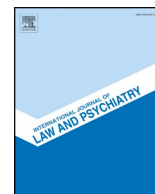




Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Elsevier hereby grants permission to make all its COVID-19-related research that is available on the COVID-19 resource centre - including this research content - immediately available in PubMed Central and other publicly funded repositories, such as the WHO COVID database with rights for unrestricted research re-use and analyses in any form or by any means with acknowledgement of the original source. These permissions are granted for free by Elsevier for as long as the COVID-19 resource centre remains active.



## Emergency mental health legislation in response to the Covid-19 (Coronavirus) pandemic in Ireland: Urgency, necessity and proportionality



Brendan D. Kelly\*

Department of Psychiatry, Trinity College Dublin, Trinity Centre for Health Sciences, Tallaght University Hospital, Dublin D24 NR0A, Ireland

### HIGHLIGHTS

- Many countries are enacting emergency mental health legislation owing to Covid-19.
- In Ireland, the review process for involuntary psychiatry patients has been amended.
- The proportionality of these changes will depend on implementation in practice.
- Good communication, team-work and professional codes of practice and ethics are vital.

### ARTICLE INFO

#### Keywords:

Mental health legislation  
Covid-19  
Coronavirus  
Ireland  
Human rights  
Mental disorder

### ABSTRACT

Many countries have enacted, or are in the process of enacting, emergency mental health legislation in response to the global pandemic of Covid-19 (coronavirus). In Ireland, the Emergency Measures in the Public Interest (Covid-19) Act, 2020 amends the Mental Health Act 2001 to permit the Mental Health Commission to request an independent psychiatric report about an involuntary patient from any consultant psychiatrist who is not treating the patient (and not just those on its designated panel). This independent examination may occur 'in person', 'by other appropriate means', or even, 'due to the exigencies of the public health emergency', not occur at all, once this is explained in the resultant report. The 2020 Act acknowledges that 'the exigencies of the public health emergency' might hamper the independent psychiatrist's work and requires a written report from the patient's treating psychiatrist 'no earlier than the day before' the tribunal, *in lieu* of the psychiatrist physically attending a tribunal hearing, although, if possible, they will attend (i.e. phone in to) a tribunal held by conference call. The 2020 Act permits the Mental Health Commission to, if necessary, appoint tribunals 'consisting of one member who shall be a practising barrister or solicitor'. Such a tribunal shall, if possible, consult with a consultant psychiatrist if the reports from the independent psychiatrist and treating psychiatrist conflict or if it is otherwise 'necessary in the interest of the patient'. A tribunal can extend an involuntary order by a second period of 14 days 'of its own motion if the tribunal, having due regard to the interest of the patient, is satisfied that it is necessary'. Tribunals for current involuntary patients will be prioritised over retrospective tribunals for discharged patients; a tribunal can direct a witness to provide 'a written statement' rather than attending; and the patient can make written representation to the tribunal instead of physically attending a tribunal hearing, although they may attend (i.e. phone in to) a tribunal held by conference call. Psycho-surgery for involuntary patients is banned. While it is clear that revisions are urgent and necessary in light of Covid-19, the proportionality of these changes will depend on how, and the extent to which, they are used in practice. With good communication, efficient team-working and close adherence to professional codes of practice and ethics, it is hoped that these amendments will result in a review system that is as reasonable, robust and reassuring as the current, highly unusual circumstances permit.

### 1. Introduction

On 11 March 2020, the World Health Organization declared that the global outbreak of Covid-19 (coronavirus) had become a pandemic. In

light of the numbers infected with the virus, and the strain it was placing on health systems and societies in virtually every country in the world, many governments enacted emergency legislation as part of their response to the pandemic. Some countries included emergency

\* Corresponding author.

E-mail address: [brendan.kelly@tcd.ie](mailto:brendan.kelly@tcd.ie).

<https://doi.org/10.1016/j.ijlp.2020.101564>

Received 1 April 2020; Received in revised form 18 April 2020; Accepted 18 April 2020

Available online 22 April 2020

0160-2527/ © 2021 The Author. Published by Elsevier Ltd. This is an open access article under the CC BY license (<http://creativecommons.org/licenses/by/4.0/>).

mental health legislation in their package of measures to address the unprecedented situation brought about by the virus. In Ireland, the Emergency Measures in the Public Interest (Covid-19) Act, 2020 was passed with some speed through the Irish parliament and signed by the president on 27 March, with a commencement date of 30 March for the provisions relating to mental health (Section 1(2)(b)).

Ireland's emergency legislation contains a broad range of measures including a nationwide freeze on rents, a ban on evictions, measures to allow the re-enlistment of former members to the defence forces and provisions to allow retired health workers to be re-hired during the emergency (Finn, 2020). There is also a large financial aid package to allow the government to contribute to wage packets during the emergency and a series of amendments to the Mental Health Act, 2001.

