 years old
Who can be detained	Individuals with severe mental illness that are a risk to themselves or the public or that would deteriorate further should they not be detained.[59]	Individuals with severe mental illness that are a risk to themselves or the public or that would deteriorate further should they not be detained
Who cannot be detained	(a) Individuals in which the behavior is explained by a personality disorder, (b) individuals that are under the influence of substances, (c) individuals in which the mental illness is secondary to an organic cause.[60]	A person may not be detained by reason *only* of the fact that the person "(a) is suffering from a personality disorder, (b) is socially deviant, or (c) is addicted to drugs or intoxicants." (s.8(2) Mental Health Act 2001)
Who can assist in the transport to the institution that can enforce treatment	Police when requested by the court Police cannot enter the premises	Assisted Admissions – Private company which assists with admissions Police (Gardaí) when requested by the Clinical Director or acting Clinical Director
Where is the MHA applicable	In any healthcare establishment	In Approved Centres only, although Form 21 can be used to transfer out of the approved centre should they need special treatment within the course of the involuntary admission
Who can request an involuntary admission	Anyone can request an involuntary admission (Almeida & Molodynski, *supra* note 30), including family member, health authority, guardian, physician, public prosecutor (Salize, Dreßing, & Peitz, *supra* note 21)	Application may be completed by anyone but most are completed by relatives, police or authorised officers. Recommendation must be completed by a Registered Medical Practitioner
Who can detain	Court (Almeida & Molodynski, *supra* note 30)	(a) Consultant Psychiatrist (b) District Court in the case of children
Rights	"Patients must be informed of their rights to be present in the procedural acts and to be heard by a judge, to be assisted by an appointed or nominated defence attorney, to submit evidence and to request the proceedings deemed necessary, and to appeal the decision. Patients also have the right to vote, to send and receive mail, and to communicate with the Monitoring Commission" (Almeida & Molodynski, *supra* note 30)	Persons who are detained must receive a written notice of their rights (s.16 of MHA)
Duties	"The detained patient is required to accept medically prescribed treatments." (Almeida & Molodynski, 2 *supra* note 30)	If the person has capacity, he/she may refuse medication. Sections 56 to 61 of MHA deal with treatment issues.
Who can end the detention	Court No temporal limit but the court must review every two months	Consultant Psychiatrist/Tribunals/Court No limit but renewal orders must be made and MHTs are held in pre-determined time frames which interval initially increases with the length of admission (see Figure 2)
Community-based compulsory care?	Yes, in specific cases the court may determine that the individual avails of community-based compulsory care	No, for the purpose of administration of treatment without consent the individual must be admitted to an Approved Centre
Regulatory bodies	The Court – joint sessions ensure application of the Portuguese MHA The Court in case of Habeas Corpus	The Mental Health Commission – Tribunals ensure application of the Irish MHA The District Court (for children) The Circuit Court (appeals from MHT decisions) The High Court in case of Habeas Corpus or Judicial Review
Other comments	(a) If the individual does not have capacity of self-determination, he or she may be given treatment (art. 12.º Portuguese MHA) (b) Presumptive consent can be used in emergency situations (art. 156.º, n.º 2 Portuguese Penal Code and art. 340º, n.º 3 Portuguese Civil Code)	If a serious and immediate risk exists, and the person lacks capacity and wishes to leave, the person may be temporarily detained due to the case of *A.C. v Cork University Hospital* [2019] I.E.S.C. 73. The authors strongly recommend that legal advice be sought should a detention need to occur outside the scope of the MHA.

[59] J. Ferreira, A. Figueiredo, & A. Marieiro, 'A Melancolia e o Internamento Compulsivo', *Psiquiatria Psicologia e Justiça* 5 (2012) 82-94.

[60] P. Soares de Albergaria, *A Lei da Saúde Mental (Lei n.º 36/98, de 24 de julho) – Anotada.* (Coimbra: Ed. Almedina, 2006).

	(Entidade Reguladora da Saúde, *Consentimento Informado - Relatório Final* (2009))	
Issues arising	No PICUs	
Other restrictive measures	Treatment should be the least restrictive possible (Salize, Dreßing, & Peitz, *supra* note 21)	Seclusion, restraint, others
ECT	Patient's written consent necessary (Salize, Dreßing, & Peitz, *supra* note 21)	If person does not consent and does not have capacity to refuse, process is set out in s.59, involving an independent psychiatrist
Psychosurgery	Requires "previous written consent and the favourable opinion of two psychiatrists designated by the National Council of Mental Health (a government advisory body)" (Almeida & Molodynski, *supra* note 30; Salize, Dreßing, & Peitz, *supra* note 21)	If person does not consent, it may be authorised by a tribunal under s.58.
Participate in investigations, clinical trials or training activities	Individuals can consent or not	Persons involuntarily admitted may not take part in clinical trials - s.70 MHA