A Prospective Evaluation of the Operation and Effects of the Mental Health Act 2001 from the Viewpoints of Service Users and Health Professionals
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Glossary

AO’s – Authorised Officers

BPRS - Brief Psychiatric Rating Scale

CAT - Client Assessment of Treatment Scale

CL – Coercion Ladder

CMHN – Community Mental Health Nurse

CTO – Community Treatment Order

DSM – Diagnostic and Statistical Manual of Mental Disorders

ECT - Electro-Convulsive Therapy

FG - Focus Group

FM - Family Member

GA – Garda Siochana

GAF - Global Assessment of Functioning

GP – General Practitioner

HDAI - Hogan Drug Attitude Scale

HSE – Health Service Executive
MDT – Multi-Disciplinary Team

MHA – Mental Health Act

MHN – Mental Health Nurse

MTA - Mental Treatment Act

MPCS - Mac Arthur Perceived Coercion Scale

NAT – National Assisted Admission Team

PSY - Psychiatrists

QOL - Quality of Life

SAI-E - Schedule for the Assessment of Insight

SCID-I - The Structured Clinical Interview for DSM-IV Axis I Disorders

SD – Standard Deviation

SU - Service User

SUMD - Scale to Assess Unawareness in Mental Disorder

TM - Tribunal Members
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Executive Summary

Coercive care through involuntary admission to an inpatient psychiatric ward and associated treatment, usually without informed consent, is applied to over 2,000 individuals nationally each year in Ireland. The intention of service providers is to reduce the immediate risk of harm and/or deliver care to those assessed as lacking capacity to consent to their admission and treatment. However the experience is often traumatic for service users who are subjected to deprivation of liberty and withdrawal of autonomy over their bodily integrity and choice of care. The Mental Health Act (MHA) 2001 (Office of the Attorney General, 2001) came into force in Ireland in 2006 and provides a statutory framework for the involuntary admission and treatment of an individual assessed as having a “mental disorder” to an approved centre. It was intended to ensure compliance with the standards set out under the European Convention on Human Rights, and introduced a number of safeguards for service users, including the right to an automatic independent review of their involuntary admission and continuing detention by a mental health tribunal.

Irish and international studies to date into the experience of involuntary admission have reported wide variation in the attitudes of service users towards their detention, with some evidence that clinical features such as greater awareness of illness and less perceived coercion are associated with more positive attitudes. Many previous studies were conducted on small numbers of individuals at a single timepoint. Some qualitative international research on people’s experiences of detention and treatment tend to portray a complex array of positive and negative experiences. Many individuals report frustration at their loss of autonomy and feelings of powerlessness. Other individuals highlight experiences of respect for autonomy and acknowledge the treatment benefits associated with care. Research with other stakeholders involved in involuntary admission is limited, but some studies of general practitioners, psychiatrists or nurses have highlighted the
frustration that these clinicians experience with the processes involved, including the time delays in implementing involuntary admission, heavy workloads and the negative impact the processes can have on the therapeutic alliance between service users and clinicians.

The current research programme comprised three studies which sought: (i) to comprehensively evaluate the attitudes towards care, and their clinical associations, of a representative cohort of service users who have been subject to the MHA 2001; (ii) to explore using qualitative research the experiences of a selection of service users throughout the trajectory of their involuntary admission; and (iii) to assess and compare the views of other key stakeholders involved in the various stages of the involuntary admission process towards the operation of the MHA 2001 in practice.

The first study was a prospective, observational study of a representative cohort of service users recruited from three psychiatric inpatient units in Galway and Roscommon, that utilized quantitative assessments of clinical features and attitudes towards their involuntary admission and care at two timepoints (a) shortly after their involuntary admission (n=263) and (b) approximately 3 months after discharge from involuntary admission, when participants were considered likely to have recovered symptomatically to their clinical baseline (n=155). Notably one third of the individuals transferred to or prevented from leaving inpatient psychiatric units under MHA 2001 over the study period were clinically assessed by consultant psychiatrists as not detainable, but no information was systematically collected about these individuals, despite having been subject to coercion under the Act.

When assessed objectively using standard psychometric instruments approximately 3 months after involuntary admission, service users demonstrated substantial symptomatic and functional improvement since their inpatient admission. Most individuals (65%) viewed the involuntary admission as necessary in retrospect. Levels of satisfaction with care were
moderate during the involuntary admission and improved further by the
time of the follow-up assessment. However attitudes towards care and
treatment varied widely with many negative attitudes towards the
experience persisting, especially in relation to assessment in the community,
the information provided about detention and medical treatment, and the
fairness of mental health tribunals. The strongest predictors of more positive
attitudes towards involuntary admission and treatment tended to be clinical
factors such as level of awareness of illness, symptomatic improvement,
diagnosis and absence of illicit substance misuse, rather than service related
factors, such as experience of actual coercive measures (physical restraint,
intramuscular medication or seclusion), whether an admission order was
completed, length of involuntary admission and whether the admission order
was reviewed by a mental health tribunal. This study indicates that certain
clinical characteristics can be identified in individuals during the involuntary
admission which are likely to be associated with persistently negative
attitudes towards care even in remission, and that it may be possible to
identify such individuals for additional supportive interventions in order to
minimise the negative impact of involuntary admission and to enhance their
engagement in community care.

The second study was a qualitative study conducted on a subset of the service
users who participated at the second timepoint of study 1, and recruited
using purposive and maximum variation sampling (n=50). Individuals
underwent semi-structured interviews and data were analysed using an
inductive thematic process and grounded theory. Service users reported
mixed experiences over the course of their involuntary admission, which
comprised of both positive and challenging aspects. Participants reported
feeling coerced, disempowered, and unsupported at various stages of their
admission process and highlighted the long-term deleterious impact this had
on their psychological well-being. However, participants also identified times
when they encountered individuals who endeavoured to initiate a
collaborative, informative and compassionate approach. Four key themes
emerged consistently across the trajectory of participants’ involuntary
admission experiences: a) feeling trapped and coerced; b) feeling disengaged and unsupported; c) admission induced distress; and d) person-centred encounters. The grounded theory analysis identified the theory of “Preserving Control” as a central process describing service users’ experience of coercive care and interactions with professionals, which in turn incorporated the three themes of Losing Control, Regaining Control and Maintaining Control.

Several of the negative issues identified by service users appeared targetable and potentially could be ameliorated by a multi-faceted strategy, inclusive of ongoing education and training of stakeholders in the principles and practices of humanising person-centred care. Additionally helpful measures are likely to include the provision of repeated and accessible information and emotional support to service users during the stages of involuntary admission, provision of familiar staff during the distressing stage of transfer to hospital, and a focus on optimising the service users’ journey towards regaining and preserving the control that was lost in the process of coercive care.

The third study was an assessment and comparison of other stakeholders’ views about the different stages of the involuntary admission process, including relatives, consultant psychiatrists, psychiatric nurses, Gardaí, general practitioners, solicitors and mental health tribunal members. The study employed two approaches: (i) a descriptive survey using the same questionnaire with the different stakeholder groups (n=503) and (ii) a series of eight focus groups conducted with each stakeholder group separately, and also including a service user group, with the data analysed using a general inductive approach (n=62).

Stakeholders agreed that individuals generally benefit from the care they receive and that the MHA 2001 ensures an independent and fair review of the person’s detention. However, substantial process difficulties for stakeholders in the implementation of MHA 2001 were highlighted, particularly at the
distressing period of clinical assessment and transfer to hospital, with the stakeholders involved in this aspect of the process expressing the highest levels of dissatisfaction. Additional service related supports appear likely to improve the negative experiences, including increased training and information for stakeholders, support and resourcing of authorised officers, provision of local assisted admission services and support staff.

Considering the three studies that comprise the research programme together, it is apparent that the implementation of MHA 2001 in clinical practice succeeds in achieving certain basic goals in ensuring that care is delivered to individuals experiencing a mental disorder and safeguarding certain human rights whilst that care is delivered coercively. However consistently across the three studies, which used complementary quantitative and qualitative methodologies with service users and other stakeholders, key substantial difficulties were identified with the experience of the processes in practice that appear open to amelioration. There is substantial dissatisfaction with the processes experienced by service users and stakeholders involved in the community assessment and transfer of individuals to hospital, which could be improved by a more central role for experienced clinicians and support staff in this process. Service users and other stakeholders identified lack of information and emotional support at critical points in the process, including prior to admission, around treatment with medication and the tribunal experience. Greater education and information for the service user and carers around the different stages of the involuntary admission process should be provided and repeated as appropriate, given the likely impact that distress and cognitive dysfunction will have on absorbing and processing information. The experience of mental health tribunals could also be improved by training participants to minimize the adversarial nature and implementing more inclusive processes, where relatives, support persons or other members of the multidisciplinary team are invited to attend with the person’s consent.
On top of their mental disorder, service users often suffer from the additionally traumatising impact of disempowerment throughout the process, which can contribute to persistent anxiety after the admission and contribute to poor engagement with community services. The positive experiences during detention that were recalled by service users tended to centre around kind and humanising care experienced in interactions with professionals. Therapeutic efforts by professionals implementing the processes should, as well as providing care and treatment for the disorder, focus on supporting individuals in their efforts to regain and maintain control through acts of emotional support and compassion, enhanced accessible information provision and maximizing service user choice where feasible.

In the light of the findings of the research programme, the project steering group propose the following recommendations:

1. The Mental Health Commission should instigate a process to ensure that information is collected through each approved centre on all service users subject to MHA 2001, even when an involuntary admission is not completed.

2. National agencies engaged in health services research, including the Health Service Executive and Health Research Board, should support research to assess the impact of any interventions on involuntary admission rates and on attitudes and experiences of service users and other stakeholders towards the involuntary admission process.

3. The Mental Health Commission, with support from the Health Services Executive (HSE), should ensure that accessible information is made readily available for all stakeholders involved with the MHA 2001 processes, including service users/families/GPs/gardai, via website and training resources.

4. Mental health service providers, including HSE and private services, should ensure that clinical staff are further trained to implement the most humanising and autonomy-enhancing care for service users at each stage.
of the involuntary admission process. Training should be mandatory and highlight the additional trauma that service users experience though care being provided coercively.

5. All clinical staff should focus on supporting service users to regain and maintain their autonomy and sense of control throughout the involuntary admission process.

6. All committees considering system reforms and staff training on the involuntary admission process should have adequate levels of representation by service users and family members who have experience of the involuntary admission process.

7. The HSE should ensure that authorised officers become the norm rather than exception for community assessments and are available at all times.

8. Support available for service users at each stage of the involuntary admission process should include a support representative of their choice, such as an advocate or peer support worker.

9. Use of national assisted admissions service should be minimised, so that it is a last resort in exceptional situations, and instead assisted admissions should be funded for implementation by staff familiar with the service user where this is possible.

10. Accessible information about involuntary admission and rights should be delivered in context and repeated as necessary to service users and family members by mental health service staff.

11. Service users should be provided with the opportunity to discuss their experience of the involuntary admission process with members of the multidisciplinary team.

12. Chairpersons of Mental Health Tribunals should ensure that all reasonable steps are taken to minimise any adversarial elements of tribunal hearings.

13. The Mental Health Commission should instigate a process for feedback by service users and other stakeholders into their experience of Mental Health Tribunals.
14. Mental Health Tribunals should welcome other stakeholders, such as a support person chosen by service user, family members or nonmedical clinical staff to attend tribunals, if requested by the service user.

15. Clinical teams should ensure that each service user subject to involuntary admission should have a documented multidisciplinary aftercare plan to include wellness maintenance and crisis intervention intended to reduce the likelihood of involuntary readmission, whilst maximising the individual’s efforts to maintain control and autonomy.
Introduction

The Mental Health Act 2001 (MHA 2001) provides a statutory framework for the involuntary admission and treatment of persons with a mental disorder to approved centres in Ireland. There is limited evidence in relation to the experiences of service users, their family members, carers and health professionals of the MHA 2001 in practice. The purpose of the research programme reported here was to comprehensively evaluate the impact and experiences of MHA 2001 from the viewpoint of both service users and other stakeholders, including carers and professionals involved in the process. The report commences with an outline of the background to the research programme including a description of the current process of involuntary admission and its context in relation to human rights law, as well as a review of Irish and international research into the experience of service users and other stakeholders of the involuntary admission process. The report then outlines in turn three studies examining (i) the attitudes, and their clinical associations, of a representative cohort of service users using a prospective observational quantitative study design, (ii) the in depth exploration of opinions and experiences of a selection of service users using qualitative research methodology, and (iii) the attitudes of other stakeholders towards the process of involuntary admission using questionnaire and focus group study designs. The report ends with a summary of findings across the studies and 15 recommendations.
Chapter 1. Background

Involuntary admission rates

There is a wide variation in the rates of involuntary admission to psychiatric inpatient units across Europe, likely related to legal, cultural and service provision differences, and reportedly ranging from 6 per 100,000 population in Portugal to 218 per 100,000 in Finland (Dressing et al., 2004; Priebe et al., 2005; Iverson et al., 2009). Some European countries such as England, Germany and the Netherlands have experienced an increase in the number and proportion of involuntary admissions in recent years (Keown et al., 2008; Mulder et al., 2008; Priebe et al., 2005). In other countries such as Sweden, Italy and Spain, however, the rate has remained steady or has even declined (Priebe et al., 2011; Guaiana et al., 2004).

Since the MHA 2001 (Office of the Attorney General, 2001) was introduced in Ireland, the overall rate of involuntary admissions per annum has remained broadly similar. Mental Health Commission compiled data indicates that the overall rate of involuntary admission was 50.14 per 100,000 population in 2007 after the introduction of the act, later marginally reducing to 46.04 per 100,000 and increasing to 51.50 per 100,000 - which comprises 2,363 involuntary admissions - in 2015 (Mental Health Commission, 2007-2015).

Legislation for involuntary admission in Ireland

Part two of the Mental Health Act (MHA) 2001 came into force in Ireland in November 2006, replacing The Mental Treatment Act (MTA) 1945 (Office of the Attorney General, 1945). The MHA 2001 provides a statutory framework for the involuntary admission and treatment of someone with a “mental disorder” to an approved centre, with a right to an independent review of their involuntary admission and continuing detention by a mental health tribunal.

"Mental disorder" is defined in Section 3 of the Act as meaning 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 judgement 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,

OR

(a) (as above) and (b) (as above).

Prior to an adult being transferred to an approved centre involuntarily, an application (Section 9) and recommendation (Section 10) must be made. The application is made by a relative, the Gardaí, an “authorised officer” or less commonly a member of the public. The recommendation must be made by a registered medical practitioner, who must not work in the approved centre, and is usually completed by a general practitioner.

On arrival at the approved centre the person must be reviewed by a consultant psychiatrist within 24 hours. If the decision is made to detain the person under the MHA 2001, an admission order (Section 14) is completed. One of the most significant changes implemented by the MHA 2001 was the introduction of an
automatic independent review process of the individuals’ detention. Under the MTA 1945, once an individual was admitted involuntarily to an acute psychiatric unit, (s)he could be detained for up to 6 months (“Temporary Chargeable”) or for an indefinite period without any independent automatic review of their detention (“Person of Unsound Mind”). In contrast all persons admitted to an approved centre under the MHA 2001, are automatically reviewed within 21 days of their admission by an independent Mental Health Tribunal that can consider relevant evidence and has the power to revoke the involuntary admission order. The tribunal consists of a barrister or solicitor, a lay person and an independent consultant psychiatrist. If the admission order is renewed for a further period, another review tribunal must be held within 21 days, and similarly in the case of further renewals at regular intervals thereafter. The person detained also has the right to appeal their detention to the circuit court.

The involuntary admission process can also be initiated from within the approved centre if an adult who had been voluntarily admitted expresses a wish to leave the approved centre, but is considered to fulfil criteria for “mental disorder” as defined under the Act. In such cases a temporary detention can be applied by a doctor or a nurse (Section 23(1)). The patient must then be assessed by the responsible consultant psychiatrist, who can initiate involuntary admission under Section 23/24 of the MHA if they believe that the person is suffering from a mental disorder. In order for the involuntary admission to be completed, another consultant psychiatrist must also assess the patient within the initial 24 hour period of Section 23 being commenced, and agree that the individual fulfills criteria for mental disorder.

**Legislation and human rights context**

The MHA 2001 was fully implemented following many years of campaigning to improve human rights in the context of involuntary admission and treatment for mental illness. It was intended to ensure compliance with the standards and safeguards set out under the European Convention on Human Rights (ECHR) (European Convention on Human Rights, 2003), which itself became part of Irish
law with the enactment of the European Convention on Human Rights Act, 2003. Section 3 of this Act places a duty on all public bodies to 'perform its functions in a manner compatible with the State's obligations under the Convention provisions'. The 2001 Act changed the legal landscape significantly in Ireland.

The prevention of arbitrary loss of liberty is central to the human rights safeguards required in mental health law under the ECHR recognising; ‘[t]he situation of vulnerability and powerlessness of persons detained in psychiatric institutions requires special vigilance on the part of the authorities.’

The most recent international human rights standards are in the UN Convention on the Rights of Persons with Disabilities 2006 (CRPD) (United Nations Committee on the Rights of Persons with Disabilities, 2006), which presents opportunities to improve significantly the rights of persons with long term mental illness. Central is the requirement ‘to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities’ in Article 1. Recognition of legal capacity in Article 12 is a core element of the CRPD with the mandate to ensure supported decision making rather than the substitute decision making on which involuntary admission rests. Article 14 is directly relevant to involuntary admission and specifies ‘the existence of a disability shall in no case justify a deprivation of liberty’. On this basis current mental health laws, both here and in neighbouring jurisdictions, violate the CRPD, and should therefore be abolished and replaced by consensual practices (Minkowitz, 2009). Thus the criteria in the 2001 Act linking the definition of mental disorder with the requirement for involuntary detention, even with the reform proposals in the ‘Report of the Expert Group on the Review of the Mental Health Act 2001’, may not be in keeping with CRPD standards (Department of Health, 2015).

The 2001 Act provides clear authorization for involuntary admission when particular criteria for mental disorder are met. The ECHR regards involuntary admission as so serious that it is only justified where other less severe measures

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1 Herczegfalvy v Austria (1993) 15 EHRR 437.
have been found to be insufficient to safeguard the person or others. These entail the provision of alternatives to the involuntary admission in order to satisfy the requirement of proportionality in interventions in this area, with detention being the last resort. The CRPD strongly affirms the need for support services in the community (UN CRPD Committee, 2006) and the allocation of resources to ensure sufficient community-based services and to avoid coercive measures (UN CRPD Committee, 2006).

**Informed consent**

The legality of any intervention to treat a person depends on informed consent, or, some other lawful authority that provides consent when the person has impaired capacity.

The 2001 Act is not in compliance with the ECHR on the automatic authorisation of treatment without consent arising from involuntary admission. The European Court of Human Rights (ECtHR) has strongly affirmed that the involuntary admission of a person should not be construed as authorising treatment without consent and has stated in *X v Finland* ‘the forced administration of medication represents a serious interference with a person’s physical integrity, and must accordingly be based on a “law” that guarantees proper safeguards...’ 2 This decision necessitates robust safeguards must be in place before treatment can be imposed following the involuntary admission. A recent amendment to the 2001 Act provides that persons who are involuntarily admitted and are ‘unwilling’ to have electroconvulsive therapy (ECT) or medical treatment will have their refusal respected provided they have capacity to do so (Office of the Attorney General, 2016). This change indicates a move towards respecting the autonomy of persons who are capable of consenting and unwilling to accept ECT, or medical treatment (after the 3 month period when refusal of treatment could have been overridden regardless of decision making ability). This is a reform

2*X v Finland* 2012 (Application No. 34806/04: 3rd July 2012 para 214).
acknowledging the dignity and autonomy of the person as required in the Principles in sections (4)(2)(3) of the Act.

The test in the 2001 Act for capacity to consent is similar to that required for informed consent to general medical treatment - that the person understands the nature, purpose, and likely effects of the treatment (s56). It places responsibility on the doctor regarding communication of information. The Committee for the Prevention of Torture (CPT) specifies “as a matter of principle that patients should be in a position to give their free and informed consent to treatment and that the involuntary admission of a person should not be construed as authorising treatment without consent” (Council of Europe Committee for the Prevention of Torture, 2004). The CPT received complaints that the consent provisions in the 2001 Act (s57) allow too much discretion to the authorities in Ireland. The Government response was to the effect that the recently enacted capacity legislation, the Assisted Decision Making (Capacity) (ADMC) Act 2015 may meet this need for change (Council of Europe Committee for the Prevention of Torture, 2011).

The UN Special Rapporteur on Torture stated that ‘[p]ersons with disabilities are particularly affected by forced medical interventions, and continue to be exposed to non-consensual medical practices’ (UN Special Rapporteur, 2013). He addressed restraint in health-care settings saying that even for a short time any restraint on people with mental disabilities may constitute torture and ill-treatment. Article 3 of the Charter on Fundamental Rights of the European Union (2000) provides that there must be respect for, 'the free and informed consent of the person concerned, according to the procedures laid down by law'. Using coercive State power to impose treatment is regarded by one commentator as one of ‘the most critical areas of human rights violations for persons with disability’ (Kayess and French, 2008).
**Legal capacity**

Recognition of legal capacity underpinned in Article 12 of the CRPD is crucial regarding the need for support in exercising free and informed consent and freedom from forced treatment, particularly when subject to coercive mental health laws. Involuntary commitment in mental health facilities carries with it the denial of the person’s legal capacity to decide about care, treatment, and admission to a hospital and therefore seems to violate Article 12 in conjunction with Article 14. Article 14 of the CRPD protects the right to liberty on an equal basis with others and states that ‘the existence of a disability shall in no case justify a deprivation of liberty.’ Article 14 does not permit any exceptions whereby persons may be detained on the grounds of their actual or perceived impairment. The UN High Commissioner for Human Rights (2009) stated that ‘legislation authorising the institutionalisation of persons with disabilities on the grounds of their disability without free and informed consent must be abolished and indicated that disability-neutral laws would meet the CRPD standards. This position has been made more stringent in recent Committee guidelines (2015) specifying that ‘[t]he involuntary detention of persons with disabilities based on risk or dangerousness, alleged need of care or treatment or other reasons tied to impairment or health diagnosis is contrary to the right to liberty, and amounts to arbitrary deprivation of liberty’ (UN Committee on the Rights of Persons with Disabilities, 2015). This presents a major challenge on how these standards can be met.

Legal capacity is relevant to persons who are subject to either formal or informal substitute decision making, in the context of overriding informed consent or when the person is deemed to lack capacity. Recognition of legal capacity is important in mental health laws where the right to liberty and bodily integrity are often denied on the presumption of lack of mental capacity without any legal clarity on how such determinations are made.

This issue is particularly important in the context of the pending introduction of the ADMC Act 2015. Findings of incapacity should not now be made without
consideration of the principles in the forthcoming ADMA 2015, even though people who are compulsorily admitted are excluded from the benefits of the Act. The principles of the ADMA 2015 will require respect for the will and preferences of the person to ensure a more collaborative and supportive approach to decision making. It will automatically apply to people who are admitted voluntarily, to people whose legal status changes from involuntary to voluntary and presumably to the ‘intermediate status’ proposed in the Expert Review Report (Department of Health, 2015). The Report proposes this new status aimed at people who have impaired capacity. This approach follows the ECtHR decision in *HL v United Kingdom* (Bournewood case)*3*, and others recognising the problem of *de facto* detention of voluntary admissions and the requirement to have appropriate safeguards.*4* The ECtHR has affirmed the equal importance of the deprivation of legal capacity with the right to liberty, but the need for deprivation of liberty safeguards has taken a long time to be recognised in Irish law.*5* It is currently being addressed in the proposed Equality/Disability (Miscellaneous Provisions) Bill 2016 and is recognised as one of the most neglected human rights issues in Ireland today, affecting a wide range of people, not only people in mental health care facilities.