This paper examines the content of this emergency legislation as it relates to mental health legislation and provides a preliminary reflection on the extent to which the measures introduced were urgent, necessary and proportionate. A more detailed, definitive assessment of these matters can only be made retrospectively, after the current public health emergency is over. For the moment, this paper (1) provides an outline of relevant sections of Ireland's Mental Health Act, 2001; (2) sets out the mental health measures introduced in the emergency legislation of March 2020 as part of the Emergency Measures in the Public Interest (Covid-19) Act, 2020; (3) discusses the new provisions and key issues that arise from them; and (4) presents some conclusions and suggestions for future work.

## 2. Ireland's Mental Health Act, 2001

Ireland's Mental Health Act, 2001 was fully commenced in November 2006 (Kelly, 2007). The legislation is primarily concerned with involuntary admission and treatment in psychiatric 'approved centres' (i.e. psychiatry inpatient units) and ensuring standards of care (Kelly, 2016). Owing to the facts that (a) key aspects of this legislation have been outlined previously in this journal (Ng & Kelly, 2012) and (b) the Emergency Measures in the Public Interest (Covid-19) Act, 2020 focuses chiefly on reviews of involuntary admissions, this section of the paper will focus on outlining the existing review mechanism under the 2001 Act, prior to the 2020 amendments, rather than outlining the 2001 Act in full. There are three areas of relevance to the present paper: (1.1) definitions of key terms in the Mental Health Act, 2001; (1.2) independent psychiatric reports; and (1.3) mental health tribunals.

### 2.1. Definitions of key terms in the Mental Health Act, 2001

The Mental Health Act 2001 defines 'mental disorder' as 'mental illness, severe dementia or significant intellectual disability where (a) because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons, or (b) (i) because of the severity of the illness, disability or dementia, the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission, and (ii) the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent' (Section 3(1)).

More specifically, a 'mental illness' is 'a state of mind of a person which affects the person's thinking, perceiving, emotion or judgment and which seriously impairs the mental function of the person to the extent that he or she requires care or medical treatment in his or her own interest or in the interest of other persons' (Section 3(2)).

'Severe dementia' is 'a deterioration of the brain of a person which significantly impairs the intellectual function of the person thereby affecting thought, comprehension and memory and which includes severe psychiatric or behavioural symptoms such as physical

aggression'. 'Significant intellectual disability' is 'a state of arrested or incomplete development of mind of a person which includes significant impairment of intelligence and social functioning and abnormally aggressive or seriously irresponsible conduct on the part of the person'.

The 2001 Act states that 'a person may be involuntarily admitted to an approved centre [...] and detained there on the grounds that he or she is suffering from a mental disorder' (Section 8(1)), but cannot be so admitted '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' (Section 8(2)). The three-step involuntary admission procedure under the 2001 Act has been previously described in this journal (Feeney, Umama-Agada, Gilhooly, Asghar, & Kelly, 2019) and results, in the first instance, in a 21-day 'admission order', which can be followed by a 'renewal order' of three months and then six months duration (Section 15), if the preceding order is affirmed by a mental health tribunal (Section 18).

### 2.2. Independent psychiatric reports under the Mental Health Act, 2001

The Mental Health Act 2001 made provision for the establishment of a 'Mental Health Commission', one of the functions of which is to appoint mental health tribunals 'to determine such matter or matters as may be referred to it by the Commission' (Section 48(1)). One of the chief functions of tribunals is to review involuntary admission and renewal orders (Section 18).

In order to inform the tribunal's decisions, Section 17 of the 2001 Act requires that the Mental Health Commission obtains an independent psychiatric report about each involuntary patient and supplies it to the tribunal. More specifically, the Act states that:

Following the receipt by the [Mental Health] Commission of a copy of an admission order or a renewal order, the Commission shall, as soon as possible (a) refer the matter to a tribunal, (b) assign a legal representative to represent the patient concerned unless he or she proposes to engage one, (c) direct in writing (referred to in this section as 'a direction') a member of the panel of consultant psychiatrists established [for this purpose] to (i) examine the patient concerned, (ii) interview the consultant psychiatrist responsible for the care and treatment of the patient, and (iii) review the records relating to the patient, in order to determine in the interest of the patient whether the patient is suffering from a mental disorder and to report in writing within 14 days on the results of the examination, interview and review to the tribunal to which the matter has been referred and to provide a copy of the report to the legal representative of the patient (Section 17(1)).

This independent psychiatric report is an essential part of the evidence used by the tribunal to decide whether to affirm or revoke the involuntary admission or renewal order:

Where the Commission gives a direction under this section, the [independent] consultant psychiatrist concerned shall, on presentation by him or her of the direction at the approved centre concerned, be admitted to the centre and allowed to (a) examine the patient and the records relating to the patient, and (b) interview the consultant psychiatrist responsible for the care and treatment of the patient (Section 17(2)).

Any 'person who obstructs or interferes or fails to co-operate with [an independent] consultant psychiatrist in the performance of his or her functions under this section shall be guilty of an offence' (Section 17(4)). Once the independent psychiatric report is prepared, the independent psychiatrist must submit it to the Mental Health Commission which supplies it to the tribunal, the patient's legal representative and the patient's treating psychiatrist, ahead of the tribunal hearing itself.

### 2.3. Mental health tribunals under the Mental Health Act, 2001

Each involuntary admission or renewal order is reviewed by a

mental health tribunal within 21 days of the making of the order (Section 18(2)), unless the order is revoked by the treating psychiatrist before the date of the tribunal, in which case the patient can elect to have retrospective tribunal at a later date (Section 28(3)(b)).

Mental health tribunals are held in the 'approved centre' (i.e. psychiatry inpatient unit) where the patient is admitted. Each tribunal comprises three members, including one consultant psychiatrist, one barrister or solicitor (of no fewer than seven years' experience) (the chairperson) and one other person, known as the lay member (Section 48(3)). Within 21 days of an involuntary admission or renewal order being made, and having received the independent psychiatric report made under Section 17 of the 2001 Act, a mental health tribunal reviews the involuntary admission or renewal order and, 'if satisfied that the patient is suffering from a mental disorder' and that appropriate procedure has been followed, shall affirm the order; if the tribunal is not so satisfied, the tribunal shall 'revoke the order and direct that the patient be discharged from the approved centre concerned' (Section 18(1)).

To make their decision, the three tribunal members all travel to the 'approved centre' for the hearing, which is also attended by the patient's treating psychiatrist, the patient's legal representative, the patient (if they wish to attend) and any witnesses that the tribunal may require. The tribunal hears evidence, facilitates cross-examination and makes its decision by majority voting (Section 48(4)).

Grounds for appeal of tribunal decisions are limited: the patient 'may appeal to the Circuit Court against a decision of a tribunal to affirm an order made in respect of him or her on the grounds that he or she is not suffering from a mental disorder' (Section 19(1)); i.e. there is no possibility of appeal to the Circuit Court on other grounds, such as procedural aberrations. Following an appeal in the Circuit Court, the patient may, if he or she wishes, appeal to the High Court, but not on grounds related to whether or not he or she suffers from a mental disorder; he or she may appeal to the High Court solely 'on a point of law' (Section 19(16)). These restrictions appear significant and it is notable that the burden of proof lies with the patient in the Circuit Court ([Expert Group on the Review of the Mental Health Act, 2001, 2015](#)). The patient may, however, make an application under Article 40 of the Constitution of Ireland or instigate a Judicial Review as an alternative way of challenging decisions made under the 2001 Act.

### 3. Emergency Measures in the Public Interest (Covid-19) Act, 2020

The Emergency Measures in the Public Interest (Covid-19) Act, 2020 makes several significant changes to the review mechanism in the Mental Health Act, 2001. These changes can be described under three headings: (2.1) background to the mental health provisions of the new legislation; (2.2) independent psychiatric reports; and (2.3) mental health tribunals.

#### 3.1. Background to the mental health provisions of the Emergency Measures in the Public Interest (Covid-19) Act, 2020

The main purpose of Ireland's Emergency Measures in the Public Interest (Covid-19) Act, 2020 is 'to make exceptional provision, in the public interest and having regard to the manifest and grave risk to human life and public health posed by the spread of the disease known as Covid-19 and in order to mitigate, where practicable, the effect of the spread of that disease and to mitigate the adverse economic consequences resulting, or likely to result from the spread of that disease and to mitigate its impact on the administration of vital public service functions' (Long Title).

The legislation also seeks 'to make provision, due to the exigencies of the public health emergency posed by the spread of Covid-19, for certain amendments and modifications to the provisions of the Mental Health Act, 2001 relating to the carrying out of reviews under Section 18 of that Act' (Long Title). Part 5 of the 2020 Act, which deals with the

2001 Act, came into effect on 30 March 2020 and is to remain in force until 9 November 2020 or longer if needed, although an extension requires a resolution passed by both Houses of the Oireachtas (parliament) (Section 1).

To outline the rationale for the new legislation, the 2020 Act inserts a new section into the 2001 Act referring to 'the exigencies of the public health emergency posed by the spread of Covid-19 and, in particular, to: (a) the manifest and grave risk to human life and public health posed by the spread of Covid-19; (b) the necessity, for compelling reasons of public interest and for the common good, for measures and safeguards to prevent, minimise or limit the risk of persons being infected with Covid-19; (c) the effect, on the availability of consultant psychiatrists and other persons to perform functions under this Act, of the spread of Covid-19 and of the deployment of the resources of the health services in order to (i) prevent, minimise or limit the risk of persons being infected with Covid-19, (ii) test persons for Covid-19, and (iii) provide care and treatment to persons infected with Covid-19' (Section 16). The two areas of the 2001 Act that are specifically amended by the 2020 Act relate to independent psychiatric reports and mental health tribunals.