**Participation**

The UN Special Rapporteur on the Right to the Highest Standard of Physical and Mental Health stated that ‘the right of persons with mental disabilities to participate in decision making processes that affect their health and development, as well as in every aspect of service delivery, is an integral part of the right to health’ (Lewis and Munro, 2012). Participation is vitally important for sustainable transformation of attitudes in policy making and delivery of

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*3* *HL v the United Kingdom*, 45508/99 (2004) ECHR 471


*5* *Shtukaturov v Russia* (Application no 44009/05 27th March 2008)
mental health services. Brosnan (2012, p.62) highlights concerns about this development stating:

*Service-user involvement is a new development in the Irish context, resisted fiercely by some interests, and welcomed as a potential source of reform by others. Like Recovery, it is being incorporated into the official discourses without sufficient attention being paid to the complexities of the social justice issues inherent in the user-perspective and failing to problematize the power dynamics service-users must engage with if they choose to enter the new spaces into which they are being invited.*

This important comment indicates that much more attention needs to be paid at a systemic level in order to avoid tokenism and ensure that this involvement achieves its potential.

Participation in one’s own individual care plan is a key element of the recovery ethos and is mandated by the 2001 Act and in the regulations (Office of the Attorney General, 2001; 2006). A Health Research Board study (Kartalova-O’Doherty and Doherty, 2010) of personal experiences of service users concluded that, ‘[p]ersoncentred care requires a paradigm shift towards refocusing on the aspirations and goals of those recovering, and the vital importance of their input in care’. The 2014 Annual Report of the Mental Health Commission incorporating the Report of the Office of Inspector of Mental Health Services (MHC, 2014) continues to highlight the poor response of services with only 22 of the 61 Approved Centres considered by the MHC to be fully compliant with the regulation on individual care plans.

**Involuntary admission and coercion from point of view of service users**

**Irish research**

To date there have been few studies in Ireland that have evaluated the experiences of individuals detained under the MHA 2001 and what factors may
predict positive or negative attitudes towards the experience. Knowing what these factors are could lead service development and/or legislative change with the objective that the experience could be as positive for the individual as possible.

An early study by Rooney et al (1996) reported that half of involuntary patients were not aware that they were admitted involuntarily and 50% of involuntary and 20% of voluntary patients described being in hospital as similar to being in prison. Of the involuntary patients, 17% initially viewed the experience as positive with this figure increasing to 32% at the end of their involuntary admission. It was a retrospective study conducted over a 6 month period and individuals were interviewed between 6 and 7 months after admission.

A more recent study after the implementation of MHA 2001 by O'Donoghue et al (2010) evaluated the experiences of 81 individuals admitted involuntarily to a Dublin hospital over a 15 month period. This study aimed to assess factors that may predict outcome or attitudes to involuntary admission such as whether levels of awareness of illness (insight) were associated with the view that involuntary admission was necessary, and whether demographic factors, diagnosis and use of physically coercive measures may play a part in this. In addition the authors assessed patients' views of mental health tribunals and their awareness of their legal rights, and the impact of involuntary admission on the relationship of the patient with their family, the treating consultant and the perceived impact that this involuntary admission might have on the prospect for future employment. A total of 72% of individuals reflected that their involuntary admission was necessary prior to discharge and 77% felt that treatment was beneficial to their health. The authors found a strong correlation between awareness of illness and whether patients perceived their involuntary admission as necessary ($r = 0.67, p < 0.001$). Greater length of time as an involuntary patient was found to be associated with the patient viewing the involuntary admission as unnecessary. In relation to mental health tribunals, 54% could identify the different roles of the three tribunal members, 57% felt their case was adequately represented by their solicitor, with 73% being aware they could
appeal the decision to the circuit court if they wished to do so. Around 53% believed the tribunals were a fair system to review involuntary admission.

Another study evaluated the same cohort of individuals (O’Donoghue et al., 2011a) one year after their involuntary admission order was rescinded. In total 68 people were interviewed at one year post discharge, representing a follow-up rate of 84%. Sixty percent of these individuals reflected that their involuntary admission had been necessary - compared to 72% of individuals who felt it necessary at baseline, which was a statistically significant reduction. A moderate correlation remained between the individuals’ level of awareness of illness at follow up and whether they viewed their involuntary admission as necessary. A number of other factors were not found to be associated with perceiving that the involuntary admission had been necessary, included male gender, being single, diagnosis, the use of coercion, integrated recovery style or global assessment of functioning.

These authors also assessed the impact that the use of coercive measures might have had on individuals involuntarily detained. They interviewed people admitted involuntarily under the MHA 2001 over a 15 month period in a Dublin hospital. Participants were interviewed prior to discharge and at one year follow up using scales to assess insight and components of the MacArthur Admission Experience interview to assess procedural justice (which refers to whether or not the individual believed that their admission was fair or justified and how much they felt the admission was done for their benefit or out of concern for their welfare) and perceived pressure (which refers to the amount of pressure the individual felt from others to go in to hospital). They also examined the use of physical restraint determined by “the clinical practice form for physical restraint” and the use of seclusion determined from the “register for seclusion”. Over half of participants experienced at least one physical coercive measure at the time of admission. Lower levels of awareness of illness were associated with greater use of physical coercive measures, but no association was found between the use of physical coercive measures and levels of perceived pressure at admission or with the levels of procedural justice at admission. The level of
procedural justice experienced was statistically significantly associated with the willingness for a service user to voluntarily engage with the mental health services on discharge (O Donoghue et al., 2011b). At follow-up assessment, 48% of participants viewed the involuntary intramuscular injection and/or restraint experienced as necessary/positive, 23% viewed it as negative and 30% were indifferent. Those with greater levels of awareness of illness at follow up were more likely to view the measures as positive or necessary. This study highlighted that the actual experience of physically coercive care during involuntary admission was separate from the procedural justice and perceived pressures that individuals experienced.

A study carried out by Smith et al (2014) found that those who were admitted involuntarily, who were subject to coercive measures and who reported feeling their admission was less justified were also less satisfied with the treatment they received. This was a multicentre study and included both individuals admitted voluntarily as well as involuntarily. The authors used a number of instruments to assess clinical and attitudinal measures. The interviews were conducted approximately one week prior to discharge and the study was carried out over a 13 month period on 129 individuals. Those who had more awareness of being unwell, those who had greater levels of functioning and those who reported a more positive therapeutic relationship with staff were found to have more positive attitudes and were more satisfied with the treatment that they received.

The most recent “Service Users’ Perspectives of their Admission” (SUPA) study by O’Donoghue et al (in press) summarised findings from assessments of 161 voluntarily and involuntarily admitted patients across three community mental health services in Ireland. Of those admitted involuntarily, 42% had experienced physical coercion and involuntary patients reported more perceived coercion and less procedural justice than voluntary patients. However 22% of voluntarily admitted patients reported levels of perceived coercion which were similar to involuntarily admitted patients, highlighting the ethical difficulties of the “coerced voluntary” group who are under treatment pressure, but do not enjoy the protections of MHA 2001 such as automatic independent review of their
admission. Therapeutic alliance was a strong predictor of satisfaction with services, and voluntary patients had higher satisfaction levels than involuntary patients.

**International research**

At the international level, a review of 18 studies performed across Europe found that a wide range from 33-81% of individuals regarded their involuntary admission as justified and/or treatment as beneficial (Katsakou and Priebe 2006). Sample sizes in these studies ranged from 16-138 individuals, half of the studies were prospective, and a wide range of observer rated and self report instruments were used to assess if participants felt admission was warranted or if treatment was perceived as beneficial. The authors reported that patients’ views towards treatment became more positive over time (within 25 days of admission 39-58% believed their admission was justified, with this increasing to 66-75% between 4 months and 3 years follow-up after involuntary admission). In relation to benefit from treatment, 39-81% of participants agreed that they benefited, 68-76% agreed that they had clinically improved, and 46-73% were satisfied with the treatment. It is clear from this review that there was a wide range of variability of attitudes towards admission and treatment within and across different studies and services, and that further research is required to attempt to identify sources of this heterogeneity.

In a large prospective study, Katsakau et al (2010) assessed involuntary patients’ satisfaction with treatment, changes over time and factors that influence satisfaction with treatment, with a focus on perceived and documented experiences of coercion. The study was conducted in 67 acute wards across 22 hospitals in England. In total, 778 individuals took part at baseline, 546 (70%) were followed up at one month, 473 (61%) were followed up at three months and 396 (51%) were followed up at one year. Satisfaction with treatment was measured at all time points using the Client Assessment of Treatment scale (CAT). Levels of coercion were measured using the Mac Arthur Perceived Coercion Scale (MPCS) and the Coercion Ladder (CL). The authors found a significant increase in satisfaction scores over time from baseline to follow up,
with the highest satisfaction score being reported at three months. At all time-points the majority of participants reported a mean satisfaction score above 5 on the 10 point CAT scale. At all time-points the participants reported the lowest scores on the item rating satisfaction with their psychiatrist and the highest scores on the item rating satisfaction with other staff. The authors found that those participants with greater levels of perceived coercion at admission and during treatment (measured by the coercion ladder) were less satisfied at follow up, whereas the actual use of coercive measures as documented in the medical notes were not associated with satisfaction levels. Those who improved more symptomatically at one month also expressed higher levels of treatment satisfaction. No baseline demographic or clinical factors including diagnosis, severity of symptoms or global assessment of functioning were found to be associated with patients’ satisfaction with their treatment.

These authors also examined what factors predicted readmission to hospital (Priebe et al., 2009). Of those who were re-interviewed at one year, 15% had been readmitted involuntarily. Similar views were found amongst those admitted voluntarily initially and then detained as were found in those admitted involuntarily. The authors found that those on social welfare benefits, those less satisfied with their treatment at baseline, those living with others and those having African and/or Carribean ethnicity were more likely to be readmitted involuntarily. The authors also found that those with lower functioning and those who were more satisfied with the treatment received were more likely to view their index admission as justified.

A prospective study of 2326 individuals carried out across 11 European countries assessed patients’ views of treatment during their involuntary admission at 1 and 3 months after admission (Priebe at al 2010). The primary outcome that the authors assessed was the individuals' retrospective view on the extent to which their involuntary admission was right or wrong. On average, 55% of individuals believed that their admission was right at one month and 63% believed their admission was right at 3 months. The percentage varied between 39% and 71% at 1 month and between 46% and 86% at 3 months. In a
multivariate analysis those with male gender and those living with others were more likely to view the admission as justified. Those with schizophrenia were more negative about their admission than those with other diagnoses. Significant differences in attitudes towards involuntary admission were found between countries with those in England having more negative views than those in Bulgaria, Greece, Spain, the Czech Republic, Italy, Germany and Slovakia. The authors were unable to determine what factors might be driving this difference from the data collected, but proposed it was potentially related to varying legislation, cultural expectations and clinical practice in different countries.

A study by Naber et al (1996) carried out in locked wards in Germany over a 14 month period evaluated 40 service users just prior to their discharge from hospital determined that awareness of illness/insight (although no standardised instrument was used) predicted whether or not individuals viewed their involuntary admission and treatment as necessary, which is similar to the findings from the Irish studies mentioned above. Data was also collected on the use of coercive measures such as involuntary injection with neuroleptic medication and physical restraint. The interview consisted of 12 questions and answers were recorded verbatim and interpreted by two psychiatrists. Forty eight percent of patients in this study retrospectively considered the coercive measures they were subjected to as necessary/positive, 23% considered them as negative and 30% were indifferent.

Notably although being admitted involuntarily to a psychiatric ward has been consistently associated with high levels of perceived coercion, the experiences of being coerced during the admission process is not solely confined to involuntary admission (Newton-Howes et al., 2015; Lidz et al., 1995). A Norwegian study compared the levels of perceived coercion amongst involuntary as well as voluntary inpatients (Iverson et al., 2002). Although involuntarily admitted patients had higher levels of perceived coercion than voluntarily admitted patients, 32% of the voluntarily admitted patients still perceived high levels of coercion whereas 41% of involuntarily admitted patients actually perceived themselves to experience low levels of coercion. Furthermore legal status did not
predict perceived coercion after taking negative pressures and process exclusion into account, which were better predictors of perceived coercion. These authors also examined the association of measures of coercion with patient satisfaction (Iverson et al., 2007). They reported that measures of self reported satisfaction were low in this sample. Only 37% of individuals scored above the midpoint of the satisfaction scale. Older age was the only patient characteristic that was found to have a significant relationship with overall satisfaction. Satisfaction was highest in the “staff-patient relationship” (79% scoring over the midpoint of the scale), followed by “subjective treatment outcome” (71% scoring over the midpoint of the scale”). Satisfaction was lowest in the area “information and influence” (26% scored over the mid-point of the scale). Overall patient satisfaction was negatively impacted by accumulated coercive events and by objective coercion alone. Being involuntarily detained and perceived coercion was not found to be associated with overall satisfaction, in contrast to the findings reported by O’Donoghue et al (2011b).

McKenna et al (1999) compared perceived levels of coercion between voluntary (n = 69) and involuntary (n = 69) individuals in a New Zealand inpatient unit. Involuntary patients experienced a stronger sense of coercion than voluntary patients, but the latter group still had quite high levels of perceived coercion. This study reported that the individual’s perception of procedural justice was strongly associated with that persons’ perception of coercion for both involuntary and voluntary patients.

Studies have shown that degrees of awareness of illness (insight) vary across different diagnoses and it is plausible that certain groups of patients will view treatment as more negative or positive depending on their underlying diagnosis. Given the clinical and cognitive features schizophrenia, patients are more likely to display persistent insight deficits when compared to those with affective psychosis. Amador et al (1994) used a structured assessment tool (SUMD) to assess awareness of illness/insight in a large group of patients (n = 412) and reported that awareness of illness deficits were more pervasive and severe in people diagnosed with schizophrenia than in major depression and
schizoaffective disorder. Weiler et al (2000) found that, out of 274 patients studied, those with a DSM diagnosis of major depressive disorder had the highest level of insight on admission which was significantly higher than those with schizophrenia or bipolar affective disorder. Insight improved with hospital treatment in all three diagnostic groups and correlated with symptom improvement. There was a strong relationship between insight deficits and involuntary admission status.

In summary, observational studies to date have identified a wide variation in attitudes of service users towards the necessity of their involuntary admission, with the strongest evidence that clinical features such as greater awareness of illness and less perceived coercion are associated with more positive attitudes. However there is inconsistency in the existing literature and the extent to which factors such as gender, diagnosis, functioning and actual levels of coercion experienced are associated with attitudes towards involuntary admission and care. Most studies have found that satisfaction with involuntary treatment increases over the course of the admission and with symptomatic improvement, however it has also been reported that individuals became less satisfied as the time from their index admission lengthened and a substantial proportion of individuals in follow-up studies retain negative attitudes about their admission. Several of the studies were conducted on small numbers of individuals at a single timepoint. In some studies individuals were interviewed just prior to their discharge and may have given biased responses to clinician researchers in this context. In addition standardised instruments were not always used in assessing factors such as awareness of illness or satisfaction with treatment. Some studies were confined to univariate analysis in assessing how clinical factors were associated with outcomes such as treatment satisfaction and thus may not have duly considered potential confounds. Further prospective observational research with representative cohorts would therefore help to elucidate predictors of service users’ attitudes towards their care and treatment throughout the process of involuntary admission under MHA 2001 in the Irish mental health services.
Qualitative research with service users

Two reviews have investigated people’s experiences of detention and treatment using subjective evaluations of experiences rather than objective measures (Katsakou and Priebe, 2007; van den Hoof and Goossensen, 2014). The studies reviewed used either in-depth semi-structured interviews, a narrative method or questionnaires and found a mix of both negative and positive experiences. Katsakou and Priebe (2007) synthesized the themes of five studies from the UK and Sweden that met inclusion criteria into three key areas: (1) ‘perception of autonomy and of participation in decision for treatment’; (2) ‘the feeling of whether or not they were being cared for, listened to or respected’; and (3) the resulting effect this has on their ‘sense of identity’. Implicit within these themes were examples of both positive and negative experiences and a limitation of this review’s findings was the inability to elicit whether the negative and positive aspects of people’s experience were pervasive – relating specifically to each person or being held by certain client groups.

Van den Hoof and Goossensen (2014) undertook a review of 22 qualitative and quantitative studies published on detention from an ‘inside’ (respondents experience) and ‘outside’ perspective (description from an external point of view of the behaviour and the situation) of the person. Across the inside and outside perspectives, the researchers synthesis of themes mainly centred on issues concerned with ‘not being listened to or listened to’. Similar to Katsakou and Priebe’s (2006) review, there was a mix of negative and positive experiences. Studies reviewed under the inside perspective were themed as either ‘powerless’ or ‘humiliation’. Implicit within the theme of ‘powerless’ was the feelings of not being understood or listened to, not receiving sufficient information, not being involved in decisions, being ignored, and feeling helpless and out of control during hospitalisation. Implicit within the theme of ‘humiliation’ was the feeling of not being treated as a human being, being dependent on health care professionals, feeling like an inferior, and not being involved in decisions, which engendered feelings of disrespect and helplessness. The positive experiences included being ‘guarded’ and ‘seen’ which included being protected, cared for,
and respected. Studies reviewed under the outsider’s perspective consisted of themes that focused on the experience during the process of people’s admission such as ‘pressure’, ‘loss of autonomy’ and ‘procedural justice’. Pressure consists of both negative and positive pressures; across these studies, the dimensions of negative pressure included the experience of threats, giving orders, deception and experience of force, while the dimensions of positive pressure include the experience of persuasion rather then force, promises and inducements. The dimensions of loss of autonomy include the experience of loss of liberty, limited possibilities of moving, and being dominated by others. The dimensions of procedural justice include the experience of fairness, that people's opinions are heard and taken on board, and that they themselves can participate in the admission decision. Implicit within this was effective interpersonal communication during the involuntary admission process. A key strength of this review is that it included qualitative and quantitative methodologies involving different aspects of the involuntary detention experience, such as the admission process.

Seed (2014) undertook a meta-synthesis of qualitative studies on people’s experience of detention, using a methodology developed by Noblit and Hare (1988). The meta-synthesis revealed seven themes; four of these dealt with ‘Sanctuary’, ‘Loss’, ‘I left terrified’ and ‘Fluctuating emotions’, while the remaining three themes (consisting of both internal and external factors) comprised ‘A continuum of person-centered practice’, ‘You’re disempowering me’ and ‘Intra-psychic coping’ which were seen as mediators of the aforementioned themes. ‘Sanctuary’ describes the feelings of protection and perspective that came from detention. ‘Loss’ describes the feelings of being deprived of independence and the loss of identity that stemmed from detention. ‘I felt terrified’ describes the fear associated with (1) encounters with professionals during the process of their detention, and (2) being in hospital. ‘Fluctuating emotions’ describes the varying emotional reactions (i.e. anger) associated with coming to terms and dealing with detention. In addition, the external factors ‘A continuum of person-centred practice’, ‘You’re disempowering me’ and the internal factor ‘Intra-psychic coping’ mediated the
feelings mentioned above. ‘A continuum of person-centred practice’ describes both the positive and negative interactions participants had with professionals and how this contributed to a feeling of sanctuary or to a feeling of loss. Across the continuum, examples included collaboration versus non-collaboration, caring versus non-caring and being treated like a human being versus not being treated like a human being. ‘You’re disempowering me’ describes the power yielding practices that professionals exerted on people which contributed to the feeling of ‘I felt terrified’, examples of which included being forced to take medication and having to comply with rules of the hospital. ‘Intra-psychic coping’ describes the coping mechanisms that people employed to deal with their detention. Examples of these included ‘fighting back’, ‘acceptance’, ‘developing a model patient role’ and ‘avoidance’.

Using a meta-ethnography design, Wyder et al (2013) employed the recovery perspective as a framework to synthesise the themes of qualitative studies on people’s experience of detention. The themes of these studies were now centred on factors that enhance and hinder recovery during detention. Wyder et al (2013) identified seven factors that have an impact on recovery during detention: ‘Having input into own treatment’; ‘Shared humanity’; ‘Power imbalance/balance’; ‘Freedom and control’; ‘In/ability to incorporate the episode/experience’; ‘Treatment factors’ and ‘Importance of relationships’.

‘Having input into treatment’ describes the extent to which people felt that they participated in their treatment. ‘Shared humanity’ describes the extent to which people felt that they were treated like a human being. ‘Power imbalance/balance’ describes how far people felt that they had information about their reasons for their detention, their rights and their treatment. ‘Freedom and control’ describes the extent to which people experienced a sense of autonomy and restriction. ‘In/ability to incorporate the episode/experience’ measures how far people were able to integrate their detention into their lives. ‘Treatment factors’ describes the extent to which people perceived their treatment as beneficial. Lastly the ‘Importance of relationships’ describes the extent to which people felt supported by staff or fellow patients.
Across studies, there was an expressed need for some semblance of control to be returned to people as soon as possible. Wyder et al (2013) states that the concept of control can be seen as a gradual concept with many different layers and one which can be enhanced by being treated respectfully, given choice, given information about hospital and treatment and informed of one's rights.

It is clear from research to date that a substantial proportion of people view their admission ambivalently or negatively at post-discharge follow-up, and qualitative studies on people's experiences of detention and treatment portray a complex array of both positive and negative experiences. Experiences encompass feelings of not being cared for and of being cared for; with frequent frustration at loss of autonomy, feeling devalued and powerless. On the other hand, some people highlighted that they did experience respect for autonomy and acknowledged the treatment benefits associated with care. Across studies, the importance of interpersonal communication and interaction was highlighted.

**Research on experiences of carers and professionals**

Although there have been no studies to date examining family members’ or carer’s views in relation to the MHA 2001, an adverse impact on their relationship with service users due to involvement in their detention under the MHA 2001 has been reported (O'Donoghue et al., 2010). Research with family members in other countries reported concern in relation to attaining support promptly from the mental health services when their relative is acutely unwell and requires involuntary admission (Jones et al., 2009; Jankovic et al., 2011). Jankovic et al (2011) interviewed 30 relatives across England to capture their experiences of the involuntary admission. Many relatives reported that the person should have been admitted sooner and discharged after a longer period. Likewise, Hallam (2007) described relatives’ frustration with trying to get timely help, reporting that they felt their pleas for help were ignored until the person’s condition reached crisis point. Furthermore, Hallam (2007) reported that, although the police response was efficient, relatives were aware that the police
were frustrated at the amount of time and effort expended, particularly when the person was not admitted.

Irish research with consultant psychiatrists on the impact of MHA 2001 reported their concern regarding increased workloads, the adversarial nature of mental health tribunals, negative impacts on therapeutic relationships with patients (Jabbar et al., 2010; Ramsay et al., 2013) and negative effects on non-consultant hospital doctor (NCHD) training and care of voluntary patients (O’Donoghue and Moran, 2009). Similarly, psychiatric nurses (predominantly nurses working in acute psychiatric units, but also a small cohort of community mental health nurses (CMHNs) (n=9)), expressed concern regarding increased workloads, particularly increased paperwork, change in the amount of time available to work clinically with service users, and excessive focus on legalities within clinical practice (Doherty et al., 2014).

General Practitioners (GPs) described particular difficulties with organising transfer of patients to approved centres due to significant time delays related to transport, leading to increased risk to the patient, family and GP (Kelly et al., 2011). Jabbar et al (2011) survey of GPs following the introduction of the MHA 2001 in Ireland found that the majority reported increased workload, and approximately half had experienced difficulties with the legislation. The study also found that formal or informal training had a positive impact on GPs’ perceptions of the ease of use of the mental health legislation (Jabbar et al., 2011).