#### 3.2. Independent psychiatric reports under the Emergency Measures in the Public Interest (Covid-19) Act, 2020

Section 17 of the 2020 Act amends Section 17 of the Mental Health Act, 2001 by revising certain aspects of the role of the independent psychiatrist sent by the Mental Health Commission to prepare an independent psychiatric report about an involuntary patient for the mental health tribunal. Under the 2020 Act, the Mental Health Commission shall 'direct in writing a member of the panel of consultant psychiatrists established under Section 33(3)(b) or a consultant psychiatrist, other than the consultant psychiatrist responsible for the care and treatment of the patient concerned, to (i) subject to Subsection (6), examine the patient concerned, (ii) interview the consultant psychiatrist responsible for the care and treatment of the patient, and (iii) review the records relating to the patient, in order to determine in the interest of the patient whether the patient is suffering from a mental disorder' and to submit a report to the tribunal (Section 17(a)).

There are two significant changes here. First, under the 2020 Act, the Mental Health Commission no longer necessarily needs to engage an independent consultant psychiatrist from their own panel of independent psychiatrists, but can engage any consultant psychiatrist who is not the patient's treating psychiatrist, in order to prepare the independent psychiatric report for the tribunal. This broadens the pool of psychiatrists from which the Mental Health Commission can choose. If the assigned psychiatrist is unable to perform this role, they must inform the Mental Health Commission of this so that another psychiatrist can be assigned to the case (Section 17(b)).

Second, under the new Section 17(6) of the 2001 Act, 'in the event that a consultant psychiatrist concerned is unable, due to the exigencies of the public health emergency, to carry out an examination, whether in person or by other appropriate means, under Subsection (1)(c)(i), he or she shall set out the particular reasons for being unable to do so in his or her report to the tribunal under that subsection'. This is a significant change that merits some exploration.

The Mental Health Act, 2001 defines an 'examination' as 'a personal examination carried out by a registered medical practitioner or a consultant psychiatrist of the process and content of thought, the mood and the behaviour of the person concerned' (Section 2(1)). The 2020 amendment indicates a tolerance for the fact that, owing to the Covid-19 emergency, the independent psychiatrist might not be able to perform such an examination 'in person' and that 'other appropriate means' can be acceptable. This, presumably, includes remote assessment using various communication technologies. In addition, the 2020 amendment suggests that the independent psychiatrist might not be able to examine the patient at all, and, if this is the case, that the independent psychiatrist must explain this in their report for the tribunal.

With regard to the independent psychiatrist gaining access to the patient, the treating psychiatrist and the records, the Mental Health Act, 2001 states that any 'person who obstructs or interferes or fails to co-operate with a consultant psychiatrist in the performance of his or her functions under this section shall be guilty of an offence' (Section 17(4)). The 2020 Act adds that 'it shall be a defence for a person who is charged with an offence under Subsection (4) of failing to co-operate with a consultant psychiatrist in the performance of his or her functions under this section to prove that the failure was attributable to the exigencies of the public health emergency' (Section 17(c)).

Finally, the 2020 Act adds a new requirement for a written report to be provided to the tribunal by the patient's treating psychiatrist 'no earlier than the day before the date of the relevant sitting of the tribunal on his or her opinion as to whether the patient continues to suffer from a mental disorder and to give a copy of the report to the legal representative of the patient' (Section 17(a)). This written report by the patient's treating psychiatrist is in addition to the report by the independent psychiatrist and is a new requirement that did not feature in the Mental Health Act, 2001 at all. This additional report appears to be *in lieu* of the treating psychiatrist actually attending a physical tribunal hearing (as was the case under the 2001 Act). The Mental Health Commission specifies that all tribunals will be held remotely (i.e. by conference call) and adds that the treating psychiatrist 'must attend' by phoning in to the tribunal, unless they 'cannot attend for Covid-19 reasons' (Mental Health Commission, 2020). This appears to exceed the requirements of the legislation.

### 3.3. Mental health tribunals under the Emergency Measures in the Public Interest (Covid-19) Act, 2020

The next amendments in the 2020 Act relate chiefly to Section 18 of the 2001 Act which concerns 'review by a tribunal of admission and renewal orders'. The 2001 Act specified that each mental health tribunal would comprise three members, including one consultant psychiatrist, one barrister or solicitor of no fewer than seven years' experience (the chairperson) and one other person, known as the lay member (Section 48(3)). The 2020 Act states that 'where it appears to the [Mental Health] Commission that, due to the exigencies of the public health emergency, a tribunal cannot be appointed in accordance with those subsections, it may appoint a tribunal consisting of one member who shall be a practising barrister or solicitor who has had not less than 7 years' experience as a practising barrister or solicitor ending immediately before such appointment' (Section 20).