Data from other jurisdictions have similarly described difficulties with the admission process. Jespen et al (2010) explored 13 Danish GPs’ experiences of involuntary admissions. Most GPs described the process as stressful and time consuming, that psychiatrists did not understand or value their contribution, and that individuals were frequently discharged from hospital without modification of treatment. Some GPs also reported that involuntary admission could cause irreparable damage to the doctor–patient relationship, and that some patients changed GPs afterwards. Røtvold and Wynn (2015) interviewed 74 Norwegian
GPs on their experiences of involuntary admissions. They found that most individuals were assessed out of hours by a GP who did not have a prior relationship with, or knowledge of, the patient, making clinical evaluation difficult. The GPs reported often feeling pressurized by relatives or police to recommend a patient’s involuntary admission.

Thus research to date with other individual stakeholder groups tends to highlight the frustrations they have experienced with the application of involuntary admission procedures from their own perspective and role in the process.

**Conclusion**

It is clear from research to date that involuntary admission is often a traumatic experience for service users and associated with negative attitudes, which can persist after the episode of illness has abated and interfere with ongoing care. The process is also frequently difficult and distressing for other stakeholders involved including family members and health professionals. Whilst the Mental Health Act 2001 introduced a number of safeguards into the operation of the involuntary admission process in Ireland, there has been limited examination of its operation in practice and the attitudes and experiences of service users and other stakeholders. This Mental Health Commission funded research study, “A prospective evaluation of the operation and effects of the Mental Health Act 2001 from the viewpoints of service users and health professionals” sought to address this and has the following aims:

1. To comprehensively evaluate the clinical characteristics and attitudes towards care in a prospective, observational study of a representative cohort of service users in Ireland who have been subject to the MHA 2001, both at the points of acute presentation to mental health services and recovery after the episode leading to their admission.
2. To identify any clinical or sociodemographic characteristics associated with variation in attitudes towards care at the points of involuntary admission and recovery to their baseline and with change in such attitudes over time.

3. To explore using qualitative interviews with a selection of service users their experiences throughout the trajectory of involuntary admission, from initial assessment and transfer to hospital, through mental health tribunal review to discharge.

4. To assess and compare the views of other key stakeholders involved in the various stages of the involuntary admission process towards the operation of the MHA 2001 in practice, including relatives, consultant psychiatrists, psychiatric nurses, Gardai, general practitioners and mental health tribunal members.
Chapter 2. Methods

Introduction

The research programme is divided into three component studies, each of which will be described in turn throughout the methodology and results. The first study is a prospective observational study of a representative cohort of service users utilizing quantitative assessments at two timepoints (i) during involuntary admission and (ii) when participants were considered to have recovered symptomatically to their clinical baseline. The second study is a qualitative study of service users’ experiences conducted on a selection of the service users recruited for study 1, and conducted at the second timepoint of the quantitative assessments. The third study is an assessment of other stakeholders’ views that employed questionnaire and focus group tools.

Study 1 – Quantitative Exploration of Service Users’ Experience of Involuntary Admission

Aim

This study addressed the first two aims of the research programme:

1. To comprehensively evaluate the clinical characteristics and attitudes towards care in a prospective, observational study of a representative cohort of service users in Ireland who have been subject to the MHA 2001, both at the points of acute presentation to mental health services and recovery after the episode leading to their admission.

2. To identify any clinical or sociodemographic characteristics associated with variation in attitudes towards care at the points of involuntary admission and symptomatic recovery to their clinical baseline and with change in such attitudes over time.
Specific hypotheses included:

- Service users’ attitudes towards their care and treatment will improve between acute admission and recovery to clinical baseline.

- Service users exposed to coercive measures such as physical restraint, seclusion and forced intra-muscular injections will report a more negative view towards their admission and treatment than those who were not subjected to these experiences.

- At initial assessment, more acutely unwell individuals will have less positive attitudes towards the process and experience of involuntary admission and treatment.

- Individuals with higher awareness of illness measures will report more positive attitudes towards the process and experience of involuntary admission and treatment.

- Individuals who demonstrate the greatest improvement in clinical symptoms, functioning or awareness of illness (insight) between acute admission and recovery will have the most favourable attitudes towards admission and treatment at follow up.

Study setting

The study was carried out across three approved centres in the west of Ireland and included the Department of Psychiatry at University Hospital Galway, St Brigid’s Hospital in Ballinasloe and the Department of Psychiatry, Roscommon County Hospital. The study covered a wide area incorporating both urban and rural settings and covering a population of about 314,000 individuals. The three mental health services chosen reflected a range of typical services as found throughout Ireland and encompassed well resourced to poorly resourced mental health services according to per capita funding (MHC 2005; 2008), a range of community based care models and inpatient units (approved centres) attached
to a tertiary referral academic hospital (Galway), a county hospital (Roscommon) and a standalone psychiatric unit (Ballinasloe).

**Ethical approval**

Ethical approval for the study was attained from the Research Ethics Committee, National University of Ireland Galway, from Galway University Hospitals Clinical Research Ethics Committee and from Roscommon Hospital Ethics Committee. Consent was viewed as an ongoing process and was negotiated with participants at each phase of the study. All participants were advised that they could refuse to complete any part of the assessment if they wished. They were also advised that they could withdraw from the study at any stage without their care being compromised.

As individuals are often involuntarily admitted due to acute and severe mental illness, they may not be fully competent to provide written informed consent in relation to the study and in particular may not be willing to sign a consent form. In such situations and given the low risk associated with participation in this observational study, the individual was considered to assent to the study if they verbally agreed to participate in the interview. However all such individuals later (after termination of involuntary admission) were invited to provide written informed consent to participate and any previously assenting individuals that refused at this time-point to provide such written informed consent had all data acquired in relation to them deleted. This approach to gaining assent and subsequent informed consent from participants was explicitly approved by the ethical committees.

**Recruitment**

Participants recruited for the study were individuals for whom applications were made for involuntary admission to the three approved centres. These mostly comprised those who were admitted involuntarily under the MHA 2001, i.e. whose application for involuntary admission was approved by a consultant
psychiatrist, and who therefore had experience of the transfer process, inpatient care and frequently had experienced mental health tribunals. A second group comprised those individuals subject to the Act, in that they were transferred and/or detained in the inpatient unit for a period of up to 24 hours, but who were not found to meet criteria for a mental disorder following a consultant psychiatrist review and thus were not subsequently involuntarily admitted. The characteristics of this second group of individuals are unknown as their details are not currently recorded for the Mental Health Commission.

The researchers contacted the three centres by telephone on a daily basis liaising with nursing staff, psychiatrists and mental health act administrators and the researcher visited the centres regularly to ascertain if individuals who may be suitable for the study were admitted to any of the three centres. Information was given to the service users that the project was ongoing by clinical staff and permission was sought from each service user for their details to be passed on to the researcher. This gave the service user the opportunity to discuss the project with the researcher. Service users had the option of speaking to an advocate about taking part in the study and from the time the researcher gave them information, the service user had 72 hours to decide if they wished to proceed with partaking in the study.

Individuals were recruited as soon as was feasible after their admission with the objective of assessing them whilst they were acutely unwell and within two weeks of the admission where possible. If it was thought either by the staff or the interviewer that the interview process might de-stabilise the individual then the assessment was delayed until such a time it was deemed appropriate to carry out the assessment. Individuals who gave either consent or assent to partake were reminded that they had the option to withdraw at any point and that they could also refuse to partake in any part of the interview process. Interviews proceeded whether or not the involuntary admission was revoked by their treating consultant prior to engaging with the clinical interview. All information was confidential (and secured) and participants were advised that the researcher could only break confidentiality where it emerged during the assessment that there was a risk to the individual or a risk to others. Each individual was given an
anonymised code to protect their identity and the spreadsheets for data analysis used this code rather than any identifying information pertaining to the individual.

**Inclusion criteria**

- Individuals involuntarily admitted under the MHA 2001 (Admission order Form 6 or Form 13).

- Individuals who were detained under the MHA 2001 for assessment by a consultant psychiatrist (Section 23(1) – holding power of 24 hours being applied to a voluntary patient to prevent them from leaving the approved centre) and individuals brought to the approved centres with an application for admission under the MHA 2001 (Forms 1, 2, 3 and 4) and recommendation from a registered medical practitioner (Form 5), but were subsequently NOT involuntarily admitted after assessment by a consultant psychiatrist.

**Exclusion criteria**

(i) Individuals with severe intellectual disability or dementia who were considered unlikely to be able to engage in the quantitative assessments.

(ii) Individuals who were unable to engage in the interview process due to the severity of their mental disorder or were unaware the Act had been applied to them (e.g. individuals with delirium).

(iii) Individuals who were children (under 18 years of age) under the Act at time of involuntary admission. In fact no children were admitted under the MHA 2001 to the three centres during the time-frame of the study.

(iv) Individuals transferred to and from the Central Mental Hospital, Dundrum.
Data collection

Individuals who consented or assented to the study underwent a series of self-rated and observer-rated assessments to ascertain their attitudes towards care and treatment as an involuntary patient, and to comprehensively establish their clinical profile including their level of symptoms, functioning, and awareness of illness. They were also asked for permission to be contacted again in order to partake in further and repeat assessments at a later date, approximately 3 months after revocation of their involuntary admission order. All assessments were carried out by the one researcher (EB) between 2011 and 2014. The assessments involved a face-to-face interview which lasted approximately one hour. In some cases the interview was conducted over two sittings. The initial interviews were conducted in the acute units in the approved centres. It was emphasised to the participants that the researcher was not part of the treating team and that partaking in the research would not impact on their care in any way.

Baseline assessments

Socio-demographic information included age, gender, socio-economic class, level of education, marital status, employment status, and living circumstances. Clinical information included diagnosis, previous history of psychiatric illness, previous voluntary and involuntary admissions, medication, medical history, family history of psychiatric illness, contact with general practitioner and contact with counselling services, duration of admission, and duration of involuntary admission. Medical records were accessed with the individual’s consent in order to supplement the clinical information collected.

The clinical scales comprised:

1. **Brief Psychiatric Rating Scale (BPRS)**

This is a well validated and widely used observer-rated scale that assesses various domains of psychopathology in patients with psychotic illness and assesses current and recent (2-3 days) symptoms (Overall and Gorham, 1962).
The scale contains 24 items each rated from 1 to 7 and takes about 20 minutes to complete. The total summed score was used in the analyses.

2. Global Assessment of Functioning

This is an observer rated numeric scale (0 through to 100) used to rate social, occupational, and psychological functioning of adults and takes approximately five minutes to complete (Hall, 1995). Higher scores indicate higher functioning, for example a score of 91-100 indicates “superior functioning in a wide range of activities, life’s problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.”, whereas a score 41-50 “serious symptoms or any serious impairment in social, occupational, or school functioning” (e.g. no friends, unable to keep a job).”

3. Schedule for the Assessment of Insight (SAI-E)

This is a well validated observer rated scale for the assessment of insight (awareness of illness) in individuals with psychotic illnesses and takes about twenty five minutes to complete (Kemp and David, 1997). It assesses insight across 9 different areas and each is scored from 0-2 (0 being “never” - no insight, 1 being “sometimes” - partial insight, 2 being “often” - full insight). Each item is scored individually and specifically three of the sub-sections include assessment of awareness of mental illness, awareness of symptoms and attribution of symptoms. The scale includes a section that examines medication and is filled out in conjunction with the individuals’ primary nurse or relative. The sum of the individual item scores was used for data analysis.

4. Hogan Drug Attitude Scale (HDAI)

This is a self rated (or observer rated) scale which takes about ten minutes to complete (Hogan, 1983). There are 30 items assessing the persons’ attitudes towards medication. Each item is rated true or false and scored +1 (true) or -1 (false) and thus the total score ranges from -30 to +30. The total score was employed in the analysis.
5. **Client Assessment of Treatment Scale (CAT)**

This is a self rated (or observer rated) scale with seven items that assess the individuals' views and attitudes towards their care and treatment and takes about ten minutes to complete (Priebe, 1995). Each item is scored on a scale of 0-10 (0 being the most negative response and ten being the most positive). In order to account for missing data (i.e. unrated) for some items by participants, the mean of the item scores answered for this scale was used in the analysis.

6. **MacArthur Admission Survey**

This is a well validated observer rated scale that takes about fifteen minutes to complete (Gardner et al., 1993). It assesses attitudes in three areas: (i) perceived coercion, (ii) perceived pressure and (iii) procedural justice.

*Perceived coercion:* This section contains 5 items and each answered yes or no, with a score of 5 indicating maximum coercion.

*Perceived pressure:* This section contains 4 items and each is answered yes or no, with a score of 4 indicating maximum pressure.

*Procedural justice:* This section contains 4 items and each item is rated across a scale of 1 to 4. A total score is then calculated by summing the individual questions and thus total scores range from 4-16. Higher total score indicates less procedural justice, i.e. the individual perceiving the admission as unjust/unfair.

7. **Coercion Ladder**

This scale ranges from 1-10 and assesses an individuals' perception of the amount of coercion they felt subject to on admission (Kjellin et al., 2006). It takes 5 minutes to complete and higher scores indicate greater levels of perceived coercion.
8. Attitudes to the process and experience of admission (Attitude Scale)

This is a 15 item study specific scale that was devised by the researchers in order to include assessments of elements of the care pathway for involuntary admission in Ireland that were not captured by the validated satisfaction scale (Client Assessment of Treatment). The scale includes assessment of the individuals’ attitudes towards the initiation of the involuntary admission process, the subsequent transfer and arrival in hospital, information provision and their experience of the mental health tribunals. The scale contains 15 items and each item is rated on a Likert scale of 1-4, with lower scores indicating more negative attitudes and higher scores indicating more positive attitudes. An even scale was used for each item with no neutral option in order to force the respondent’s choice if undecided. Items were scored individually and, in order to account for missing data for some items, the mean value of the items answered for this scale was used in the analysis. This scale takes about fifteen minutes to complete (see Appendix 1 for full scale).

Follow-up assessments

Follow up assessments were completed approximately 3 months after the involuntary admission order was revoked (for detained individuals: approximately 3 months after the discharge date for individuals for whom an involuntary admission was initiated but who were not subsequently detained). Attempts were made to re-recruit all those who participated in the initial assessments. Participants were contacted directly via telephone or letter, or else through their community mental health team. Assessments were carried out by the same researcher in community based mental healthcare facilities or other settings of the participant’s preference. Individuals were compensated for their time and any travel expenses incurred were refunded. If the person requested, family members could also attend with the participant - three participants opted for this. Follow up assessments took approximately two hours to complete. All of the clinical scales completed at baseline were also completed at follow up and in addition the following assessments were added.
1. SCID- The Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I)

A diagnostic exam used to determine DSM-IV Axis I disorders (major mental disorders) and Axis II disorders (personality disorders) (First et al., 2002). For the purposes of the analysis of data diagnosis was collapsed into three categories: (i) affective psychotic illness (including bipolar affective disorder, schizoaffective disorder and major depressive disorder with psychotic symptoms); (ii) non-affective psychotic illness (including schizophrenia, delusional disorder, psychotic disorder-not otherwise specified, brief psychotic episode, and schizophreniform disorder); (iii) other (including major depressive disorder without psychotic symptoms, alcohol dependence, personality disorders, eating disorders, and substance use disorder).

2. Heinrich’s Quality of Life Scale (QOL)

This semi-structured interview is designed to evaluate the current functioning of non-hospitalised patients and consists of 21 items (Heinrichs et al., 1984). A seven-point scale is provided for each item with some suggested questions to assist the interviewer make his judgment. A total score is obtained along with four subscales: interpersonal relations, instrumental role, intrapsychic foundations and common objects and activities. The sum of the individual item scores was used in data analysis.

Data analysis

Initially all data were cleaned and checked for outliers by generating suitable numerical, tabular and graphical summaries at baseline and follow-up. Case profile plots were used to identify any overly influential changes in each variable over time. Descriptive statistics were used to evaluate the data at the initial baseline assessment and at follow up. Univariate associations between clinical
factors and between clinical measures and attitudinal measures were examined using Pearson’s correlation coefficient test. Clinical measures across time-points for individuals who were successfully re-recruited were analysed using paired t-tests. The significance level was set at p=0.05 for these statistical analyses.

As the primary responses of interest (CAT and Attitudes scale) behaved as continuous variables, multiple regression models were used to model the relationship between each primary and potential explanatory variable. Three models were explored: (i) explanatory variables associated with attitudes at baseline; (ii) explanatory variables associated with attitudes at follow-up; (iii) explanatory variables associated with change in attitudes between baseline and follow-up.

The variables chosen at baseline were symptoms (BPRS), awareness of illness (SAI-E), functioning (GAF), diagnosis, age, gender, whether or not an admission order was completed, the total number of previous involuntary admissions, history of alcohol abuse, and history of drug abuse. The variables chosen for the follow-up model and the changes over time included the above and also included quality of life scores, whether or not the person was subjected to coercive measures, the length of time the person was detained for, and whether their involuntary admission had been reviewed by an independent tribunal.

When modelling attitudes at follow-up, the regression model included the primary response at baseline as a covariate. This was in addition to the pre-selected set of explanatory variables. In order to investigate how changes in attitudes over time were associated with changes in the explanatory variables, the change score in the response was regressed on the change score in the set of explanatory variables where relevant.

The relationship between significant variables was displayed using scatter plots with smoothers, labelling by factors as needed. The Likelihood ratio test and Akaike information criterion were used to identify the correct functional form for each explanatory by fitting higher order splines for each covariate. The assumptions underlying each regression model were assessed using suitable residual plots.
As an addition to the regression models, regression trees using conditional inference (Hothorn et al., 2006) were used to identify subgroups in the sample that explained significant components of variability in the attitude variables and to identify the presence of interactions between explanatory variables.

**Study 2 - Qualitative Exploration of Service Users’ Experience of Involuntary Admission**

**Aim**

This study addressed the third overall aim of the study programme, ie. to explore using qualitative interviews with a selection of service users their experiences throughout the trajectory of involuntary admission.

**Recruitment**

Interviews were conducted with 50 service users who comprised a subset of those participating in the second timepoint assessment of study 1 across the three sites.

Services users eligible to participate in Study 2 were those who:

(i) had agreed to participate in the second timepoint assessments of study 1 – ie. undergo assessments approximately three months after revocation of their involuntary admission or discharge.

(ii) were over 18 years of age.

(iii) had the capacity to consent to interview.

Potential participants were re-contacted by the researchers to ascertain willingness to engage in the study. At that stage purposive and maximum variation sampling was employed in order to explore the breadth of service user experience, rather than provide an epidemiologically representative sample. Open sampling was initially used to sample participants on the basis of their potentially different experiences. These included choosing participants from (1) different inpatient units, (2) a broad age distribution, (3) both urban and rural
backgrounds, (4) short and longer admission periods, (5) different psychiatric diagnoses including schizophrenia and bipolar affective disorder, (6) participants who were admitted directly from the community and participants originally voluntarily admitted and subsequently subject to involuntary admission, and (7) sampling by revisiting the previously collected and analysed data to further explore tentative concepts in light of their emergence in data analysis.

Next relational and variational sampling was employed so that data was collected to allow for the greatest exploration of emerging concepts and categories. Participants were also selected using information from the prior quantitative assessments – for example participants with significant changes on insight scores between baseline and recovery were specifically selected and interviewed. Discriminate sampling was also used and focused on selecting participants that maximised opportunities for comparative analysis (Strauss and Corbin, 1998). For example, two participants whose involuntary admissions were revoked at mental health tribunals were selected for recruitment.

Ethical approval for the study was attained from the research ethics committees as outlined for Study 1. Written informed consent was attained from all study participants prior to commencing the interviews. Participants were assured that they were free not to participate and had the right to withdraw at any time without penalty and that they could decline to answer any of the questions during the interview.

Data collection

The interviews were conducted using a semi-structured interview guide which was developed with input from the research team and informed by the literature and aims of the study (Appendix 2). The semi-structured format provided a common framework across all data sources, ensured that the aims were satisfied, and allowed the emergence of any unanticipated findings. The interview schedule included open-ended and focused questions relating to four general topics: 1) experience of transfer and detention, 2) hospital experience (e.g. non-
consensual medication and seclusion) 3) mental health tribunal experience, and 4) going home. Comparative questions to attain a deeper understanding of participants’ experiences and to elicit commonalities and differences across participants were also utilised. Interviews were face to face and audio-recorded. The mean duration of interview was 47 minutes (range 10-95 minutes). One participant declined to have the interview audio-recorded.

**Data analysis**

After being transcribed in full and removal of any identifying material, the data were analysed using thematic analysis (Braun et al., 2014). Data were analysed firstly through a process of open coding. Individual transcripts were examined systematically, and coded line by line. Once all transcripts were coded, each code was examined to identify the relationships and connections between codes. Any overlapping codes were collapsed to form larger, more inclusive categories. These categories were then cross-checked against the raw data by two members of the research team and consensus reached regarding interpretation, relationships and titles.

**Study 3 – Qualitative Exploration of Professionals & Carers Perspectives on Involuntary Admission**

**Aim**

This study addressed the fourth overall aim of the study programme, ie. to assess and compare the views of other key stakeholders involved in the various stages of the involuntary admission process towards the operation of the MHA 2001 in practice, including relatives, consultant psychiatrists, psychiatric nurses, Gardai, general practitioners and mental health tribunal members.

**Data collection**

Data collection consisted of two approaches: (i) a descriptive survey using the same questionnaire with the different stakeholder groups and (ii) a series of
focus groups conducted with each stakeholder group separately, and also including a service user group.

Descriptive survey
The interdisciplinary research group designed a paper based and online questionnaire intended to probe attitudes towards the various phases of assessment, admission, treatment and review of involuntary admission from the stakeholder viewpoint. The group consisted of representatives from psychiatry, general nursing, mental health nursing, mental health law, ethics and service user advocates. Questions were phrased in such a way so that the same questions could be answered by the different stakeholders despite their different professional roles and experiences. "Free-text" options were included to enable respondents to elaborate on their experiences regarding the operation of the MHA 2001. Initially the questionnaire included seven items however subsequent to free text responses from GPs, two extra items regarding patients’ transfer to an approved centre and the use of less restrictive alternative(s) than involuntary admissions to approved centres were added to the questionnaire. An ordinal Likert scale from 1 ("strongly disagree") to 5 ("strongly agree") was employed for each item, but with reverse coding utilised for two items with high values on these items representing disagreement. GPs and tribunal members completed the original questionnaire only.

Focus groups
Focus groups were used to collect data because they facilitate ‘understand(ing) differences in perspectives among groups or categories’ (Krueger and Casey 2015; p. 22), and have the potential of opening up discussion on points of difference within the same group. Stakeholders interviewed were service users, relatives, GPs, psychiatrists, community mental health nurses, solicitors/tribunal members and Gardai. The focus group schedule was devised by members of the research group and two researchers conducted each group, one in the role of moderator and the other facilitator. A copy of the focus group schedule is provided in Appendix 3. Focus groups were held in a neutral venue that was easily accessible for participants. Focus groups conducted with different
stakeholder groups were homogenous in an effort to stimulate frank and open discussions (Kruger 1994), without the risk of potential power imbalances that could limit individuals expressing their viewpoint freely (Kruger and Casey 2015). Written informed consent was attained for all individuals who participated in focus groups. Focus group discussions were audiotaped, transcribed and any identifying material was removed from transcripts. Ethical approval for the study was attained from the Clinical Research Ethics Committees for Galway University Hospitals and the National University of Ireland, Galway, Ireland.

**Recruitment**

**Descriptive survey**

A paper version of a study specific questionnaire was distributed to all consultant psychiatrists (n = 19), inpatient unit psychiatric nurses (n = 71), and community mental health nurses (CMHNs) (n = 30) in the Galway-Roscommon region and to GPs in the associated primary care services (n = 205). Similarly this questionnaire was distributed to all tribunal members attending tribunals at the approved centres in this region (n = 55). The 50 service users who had participated in study 2 were asked if a preferred family member (first degree relative) could be contacted and asked to complete the questionnaire, which was then distributed to 33 family members. Gardai Superintendents distributed questionnaires to all Gardai working in the same geographical region (n=609), after consultation and agreement from the Garda Commissioner. The total number of questionnaires distributed was 1,022.

In order to obtain a larger sample of respondents, given the relatively small sample size in some stakeholder groups, especially consultant psychiatrists and family members, a link to an anonymised online version of the questionnaire (using the software Survey Monkey) was created. This was advertised locally and nationally in Ireland to consultant psychiatrists, acute inpatient unit psychiatric nurses and CMHNs using the authors' professional networks. The voluntary support group Shine also distributed the survey link to family members of
service users. Only individuals who had experience with at least one involuntary admission under the MHA 2001 and who provided consent to this research were invited to participate.

Incomplete responses from online data (n = 42) and respondents who stated that they only had experience with involuntary admissions of patients under the MTA 1945 (n = 17) were excluded. Thus, the final sample comprised 503 respondents, including 397 paper respondents and 106 online respondents fulfilling the above criteria. The overall response rate for the paper respondents was 39%, ranging from 34% for Gardai to 64% for tribunal members.

**Focus groups**
A purposeful sampling strategy was used to ensure representation of stakeholders at the focus group assessments. Individuals from different stakeholder groups who participated in the descriptive survey were invited to participate in focus groups. Invitations were sent in sets of 10 to randomly selected participants from these groups until there were at least 10 participants in each stakeholder group. In addition, a service user focus group was included and for this a selection of service users who had previously participated in Study 2 were invited to additionally participate in a focus group. Researchers employed an over-sampling strategy because it was anticipated that one of every two participants who agreed to attend would actually do so. Participants were interviewed in disciplinary groups as it was felt this would give them the best opportunity to express their viewpoint freely (Kruger and Casey, 2015). In total, eight focus groups were held (1 focus group for each stakeholder group except for GPs where there were 2 groups), lasting on average 1-2 hours. Focus group sizes ranged from 5 to 14 participants. Written, informed consent was obtained from all participants who took part in focus groups.
Data analysis

Descriptive survey

In relation to the descriptive questionnaire, statistical analysis was performed using the Statistical Package for Social Sciences 20.0 for Windows (SPSS Inc., IBM, New York, USA). Chi-square ($\chi^2$) test was utilised to examine differences in demographic characteristics between groups and post-hoc procedures using adjusted standardised residuals associated with each cell to estimate significance with Bonferroni corrected p values (Beasley and Schumacker, 1995). An ordinal logistic regression model was employed to compare the stakeholders’ views on the operation of the MHA 2001 with "stakeholder group" as the independent variable (McCullagh, 1980) and controlling for gender, age, number of experienced involuntary admissions and type of data collection (paper vs. online). Although all group responses are relative, one group was identified as a reference group for the analysis so that stakeholder group comparisons could be expressed as odds ratios. The "Gardai" group was chosen as this reference group since it contained the highest number of respondents and had answered all items on the questionnaire. Free-text data from both the paper and online questionnaires were examined according to stakeholder group and were open-coded based on the framework of the questionnaire and on any other themes unrelated to these questions that emerged. The data attained from the free-texts was then grouped into themes by consensus of the researchers.

Focus groups

Data were analysed using a general inductive approach (Thomas, 2006; Elo and Kyngas, 2008). Analysis began with the repeated reading of interview transcripts to facilitate understanding of the experience as a whole. Two transcripts, selected at random, were then open-coded by two of the researchers and a coding framework was developed. Following this, each of four researchers independently analysed one focus group transcript and agreed on it together using the framework. The resulting coding was compared and found to be similar across all authors. All focus groups were then coded using this framework, and ‘general’ or ‘upper level’ categories were identified (Thomas,
The categories evolved to ‘specific’ or ‘lower’ level categories as the analysis proceeded and new categories were identified, and compared. Through this process of comparison, similar and related categories were grouped to form three higher order (Elo and Kyngas, 2008) or summary categories (Thomas, 2006), which were used to describe the phenomena. This involved the coming together of four researchers to review the files and agree on the final categories. Therefore, rigour was further strengthened by shared agreement among the authors on the developing categories and supporting literature (Guba and Lincoln, 2005).
Chapter 3. Quantitative Exploration of Service Users’ Experience of Involuntary Admission (Study 1)

Introduction

This chapter outlines the findings from study 1, which used quantitative measures to explore service users’ attitudes towards their experience of involuntary admission and sought to identify clinical predictors of variation in such attitudes. The chapter outlines the main results from this study and ends with a discussion of the findings in light of the prior literature.

Participant profile

There were 559 presentations during the study period in which an application for involuntary admission was made across the three approved centres. This consisted of n = 285 (51%) from Galway, n = 189 (34%) from Ballinasloe, and n = 85 (15%) from Roscommon. Of the 559 presentations, 370 (66%) had an Admission Order completed by the treating consultant psychiatrist. For the remaining 189 (34%) presentations, the MHA 2001 was applied to the individual for transfer/holding in hospital, however a subsequent involuntary admission order was not completed after assessment by the consultant psychiatrist, and the individual either stayed as a voluntary patient or was discharged.

A total of 105 potential presentations were missed, mostly individuals who were not admitted involuntarily, and 69 were excluded because they did not meet the inclusion criteria (see Figure 3.1 below). Out of the remaining 385 presentations who were approached to participate in the study, a total of 263 (68%) were successfully recruited and completed the initial baseline assessments (this included 228 individuals) with 155 presentations subsequently completing follow up assessments (this included 139 individuals). Figure 3.1 displays a flowchart for recruitment of individuals.
*Excluded: Individuals with severe dementia, severe learning disability, delirium, transferred to other centre, or unable to partake in the interview process.

**Missed: Individuals who could not be recruited either because they left hospital after a brief period or the researcher was unavailable.

Form 6: individuals transferred from the community
Form 13: voluntary inpatients transferred to involuntary status

Of the 107 presentations who did not complete the follow up assessments, 41 (38%) refused consent, 33 (31%) could not be contacted, 28 (26%) were unable to participate (eg had moved abroad, were too unwell) and 5 (5%) were deceased.

**Consent**

In total n = 266 presentations completed the assessment at baseline. Initially 31 (11.8%) of these presentations “assented” to take part in the study as it was not possible to obtain informed consent at that point in time. At a later stage three individuals were excluded from the data analysis as it was not possible to obtain informed consent from them at follow up assessments. Information pertaining to
those three individuals was thus destroyed in accordance with the protocol and ethical guidelines. Results are reported for the remaining 263 presentations at baseline who provided informed consent. At follow up all 155 presentations provided fully informed consent to take part in the study.

**Sociodemographic information**

The majority of individuals who took part in the study were male, were single and spoke English as their first language. Table 3.1 displays the demographic information for the participants.

Table 3.1 Socio-demographic information at baseline and follow-up on individuals who participated in the study.

<table>
<thead>
<tr>
<th>Demographic variable</th>
<th>Baseline (n=263) n (%)</th>
<th>Follow up (n=155) n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>167 (63.5)</td>
<td>101 (65.2)</td>
</tr>
<tr>
<td>Female</td>
<td>96 (36.5)</td>
<td>54 (34.8)</td>
</tr>
<tr>
<td><strong>Age-Group:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-24Yrs</td>
<td>29 (11)</td>
<td>18 (11.6)</td>
</tr>
<tr>
<td>25-44Yrs</td>
<td>123 (46.8)</td>
<td>74 (47.7)</td>
</tr>
<tr>
<td>45-64Yrs</td>
<td>86 (32.7)</td>
<td>52 (33.5)</td>
</tr>
<tr>
<td>65Yrs+</td>
<td>25 (9.5)</td>
<td>11 (7.1)</td>
</tr>
<tr>
<td>(Age range 19yrs to 88yrs, mean 43.05 yrs (SD 15.59))</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>161 (61.2)</td>
<td>96 (61.9)</td>
</tr>
<tr>
<td>Married</td>
<td>40 (15.2)</td>
<td>23 (14.8)</td>
</tr>
<tr>
<td>Significant relationship</td>
<td>15 (13.7)</td>
<td>3 (1.9)</td>
</tr>
<tr>
<td>Divorced/Separated</td>
<td>36 (13.7)</td>
<td>23 (14.8)</td>
</tr>
<tr>
<td>Widowed</td>
<td>11 (4.2)</td>
<td>10 (6.5)</td>
</tr>
<tr>
<td>Lives alone</td>
<td>Yes</td>
<td>94 (35.7)</td>
</tr>
<tr>
<td>-------------</td>
<td>-----</td>
<td>-----------</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>169 (64.3)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>English as first language</th>
<th>Yes</th>
<th>241 (91.6)</th>
<th>141 (91.0)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>22 (8.4)</td>
<td>14 (9.0)</td>
</tr>
<tr>
<td>(Other languages included Polish, Irish, Spanish, French, Lithuanian)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Caucasian</th>
<th>261 (99.2)</th>
<th>153 (98.7)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Asian</td>
<td>2 (0.8)</td>
<td>2 (1.3)</td>
</tr>
</tbody>
</table>

| Educational level attained | Completed primary level | 110 (41.8) | 70 (45.2) |
|                           | Completed secondary level | 70 (26.6) | 35 (22.6) |
|                           | Completed third level | 63 (24.0) | 33 (21.3) |
|                           | Completed post-grad | 20 (7.6) | 17 (11.0) |

<table>
<thead>
<tr>
<th>Socioeconomic group at assessment</th>
<th>I</th>
<th>2 (0.8)</th>
<th>1 (0.6)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>II</td>
<td>14 (5.3)</td>
<td>8 (5.2)</td>
</tr>
<tr>
<td></td>
<td>III</td>
<td>62 (23.6)</td>
<td>35 (22.6)</td>
</tr>
<tr>
<td></td>
<td>IV</td>
<td>23 (8.7)</td>
<td>19 (12.3)</td>
</tr>
<tr>
<td></td>
<td>V</td>
<td>162 (61.6)</td>
<td>92 (59.4)</td>
</tr>
</tbody>
</table>

**Clinical information**

The majority of individuals (n = 166, 63%) were admitted under section 14/15 of the MHA 2001, ie transferred from the community to the inpatient units. In almost half of cases (n = 119, 45%) the index admission was the first ever involuntary admission for that individual. Over eighty percent of individuals (n = 225, 86%) had had previous contact with the psychiatric services. A proportion of the individuals were admitted more than once on an involuntary basis during the time-frame of the study (n = 35, 13%) - mostly on two occasions (n = 24), with others admitted three times (n = 5), four times (n = 3), five times (n = 2) and
six times \((n = 1)\). For the purposes of the study each involuntary admission was counted as a separate presentation. Table 3.2 below displays the preliminary clinical information for the individuals who took part in the study.

Table 3.2 Basic clinical characteristics of participants at baseline and follow up.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Baseline n (n=263)</th>
<th>Follow up n (n=155)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Status of admission</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section 14/15</td>
<td>166 (63.1)</td>
<td>98 (63.2)</td>
</tr>
<tr>
<td>Section 23/24</td>
<td>39 (14.8)</td>
<td>29 (18.7)</td>
</tr>
<tr>
<td>Section 14 (2)</td>
<td>47 (17.9)</td>
<td>8 (5.2)</td>
</tr>
<tr>
<td>Section 23 (1)</td>
<td>11 (4.2)</td>
<td>20 (12.9)</td>
</tr>
<tr>
<td><strong>Consent/Assent</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initial consent</td>
<td>232 (88.2)</td>
<td>139 (89.7)</td>
</tr>
<tr>
<td>Initial assent</td>
<td>31 (11.8)</td>
<td>16 (10.3)</td>
</tr>
<tr>
<td><strong>Past psychiatric history</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>225 (85.6)</td>
<td>132 (85.2)</td>
</tr>
<tr>
<td>No</td>
<td>38 (14.4)</td>
<td>23 (14.8)</td>
</tr>
<tr>
<td><strong>Index admission is first involuntary admission</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>119 (45.2)</td>
<td>73 (47.1)</td>
</tr>
<tr>
<td>No</td>
<td>144 (54.8)</td>
<td>82 (52.9)</td>
</tr>
<tr>
<td><strong>Family History of psychiatric illness</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>122 (46.4)</td>
<td>73 (47.1)</td>
</tr>
<tr>
<td>No</td>
<td>80 (30.4)</td>
<td>50 (32.3)</td>
</tr>
<tr>
<td>Unknown</td>
<td>61 (23.2)</td>
<td>32 (20.6)</td>
</tr>
<tr>
<td><strong>History of alcohol abuse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>115 (43.7)</td>
<td>64 (41.3)</td>
</tr>
<tr>
<td>No</td>
<td>148 (56.3)</td>
<td>91 (58.7)</td>
</tr>
<tr>
<td><strong>History of illicit substance abuse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>79 (30.9)</td>
<td>44 (28.4)</td>
</tr>
<tr>
<td>No</td>
<td>184 (69.1)</td>
<td>111 (71.6)</td>
</tr>
<tr>
<td>Type of illicit substance used</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Cannabis</td>
<td>36 (45.6)</td>
<td>24 (54.5)</td>
</tr>
<tr>
<td>Other</td>
<td>7 (9.0)</td>
<td>5 (11.4)</td>
</tr>
<tr>
<td>Cannabis and other</td>
<td>36 (45.6)</td>
<td>15 (34.1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age at first admission</th>
<th>Mean (SD), range</th>
<th>Mean (SD), range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>32.1 (14.7), 13-85yrs</td>
<td></td>
<td>31.8, (14.1); 13-85yrs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time spent in hospital for index admission</th>
<th>Mean, (SD); Range</th>
<th>Mean, (SD); Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of days detained / number of days admitted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.1, (35.9); 1-219/38.4, (39.5); 1-241</td>
<td></td>
<td>25.3, (33.8); 1-181/39.7, (39.2); 1-220</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Time to completion of baseline and follow up assessments</th>
<th>Mean, (SD); Range</th>
<th>Mean, (SD); Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of days between admission and baseline assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.9, (7.7); 1-43</td>
<td></td>
<td>8.3, (6.9); 1-34</td>
</tr>
<tr>
<td>Number of days between revocation of involuntary order and follow up assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>93.5, (38.5); 6-236</td>
<td></td>
</tr>
</tbody>
</table>

For those transferred from the community on an admission order, the majority of applications for involuntary admission were made by a relative (n = 110, 51.5%). Gardaí made the application for involuntary admission next commonly (n = 85, 39.5%). An authorised officer made the application in only four cases (1.9%). The remaining applications were made by other persons (n = 16, 7.5%). Where the individual was brought to hospital with an application and recommendation for involuntary admission, they were transferred to hospital by an “assisted admission team” in almost half of cases (n = 86, 40%). This was either a team of community mental health nurses from the relevant approved centre or else the national assisted admissions team, a private company to whom this function had been outsourced by the HSE. Most individuals were brought to
hospital outside of routine working hours (n = 83, 56.0%). In the majority of cases the individual was detained by their own treating consultant (n = 146, 73%). These figures relate only to individuals on whom an admission order was completed and do not relate to those who were held on mental health act forms but not subsequently detained.

Following completion of an admission order just under half of individuals (n = 99, 48.2%) recalled being given a booklet with information about their rights and the MHA 2001. Less than two thirds (n = 130, 63.4%) recalled being told that they were being detained under the MHA 2001. Just over half of individuals (n = 71, 52.9%) recalled being told that they had a right to appoint an independent solicitor for their tribunal and they did not have to accept the solicitor appointed by the Mental Health Commission. This information however, is actually provided to all individuals on a standard patient notification form (as specified under Section 16(1)(b) and 16(2) of the Mental Health Act 2001) that is given to individuals when each involuntary admission order is completed, and is confirmed as such by the consultant psychiatrist in the Form 6 Admission Order that is sent to the Mental Health Commission.

**Diagnosis**

The primary diagnoses as formally ascertained at followup using the structured diagnostic interview is displayed in Table 3.3. Most individuals (82%) had experienced a psychotic illness. For the purpose of the analysis, these diagnoses were collapsed into 3 categories "affective psychotic illness" (n=65, 42%), "non-affective psychotic illness" (n=65, 42%) and "other" (n=25, 16%).
Table 3.3 Primary diagnosis as determined by the SCID.

<table>
<thead>
<tr>
<th>Primary Diagnosis (SCID)</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>47</td>
<td>30.1</td>
</tr>
<tr>
<td>Bipolar affective disorder</td>
<td>46</td>
<td>29.5</td>
</tr>
<tr>
<td>Schizoaffective disorder</td>
<td>16</td>
<td>10.3</td>
</tr>
<tr>
<td>Major depressive disorder (n=3 had psychotic symptoms)</td>
<td>8</td>
<td>5.1</td>
</tr>
<tr>
<td>Alcohol dependence syndrome</td>
<td>8</td>
<td>5.1</td>
</tr>
<tr>
<td>Borderline personality disorder</td>
<td>6</td>
<td>3.9</td>
</tr>
<tr>
<td>Brief psychotic episode</td>
<td>5</td>
<td>3.3</td>
</tr>
<tr>
<td>Delusional disorder</td>
<td>5</td>
<td>3.3</td>
</tr>
<tr>
<td>Substance induced psychotic disorder</td>
<td>3</td>
<td>1.9</td>
</tr>
<tr>
<td>No SCID diagnosis</td>
<td>3</td>
<td>1.9</td>
</tr>
<tr>
<td>Schizophreniform disorder</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>Psychotic disorder – not otherwise specified</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>Substance induced mood disorder</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>Eating disorder</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>Substance use disorder – cannabis</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>Adjustment disorder with disturbance of conduct</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>Total</td>
<td>155</td>
<td>100</td>
</tr>
</tbody>
</table>

**Individuals on whom an involuntary admission order was not completed**

In this study as well as individuals who were detained, individuals were included who had some degree of detention under the MHA 2001 (for up to 24 hours), but who were not subsequently admitted involuntarily after assessment by a consultant psychiatrist. Table 3.4 displays the clinical and attitudinal measures comparing individuals on whom an admission order was completed and those whose admission order was not completed. A greater proportion of those not detained than those detained were lost to followup.
There was no difference in terms of age between those detained and those who were not subsequently detained. Those who were detained had a greater number of previous involuntary admissions which reached statistical significance at baseline. Those who were not subsequently detained were less unwell (lower BPRS scores), had greater levels of functioning (higher GAF scores), higher awareness of illness scores (SAI-E) and higher attitudes to medication scores (HDAI) at baseline than those who were involuntarily admitted. They also had significantly more positive attitudes towards their care and treatment at both baseline and followup as evidenced by higher mean attitude scores on both the CAT and Attitude scales.

Individuals who were not detained reported lower levels of perceived coercion and procedural justice (ie. that their admission was not unjust) at baseline and at follow up compared to individuals on whom an admission order was completed. Those who were not detained were also less likely to have a diagnosis of a non-affective psychotic illness.

As subsequent analyses sought to assess variation over time and their clinical predictors, the 263 participants subject to MHA 2001 are considered together as a single group, with the variable “Admission status” representing whether individuals detained or not included as a covariate in the multivariate analysis.
Table 3.4 Comparison of clinical and attitudinal measures between those detained and those not detained.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Range</th>
<th>Baseline Detained (Mean, SD) n=205</th>
<th>Baseline Not detained (Mean, SD) n=58</th>
<th>t</th>
<th>p</th>
<th>Follow up Detained (Mean, SD) n=127</th>
<th>Follow up Not detained (Mean, SD) n=28</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>19-88</td>
<td>42.38 (15.57)</td>
<td>45.41 (15.56)</td>
<td>1.31</td>
<td>0.19</td>
<td>41.80 (15.28)</td>
<td>46.11 (14.39)</td>
<td>1.41</td>
<td>0.16</td>
</tr>
<tr>
<td>No. of previous invol. admissions</td>
<td>0-30</td>
<td>2.71 (4.17)</td>
<td>1.36 (2.67)</td>
<td>-2.97</td>
<td><strong>0.003</strong></td>
<td>2.55 (4.43)</td>
<td>1.89 (3.14)</td>
<td>-0.92</td>
<td>0.36</td>
</tr>
<tr>
<td>Symptoms (BPRS)</td>
<td>0-55</td>
<td>23.57 (12.82)</td>
<td>14.22 (9.61)</td>
<td>-6.07</td>
<td><strong>&lt;0.001</strong></td>
<td>4.58 (4.57)</td>
<td>4.14 (4.10)</td>
<td>-0.50</td>
<td>0.62</td>
</tr>
<tr>
<td>Awareness of illness (SAI-E)</td>
<td>0-22</td>
<td>4.78 (4.44)</td>
<td>7.67 (5.89)</td>
<td>2.43</td>
<td><strong>0.021</strong></td>
<td>11.19 (7.43)</td>
<td>11.78 (8.70)</td>
<td>0.25</td>
<td>0.80</td>
</tr>
<tr>
<td>Functioning (GAF)</td>
<td>0-100</td>
<td>24.89 (11.19)</td>
<td>32.15 (15.50)</td>
<td>3.32</td>
<td><strong>0.001</strong></td>
<td>66.88 (11.82)</td>
<td>69.17 (10.58)</td>
<td>1.01</td>
<td>0.32</td>
</tr>
<tr>
<td>Attitudes (CAT scale)</td>
<td>0-10</td>
<td>5.84 (3.19)</td>
<td>7.53 (2.66)</td>
<td>4.07</td>
<td><strong>&lt;0.001</strong></td>
<td>6.45 (2.93)</td>
<td>7.68 (2.43)</td>
<td>2.32</td>
<td><strong>0.02</strong></td>
</tr>
<tr>
<td>Attitudes scale</td>
<td>1-4</td>
<td>2.56 (0.74)</td>
<td>3.21 (0.53)</td>
<td>7.36</td>
<td><strong>&lt;0.001</strong></td>
<td>2.74 (0.76)</td>
<td>3.08 (0.68)</td>
<td>2.29</td>
<td><strong>0.03</strong></td>
</tr>
<tr>
<td>Perceived coercion</td>
<td>0-5</td>
<td>4.41 (1.22)</td>
<td>3.59 (1.75)</td>
<td>-3.30</td>
<td><strong>0.001</strong></td>
<td>4.60 (1.08)</td>
<td>3.96 (1.45)</td>
<td>-2.17</td>
<td><strong>0.04</strong></td>
</tr>
<tr>
<td>Perceived pressure</td>
<td>0-4</td>
<td>1.37 (0.98)</td>
<td>1.24 (0.85)</td>
<td>-0.97</td>
<td>0.33</td>
<td>1.05 (0.85)</td>
<td>0.85 (0.76)</td>
<td>-1.22</td>
<td>0.23</td>
</tr>
<tr>
<td>Procedural justice</td>
<td>0-16</td>
<td>10.19 (4.30)</td>
<td>8.25 (3.83)</td>
<td>-3.25</td>
<td><strong>0.002</strong></td>
<td>8.84 (4.05)</td>
<td>6.61 (2.62)</td>
<td>-3.53</td>
<td><strong>0.001</strong></td>
</tr>
<tr>
<td>Attitudes to medication (HDAI)</td>
<td>-30-+30</td>
<td>-2.69 (15.93)</td>
<td>8.14 (16.81)</td>
<td>3.99</td>
<td><strong>&lt;0.001</strong></td>
<td>4.57 (16.25)</td>
<td>9.91 (16.74)</td>
<td>1.43</td>
<td>0.16</td>
</tr>
</tbody>
</table>

Statistically significant differences are highlighted in bold. (BPRS = Brief Psychiatric Rating Scale, SAI-E = Scheduled for Assessment of Insight in Psychosis, GAF = Global Assessment of Functioning, CAT = Client Assessment of Treatment, HDAI = Hogan Drug Attitude Inventory)
Change in clinical variables between baseline and followup

Individuals improved substantially over time from a clinical point of view between baseline and follow up (Table 3.5). Levels of symptoms, insight and functioning all improved significantly.