If a one-person tribunal is appointed, 'the tribunal concerned shall consult with a consultant psychiatrist, other than the consultant psychiatrists who prepared the reports under Section 17(1) (c) [the independent psychiatrist] and (d) [the treating psychiatrist], for the purpose of making a decision [...] where (a) the opinions expressed in the reports under Section 17(1)(c) and (d) as to whether the patient is suffering from a mental disorder differ, or (b) it otherwise considers that it is necessary in the interest of the patient to do so' (Section 18). The Mental Health Commission shall appoint a consultant psychiatrist for this consultation purpose (Section 21) although this provision 'shall not apply where the tribunal is unable, due to the exigencies of the public health emergency, to consult' in this way (Section 18).

There is also a change to the power of tribunals to extend involuntary admission or renewal orders. The 2001 Act stated that such orders 'may be extended by order by the tribunal concerned (either of its own motion or at the request of the patient concerned) for a further period of 14 days and thereafter may be further extended by it by order for a period of 14 days on the application of the patient if the tribunal is satisfied that it is in the interest of the patient' (Section 18(4)). The 2020 Act adds that the second extension can also be made by the tribunal 'of its own motion if the tribunal, having due regard to the interest of the patient, is satisfied that it is necessary due to the exigencies of the public health emergency' (Section 18).

With regard to retrospective tribunals for discharged patients, the 2001 Act states that, if an involuntary admission or renewal order is revoked prior to a mental health tribunal, the treating psychiatrist will inform the patient that they are 'entitled to have his or her detention reviewed by a tribunal' if 'he or she so indicates by notice in writing addressed to the [Mental Health] Commission within 14 days of the date of his or her discharge' from the order (Section 28(3)(b)). The 2020 Act adds that, for such a retrospective tribunal for a discharged patient, 'a decision under Section 18(1) shall be made as soon as is reasonably practicable having regard to (i) the exigencies of the public health emergency, and (ii) the need for the tribunal to afford priority to reviews relating to patients who are being detained pursuant to an admission order or a renewal order' (Section 19).

The 2020 amendments also allow for a tribunal to direct a witness to provide 'a written statement' rather than attending the tribunal, owing to 'the exigencies of the public health emergency' (Section 21), and, instead of the patient being physically present at a tribunal hearing, the tribunal shall make provision 'enabling the patient the subject of the review to present his or her case to the tribunal by way of representations in writing made by the patient or his or her legal representative' (Section 21). The Mental Health Commission (2020) specifies that all tribunals will be held remotely (i.e. by conference call) and the Mental Health Act Administrator at the approved centre shall organise for a telephone to be made available to the patient to that they can attend (i.e. phone in to) the tribunal.

Finally, psycho-surgery for involuntary patients, which required written consent and tribunal approval under the 2001 Act (Section 58), is no longer permitted under the 2020 amendments (Section 22). Transitional provisions are also outlined (Section 24).

## 4. Urgent, necessary and proportionate?

Ireland's Emergency Measures in the Public Interest (Covid-19) Act, 2020 introduces significant changes to the Mental Health Act, 2001 owing to the public health emergency presented by Covid-19. In summary, the 2020 amendments permit the Mental Health Commission to request an independent psychiatric report about an involuntary patient from any consultant psychiatrist who is not treating the patient (and not just those on the designated panel). The independent examination may occur 'in person', 'by other appropriate means', or even, 'due to the exigencies of the public health emergency', not occur at all, once this is explained in the report (Section 17(c)). The 2020 Act acknowledges that 'the exigencies of the public health emergency' might hamper the independent psychiatrist in their work and requires a written report from the patient's treating psychiatrist 'no earlier than the day before' the tribunal (Section 17(a)), *in lieu* of the treating psychiatrist physically attending a tribunal hearing, although the treating psychiatrist will still attend (i.e. phone in to) a tribunal held by conference call (Mental Health Commission, 2020).

The 2020 Act permits the Mental Health Commission to, if necessary, appoint tribunals 'consisting of one member who shall be a practising barrister or solicitor' (Section 20). Such a tribunal shall, if possible, consult with a consultant psychiatrist if the reports from the independent psychiatrist and treating psychiatrist conflict or if it is otherwise 'necessary in the interest of the patient' (Section 18). A tribunal can extend an involuntary order by a second period of 14 days 'of its own motion if the tribunal, having due regard to the interest of the patient, is satisfied that it is necessary due to the exigencies of the public health emergency' (Section 18). Tribunals for current involuntary patients will be prioritised over retrospective tribunals for discharged patients (Section 19); a tribunal can direct a witness to provide 'a written statement' rather than attending a physical tribunal hearing (Section 21); and the patient can make written representation to the tribunal instead of attending, although they can attend (i.e. phone in to) a tribunal held by conference call (Mental Health Commission, 2020). Psycho-surgery for involuntary patients is banned



(Section 22).