Attitudes to involuntary admission and treatment also improved significantly on the Attitudes scale and at statistical trend level on the CAT scale, supporting the initial hypothesis for the study. However the absolute change in these measures was modest and it is notable that even at baseline the mean overall attitudes towards care was more positive than negative at a level of 6.2 on the 10 point CAT scale. Furthermore the relatively high standard deviations of these attitudinal measures reflected a high variability of responses. Notably these attitudinal scales were highly correlated both at baseline (r = 0.77, p < 0.001) and at follow up (r = 0.77, p < 0.001), indicating that they variables were largely measuring similar constructs.

The coercion ladder was highly correlated with the subcategory “perceived coercion” on the MacArthur admission interview both at baseline (r = 0.68, p < 0.001) and at follow-up (r = 0.68, p < 0.001). Levels of perceived coercion did not differ over time, whereas levels of perceived pressure and procedural justice both significantly improved, indicating that service users at followup considered themselves under less pressure and that their admission was more justified when at the point of recovery than they did during their acute admission. However individuals continued to report high levels of perceived coercion even when they had recovered from the acute episode of illness.

In relation to those individuals lost to followup, there was no significant difference in attitudes towards care and treatment at baseline between those who completed the follow up assessments and those who didn’t either on the CAT scale (t = 0.08, p = 0.93) or on the Attitude scale (t = -0.71, p = 0.48).
Table 3.5 Changes in clinical and attitudinal measures over time

<table>
<thead>
<tr>
<th>Scale</th>
<th>Baseline Mean (SD); Range, (n)</th>
<th>Follow up: Mean (SD); Range, (n)</th>
<th>Paired t test</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptoms (BPRS total score)</td>
<td>45.62 (12.85); 0-55, (n=263)</td>
<td>28.50 (4.48); 0-55, (n=155)</td>
<td>18.78</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Functioning (GAF)</td>
<td>26.49 (12.60); 8-88, (n=263)</td>
<td>67.30 (11.61); 28-90, (n=155)</td>
<td>-32.47</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Awareness of illness (SAI-E total score)</td>
<td>5.18 (4.76); 0-22, (n=197)</td>
<td>11.27 (7.57); 0-26, (n=124)</td>
<td>-9.10</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Attitude to medication (HDAI)</td>
<td>-0.05 (16.65); -30+30, (n=233)</td>
<td>5.30 (16.52); -30+30, (n=145)</td>
<td>-5.37</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Attitudes to involuntary admission (CAT)</td>
<td>6.21 (3.16); 0-10, (n=260)</td>
<td>6.68 (2.88); 0-10, (n=152)</td>
<td>-2.78</td>
<td>0.06</td>
</tr>
<tr>
<td>Attitudes to involuntary admission (Attitude Scale)</td>
<td>2.71 (0.76); 1-4, (n=258)</td>
<td>2.80 (0.76); 1-4, (n=152)</td>
<td>-1.52</td>
<td>0.002</td>
</tr>
<tr>
<td>Coercion Ladder</td>
<td>7.89 (2.97); 1-10, (n=252)</td>
<td>8.11 (2.56); 1-10, (n=145)</td>
<td>-0.44</td>
<td>0.965</td>
</tr>
<tr>
<td>Perceived Coercion (MacArthur Admission Interview)</td>
<td>4.23 (1.39); 0-5, (n=257)</td>
<td>4.52 (1.15); 0-5, (n=152)</td>
<td>-1.74</td>
<td>0.085</td>
</tr>
<tr>
<td>Perceived Pressure (MacArthur Admission Interview)</td>
<td>1.35 (0.96); 0-4, (n=257)</td>
<td>1.01 (0.84); 0-4, (n=152)</td>
<td>4.83</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Procedural Justice (MacArthur Admission Interview)</td>
<td>9.76 (4.27); 1-16, (n=253)</td>
<td>8.43 (3.91); 2-16, (n=150)</td>
<td>4.19</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Statistical significance highlighted in bold.

(BPRS = Brief Psychiatric Rating Scale, SAI-E = Scheduled for Assessment of Insight in Psychosis, GAF = Global Assessment of Functioning, CAT = Client Assessment of Treatment, HDAI = Hogan Drug Attitude Inventory, QOL=Quality of Life)
Attitudes towards care across stages of the admission process

Individual elements of the Attitudes scale are presented in Table 3.6. At baseline 43% of individuals believed that their involuntary admission had been necessary which increased to 65% at follow up.

As well as variation over time, there was substantial variation in attitudes towards different elements of assessment and care. Only one third of individuals believed at baseline that an adequate assessment of their need for admission had been carried out prior to admission, which increased a little to 40% at follow-up. On the other hand most individuals felt safe during transfer to hospital and agreed that their dignity was respected.

Most individuals reported feeling safe and not threatened in hospital, that they were treated with dignity and respect and that they could talk to staff about their involuntary admission, however only 40% reported receiving adequate information about their detention under MHA 2001 at baseline, which increased a little to 55% at followup. Around half of individuals reported feeling forced into taking medication and that they did not receive adequate information about medication.

Very few individuals (n=8) had experienced a tribunal by baseline assessment and so this data is confined to assessment at follow-up. Around half of individuals reported feeling listened to at the mental health tribunal and believing that the tribunal acted independently, whereas most reported that their solicitor appropriately represented their case.
Table 3.6 Components of the attitude scale and responses at baseline and follow-up.

<table>
<thead>
<tr>
<th>Category</th>
<th>Attitude scale items</th>
<th>Baseline: n= 263</th>
<th>Follow up: n= 155</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly agree/ agree; n (%)</td>
<td>Mean (SD) n</td>
<td>Strongly agree/ agree; n (%)</td>
</tr>
<tr>
<td>Transfer Process</td>
<td>Believes admission necessary</td>
<td>109 (42.9)</td>
<td>2.28 (1.21) n =254</td>
</tr>
<tr>
<td></td>
<td>Believes adequate assessment carried out prior to transfer to hospital</td>
<td>73 (33.4)</td>
<td>2.02 (1.12) n = 219</td>
</tr>
<tr>
<td></td>
<td>Rights and dignity were respected during transfer to hospital</td>
<td>123 (55.9)</td>
<td>2.63 (1.21) n =220</td>
</tr>
<tr>
<td></td>
<td>Felt safe during transfer to hospital</td>
<td>162 (74.3)</td>
<td>3.01 (1.08) n = 218</td>
</tr>
<tr>
<td>Care and treatment in hospital</td>
<td>Rights and dignity respected on arrival in hospital</td>
<td>163 (67.9)</td>
<td>2.90 (1.13) n =240</td>
</tr>
<tr>
<td></td>
<td>Felt safe in hospital</td>
<td>196 (79.0)</td>
<td>3.15 (1.00) n = 248</td>
</tr>
<tr>
<td></td>
<td>Rights and dignity were respected during admission</td>
<td>197 (78.5)</td>
<td>3.13 (1.03) n = 251</td>
</tr>
<tr>
<td></td>
<td>Received adequate information about being detained under the MHA</td>
<td>81 (40.9)</td>
<td>2.29 (1.09) n = 198</td>
</tr>
<tr>
<td></td>
<td>Didn't feel threatened during admission</td>
<td>173 (70.6)</td>
<td>3.04 (1.13) n = 245</td>
</tr>
<tr>
<td></td>
<td>Felt able to talk to staff about feelings</td>
<td>176 (71.6)</td>
<td>2.98 (1.05) n = 246</td>
</tr>
</tbody>
</table>
### Views towards medication

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Felt forced to take medication</td>
<td>141 (57.3)</td>
<td>2.63 (1.25)</td>
<td>76 (50.7)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>n = 246</td>
<td></td>
<td>n = 150</td>
</tr>
<tr>
<td></td>
<td>Provided with adequate information about medication</td>
<td>118 (49.8)</td>
<td>2.45 (1.13)</td>
<td>75 (51.7)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>n = 237</td>
<td></td>
<td>n = 145</td>
</tr>
</tbody>
</table>

### Experience of Mental Health Tribunal

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Felt listened to at Mental Health Tribunal</td>
<td>-</td>
<td></td>
<td>24 (53.3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>n = 45</td>
</tr>
<tr>
<td></td>
<td>Solicitor appropriately represented case at Tribunal</td>
<td>-</td>
<td></td>
<td>36 (83.7)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>n = 43</td>
</tr>
<tr>
<td></td>
<td>Believed Mental Health Tribunal acted independently and objectively</td>
<td>-</td>
<td></td>
<td>20 (50.0)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>n = 40</td>
</tr>
</tbody>
</table>

*Red denotes responses where less than 60% of respondents answered agree/strongly agree. Number of respondents is shown for each question since some questions were not answered by all participants.*
**Diagnosis and attitudes towards involuntary admission and treatment**

Those with a diagnosis of an affective psychotic illness had significantly greater (t=3.178, p=0.002) awareness of illness (mean SAI-E = 13.39, SD = 7.23) at follow-up compared to those with a diagnosis of non-affective psychotic illness (mean SAI-E= 9.11, SD = 7.41).

However there was no statistically significant difference (t = 1.54, p = 0.125) in attitudes towards involuntary admission at follow-up between those with a diagnosis of an affective psychotic illness (CAT scale: mean = 6.48, SD = 2.80; Attitude scale: mean = 2.81, SD = 0.72) compared to those with a diagnosis of a non affective psychotic illness (CAT scale: mean = 6.38, SD = 3.05; Attitude scale: mean = 2.61, SD = 0.73).

**Experience of coercive practices and attitudes to care**

There was no association between having experienced physical restraint and attitudes to involuntary admission and treatment on the CAT scale (t = 0.03, p = 0.97) or the Attitude scale (t = 0.43, p = 0.66). Nor was there an association between having been subject to seclusion and attitudes to the experience of involuntary admission and treatment on the CAT scale (t = 0.21, p = 0.84) or the Attitude scale (t = 0.34, p = 0.74). Nor was there an association between having been subject to forced intramuscular injection and attitudes to the experience of involuntary admission and treatment on the CAT scale (t = 0.21, p = 0.84) or the Attitude scale (t = 0.25, p = 0.80). This lack of association between attitudes to care and being subject to coercive measures was in contrast to what had been hypothesised.

**Clinical characteristics and attitudes to care at baseline**

Attitudes to involuntary care and treatment were significantly moderately correlated with SAI-E (CAT scale: r = 0.40, p < 0.001, Attitude scale: r = 0.42, p < 0.001), BPRS (CAT scale: r = -0.39, p < 0.001, Attitude scale: r = -0.49, p < 0.001),
and GAF scores (CAT scale: \( r = 0.32, p < 0.001 \), Attitude scale: \( r = 0.48, p < 0.001 \)) at baseline. Thus individuals who had less symptoms, greater insight and greater levels of functioning were found to have more positive attitudes towards involuntary admission, treatment and care on both attitude scales at baseline assessments, in keeping with what had been hypothesised.

**Baseline clinical associations of attitudes towards involuntary admission and treatment at baseline**

In these subsequent multivariate analyses, optimal clinical predictors of attitudes towards care and treatment are assessed, whilst controlling for potential confounds. Given the high degree of correlation between the study specific Attitudes scale and the CAT scale, results are presented here using the former measure. Repetition of the same multivariate analyses using the CAT scale as the outcome variable produced largely similar results.

Multiple linear regression modelling and data driven trees were used to identify potentially useful explanatory variables for attitude mean scores at baseline. The following potential explanatory variables were included; gender, age, diagnosis, levels of insight, symptoms, functioning, number of previous involuntary admissions, number of days detained, history of alcohol or drug misuse and whether or not an admission order was completed. The results of the multivariate analysis is displayed in Table 3.7. More positive attitudes at baseline as measured by the Attitude scale were significantly associated with better awareness of illness, being older, having had fewer numbers of previous involuntary admissions, not having a lifetime history of illicit drug misuse but having a history of alcohol misuse. The variance explained by this model was 32.9%. Figure 3.2 below shows the association between awareness of illness and attitudes to involuntary admission and treatment at baseline as measured by the Attitude scale. Figure 3.3 below shows the tree model that displays the useful cut off points for each variable.
Figure 3.2 Association between awareness of illness and attitudes (Attitude scale) towards involuntary admission at baseline.

This figure demonstrates that individuals who had a greater awareness of illness at baseline had more positive attitudes to the process and experience of involuntary admission and treatment. The shaded area on the graph represents the 95% confidence interval.
Figure 3.3 Tree model showing baseline predictors of attitudes towards involuntary admission and treatment (Attitude scale).

The tree model indicates that awareness of illness (Insight1), level of symptoms at baseline (BPRS1Tot) and whether a detention order was completed are useful predictors of attitudes towards care at baseline, with data driven cut-off points on the scales for each variable used to predict categories. For example those with less symptoms at baseline (<14 BPRS score) and for whom an admission order was not completed had more positive attitudes as measured by the Attitude scale (Node 3 with mean scores of 3.5 out of a total of 4). Similarly individuals with high level of symptoms (BPRS>14), poor insight (SAI-E<3) who were detained more negative attitudes towards their care (Node 8: mean Attitudes score of 2.1).
Table 3.7 Results of the multiple regression analysis for the Attitude scale at baseline.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Estimate (b)</th>
<th>Standard error</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness of illness (SAI-E)</td>
<td>0.041</td>
<td>0.011</td>
<td>3.595</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Symptoms at baseline (BPRS)</td>
<td>-0.008</td>
<td>0.004</td>
<td>-1.646</td>
<td>0.101</td>
</tr>
<tr>
<td>Functioning at baseline (GAF)</td>
<td>0.006</td>
<td>0.005</td>
<td>1.112</td>
<td>0.267</td>
</tr>
<tr>
<td>Age in years</td>
<td>0.009</td>
<td>0.003</td>
<td>2.919</td>
<td>*0.003</td>
</tr>
<tr>
<td>Gender</td>
<td>0.023</td>
<td>0.096</td>
<td>0.242</td>
<td>0.808</td>
</tr>
<tr>
<td>Diagnosis affective vs. non-affective</td>
<td>-0.006</td>
<td>0.094</td>
<td>-0.065</td>
<td>0.947</td>
</tr>
<tr>
<td>Diagnosis affective vs. other</td>
<td>0.170</td>
<td>0.158</td>
<td>1.073</td>
<td>0.284</td>
</tr>
<tr>
<td>Lifetime history of alcohol abuse</td>
<td>0.249</td>
<td>0.102</td>
<td>2.442</td>
<td>*0.015</td>
</tr>
<tr>
<td>Lifetime history of illicit drug abuse</td>
<td>-0.247</td>
<td>0.124</td>
<td>-1.990</td>
<td>*0.048</td>
</tr>
<tr>
<td>Admission status (admission order completed or not)</td>
<td>-0.220</td>
<td>0.131</td>
<td>-1.681</td>
<td>0.094</td>
</tr>
<tr>
<td>Number of previous involuntary admissions</td>
<td>-0.036</td>
<td>0.011</td>
<td>-3.266</td>
<td>*0.001</td>
</tr>
</tbody>
</table>

*Significant tests are highlighted in bold. (BPRS = Brief Psychiatric Rating Scale, SAI-E = Scheduled for Assessment of Insight in Psychosis, GAF = Global Assessment of Functioning)*
Baseline clinical associations of attitudes towards involuntary admission and treatment at follow-up

In this second multivariate analysis using baseline clinical predictors of attitudes at follow-up, the outcome variable was score on the Attitudes scale at 3 month follow-up. Added to this analysis were additional clinical variables that were collected on the follow-up sample including the quality of life, duration of involuntary admission, whether a mental health tribunal was experienced and whether the individual had been subject to coercive experiences during the admission, such as physical restraint, intramuscular injection or seclusion. The results of the analysis are displayed in Table 3.8. Almost 40% of the variance was explained by this model.

More positive attitudes towards care at follow-up were significantly associated with having more symptoms at baseline, being male, not having a history of illicit drug abuse and not having a diagnosis of an affective psychotic illness or a psychotic illness after adjusting for several variables including symptoms, insight, gender, diagnosis, quality of life, having been subject to coercive measures, status of admission, history of alcohol abuse and history of illicit substance abuse. Given the very strong association of attitudes at follow-up with attitudes at baseline in the model, the analysis was repeated excluding “attitudes at baseline” as an independent variable (Table 3.9). In this analysis, awareness of illness at baseline also emerged as a significant predictor of attitudes towards involuntary admission and treatment at follow-up and symptoms at baseline were no longer significant.

Notably here was no association between attitudes towards involuntary care and experience of coercive measures or whether or not an admission order was completed in either model.
Table 3.8 Results of the multiple regression analysis for baseline predictors of attitudes at follow-up on the Attitude Scale.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Estimate (b)</th>
<th>Standard error</th>
<th>t</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitudes at baseline</td>
<td>0.507</td>
<td>0.095</td>
<td>5.339</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Awareness of illness / Insight at baseline (SAI-E)</td>
<td>0.023</td>
<td>0.014</td>
<td>1.650</td>
<td>0.101</td>
</tr>
<tr>
<td>Symptoms at baseline (BPRS)</td>
<td>0.013</td>
<td>0.005</td>
<td>2.369</td>
<td>0.019</td>
</tr>
<tr>
<td>Quality of life (QOL)</td>
<td>-0.001</td>
<td>0.002</td>
<td>-0.364</td>
<td>0.716</td>
</tr>
<tr>
<td>Age in years</td>
<td>0.006</td>
<td>0.004</td>
<td>1.533</td>
<td>0.128</td>
</tr>
<tr>
<td>Gender</td>
<td>-0.343</td>
<td>0.123</td>
<td>-2.774</td>
<td>0.006</td>
</tr>
<tr>
<td>Diagnosis affective vs. non-affective</td>
<td>-0.099</td>
<td>0.122</td>
<td>-0.811</td>
<td>0.419</td>
</tr>
<tr>
<td>Diagnosis affective vs. other</td>
<td>0.614</td>
<td>0.292</td>
<td>2.106</td>
<td>0.037</td>
</tr>
<tr>
<td>Lifetime history of alcohol abuse</td>
<td>0.080</td>
<td>0.130</td>
<td>0.618</td>
<td>0.537</td>
</tr>
<tr>
<td>Lifetime history of illicit drug abuse</td>
<td>-0.344</td>
<td>0.159</td>
<td>-2.162</td>
<td>0.032</td>
</tr>
<tr>
<td>Admission status (admission order completed or not)</td>
<td>0.151</td>
<td>0.180</td>
<td>0.839</td>
<td>0.403</td>
</tr>
<tr>
<td>Number of previous involuntary admissions</td>
<td>-0.007</td>
<td>0.014</td>
<td>-0.551</td>
<td>0.583</td>
</tr>
<tr>
<td>Use of coercive measures (yes/no)</td>
<td>0.142</td>
<td>0.132</td>
<td>1.077</td>
<td>0.284</td>
</tr>
<tr>
<td>Length of detention</td>
<td>-0.001</td>
<td>0.003</td>
<td>-0.045</td>
<td>0.963</td>
</tr>
<tr>
<td>Experience of tribunal during index admission</td>
<td>-0.070</td>
<td>0.128</td>
<td>-0.547</td>
<td>0.585</td>
</tr>
</tbody>
</table>

Significant tests are highlighted in bold. Variance explained by the model 39% (BPRS = Brief Psychiatric Rating Scale, SAI-E = Scheduled for Assessment of Insight in Psychosis, QOL = Quality of Life).
Table 3.9 Results of the multiple regression analysis for baseline predictors of attitudes at follow-up on the Attitude Scales, excluding attitudes at baseline as a predictor variable.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Estimate (b)</th>
<th>Standard error</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness of illness / Insight at baseline (SAI-E)</td>
<td>0.042</td>
<td>0.015</td>
<td>2.779</td>
<td>0.006</td>
</tr>
<tr>
<td>Symptoms at baseline (BPRS)</td>
<td>0.009</td>
<td>0.006</td>
<td>1.510</td>
<td>0.134</td>
</tr>
<tr>
<td>Quality of life (QOL)</td>
<td>-0.000</td>
<td>0.002</td>
<td>-0.178</td>
<td>0.859</td>
</tr>
<tr>
<td>Age in years</td>
<td>0.012</td>
<td>0.005</td>
<td>2.474</td>
<td>0.014</td>
</tr>
<tr>
<td>Gender</td>
<td>-0.280</td>
<td>0.138</td>
<td>-2.024</td>
<td>0.045</td>
</tr>
<tr>
<td>Diagnosis affective vs. non-affective</td>
<td>-0.146</td>
<td>0.137</td>
<td>-1.064</td>
<td>0.289</td>
</tr>
<tr>
<td>Diagnosis affective vs. other</td>
<td>0.653</td>
<td>0.330</td>
<td>1.977</td>
<td>0.050</td>
</tr>
<tr>
<td>Lifetime history of alcohol abuse</td>
<td>0.201</td>
<td>0.143</td>
<td>1.403</td>
<td>0.163</td>
</tr>
<tr>
<td>Lifetime history of illicit drug abuse</td>
<td>-0.443</td>
<td>0.175</td>
<td>-2.531</td>
<td>0.012</td>
</tr>
<tr>
<td>Admission status (admission order completed or not)</td>
<td>0.067</td>
<td>0.202</td>
<td>0.333</td>
<td>0.739</td>
</tr>
<tr>
<td>Number of previous involuntary admissions</td>
<td>-0.020</td>
<td>0.015</td>
<td>-1.327</td>
<td>0.187</td>
</tr>
<tr>
<td>Use of coercive measures (yes/no)</td>
<td>0.229</td>
<td>0.148</td>
<td>1.540</td>
<td>0.126</td>
</tr>
<tr>
<td>Length of detention</td>
<td>0.000</td>
<td>0.003</td>
<td>0.077</td>
<td>0.938</td>
</tr>
<tr>
<td>Experience of tribunal during index admission</td>
<td>-0.081</td>
<td>0.144</td>
<td>-0.567</td>
<td>0.572</td>
</tr>
</tbody>
</table>

Significant tests are highlighted in bold. Variance explained by the model 21%. (BPRS = Brief Psychiatric Rating Scale, SAI-E = Scheduled for Assessment of Insight in Psychosis, QOL = Quality of Life).
Clinical associations of improvements in attitudes towards involuntary admission and treatment over time

In this third multivariate analysis the outcome variable was change in attitudes between baseline and follow-up assessments, and the independent variables included change in scores of the clinical variables relating to symptoms and insight that previously were associated with baseline attitudes scores. The results are displayed in Table 3.10 and this model explained 32% of the variance in attitude change.

Change towards more positive attitudes towards the process and experience of involuntary admission over time was significantly associated with attitudes at baseline, changes in awareness of illness over time, gender, and diagnosis after adjusting for several other potential explanatory variables including insight, symptoms, age, gender, status of admission, experience of coercive measures, history of drug/alcohol use, duration of admission and number of previous admissions. Individuals who had more negative attitudes at baseline, who were male, who had greater improvements in the awareness of illness over time and those who didn’t have a diagnosis of psychotic illness were found to have more positive changes in attitudes to the process and experience of involuntary admission over time. The association of improved awareness of illness with improved attitudes towards care is in keeping with what had been hypothesised for the study. Figure 3.4 displays the association between change in awareness of illness over time and change in attitudes towards involuntary admission and treatment over time.