#### 4.1. Independent psychiatric reports

The independent psychiatric report is a key element in the review process for involuntary patients. The amendments outlined in the 2020 Act make significant changes to this element of the process. To date, psychiatrists who carry out these independent psychiatric reports are formally recruited by the Mental Health Commission to a panel of independent psychiatrists through competitive interviews that are followed by a training programme for successful candidates. The 2020 Act allows the Mental Health Commission to engage psychiatrists who have not undergone these interview and training processes to carry out independent reports.

This provision presumably reflects, in the words of the 2020 Act, 'the effect, on the availability of consultant psychiatrists and other persons to perform functions under this Act, of the spread of Covid-19 and of the deployment of the resources of the health services in order to (i) prevent, minimise or limit the risk of persons being infected with Covid-19, (ii) test persons for Covid-19, and (iii) provide care and treatment to persons infected with Covid-19' (Section 16). In other words, there might be a shortage of independent psychiatrists from the formal panel if too many of them are either ill or redeployed to other areas of the health service. This measure, then, broadens the pool of psychiatrists from which the Mental Health Commission can recruit independent psychiatrists and increases the chances that independent psychiatric reports will indeed be performed for the duration of the public health emergency. This measure seems urgent and proportionate, although whether or not it is necessary will depend on the course of the pandemic itself. Nonetheless, its inclusion in the emergency legislation appears prudent.

The more significant change to Section 17 of the 2001 Act concerns the content of the independent psychiatric report itself. Prior to the 2020 Act, the 2001 Act required the independent psychiatrist to examine the involuntary patient in person, interview the treating psychiatrist and review the records (Section 17(1)(c)). While the treating psychiatrist was generally interviewed by telephone, the other two elements of this assessment required the independent psychiatrist to attend the approved centre in person in order to examine the involuntary patient and review the records. The 2020 Act suggests that the independent psychiatrist might not need to attend the approved centre at all.

In the first instance, the 2020 Act permits the independent examination of the patient to be performed 'in person or by other appropriate means' and states that if the independent psychiatrist is 'unable, due to the exigencies of the public health emergency, to carry out an examination', they 'shall set out the particular reasons for being unable to do so' in their report (Section 17(c)). Permitting the independent examination to be performed by 'other appropriate means' presumably permits remote examination, by video-link or telephone. The tolerance of no examination whatsoever presumably acknowledges the fact that remote examination is not always possible with, for example, a highly disturbed patient who is in seclusion. While this amendment to the legislation appears both urgent and necessary in the context of Covid-19, the requirement to explain the absence of an independent examination in certain cases is vital because this is a key element of the 2001 Act's protection of patients' rights.

The 2020 Act does not remove the requirement for the independent psychiatrist to review the patients' records, which is the second reason why independent psychiatrists visit approved centres (in addition to examining the patients). Retaining the requirement to review the records presumably reflects an assumption that, if the independent psychiatrist does not attend the approved centre in person, the approved centre will find a secure way to convey the records to the independent psychiatrist, notwithstanding the likely impact of Covid-19 on administrative and clinical staff in approved centres. This is a considerable

assumption in terms of both the human resources and technological capabilities of approved centres during the public health emergency. Against this background, it is reasonable that 'the exigencies of the public health emergency' (Section 17(c)) will be taken into account if the independent psychiatrist encounters difficulties in their work (e.g. difficulties accessing records).

Finally, the requirement for a written report from the patient's treating psychiatrist, rather than the psychiatrist physically attending a tribunal hearing (Section 17(a)), is a reasonable change in the circumstances, as it permits tribunals to be held remotely, by video-meeting or conference call, presuming that appropriate technology is available. The treating psychiatrist will still phone in to a tribunal held by conference call in order to attend ([Mental Health Commission, 2020](#)). Clear, secure communication will be vital in order to maintain the integrity of, and confidence in, the new procedures.

#### 4.2. Mental health tribunals

The Emergency Measures in the Public Interest (Covid-19) Act, 2020 introduces significant changes in relation to mental health tribunals. Perhaps the most dramatic shift is the possible move from a three-person to a one-person tribunal, if necessary. Such a tribunal shall consist 'of one member who shall be a practising barrister or solicitor who has had not less than 7 years' experience as a practising barrister or solicitor' (Section 20). The idea of a one-person tribunal was previously considered in Ireland by a government-appointed expert group that reviewed the 2001 Act in 2015:

While recognising that the most common international practice is for a three-person review board comprising a psychiatrist, a person with legal qualifications and what is generally regarded as a community/lay member, the group members opted to look for evidence of the operation of a one-person review board elsewhere. Other jurisdictions specifically reviewed include England, Scotland, Victoria and New South Wales.