There were no significant differences in attitudes between those with a diagnosis of a non-affective psychotic illness compared to those with an affective psychotic illness. There was no association between actual experience of coercive measures, experience of tribunal, duration of involuntary treatment, or admission status and attitudes towards involuntary admission and treatment.
Table 3.10 Results of the multiple regression analysis examining clinical associations of changes in attitudes between baseline and follow-up.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Estimate (b)</th>
<th>Standard error</th>
<th>t</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attitudes towards admission (baseline)</td>
<td>-0.427</td>
<td>0.086</td>
<td>-4.950</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Change in awareness of illness / insight (SAI-E)</td>
<td>0.022</td>
<td>0.008</td>
<td>2.649</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Change in symptoms (BPRS)</td>
<td>0.010</td>
<td>0.005</td>
<td>1.925</td>
<td>0.057</td>
</tr>
<tr>
<td>Quality of life (QOL)</td>
<td>-0.002</td>
<td>0.002</td>
<td>-0.866</td>
<td>0.388</td>
</tr>
<tr>
<td>Age in years</td>
<td>0.004</td>
<td>0.004</td>
<td>1.142</td>
<td>0.256</td>
</tr>
<tr>
<td>Gender</td>
<td>-0.281</td>
<td>0.113</td>
<td>-2.485</td>
<td>0.014</td>
</tr>
<tr>
<td>Diagnosis affective vs. non-affective</td>
<td>-0.025</td>
<td>0.121</td>
<td>-0.210</td>
<td>0.833</td>
</tr>
<tr>
<td>Diagnosis affective vs. other</td>
<td>0.732</td>
<td>0.277</td>
<td>2.636</td>
<td>0.009</td>
</tr>
<tr>
<td>Lifetime history of alcohol abuse</td>
<td>0.059</td>
<td>0.125</td>
<td>0.476</td>
<td>0.635</td>
</tr>
<tr>
<td>Lifetime history of illicit drug abuse</td>
<td>-0.300</td>
<td>0.152</td>
<td>-1.968</td>
<td>0.051</td>
</tr>
<tr>
<td>Admission status (admission order completed or not)</td>
<td>0.097</td>
<td>0.171</td>
<td>0.567</td>
<td>0.572</td>
</tr>
<tr>
<td>Number of previous involuntary admissions</td>
<td>-0.002</td>
<td>0.013</td>
<td>-0.173</td>
<td>0.862</td>
</tr>
<tr>
<td>Use of coercive measures (yes/no)</td>
<td>0.072</td>
<td>0.127</td>
<td>0.567</td>
<td>0.571</td>
</tr>
<tr>
<td>Length of detention</td>
<td>0.001</td>
<td>0.003</td>
<td>0.496</td>
<td>0.620</td>
</tr>
<tr>
<td>Experience of tribunal during index admission</td>
<td>-0.159</td>
<td>0.124</td>
<td>-1.282</td>
<td>0.202</td>
</tr>
</tbody>
</table>

Significant tests are highlighted in bold. Variance explained by the model 32%. BPRS = Brief Psychiatric Rating Scale, SAI-E = Scheduled for Assessment of Insight in Psychosis, QOL = Quality of Life.
Discussion

Attitudes towards necessity of involuntary admission

At baseline under half of individuals who took part in the study (43%) believed that their involuntary admission had been necessary, with this figure increasing to 65% at follow up. This figure is similar to findings from another Irish study by O’Donoghue et al (2010) who found that 72% of individuals, who were assessed after revocation of their involuntary admission but prior to hospital discharge, viewed their admission as necessary and 60% did so one year later (O’Donoghue et al., 2011a).
A review article that included 18 studies by Katsakou et al (2006) found that between 39-75% of individuals retrospectively reported that their involuntary admission had been necessary. Only three of the studies followed up individuals beyond their discharge. In addition some of the researchers were clinicians involved in the individuals' care which may have biased some responses into being more positive. The authors found that the greater the length of time that had elapsed since the admission that the individual was more likely to report the involuntary admission as necessary. Interviews conducted between 4 months and 3 years found that between 66% and 75% reported retrospectively that their admission had been necessary, which are similar to the findings of the current study.

**Overall attitudes towards care and treatment**

In general individuals' attitudes towards involuntary admission and treatment were more positive than negative with individuals being over 60% satisfied with most aspects of care and treatment at baseline, whilst they were acutely unwell, and attitudes to involuntary admission and treatment improving further at follow-up. This was true for attitudes measured both by the standard CAT scale and also by the Attitudes scale. Of note scores on the CAT scale, which is validated and widely used across studies, and the study specific Attitudes scale were highly correlated at both time-points, indicating convergent validity for the latter scale.

However despite the relatively high mean scores on these attitudes scales, it was notable that there was a large variance in the scale measures, indicating wide heterogeneity amongst respondents. When subcomponents on the Attitudes scale were scrutinized, the areas that individuals reported the least satisfaction with, both at admission and also after the involuntary admission order was revoked by the consultant (or tribunal), related to the assessment process prior to admission to hospital, the amount of information received about medication and about the MHA 2001, and the experience and perceived independence of mental health tribunals.
The finding that individuals were mostly positive about their care during involuntary admission and treatment is consistent with Smith et al (2014), where the authors found that in general individuals who were admitted involuntarily reported overall good levels of satisfaction with the care and treatment they received. An observational prospective multi-centre study conducted in England included large numbers of individuals and assessed various factors associated with satisfaction towards involuntary admission and treatment at 4 time-points. The authors of this study also found that mean attitude scores as measured by the CAT scale was over 5 at all time-points. The most positive results were reported at the three month follow-up, with the scores reducing slightly at the one year follow up but still remaining greater than 5 (Katsakou et al., 2010).

Katsakou et al (2006) found that in general between 46% and 73% of individuals believed that they had benefited from the treatment received. Out of the 18 studies included in the review two studies found that between 68-76% of individuals reported a positive improvement and were happy with the treatment and care they received (Kjellin et al., 1997; Kjellin et al., 2004). In contrast a study including smaller numbers found that only 37% of individuals scored above the midpoint of the satisfaction scale (CSQ) when they were assessed just prior to their discharge from hospital (Iversen et al., 2007).

In general results from this study are consistent with the international literature in finding that patients on average are satisfied, despite the large variation in responses, and that satisfaction levels improve over time. However a substantial minority have persistently negative attitudes, even when they have returned to their baseline levels of symptoms and functioning. It is possible that some of this dissatisfaction in the current study is related to general dissatisfaction among patients with mental illness about the emphasis on medication and lack of information (Chandra et al., 2014) and not specific to those patients subject to involuntary admission. This possibility could not be assessed in the present study as no comparison group of patients who were voluntarily admitted was included.
Procedural justice, perceived coercion and perceived pressure

Individuals who were more likely to believe that their admission was justified/fair had more positive overall attitudes to the process and experience of involuntary admission at follow-up both on the CAT and Attitudes scales. This was true both at baseline and at follow-up. This variable was not included in the multivariate analysis, since it can be considered an outcome variable, similar to Attitudes/CAT, rather than an explanatory variable related to the illness, clinical features or the services.

There were significant associations between levels of perceived coercion and levels of perceived pressure experienced by individuals and their attitudes towards involuntary admission and treatment on univariate analysis both at baseline and at follow-up. The correlations were stronger for the baseline data when the individual was more acutely unwell and there was more variation in the perceived coercion and perceived pressure scores. As with procedural justice these variables were not included in the multivariate analysis since they were considered outcome variables, similar to Attitudes/CAT, rather than potential explanatory variables related to the illness, clinical features or the services received.

The study by Katsakou et al (2010) reported that higher levels of perceived coercion on the MacArthur admission interview were associated with higher levels of dissatisfaction with involuntary admission and treatment on the Client Assessment of Treatment Scale, both at baseline and at follow-up on both univariate and multivariate analysis. Similarly a study by Strauss et al (2013) found a significant association between higher levels of perceived coercion and being less satisfied with inpatient treatment during involuntary admission. This finding was consistent on both univariate and multivariate analysis.

In summary, findings from the current study are consistent with findings from some previous studies in that it is the level of perceived coercion experienced by individuals which is associated with attitudes towards their care and treatment,
rather than the experience of actual documented coercive measures, such as physical restraint or forced intramuscular injection. Interestingly in this regard, The MacArthur Coercion study found that where individuals felt they had a “voice” in the admission process and were treated by others with respect, concern and good faith, that levels of perceived coercion experienced were less (MacArthur Research Network on Mental Health and the Law, 2004).

Predictors of attitudes towards involuntary admission and treatment

Awareness of illness
In this study awareness of illness (insight) was found to be one of the strongest predictors of attitudes towards involuntary admission and treatment both at baseline, when the individual was acutely unwell, and three months following revocation of the involuntary admission order, when the individual was back to their regular level of functioning. This finding was evident on the univariate analysis but also remained strongly significant on the multivariate analysis, when other potential explanatory factors associated with attitudes to care were adjusted for. Additionally, greater improvement in awareness of illness over time was found to be associated with more positive attitudes to the experience of involuntary admission and treatment at follow up.

These results are consistent with findings from the studies by O’Donoghue et al (2010; 2011a; 2011b) who found a strong correlation between insight and whether or not individuals viewed their involuntary admission as necessary. Indeed insight remained the only factor that was predictive of attitudes when a multivariate analysis was carried out. The authors used the Birchwood Insight Scale, which in contrast to the SAI-E scale used in the current study is a subjective rated instrument that assesses the recognition of the need for treatment, the ability to re-label psychotic symptoms and the recognition of mental illness. A study by Smith et al (2014) also found that insight was associated with more positive attitudes towards involuntary admission and
treatment. Smyth et al’s study did not specifically focus on individuals who were admitted involuntarily, but included those admitted voluntarily also. As with the study by O’Donoghue et al (2010) individuals were assessed just prior to their discharge from hospital, a self report questionnaire rather than objectively administered scale was employed and sample size was more modest than the current study. Similarly an earlier study by Naber et al (1996) noted that awareness of illness was associated with whether or not individuals viewed their admission as necessary, albeit the number of study participants was relatively modest (n=40) and no validated psychometric instrument was utilised for this assessment.

The current study builds upon this previous literature and provides strong evidence that awareness of illness is a strong clinical association of attitudes towards involuntary treatment and care. This finding is strengthened in the current study since several additional potential explanatory variables were included in the multivariate model, a large representative sample was employed, the relationship was present both at baseline during acute admission and at recovery on follow-up, and patients who displayed improved awareness of illness over time also displayed improved attitudes towards their care and treatment during the involuntary admission. However, although the multivariate model explained 24-39% of the variance, which is common for such analyses, up to 60% of the variance remained unexplained, and other unmeasured clinical factors affecting attitudes towards involuntary treatment and care may be present. Furthermore the wide variation in attitudes reflects a very heterogeneous group of respondents that renders it difficult to identify strong clinical predictors, and clinical subgroups may exist that were not identified by the current analysis.

**Symptoms**

In univariate analysis individuals who had more symptoms at baseline were found to have more negative attitudes towards the process and experience of
involuntary admission and treatment at baseline, but this variable lost significance in the multivariate analysis when potential explanatory variables were adjusted for. However on multivariate analysis modelling, a significant association was identified between a greater reduction in symptom levels and improvement in attitudes to the process and experience of involuntary admission. On the multivariate analysis modelling baseline predictors of follow-up responses, those who had more symptoms at baseline (i.e. those who were more unwell) had more positive attitudes to the process and experience of involuntary admission at follow-up. This is likely due to the fact that these individuals had a greater scope to improve in their symptoms as they were more unwell and this is further supported by the finding mentioned above that those who improved most symptomatically over time had more positive attitudes to the process and experience of involuntary admission at follow up. Indeed when the multivariate model was repeated excluding attitudes at baseline, the previously significant association of symptoms at baseline with attitudes at follow-up disappeared, supporting this interpretation.

Savill et al (2012) found an association on multivariate analysis between level of symptoms and the individuals’ initial appraisal of their treatment with lower levels of manic and positive symptoms being associated with more positive attitudes as measured by the CAT scale. This was a cross sectional study including the Involve study (Priebe et al., 2009), the Eunomia study (Kallert et al., 2005; Priebe et al., 2010) and the Eden study (Kallert et al., 2007). In contrast to the current study, some individuals included in this cross sectional study by Savill et al (2012) were attending out-patient settings and so the study was not solely focused on individuals who were admitted involuntarily. In the Katsakou and Priebe (2006) review of 18 studies, those individuals who had the greatest clinical gains in their admission had the most positive attitudes towards their involuntary admission and care retrospectively. Katsakou et al (2010) also found that a greater improvement in symptoms over time was associated with more positive attitudes to the process and experience of involuntary admission. Overall the current study supports evidence from some previous literature that individuals who had less symptoms at admission and who experienced
symptomatic improvement over time were more likely to view their involuntary admission and treatment as necessary.

**Functioning**

Despite finding an association on the univariate analysis between baseline overall functioning and attitudes towards involuntary admission and treatment at baseline with greater levels of functioning being associated with more positive attitudes to the process and experience of involuntary admission, this finding did not hold on the multivariate analysis when potential explanatory factors were controlled for. Similarly, significant correlations on the univariate analysis between overall level of functioning and attitudes towards involuntary admission and treatment at follow up were identified but this significance did not hold on any of the multivariate models. A study by Roche et al (2014) found that higher functioning scores as measured by the GAF were associated with a more positive therapeutic relationship. However, similar to the findings in the current study this finding was no longer significant on multi-variate analysis. O'Donoghue et al (2011a) found no association with overall functioning as measured by the GAF and whether or not individuals believed that their index admission had been necessary. Other studies have found that poorer overall global functioning at the time of admission was associated with a more positive view of the involuntary admission on follow up assessments (Priebe et al., 2009). Thus, some conflicting evidence exists in the literature regarding the association with levels of functioning and attitudes towards involuntary admission. Overall, it appears likely that functioning is not associated with attitudes towards involuntary admission and treatment when the impact of stronger explanatory variables like insight and symptoms are taken into consideration.

**Age**

Individuals who were older had more positive attitudes towards the process and experience of involuntary admission at baseline and at follow up. This is similar to findings from a large cross sectional study by Savill et al (2012). Iversen et al (2007) also found age to be significantly associated with satisfaction with
treatment. Other studies report no association between age and attitudes towards involuntary admission and treatment (O’Donoghue et al., 2010). It is unlikely that the association between age and attitudes towards involuntary care is related to previous experience of involuntary admission as this was included as a potential explanatory variable, however a potential interpretation is that older individuals are more likely to have experienced other exposures to mental health services as outpatients or voluntary patients and this may have improved their attitudes towards services.

**Gender**

There was no significant relationship on the multivariate analysis between gender and attitudes to the process and experience of involuntary admission at baseline, but being male was associated with more positive attitudes to the process and experience of involuntary admission at follow-up. The large cross sectional study by Savill et al (2012) also reported that being male was associated with more positive attitudes to the process and experience of involuntary admission as measured by the CAT scale at baseline. Further research may clarify the possible reasons behind the gender differences identified in this study and whether gender specific attitudes towards coercive care are consistent.

**Alcohol and illicit substance abuse**

Having a lifetime history of alcohol abuse but not of illicit substance abuse was associated with more positive attitudes to the process and experience of involuntary admission at baseline. Similarly Smith et al (2014) found that those with co-morbid illicit substance use had more negative attitudes to the process and experience of involuntary admission. It is possible that those with illicit substance misuse are less likely to engage with healthcare services.
**Previous experience of involuntary admissions**

Greater number of previous involuntary admissions was associated with more negative attitudes to the process and experience of involuntary admission at baseline. Katsakou et al (2010) also found that not having had previous involuntary admissions was associated with better attitudes towards involuntary admission and treatment on the CAT scale, but this lost its significance on the multivariate model. It is possible that individuals who had more involuntary admissions also had more severe or resistant mental illness and/or were more likely to default from community follow up, perhaps reflecting a more negative relationship with the mental health services in general or negative attitudes towards their care.

**Experience of coercive measures**

There was no association between actual experience of coercive measures and attitudes towards involuntary admission and treatment. The study by Smith et al (2014) found on multivariate analysis that individuals who had experienced seclusion were less satisfied overall with the services during their involuntary admission and treatment, but similar to the current study they did not find any statistically significant association between the experience of restraint or forced intramuscular injection and attitudes towards involuntary treatment. O’Donoghue et al (2011a) similarly did not find any association between the experience of physical coercion and whether or not the individual believed that their involuntary admission had been necessary at one year follow up. Notably a study by Iversen et al (2007) reported on multivariate analysis that as the number of coercive events increased that the individuals’ satisfaction with treatment decreased. This study included voluntarily admitted as well as involuntary patients. However when the authors looked at the individual measures of coercion, they were not significantly associated with overall satisfaction or levels of satisfaction on the satisfaction subscales. By comparison the current study included more explanatory variables, such as awareness of illness, and this may explain the differences in findings.
In general findings from the current study are in keeping with findings from most previous studies relevant to the area; in that experience of coercive events was not found to be significantly associated with attitudes towards involuntary admission and treatment. Rather it appears that it is perceived coercion that is associated with attitudes towards involuntary admission and treatment rather than the experience of actual coercive events. This suggests that, if measures could be identified that could reduce the level of perceived coercion experienced by individuals in the process of being involuntarily admitted, their implementation could enhance the individuals’ sense of autonomy and improve satisfaction with care and treatment overall.

**Diagnosis**

On multivariate analysis, those with a non psychotic illness had more positive attitudes to the process and experience of involuntary admission when compared to those with a diagnosis of either an affective or non-affective psychotic illness (which did not differ from each other). This finding contrasts with those of Smith et al (2014). Similarly O’Donoghue et al (2011) did not find any significant association between diagnosis and the view that the individual believed the involuntary admission had been necessary. The results of the current study indicate that, whereas having a psychotic illness is associated with lower levels of satisfaction than not, having a diagnosis of a non-affective psychotic illness such as schizophrenia is not associated with more negative attitudes towards care than other psychotic illness.

**Duration of index involuntary admission and experience of mental health tribunals**

There was no significant association on any of the multivariate models between whether or not an admission order was completed and attitudes towards involuntary admission and treatment. In the study by Savill et al (2012) the authors found on multivariate analysis that those detained had more negative attitudes towards involuntary admission on the CAT scale. The authors in this study included both detained and non-detained individuals and the study was restricted to individuals who had a diagnosis of schizophrenia.
On the multivariate analysis there was no association between having had an independent review of involuntary admission by a mental health tribunal and attitudes towards care and treatment. Similarly the length of time as an involuntary patient was not associated with attitudes towards involuntary admission and treatment on any of the multivariate models.

**Conclusions of Study 1**

In this large prospective observational study of a representative cohort of individuals subject to MHA 2001 assessed using quantitative measures, the majority of participants viewed their index involuntary admission as necessary in retrospect. However there was a wide variation in satisfaction with the care and treatment received and a substantial minority had persistently negative attitudes towards their experience, despite overall evidence of symptomatic and functional recovery as assessed by standard psychometric instruments. The strongest predictors of more positive attitudes towards involuntary admission and treatment tended to be clinical factors such as level of awareness of illness, symptomatic improvement, diagnosis and absence of illicit substance misuse, as distinct from service related factors such as experience of coercive measures, whether an admission order was completed, length of involuntary admission and whether the admission order was reviewed by a mental health tribunal. This study indicates that certain clinical characteristics can be identified during the involuntary admission which are likely to be associated with persistently negative attitudes towards care even in remission. It may be possible to identify such individuals for additional supportive interventions in order to minimise the negative impact of involuntary admission and to enhance their engagement in supportive care.
Chapter 4. Qualitative Exploration of Service Users’ Experience of Involuntary Admission (Study 2)

Introduction

This chapter outlines the findings from Study 2, which used qualitative methodology to explore the service user experience of the entire involuntary admission process. Firstly, a profile of the study’s participants is provided, followed by a description of the qualitative findings. The chapter concludes with a discussion on the study findings.

Participant profile

Across the three sites, 50 service users were interviewed regarding their experiences. Participants were recruited from the larger cohort of individuals (n=155) who had participated in the follow-up interviews for Study 1. Purposive and maximum variation sampling was employed in order to explore the breadth of service user experience, rather than provide an epidemiologically representative sample.

The following tables and figure demonstrate the profile of the service users interviewed. One service user did not give consent to access medical notes; therefore, some clinical information relating to this participant were omitted.

Table 4.1 Participants’ Gender and Age.

<table>
<thead>
<tr>
<th>Years</th>
<th>18–24</th>
<th>25–34</th>
<th>35–44</th>
<th>45–54</th>
<th>55–64</th>
<th>65 +</th>
</tr>
</thead>
<tbody>
<tr>
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<td>6</td>
<td>10</td>
<td>6</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Female</td>
<td>2</td>
<td>4</td>
<td>7</td>
<td>3</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
<td>10</td>
<td>17</td>
<td>9</td>
<td>7</td>
<td>3</td>
</tr>
</tbody>
</table>
Table 4.2 Participants’ location and type of involuntary admission.

<table>
<thead>
<tr>
<th>Form</th>
<th>Form 6</th>
<th>Form 13</th>
<th>Held</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site 1</td>
<td>11</td>
<td>0</td>
<td>1</td>
<td>12</td>
<td>24</td>
</tr>
<tr>
<td>Site 2</td>
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<td>0</td>
<td>0</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Site 3</td>
<td>20</td>
<td>7</td>
<td>5</td>
<td>32</td>
<td>65</td>
</tr>
<tr>
<td>Total</td>
<td>36</td>
<td>7</td>
<td>6</td>
<td>49</td>
<td>99</td>
</tr>
</tbody>
</table>

Form refers to the type of Admission Order completed: Form 6 relates to involuntary admission from the community and Form 13 to detention of an individual already admitted on a voluntary basis. Site refers to each of the 3 approved centres included in the study.

Figure 4.1 Participants by Diagnosis.
Table 4.3 Site by Number of Involuntary Admissions.

<table>
<thead>
<tr>
<th>Number of detentions</th>
<th>0</th>
<th>1</th>
<th>2–3</th>
<th>4–5</th>
<th>6–7</th>
<th>8–9</th>
<th>10–17</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site 1</td>
<td>6</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>11</td>
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<tr>
<td>Site 2</td>
<td>16</td>
<td>3</td>
<td>7</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td></td>
<td>32</td>
</tr>
<tr>
<td>Site 3</td>
<td>2</td>
<td>2</td>
<td></td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>24</td>
<td>9</td>
<td>7</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td></td>
<td>49</td>
</tr>
<tr>
<td>%</td>
<td>49</td>
<td>18</td>
<td>14</td>
<td>10</td>
<td>4</td>
<td>2</td>
<td></td>
<td>99</td>
</tr>
</tbody>
</table>

*Site refers to approved centre.*

Table 4.4 Type of Applicant.

<table>
<thead>
<tr>
<th>Form</th>
<th>Type</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Spouse, Civil Partner, Relative</td>
<td>17</td>
<td>34</td>
</tr>
<tr>
<td>2</td>
<td>Authorised Officer</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>Garda Síochána</td>
<td>20</td>
<td>41</td>
</tr>
<tr>
<td>4</td>
<td>Any Other Person</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>23(1)</td>
<td>Power to prevent a voluntary patient form leaving the approved centre for 24 hours</td>
<td>9</td>
<td>18</td>
</tr>
</tbody>
</table>

Findings

Qualitative study findings were garnered from a descriptive analysis of the 50 participants’ narratives. The analysis identified that the vast majority of participants reported mixed experiences, which comprised of both positive and challenging aspects, over the course of their involuntary admission. While participants reported feeling coerced, disempowered, and unsupported at various stages of their admission, they also identified times when they encountered individuals who endeavoured to initiate a more collaborative, informative and compassionate approach.

The findings from the analysis were categorised into five overarching themes. The first four themes presented are 1) Experiences of transfer and detention; 2)
Experiences of hospital; 3) Tribunal experiences; 4) Going home. These four themes focus on the difficulties encountered by participants during the distinct stages of the their involuntary admission journey; from the first point of contact with the multiple stakeholders involved through to their experiences of living post-discharge from hospital. The fifth theme, ‘Person-centred encounters’, is focused on the positive encounters that participants identified as good practice and which they and other participants expressed a desire for in the future.

1. Experiences of transfer and detention

In this theme, participants’ initial experiences of their transfer to and detention in hospital are explored under four sub-themes: 1a) Feeling trapped and coerced; 1b) Feeling disengaged and unsupported; 1c) Feeling stigmatised and criminalised; and 1d) Exacerbation of distress.

Feeling trapped and coerced

For many of the participants, and especially those who were being detained under the Mental Health Act for the first time, their initial experience of transfer and admission into hospital imbued in them an overwhelming sense of invasion, violation, shock and coercion. Participants recounted that they were often unaware of any forthcoming plans for their admission and as a result were shocked and confused when approached by members of the Garda Síochána and/or people they were unfamiliar with from the national assisted admissions team. This was particularly the case when initial approaches were perceived to be implemented in a rigidly assertive or aggressive manner. In some cases, participants’ narratives suggest that the coercive manner adopted by the various people involved was silently conveyed via their firm stance on their immediate arrival to the person’s home. Such a stance was perceived to occur with limited consideration of participants’ concerns and needs, and with no alternative options or nuanced negotiation provided;

At that stage I almost felt like I was violated. I think that was one of the words I used, that I was basically like taken. Someone came to my house,
came into the house and then said “you’re coming with us. We want you to come”, but [participant pauses] it’s always that ‘but’ and that sort of silent threat, that sort of coercion. (Male, 47, 19)

In other instances, participants recounted how they were coerced by the admissions team via their use of ultimatums, including the warning of Garda involvement;

They come in and say “if you don’t come with us we’ll get the Guards involved and we’ll put handcuffs on you and bring you”. This kind of thing and they actually did that once. (Female, 41, 100)

As soon as I saw them I knew where I was going like. I didn’t fight against them or anything like that. Just sat here in the bed and then I didn’t really want to go in but they said they would get the Guards then and the Guards came anyway, two of them. In the name of God [inaudible]. For one person that wouldn’t kill a fly even [...] (Female, 41, 27)

As the above quotation alludes to, many of the participants described feeling overwhelmed by the physical presence of numerous people in their personal space which they experienced as disproportionate to the situation. People spoke of the fear and distress associated with the absence of a ‘familiar face’ or ‘familiar voice’, and likened the unexpected arrival of strangers (who proceeded in some cases to forcefully enter their home) as akin to being ambushed in their home and/or physically trapped in the Garda station (10 of the 50 participants were taken to a Garda Station prior to their transfer to hospital).

So, and then for me to have the arrival of these people at your door to take you off is very hard. [...] Like you can’t even control your own house any more. (Female, 41, 100)

It’s very bizarre. It’s very frightening. It’s very confusing. You’re very confused and you want to sort of stand up and try to defend yourself but you
know that it’s pointless because you’re surrounded. They had me ambushed, surrounded. (Female, 46, 63)

He [the GP] did and he said to me that you’ll have to go to a psychiatric, so I said fair enough. There was nothing I could do because I was in a police station, do you understand? There was no way I could get out, you know. (Male, 49, 10)

The described approaches resulted in many of the participants feeling that they had no other choice but to reluctantly comply with hospital admission;

He [the GP] was basically telling me to go to hospital. He didn’t give me any choice. He didn’t say anything about medication, about counselling. He just said “I think you should go to hospital”. I just went along with that. I don’t know why I did. I was in shock. I’m still in shock in a way. (Female, 36, 59)

However for other participants, the experience induced within them an equally rigid refusal to comply with ultimatums, which resulted in physical strategies being utilised by the national assisted admissions team (NAT - this centrally funded national team had the function of transferring patients to approved centres). In these instances, participants describe their reactionary physical resistance, and the resulting physical altercations. In some cases, such physical altercations resulted in bruising of the participants;

They [NAT] came into my garden where I was working. I heard my dog barking. I came in, three of them and this woman and I didn’t know were they politicians or what they wanted and they showed me the cards [ID] and said they were from [NAT] whatever and they had to bring me into the unit and I said to them I had responsibilities, that I couldn’t just go like that, but they didn’t... they weren’t interested. So, I said I wasn’t going with them and when I resisted, then they took me by force. [...] They got hold of me, the three of them and, if you like, tried to drag me. Now, they didn’t carry me or anything but they brought me along because I didn’t resist if you like. I
could have resisted more, if you like. Then it would have got more serious. (Male, 56, 230)

I couldn’t understand them coming into my house and the cheek of them and who did they think they were thinking they could just come in and strap me into the trolley or whatever it was and just take me away? I still thought I will be out of that stretcher before we get to town. Fought and fought and I was more or less exhausted really when we did get, you know, to town but I still fought my way, like I said to you, to the green room and I was awful bad about that .... they just pushed me down on the floor and stuck that injection in. [inaudible] and my two arms from here to my shoulder, black and blue the whole way. [...] They were dragging me. I was pulling against them. I must be honest, like, but I was completely black and blue (Female, 68, 139)

**Feeling disengaged and unsupported**

With little reported prior discussion or co-operative negotiation regarding their need to be admitted into hospital, participants perceived that they were provided with limited emotional support and information throughout the various stages of the process. In the first instance, some of the participants felt that they were not given adequate time to prepare personal belonging or to ensure all of their responsibilities at home were taken care of prior to their departure to the hospital;

My dignity and respect weren’t, if you like. [...] They were only interested in doing their own work. They didn’t take my considerations into account at all, or they had no interest. I told them that I had my animals, my feed, and all this. They weren’t interested. They didn’t want to hear it. (Male, 56, 230)

In some cases, the described deficit of emotional support was also evident for participants who were physically restrained during their transfer to the hospital.
These participants recalled that the absence of familiar person during their being restrained was extremely disconcerting and frightening for them;

[...] I was sure that someone I knew would come and help me. Trying to find a voice, like, I remember lying down on the floor, all the men [members of the assisted admission team] pushing me down and I was trying to find a voice I could recognise, someone I knew to say “please, help me. I haven't done anything wrong”. [...]  

**INT: Okay. So, all the time you said you were looking for someone to help you, is it?**

Yeah. A familiar voice. Someone who knew me, who loved me, who was good to me because I just wished I had that, they just didn’t care like violence, so much. I remember them pushing me down on the floor. I just started fighting. I couldn't like, just like they were saying “don't do it so difficult. Just let us do it” or whatever. “What? You're in my room”. (Female, 30, 214)

In a number of cases, participants recalled that plans for their admission were actively hidden from them. In these cases, they were asked by family and/or the admission team to go to the hospital on the pretence that they would be simply attending an out-patient appointment. Consequently, when it was eventually revealed to them that they would be staying in the hospital, participants felt extremely betrayed, confused and shocked;

You're basically brought in under the pretence of you're just being checked up on and then you wait for the Guards and the next thing the Guards leave and you think who is bringing you home and, you know, who is bringing me home or will I stay, you know. What do I have to stay with? I've been brought into hospital with nothing and had to stay for two days until my stuff came in. Personal belongings, yeah. It's like an emergency every time and you don’t know what the emergency is about. (Female, 41, 100)
No, they didn’t explain anything. They told me I was just coming up for a chat and I said to them are you sure I’m not held there and they said they wouldn’t, but they lied. (Male, 39, 3)

I knew what was going on except I just thought I was meeting Dr [name of consultant] for an appointment. That’s what I thought. That’s what I thought was happening. Meeting her for an appointment and she was going to put me on more medication. That’s what I thought was happening.

**INT:** Yeah and did you realise at that point that you were going to be staying in the hospital?

**RESP:** No. Not until she said it. (Female, 60, 31)

As the following quotation indicates, a number of the participants recalled that even during transit to the hospital, they were unsure as to where they were going;

No, nothing was explained to me. [...] No, no one even said where my family had gone to, you know, why was I even in there? Even if someone had sat me down and said you’ve been acting behaving really strangely and you ran into the sea. I didn’t realise until I was, I suppose, in the vehicle on the way going down there [to hospital] and even at that stage I wasn’t even sure where I was going. (Female, 20, 55)

This approach of providing limited information or explanation appeared to continue when participants arrived at the hospital and their questions subsequently changed from what was happening to why they were there;

No, not really. I did. I know I was in hospital. I had done the interview [with Psychiatrist]. I wasn’t quite sure why I was there. I was saying ‘why am I here?’ You know, because I believed I was fine at the time. I wasn’t quite sure why I was there [...] (Female, 46, 63)
Interestingly, participants recalled very little about the administrative process involved in their admission. The vast majority of participants had little recollection of the bureaucratic details involved, including who signed the application form and whether they were voluntary or involuntary;

*I think the Guard signed them over to me. I'm not quite sure, you know that.*

*You'd have to look through all that now. I don't know. I know there was a bit of signing going on here and there but I don’t know what the story was. I knew I was going to be admitted. I didn’t know by who or was I voluntary. I think I was a voluntary. I think I was because I was told that I could walk out any time. (Male, 49, 10)*

**Feeling stigmatised and criminalised**

In the view of many of the participants, certain aspects of the transfer process resulted in them feeling criminalised and stigmatised. The involvement of the Garda Síochána, for example, appeared to firstly induce a sense of confusion in participants, as they thought they were being arrested for an illegal act that they had not done;

*I came in by the Guards, yes. They came into the pub and took me out. Oh, I got the fright of my life, you know? It was after... it was about twenty past, it was near enough to twelve o’clock I’d say. Yeah, the Guards came in then and all the people were in there like Friday as well. So, they came in and asked me ‘is your name [NAME]?’ I said ‘yes’ and they said ‘can you come with us?’ So I did. I did. I went voluntary. Well, I...*  

**INT:** And what did you think was happening?  
**RESP:** I didn’t know. I thought I was getting arrested for something I didn’t do. I know I didn’t do anything. (Male, 49, 10)

*When I got to the station there was a couple of family members there as well which kind of frightened me a little bit and then the doctor was there as well so I think they actually arrested me, or they wrote out something anyway. I was being detained by them. I don’t know was it an arrest or a detention once I was in the police station (Female, 46, 63)*
Secondly, their confusion was further exacerbated by their transportation to Garda stations wherein they were often kept in cells for a number of hours. Such actions, participants felt, criminalised them and was far removed from the non-threatening therapeutic environment that they believed they required;

*Well, as I say, I was unaware of what was going on. If you like I was kind of convicted and tried without any say in the matter. I was treated like a convicted criminal. I was taken from my place of work against my will [...] I was in a cell, yeah. [...] They took up to 10 o’clock, sorry 8 o’clock for me to see a doctor, you know. (Garda Station) I was there since 2 o’clock. It was a long time, yeah, yeah.* (Female, 42, 200)

*Then they said that since I wouldn’t sit down, like I was kind of running around the place and stuff that they had to put me into the cell and ended up staying in there for three to four hours, which was crazy because I was going so mad. It was like you know, ‘is [NAME] coming?’ ‘Who is coming here?’ My best friend’. Then, you know, ‘can I talk to someone?’ They were like ‘oh you’ll be out in five minutes.’ ‘You’ll be out in five minutes’. This went on for, I found out afterwards three to four hours or something like that* (Female, 20, 55)

In addition to the sense of criminalisation, the public nature of their admission was also perceived to stigmatise them within their communities. Participants disclosed that they felt extremely embarrassed and humiliated whilst their neighbours and other onlookers watched them being publicly escorted from their homes, their place of work or from public spaces (eg. restaurant/public house). The presence of Gardai, Garda cars, ambulances and vehicles with blacked out windows, alongside officials escorting them, served as a public demarcation that they were being involuntarily removed from their homes or public spaces;
See, it was all over the village. If you seen the ambulance and the Garda car, you know, you’d say something is wrong. They weren’t just, the Guards weren’t just visiting. You know that sort of way? I would feel that they’d be all talking about me. A bit of a head case or something and had to be taken away by the ambulance people and Guards, you know and that sort of way. I would feel a bit, you know, that I’m a head case as far as some people are concerned. (Female, 68, 139)

[...] Yeah, so basically they said to me you have to go. So, okay, got my stuff together. I’m walking around the kitchen and I’m thinking to myself, oh my God, how do I go outside this door and the look… people will be looking, you know. So, then we get to the door and lock up and there I am in my coat in my hand and basically it’s almost like a president being escorted. These are bodyguards. No one’s got a hand on you, but they’re all standing before you, behind you, beside you, walking down my drive and I’m seeing my [...] neighbour standing outside, looking across, [other people] over there. I get to my gate and as I get to my gate, the cop car drives away. He was parked down the lane. Didn’t even know he was there. So there I am walking down into a taxi with blacked-out windows. I felt like I could have been a criminal murderer or something like that. (Male, 47, 19)

**Exacerbating distress and fuelling anger**

Participants’ narratives indicated that the coercive, criminalising, and stigmatising experiences surrounding their admission only served to exacerbate, rather than de-escalate, an already distressing situation. Participants felt that the disproportionate measures utilised (including the physical presence of numerous people, the involvement of the Garda Siochana, and in some cases being detained in the Garda station) fuelled their distress, exacerbated their anger and lessened the probability of any level of co-operation with the admissions team;
It was just the fact that there was so many people. Five, like definitely five came to my house now and I know they kind of a bit did try to talk me around and see if I would go and all this but all I could think was they’re going to pressurise me because there’s too many here and if they just want me to go there wouldn’t be more than two. No, there wouldn’t be sort of five people in cars. They’re not just... I could go back [to hospital] if there was just the two [people]. (Female, 68, 139)

Furthermore, participants noted that the lack of honest information and in some situations the provision of false or misleading information not only exacerbated their distress and anger and broke trust, but it fuelled ‘their paranoid, strange and ‘delusional’ thinking:

Being taken to the Garda station had an impact on me. That really sent me over the edge. Off into my own world, you know, the paranoia came to the fore with that. All types of conspiracies emerged (Male, 32, 162)

Had I been told like I was going back to hospital I would have accepted that, but I hadn’t been told that and been told by a doctor who barely saw me like for more than a minute that I had to go back in. That sort of angered me more than anything else. (Male, 39, 66)

It also, in some cases, led to participants being uncooperative and resisting admission;

I got very angry because I was very angry that I was being forced into an area where there was no explanation or understanding of what was going through.

**INT:** So, you had no understanding of what was happening?

**RESP:** Nobody. No understanding at all. [...] So, that was that. So, I was brought over to the area in the hospital and I was just really angry because I can never understand what on earth is going on with the situations at these times. I just, I don’t understand why nobody is explaining to me before I had to go or suggesting that perhaps they’re wrong, that there was no need to bring me over. That kind of thing, you know. It just seems ridiculous. That was that (Female, 36, 60)
They said that they thought I should stay there for a while and could they have my consent, but I wasn’t going to give it because I’d been, as I said, more or less given the impression that I was just there to see a specialist for epilepsy. (Male, 39, 66)

2. Hospital experiences

Participants’ narratives often moved sequentially from their initial transfer to hospital to their experiences whilst in hospital. While participants identified a number of concerns including but not limited to a non-therapeutic hospital environment, and the limited availability of talking therapy, this section focuses primarily on the aspects which arise from their being admitted involuntarily under the Mental Health Act. Study findings in this regard are discussed under three sub-themes; 2a) Feeling trapped; 2b) Compliance in the interest of release; and 2c) A constant state of apprehension.

Feeling trapped

In a similar vein to participants’ transfer and detention experiences, the vast majority of participants, including those who were initially admitted voluntarily and were subsequently detained, recalled feeling trapped during their hospital stay. Many likened their involuntary stay to that of being in prison. The curtailment of their movements, specifically their inability to leave the hospital, and their perceived limited potential to wield self-efficacy in any form appeared once again to exacerbate their feelings of being trapped and controlled;

I suppose when you’re involuntary, having that sort of label on you and knowing that you’re trapped there, [...] feel very much like you’ve had your human rights taken away, you feel imprisoned and you kind of feel, as I said before, a second-class citizen (Female, 33, 24)

I just felt I hadn’t any control of what was going to happen with me, how long I was going to stay in or anything. I think they had the decision made
up already beforehand and that was it. Even if I was progressing in my health as the days went on, they wouldn’t release me. (Female, 24, 15)

As the quotations above illustrate, participants’ feelings of imprisonment were further intensified by a sense that they had lost all rights and their perception that they received little or no information about being involuntary. Some participants recalled that although they did receive written information, they would have preferred had someone talked to them. Participants felt that that this would have been particularly important to do for the individuals experiencing involuntary admission for the first time;

*INT:* Did you feel you had enough information about being involuntary?

*RESP:* Not really, but if it was printed out and given to me I would have probably gone through it cynically, thinking oh here we go again, you know? Here’s more information. To talk with someone would have been the important thing [...] just have one person that you’re comfortable with to talk with when you’re there. (Male, 35, 46)

Well, they could at least... at the time when I ended up going involuntary I was going cracked. I was very, very angry with them. They could at least have someone there to explain things a bit better because you don’t get a good explanation about it. You get told that you’re going involuntary and that’s it. You’ve no opinion like. In this day and age I just felt that was wrong. [...] Just to have someone there to explain things a bit better really. At least that way then you know what’s going on. Especially it being my, being your first time in there. (Male, 23, 50)

Further, some of the participants recalled the uncertainty they felt about how long they would remain in hospital and when their involuntarily status might come to an end. As the days and in some cases weeks passed, some felt their protracted admission and the uncertainty around their discharge was akin to a punishment, which in turn had a negative impact on their recovery;
It’s like being in prison and being ready to go, ready to leave and being detained further and further and further. It has a detrimental effect, I think. (Male, 39, 146)

I believe that they have kept me too long. You know, I think it’s like a flu. You know, you’re sick and you get over the sickness and you should be let out and you shouldn’t be kept, you know, for extra weeks just for them to… it’s like punishment (Male, 39, 3)

The feeling of being trapped was also evident among participants who initially were admitted voluntarily but who subsequently experienced the imposition of a holding power (section 23) and/or their being detained involuntarily. Participants in this cohort described how the rights or freedoms they thought they had by being voluntary were actually very limited once they verbally expressed their desire to leave. They subsequently surmised that being admitted voluntarily made very little difference to their experience as they felt just as trapped as those admitted involuntarily;

It’s very hard when you’re made involuntary, but even when you’re voluntary you still don’t have a whole lot to say. [...] You can’t walk out the door. You can’t just turn around and say I’m going home, because if you say that they make you involuntary. So, it’s only a word really, you know. (Male, 39, 3)

Well, the second night I wanted to go home. I didn’t want to be there anymore the second night. I don’t think I could sleep that night and I remember asking the night nurse at the time could they call a doctor and get someone to talk to me and nobody came like, so the next morning then I was approached by the doctors and they were asking me why I wanted to go home, and they kept asking me why I wanted to go home. I kept telling them I wanted to go home because I wanted to get out of here like. I didn’t think there was a need for me to be here. [...] they went through a form of keeping
me as an involuntary patient [...] I felt like I was losing again. I had no choice then but to sign it. I wasn’t going anywhere and I was told if I left of my own will that the Guards would come and collect me and bring me back. I didn’t want that either, that’s why I stayed in the end. Oh, I felt trapped, yeah. I couldn’t understand why everyone was keeping me here like. (Male, 23, 50)

I was told we’d like you to stay but do you know the “but”. [...] I was told we’d like you to stay, but if you don’t we can make you, then it was okay you are taking me in. You are here, you know. You are ours. We have you and that kind of thing. That was the feeling I had you know and I know they kept saying you were voluntary but even when I was being let out, you did know you were voluntary and I was like okay yeah, this is kind of softening the blow now. Saying to me, you know you were here for your own good and you know [...] you could have walked out at any stage, but I wasn’t told that. I was kind of led to believe that in the beginning but the “but” was always there in that sentence. So, it was like saying you can go but you can’t go. (Male, 47, 19)

Compliance in the interest of release

Participants’ narratives also suggested that they perceived a strong association between their willingness to take prescribed medication, and their subsequent discharge from hospital. Repeatedly, participants recounted a belief they would not have been discharged without demonstrating their commitment to complying with prescribed medication. In many cases, this caveat to discharge was perceived by participants to be coercively implemented. As the following quotations illustrate, many of the participants were reluctant to take medication, but were strongly persuaded to do so by their psychiatrists and/or nurses;

Well, I preferred the [names a drug] over two weeks but then when it was changed I went through every drug on the market and now we finally found [names another drug] which Dr. [NAME] wanted me on in the first place
and wouldn’t let me leave hospital without me going on it. So, I was beaten into it in the end. (Female, 41, 100)

Many of the participants were therefore of the opinion that in order to be discharged they needed to comply with their psychiatrist and nurses and take medication. Hence, they felt that they had no other choices available to them which would ensure their successful discharge, even if complying conflicted with their own belief system;

I had to say the right thing to everybody to get out. That’s what I felt. That I had to say the right thing to everybody to get out, you know, of jail basically. To be allowed out I had to, I wouldn’t want to be disagreeing with anybody or with the medication. So, I just took everything I was given and you know tried to keep quiet and agree with everyone. You know, just to get out that’s what I felt. (Female, 42, 200)

[…] You know, because I felt trapped, as I said. When you feel trapped like that you have to kind of try and work a way of getting around it and try and get them on your side so you can go home. That’s the way it was like. That’s exactly how it was. You were trapped and if they didn’t like you for some reason, then you had to try to be nice and quiet and just go about your business, you know? And eventually you’d get out. [LAUGHS] That’s the way it was. Like I know that’s the way it was (Male, 23, 50)

For some participants, complying sapped their spirit as they felt ‘ground down’ or ‘beaten’ by the system;

[…] Hospitals grind you down. You’re just ground down into nothing until the doctor feels that you’re supplicant or whatever the word is. […] Until you’re nothing, until you agree with them. So, the doctors will keep you here until you agree with them. They break you down like that […] (Male, 32, 162)
There was also a consistent narrative regarding coerced compliance with medication from the participants who experienced a voluntary admission, at least initially. This cohort described that their compliance with medication was coerced via veiled and not so veiled threats of being detained involuntarily;

 [...] it was all about medication and I still am kind of cross about it because my doctor came in with the detention order [not signed] in one hand and the [names a drug] in the other hand. So, like it’s like you’re detained now and I panicked so I took the medication. Whereas if I had known your detention order and your medication were two different things I would have just said fine and just left the room without having taken the drug, but I was so stressed and so panicked that I ended up taking the [names drug] because it was like oh God, this is after getting really serious now. I’m detained, so the only way out is to take my medication (Male, 24, 28)

I felt kind of the bottom-line was your only choice here is medication and you don’t really… you’re told that you have a choice in taking it but the bottom line is that if you’re going to be involuntary at their command. [...] medication is the only option because if you’re going to be involuntary the only option to go with that is medication while you’re in there. Or else it’s kind of like if you don’t take it we’ll keep you here longer. So, that’s what I feel is the only… there is no real choice there. [...] The involuntary label was used as a kind of stick to take your medication or not take your medication. (Male, 35, 46)

The following excerpt from one participant was particularly disturbing in this regard. The very real possibility of being involuntarily detained had, like many of the other participants, influenced this participants’ willingness to adhere to the clinicians’ recommended care plan by staying in the hospital and taking the prescribed medication. In this case, she perceived that in spite of her efforts to comply, she was subsequently detained involuntarily. As a result, this participant believed that her psychiatrist had lied to her; an action which upset her deeply and which served to erode trust between them;
I basically said to my doctor I want to leave. I didn’t leave. I just said the words I want to leave and he said ‘oh, we’re going to have to get you to talk to this other doctor is going to come in and talk to you’ and also I hadn’t taken medication one weekend and the nurse said we’re going to talk to the doctor about that because I didn’t know. [...] My doctor said we’re going to make you... he said, he laughed, he kind of laughed and went ‘I’m going to make you involuntary’, like his face was coming towards me ‘I’m going to make you involuntary’ and I was really upset and then I said ‘no, I’ll stay here’. ‘I will stay here’ I said and ‘I didn’t say I was leaving. I said I want to leave. That’s the only words I said and I will take the medication. I’ll do everything if I can just stay voluntary’ and he said ‘okay, we’ve got to get this other doctor to see you because I’ve already called him’. I said ‘cancel him because I’m going to stay here voluntary. I’m going to take the medication’ and so he said, the doctor came in anyway, ‘speak to him anyway’ and I spoke to him but he made me involuntary even though he promised he’d make me voluntary if I spoke to this doctor. So, he lied completely. He lied to me. Yeah, he lied. My doctor lied. (Female, 36, 59)

A constant state of apprehension

One of the consequences of experiencing a hostile or coercive environment was that some of the participants remained in a constant state of apprehension, fear and stress. Participants recalled experiencing a heightened awareness of doctors and nurses’ surveillance of them. They were extremely nervous therefore of doing or saying anything, in their words, ‘wrong’ which would have had a detrimental effect on their voluntary status, the length of time they remained in hospital, or on the treatment they received;

It felt like I had no say and no power and yet there was hints that you’re here voluntary, but with every hint you’re here voluntary was backed up with the fact that, you know, we can detain you if we felt you needed to be detained. So I’m thinking to myself okay, you kind of shut your mouth and go
along with it and smile and wave boys and hopefully get out fast [...] I'm a quiet type of person. I mean, that's what made me worse. I nearly felt like you know what, I can't say anything because if they do come the heavy, then you're worse off. So, it was basically a fear of saying the wrong thing, doing the wrong thing [...] (Male, 47, 19)

In many cases, participants' trust of the system and the various people operating within it had become so eroded that their level of apprehension and mistrust remained even when their status was changed to voluntary or when their discharge from hospital was imminent. A number of the participants still did not trust that they would be discharged and were consistently anxious that something would happen which would hinder their leaving the hospital;

 [...] I was conscious of the last night [of stay in hospital], the last evening, I was just conscious of how do I look. I was starting to feel a little bit edgy that evening, thinking well hang on, you know, you've almost got the end in sight but if you do the wrong thing or say the wrong thing, things could change. You mightn't be going home tomorrow, you know. (Male, 47, 19)

I was made voluntary. [...] I tried not to get too excited because I knew, I'd been told as well they have a habit if they put you on voluntary and you, if you try to leave straight away they put you back involuntary and you have to wait another 21 days for your next tribunal. So, I was still to myself, okay [NAME], you're so close, don't fuck it up, you know? [...] So, as I had one bag in my hand to go, a nurse stopped me. She said '[NAME] where are you going?' I was like 'I was made voluntary. I can go now'. She goes 'no, but you still have to take your medication'. She said 'you said you would still stay here. You never said you'd leave straight away' [...] and then she like caught me by my hand and like pushed me back. Well, didn't push me back, kind of like coaxing me back into the room and just by luck and I really mean by luck, [...] the one who organises the tribunal, she happened to be passing by the corridor and I was 'oh, excuse me'. I was like, [...] 'I'm voluntary now, I want to leave but the nurse won't leave me go' and then she brought, that
lady she brought the nurse aside and told her whatever and that’s when I finally got to go, but I don’t think if she hadn’t been passing by I would have gotten out that day. (Female, 20, 55)

3. Experience of tribunals: Mixed views

In total, 23 participants spoke about the tribunal process, with 20 of these participants attending a mental health tribunal, and 3 others solely having the experience of the preparatory process for a mental health tribunal. Their narratives are explored within three sub-themes; 3a) Limited information and support; 3b) Limited engagement; and 3c) Positive tribunal experiences. From the outset, it is important to highlight that the narratives included in sections 3a and 3b were predominantly from participants whose involuntary status was not revoked by the tribunal and the participants’ narratives included in 3c were from those whose involuntary status was revoked. It may be therefore surmised that their subsequent appraisal of the tribunal experience may have been informed, at least in part, by the outcome of the tribunal.