The suggestion put forward to the group members was that a single-person review board with a high-level legal qualification who perhaps would operate on a full-time basis might not just offer an alternative structure to the current one in operation, but would allow the sole person to develop particular 'judicial' expertise in this field while still having a medical report prepared for him/her by an independent consultant psychiatrist. While members saw certain merits in this proposal, the fact that the state of Victoria in Australia seems to be the only jurisdiction which has operated a one-person review board system did not offer high hopes that this was the way of the future. Victoria, in fact, has recently decided to return to a three-person model...

On that basis and in the absence of any compelling reasons for change the group recommends that there should be no change in the current composition of review boards at this time. However, this question should be re-examined in any future review of the mental health legislation ([Expert Group on the Review of the Mental Health Act, 2001, 2015](#); p.45).

Clearly, the possible loss of the perspective of the lay person from some tribunals as a result of the 2020 Act would be significant, but it is helpful that a one-person tribunal shall, if possible, consult with a consultant psychiatrist if the reports from the independent psychiatrist and treating psychiatrist conflict or if it is otherwise 'necessary in the interest of the patient' (Section 18). The possibility of one-person tribunals is the most questionable change introduced in the new legislation and it is difficult to justify in terms of proportionality, especially if tribunals can be held remotely. It is to be hoped that one-person tribunals, if used at all, will be constituted only as a last resort when a three-person tribunal absolutely cannot be assembled.

The possibility of a tribunal extending an admission or renewal

order by a second period of 14 days 'if the tribunal, having due regard to the interest of the patient, is satisfied that it is necessary due to the exigencies of the public health emergency' (Section 18) appears reasonable if regrettable, as are the prioritisation of tribunals for current involuntary patients over discharged patients (Section 19) and the possibility of written statements from witnesses (Section 21). The ban on psycho-surgery for involuntary patients (Section 22) and the transitional provisions are also reasonable (Section 24).

The final change worthy of attention is that, instead of the patient having the right to physically attend their mental health tribunal hearing, the 2020 Act states the tribunal shall make provision for 'enabling the patient the subject of the review to present his or her case to the tribunal by way of representations in writing made by the patient or his or her legal representative' (Section 21). While not all patients attended their tribunals in the past, many of them did, and this change will have considerable psychological and emotional significance for certain patients. In addition, some patients might have poor reading and writing skills, so this provision will place considerable additional responsibility on patients' legal representatives to ensure that their clients' views are conveyed to the tribunal, although patients will still be able to attend (i.e. phone in to) a tribunal held by conference call (Mental Health Commission, 2020). All told, this is a proportionate if regrettable change, and one that is necessary in the context of tribunals being held remotely.

## 5. Conclusions

The rights of people with mental illness, especially those experiencing involuntary admission and treatment, are, quite rightly, the subject of ongoing concern (Funk & Drew, 2017), especially in light of the United Nations Convention on the Rights of Persons with Disabilities (Committee on the Rights of Persons with Disabilities, 2014; United Nations, 2006). While human rights are not the only or necessarily the best ways to fulfil all human needs (Osiatyński, 2009), robust observance of rights is vital in the setting of involuntary mental health care (Kelly, 2015). The law plays a particular role in promoting and protecting such rights and all amendments require very close scrutiny as a result (World Health Organization, 2005; World Health Organization, 2017).

In Ireland, the amendments to the Mental Health Act, 2001 introduced by the Emergency Measures in the Public Interest (Covid-19) Act, 2020 are generally reasonable, necessary and (for the most part) proportionate, with the possibility of one-person tribunals providing the greatest cause for concern.

The changes have considerable significance for involuntary patients who now might not be examined by an independent psychiatrist as part of the review process and who will no longer physically attend a mental health tribunal hearing, although they can attend (i.e. phone in to) a tribunal held by conference call (Mental Health Commission, 2020). While their cases will still be considered by an independent psychiatrist and patients can still represent their views to the tribunal (which might comprise just one person), the changes to these processes necessitated by the public health emergency are significant. It is hoped that they will be short-lived.

It should, however, be noted that most provisions of Ireland's Mental Health Act, 2001 have *not* been changed by the 2020 Act. The involuntary admission process, for example, remains the same. This is not the case in all jurisdictions. The UK's Coronavirus Act, 2020, for example, sets out extensive changes to mental health and mental capacity legislation in England and Wales (Schedule 8), Scotland (Schedule 9) and Northern Ireland (Schedules 10 and 11). Notwithstanding the difficulties of cross-jurisdictional comparison, it is notable that the UK legislation makes significant changes to the involuntary admission process in England and Wales, stating that:

An application by an approved mental health professional under Section 2 or 3 made during a period for which this paragraph has

effect may be founded on a recommendation by a single registered medical practitioner (a 'single recommendation'), if the professional considers that compliance with the requirement under that section for the recommendations of two practitioners is impractical or would involve undesirable delay (Section 3(1) of Schedule 8).

This is a significant change for England and Wales and it has already raised significant human rights concerns (Hosali, 2020). There are also changes to various time-frames under the legislation in England and Wales which have given rise to similar concerns (Liberty, 2020). In Ireland, the involuntary admission process remains unchanged.

As with all legislative changes, the proportionality of the amendments to mental health legislation in Ireland's 2020 Act will ultimately depend on implementation on the ground (Sen, 2009). Independent psychiatrists might well feel that, in particular cases, they cannot examine a given patient in person (owing to public health guidance) or remotely (owing to the patient's mental state on the day), and it is not clear how tribunals will respond to independent reports that outline this. It is also not clear to what extent Ireland's Mental Health Commission will need to constitute one-person as opposed to three-person tribunals, as this will only become apparent as the public health emergency unfolds. All of these matters will require careful monitoring and study, and it is to be hoped that all efforts will be made to minimise any dilution of, or delay to, the review process.

Finally, it is not clear how patients and their legal representatives will respond to these new arrangements. While the need for modifications in light of Covid-19 is clear and is likely to be universally agreed, the proportionality of these changes and how they work out in practice are yet to be established. With good communication, efficient team-working and close adherence to professional codes of practice and ethics, it is hoped that these amendments will result in a review system that is as reasonable, robust and reassuring as these highly unusual circumstances permit.

## Animal and human rights

Not applicable.

## Role of the funding source

This study had no funding.

## Declaration of Competing Interest

The author was a member of the Expert Group on the Review of the Mental Health Act, 2001 (2015); was consulted by various parties at different stages in the development of the Emergency Measures in the Public Interest (Covid-19) Act, 2020; and is Editor-in-Chief of the *International Journal of Law and Psychiatry* and a co-editor of this special issue, but he played no role in the management of this paper during the editorial process. There is no other interest to declare.

## Acknowledgements

The author is very grateful to the co-editors of this special issue and the peer-reviewers.

## References

- Committee on the Rights of Persons with Disabilities (2014). *General comment no. 1*. Geneva: United Nations.
- Expert Group on the Review of the Mental Health Act, 2001 (2015). *Report of the expert group on the review of the mental health act, 2001*. Dublin: Department of Health.
- Feeney, A., Umama-Agada, E., Gilhooley, J., Asghar, M., & Kelly, B. D. (2019). Gender, diagnosis and involuntary psychiatry admission in Ireland: A report from the Dublin Involuntary Admission Study (DIAS). *International Journal of Law and Psychiatry*, 66, 101472.
- Finn, C. (2020). 'Many people will now get paid': Emergency Covid-19 legislation signed

- into law by President Higgins. TheJournal.ie, 27 March [www.thejournal.ie/seanad-simon-coveney-5059598-Mar2020](http://www.thejournal.ie/seanad-simon-coveney-5059598-Mar2020).
- Funk, M., & Drew, N. (2017). WHO QualityRights: Transforming mental health services. *Lancet Psychiatry*, 4, 826–827.
- Hosali, S. (2020). *The Coronavirus Bill and human rights*. London: British Institute of Human Rights. [www.bihhr.org.uk/blog/the-corona-virus-bill-and-human-rights](http://www.bihhr.org.uk/blog/the-corona-virus-bill-and-human-rights) Accessed 1 April 2020.
- Kelly, B. D. (2007). Ireland's Mental Health Act, 2001. *Psychiatric Bulletin*, 31, 21–24.
- Kelly, B. D. (2015). *Dignity, mental health and human rights: Coercion and the law*. London and New York: Routledge.
- Kelly, B. D. (2016). *Mental illness, human rights and the law*. London: RCPsych Publications.
- Liberty (2020). *Liberty Calls for Continuous Scrutiny of Coronavirus Bill*. London: Liberty. [www.libertyhumanrights.org.uk/issue/liberty-calls-for-continuous-scrutiny-of-coronavirus-bil](http://www.libertyhumanrights.org.uk/issue/liberty-calls-for-continuous-scrutiny-of-coronavirus-bil) Accessed 1 April 2020.
- Mental Health Commission (2020). *Guidance for Mental Health Tribunals: Re the Emergency Measures in the Public Interest Act, 2020 and the Covid-19 Public Health Emergency*. Dublin: Mental Health Commission.
- Ng, X. T., & Kelly, B. D. (2012). Voluntary and involuntary care: Three-year study of demographic and diagnostic admission statistics at an inner-city adult psychiatry unit. *International Journal of Law and Psychiatry*, 35, 317–326.
- Osiatyński, W. (2009). *Human rights and their limits*. Cambridge: Cambridge University Press.
- Sen, A. (2009). *The idea of justice*. London: Allen Lane/Penguin Group.
- United Nations (2006). *Convention on the rights of persons with disabilities*. New York: United Nations.
- World Health Organization (2005). *WHO resource book on mental health, human rights and legislation*. Geneva: World Health Organization.
- World Health Organization (2017). *Advancing the right to health: The vital role of law*. Geneva: World Health Organization.