Limited information and support

Similar to the reported experience of receiving limited information on the processes and procedures which encompassed being involuntary detained, participants also reported feeling a sense of disengagement from the tribunal process. For example, there was a distinct lack of commentary from participants about the tribunal members. Whilst some of the participants’ did not mention the tribunal members and their discrete roles, others seemed unsure or could not remember who was present. Interestingly, participants’ rarely mentioned the lay person and/or the lay persons’ role in the tribunal. Participants did however disclose that they were unsure what the tribunal was, why they needed to attend, and what the outcome of their tribunal was. There was a cohort of participants who even after discharge from hospital remained unsure about the purpose of the tribunal on the date of data collection (3 months post discharge);
[...] I remember being told there was going to be a tribunal and didn’t quite understand what that meant at the time and kind of time passed by and then the tribunal happened. [...] Part of me does question actually what the purpose of it was even now, you know, when I suppose there was no implications for me. I question whether or not there was a need to go through that [...] (Male, 37, 114)

I don’t know. I think I was told what it was for. I was never asked to go to the tribunal or whatever. I don’t understand what the tribunal was anyway. (Male, 23, 50)

The result of participants receiving limited information about the tribunal process was that they felt unprepared for the various steps involved. In particular, they reported that they were unaware until the last minute of upcoming appointments with their solicitor and the independent psychiatrist;

The tribunal thing came up. I was given fourteen days and I saw a solicitor on the following Friday I think it was. I saw [NAME] too and I saw a solicitor the following Friday I think it was, but I was given no notice of anything and told nothing. Not prepared [Tribunal], didn’t even know the solicitor was coming. [...] I was just sitting down on the chair beside the bed relaxing when in comes this man and he said ‘I’m your solicitor, I’m going to represent you at the tribunal’ and I said fine. He introduced himself. Sure I didn’t know what was happening, [NAME] about tribunals. [...] the day that the independent psychiatrist arrived, I never knew he was coming either. Never told, had no time to prepare. Went inside to this doctor, never saw him in my life before. He told me he was from Dublin and that he was the independent psychiatrist and I asked him would he be present at my tribunal and he said he didn’t know (Female, 60, 31)

Whilst the lack of information provision was a source of contention for many of the participants, they also reported feeling scared and anxious about the tribunal. Specifically, they recalled that they were worried about what would be
discussed and/or felt that tribunal members would be judging them, which induced for them a sense of discomfort;

*I hate going into them. Just the idea that people are sitting there watching me. I don’t know. Watching me and deciding it’s right for me to be there with them. I don’t know. I don’t know. I just feel bizarre.* *(Female, 36, 60)*

*You had the panel of three and you know I can remember the conversations that went on and it’s I suppose it’s weird feeling of being judged in many different ways because I suppose you are being judged in some sense. They’re judging what state you’re at mentally or whatever.* *(Female, 33, 24)*

Participants also disclosed that they would have liked increased support before, during, and after the tribunal. They identified that at critical times, such as receiving letters in relation to the tribunal or indeed directly after receiving the outcome of the tribunal, there was no one to talk to. Participants felt that it would be integral to offer support to service users at these times given that there were still coming to terms with being admitted involuntarily and that subsequent stressors, such as official communications regarding their upcoming tribunal, had the potential to exacerbate their distress. It would appear however that from the perspective of the participants, such support was rarely forthcoming as the following quotations illustrate;

*So, I kept getting these letters then, all the time getting these letters. I’d come back from lunch and there would be a letter on my pillow, which was very annoying because there was no one to talk to about it, about the tribunal. I felt there wasn’t.* *(Female, 60, 31)*

*[…] I got all the letters of course, the solicitors’ letters. […] But they give you those letters there and that. I don’t know if it’s a good idea handing you… for somebody that’s unwell, if it’s a good idea handing them those letters. I was handed two letters about solicitors and about you know and I think you’re still in a bit of a state of shock […]* *(Female, 42, 200)*
In the absence of support by staff members, participants recalled that it was their peers who often provided invaluable comfort to them, especially after the tribunal process had been completed as the following quotation illustrates;

 [...]They told me, you know, you’re going to have to stay in. We’re making you involuntary. You cannot go home for weekends. You cannot get out, except for being accompanied by a family member. This is ridiculous. I thought this is just something out of the dark ages [result of tribunal].[...] I thought this is something out of the dark ages and I was just listening to them and I said nothing at that point because I felt this is it now. There’s no point in me saying anything. It was a bit upsetting [name of interviewer]. It [the tribunal] was very upsetting because I cried and cried and cried.  
**INT:** Was there anyone to support you afterwards?  
**RESP:** No, the patients.  
**INT:** Just the patients?  
**RESP:** Just the patients (Female, 60, 31)

**Limited engagement and involvement**

Many of the participants were of the view that the tribunal did not adequately involve them or consider their opinion. They believed that the medical opinion of the psychiatrist was given primacy over and above their contribution;

 [...] would there be any point in having a tribunal? Because it would be all medical so they would have their own opinions. I feel it would be a waste of time. (Male, 56, 230)

 [...] I kind of got the feeling that you know sort of medics stick with medics as it were and in tribunal situations I always, you kind of get the feeling that they would take the medics' view over the patients' view because they are medics and it's a medical situation. Maybe you know they're not really listening to the patient. Obviously when someone has been sectioned you do
feel like that the overriding view would be the medics’ view rather than... because they're medics themselves. (Female, 33, 24)

[...] I believe they're all for the doctors and they’re not going to run against the doctors no matter what you say. So, I don’t believe the tribunals work at all. I believe they’re a cop-out and that it’s just more ways of getting... that I don’t believe they’re for the patient, even though they say they are. I believe they’re more so for the doctor, the psychiatrist, to back him up more so than to back the patient up. (Male, 39, 3)

This was perceived to be particularly the case if the participants’ opinion on mental health difficulties contrasted strongly with what they perceived as the predominantly medical discourse operating within the mental health services, with some participants feeling they lacked the articulacy to counter any medical argument put forward within the tribunal;

**INT:** Do you feel your views were represented at the Mental Health tribunal?

Not really. My solicitor stayed quiet, you know? I think my view was that it was very hard to get my view across [...] I couldn’t coherently disagree with my psychiatrist that I was suffering from a mental disorder rather than looking at it as mental diversity. It sounds a little bit airy fairy. It’s an argument that doesn’t float in a room full of people who are focused on boxes, criteria, and medication [...] (Male, 24, 28)

Some of the participants also questioned the feasibility of conducting an independent tribunal when Ireland is such a small country, and the likelihood of psychiatrists knowing each other was extremely high. Therefore the potential for the independent psychiatrist to contradict the opinion of their treating consultant was perceived by many to be improbable;

I think I was only involuntary for a week or two. I can’t remember. All I remember is the solicitor coming and he was explaining it and as I said to
him well, because Ireland is such a small country, you’re not going to have one psychiatrist saying that, you know, she’s unfit and the other one saying she’s fit. They’re colleagues. They’re not going to... you know what I mean? They’re not going to go against each other because Ireland’s such a small country and there’s only so few psychiatrists, do you know what I mean? It’s a laugh do you know? As he said, yeah, I suppose really there should be one coming from England like [...] (Female, 47, 32)

If the notes were sent to another psychiatrist in another country or something like that you’d say something about it like but this (Male, 37, 71)

The limited sense of co-operative engagement that participants felt may have induced a sense that the tribunal was conducted within a competitive or adversarial atmosphere. Participants narratives conveyed an impression that everyone involved in the tribunal was against them and that they had either no say in it or that they had to fight their corner;

The circuit court was extremely scary. [...] It was only me against the judges. [Circuit Court] Yeah, it felt one of the two of us were going to be let down basically. That one of the two of us were going to lose out so she went to her extreme and I just had to fight my corner then. (Female, 41, 100)

In keeping with the perception that the tribunal was adversarial and competitive, it is noteworthy to consider the language that some of the participants utilised when speaking about the Tribunal. Their likening the outcomes of the tribunal to either ‘losing’, ‘winning’ or ‘getting off’ provides insight into how they viewed the tribunal, its procedures, and their relationship and interaction with the tribunal members.

Positive tribunal experiences
In contrast to the experiences described above, there were a number of cases in which participants positively recalled the tribunal process and the associated
personnel. In these cases, participants reported that they received very good information about the tribunal, both in written and verbal form, and felt very supported throughout;

\[
\text{I was given plenty of information. I had somebody come to me and talk to me. They gave me the mental health booklet. Somebody talked to me about the tribunal. Nurses came over to me regularly and asked me what was going on. They were very insightful at the time, I found regarding what was happening to me and what would possibly happen next. Do you know, removing any sense of anticipation I would have needed or any kind of worry that was there. They always made sure that I was aware of what was coming up next. (Male, 37, 114)}
\]

In addition to receiving adequate and accessible information, some participants also noted that they were actively encouraged and supported to attend the tribunal;

\[
[...] So, then I suppose Dr. [name of consultant] did come down and convinced me to go up and there was an intern there as well who actually had been very nice. She was very nice when I was in there. She was a very kind of consoling person. [...] (Female, 42, 200)
\]

Some of the participants also acknowledged that they did experience a fair and transparent tribunal wherein they felt their opinions were listened to and they received good explanations about the purpose of the tribunal, its content and its outcomes;

\[
\text{Well, I can remember being included into it. Like, with the other tribunal [person had attended more than one] [...] they discussed me without discussing with me. You know, they sit down, they say have you tried ECT on her? Or have you tried Lithium and all the things I'm afraid of like and it's like a threat the whole time. Whereas, the tribunal that I won there was none of that. There was the chairperson and the psychiatrist, I suppose that really listened, you know (Female, 41, 100)}
\]
I wanted to frame it [written confirmation of tribunal outcome]. The tribunal was, like I said, they discussed better. They really did. They included me in everything and asked me how I felt about certain things and then they said you know, it was just a better one. [...] See, tribunals are... They’re terrible because it’s so personal. It’s horrible. If you get a bad tribunal you think the world’s against you when you’re sick. (Female, 41, 100)

The tribunal was very fair. It lasted I suppose about half an hour and then we just went downstairs for a cup of tea. I couldn’t really believe that I was getting off. I think they were very fair. The two men. The woman, she didn’t seem to like me. Just some of the questions she asked me. I suppose she looked at the history and that so... No, but it was very fair. [...] (Female, 42, 200)

In contrast to the above cases wherein participants’ involuntary admission was revoked at tribunal, there was also one participant who, although their involuntary status was not revoked by the tribunal, still felt listened to and actively involved in the tribunal process;

Again, that [describes chair-person of tribunal] was brilliant. Brilliant. I’ve come across him in other tribunals that I haven’t won but he has explained to me why I haven’t won them. I can say okay. [...] It’s the communication, yeah, yeah (Female, 41, 100)

4. Going home

‘Going home’ elucidates some of the detrimental outcomes experienced by participants as a result of their involuntary admission. Participants narratives in this regard are discussed with three sub-themes including; 4a) Living in fear of return; 4b) Admission induced trauma and distress; and 4c) Stigmatised identity.
Living in fear of return

As discussed in section 2c, participants experienced significant apprehension during their stay in hospital. Such levels of apprehension appeared to remain post-discharge as participants recalled that even at home they were fearful that they were being watched and could be re-admitted once again;

[…] If [husband] died now, would they take me into hospital and take the kids off me? I worry about things like that.

INT: That’s your fear…
They’ll try and control me at home as well as in the hospital. (Female, 41, 100)

So, I was thinking okay, apart from being taken into there, now all of a sudden I’m going to be watchful and the cops are waiting for me as well. (Male, 47, 19)

Participants were particularly cautious of how they acted around family members for fear of being re-admitted, especially if those family members had been directly involved in their admission. Participants recalled monitoring what they said and did around their families and in public, with some opting to verbally and physically withdraw themselves from their family and public spaces;

[…] it’s so much better but I have to mind by Ps and Qs because my husband needs a certain amount of time to himself and he’s my carer. You have to mind your Ps and Qs when you’re like that. You know, just… he’s [husband] good but if you got into a mood and it lasted too long, he’d probably sign me in again. (Female, 41, Female, 41, 100)

I felt I couldn’t actually say anything ever again without it being taken the wrong way. (Male, 47, 19)
[..] my husband thinks I should be back here after a weekend out because I was quiet. Is that a reason? You know, the weekend that I got out before the tribunal. I mean, you know, they asked how I got on and he said I was quiet. I would have thought they’d be delighted with that.

**INT: Were you quiet for a reason?**

I didn’t want to say anything and be back there again, you know. That was the predominant fear, that I would be sent back (Female, 42, 200)

In some cases, participants described how they felt they needed to prove themselves as a ‘normal’ or ‘valid’ person to their families in order to avoid re-admission;

*You have to prove your piece that you’re pretty normal to stay out in the normal world.*

**INT: Who do you have to do that for?**

Just the people that signed you in, I suppose. [...] (Female, 42, 200)

Whereas, really what it’s about, it’s about yourself being able to bounce back and show them that you’re not a waste of time, that you were a valid human being before you came in. You’re still a valid human being... you could be a valid human being when you get out. It’s just how you perceive yourself and the steps you take to sort of prove to yourself. Initially you’ve proven to yourself that you’re valid. That’s the main sort of battle. (Male, 39, 146)

Perhaps in part because of their belief that they needed to prove themselves as ‘normal’ or ‘valid’ people, participants indicated that they were very conscious of adhering to the recommended treatment, especially medication. For some participants, adherence to their medication was driven by fear of a re-admission, whereas others felt that they were still being forced to take it, as they had been in hospital;
Well, the third time... I don’t know. It must have had an effect. I think I’ve changed as a person. I’m a lot more reserved and withdrawn and I have to be mindful, you know.

**INT: Mindful of?**

Of myself for fear that that could happen again and that you mightn’t be surrounded by the people you need to be surrounded by. Do you know what I mean? I’m convincing myself that once I continue with taking the injection that it won’t happen again. (Female, 48, 208)

Well, I’m going to stay on it. I don’t want to be in hospital so I have no choice but to stay on it. (Male, 33, 29)

If I had refused to take it then, I might have been there even longer. When I came out I was an outpatient for three weeks and she did say to me, the consultant, if I didn’t take it I’d be back in there. So, it’s kind of a threat, isn’t it? (Female, 42, 200)

No, I come in here myself. I kind of have to take it because my family would be worrying and my sister would be crying and they’d be all freaking out. So, in a way that is forcing me to take it, but at the same time the last time I crashed was pretty out there. (Male, 32, 43)

### Admission induced trauma and distress

A number of participants’ narratives also suggested that they experienced substantial trauma and distress as a result of their admission and time spent in hospital; distress which remained with them post discharge. Rather than having perceived the intervention as therapeutic, many of the participants likened their overall experience of being admitted and hospitalised to that of enduring a trauma. They described themselves as feeling worse after coming out of hospital than they did prior to their admission with participants citing an exacerbation of their distress and the onset of anxiety;
[...] The whole experience was very traumatic and I didn’t expect to go in again or understand after nine years why it happened again. There was so much under control [in the hospital]. Everything. [...] The whole thing was very bad, very traumatic. (Female, 30, 214)

If I didn’t have those [out-patient appointments & group sessions] I would have been a hell of a lot worse because as I said when I came out of here I felt I needed more therapy than when I came in. You know what I mean, I felt there were more issues because it was something that, you know it was like a nightmare (Male, 47, 19)

[...] Leaving the hospital, I don’t remember and that’s even worse because that’s when the trauma comes in and the fear comes in to your normal life. You have to go to work and keep living this like big trauma caused by these people and this trauma is the one that's going to cause more severe and more problems. (Female, 30, 214)

So, when I came home into my own environment it was like then I had to go through post-traumatic stress of being in the hospital and within a few days I did bring terrible anxiety over... I was terrified... I just went through a period of horrendous anxiety. (Female, 56, 217)

In a number of instances, negative memories were triggered by seeing people or being in similar rooms which reminded them of the trauma of their admission process, the hospital, or the treatment received. These negative associations and memories not only impacted on their waking moments, but induced difficulties sleeping and in some cases seeped into the content of their dreams;

I would still get freaked about people strapped into wheelchairs. You know, strapping...

INT: From this admission, is it?
Yeah and then an awful lot of things that would haunt me a lot and even just a small thing when we go to Saturday night mass, you know. This one girl, she’s lovely and she’s a charge nurse and she was in mass, you know. God, that flipping unit and all I could think about was the unit during mass and say if I was shopping I’d meet one of the girls or see someone from this flipping place. It would affect me, it definitely would affect me still, you know. Just [inaudible] that place and it wasn’t her fault or it wasn’t her fault but it just brings it all back and I would still have dreams, yeah.[...] Sometimes now I can’t remember my dreams but it probably is just as well. A lot of times I would have dreams that somebody has strapped me in a wheelchair. I wake up then and I’d be all hot and bothered and I wouldn’t be able to get back to sleep and all this.[...] Yeah and then I’d dream again of them putting me in a stretcher and strapping me up and me fighting. Then I’d wake up and again I’d be really, you know, it would wreck my sleep, you know (Female, 68, 139)

It was really traumatic. I have nightmares about it. [...] Seeing the staff. Experiencing the choking [as a result of restraint] again. Then sometimes I wake up in the middle of the night screaming. It was the most traumatic and stressful experience so it’s like it left a scar in my past and it’s now sometimes I get repeated thoughts about it and then it’s like flashbacks. It wasn’t very pleasant at all. (Female, 26, 72)

Well, then I started going back to my room trying to sleep and that was this place where people handcuffed me, treated me with so much aggression. I couldn’t sleep. I had lots of fear in my own room because of them. Not even with sleeping tablets I could sleep like. It was so difficult. During the day I was kind of okay but then going to sleep back to the place, I just kept remembering all that happened and all they did to me and I just couldn’t feel safe. I couldn’t feel safe in my room. I couldn’t feel safe in the world. Because you have to feel maybe they can come in again. I mean you just don’t feel safe like. Like, if that happened one time, it could happen another one. Like, fear of something could happen. (Female, 30, 214)
As the quotation above highlights, the fear of reoccurrence was extremely strong for many of the participants. They described the, often debilitating, anxiety they experienced as they worried that they could be re-admitted at any moment. For some participants, a sense of panic was again induced by particular triggers like, as the below quotation illustrates, seeing a similar vehicle to the one they were transported to hospital in. Common across all of the narratives were participants’ fears of being potentially involuntarily admitted again;

 [...] So, I seen this van turning down the drive and I’m thinking to myself, I’m actually trembling inside. I froze thinking hang on, this van is coming to take me away. That’s just the way I felt. I still wasn’t inside my door and all of a sudden there was a van turning down towards the house. It didn’t come into my place. It went next door, but it was just that feeling, you know? I remember feeling that cold feeling of hang on, you’re still not out. (Male, 47, 19)

I think it’s the, I suppose it’s the fear of the reoccurrence of it. The fear of the fact that this abuse or whatever can happen again. That other people can decide how well I am without me expressing it. Other people can take charge, you know. (Female, 40, 23)

This apprehension was also experienced in conjunction with what appeared to be a significant crisis of confidence in many of the participants. They described how they no longer trusted their own judgment or felt in control. A number of participants noted that they felt like a shadow of their former selves;

I just don’t feel that I’m in control any more. You know, I don’t feel that I’m carefree and do as I like kind of. I feel I’m... I don’t know. I can’t put a word on it. Do you know, I’m not responsible for myself any more. I feel I lost that. Every time I have a conversation with the doctor or a psychiatrist or whatever, that it’s been naturally analysed in one sense but I don’t feel that... I probably don’t trust myself even. I don’t trust my own thinking. I
don’t feel capable of making decisions because I’m unsure of whether it’s right or wrong now as where before I trusted my own gut instinct, you know. I trusted my gut and I’m sure you know that’s what gets you through life when you trust your gut as in this is the right thing for me to do. This is the wrong thing for me to do. That for me has gone now. I’m uneasy most of the time. (Female, 40, 23)

When I immediately left the hospital, I went to stay somewhere for a few days. I felt like a ghost of myself. [...] I did feel like a ghost of myself. Like people could see I was transparent or ghostly. I really felt like I’d lost myself completely. (Female, 36, 59)

I must say it made me very nervous. My confidence went altogether. I didn’t have the same confidence. I haven’t been out really shopping since it happened. I have a young fella that brings me in my groceries and that, but I used to go out and down to the church and around, but I don’t feel confident enough now to do that on my own. I don’t know. Sort of a nervousness I got since this happened, you know. The only place I go is down to the centre. Yeah, I haven’t been out yet. I’ve been out but only with other people. There is a bit of anxiety about you’re not doing things right. Worrying about what other people think, you know. They might think your behaviour or something is not right. (Male, 26, 51)

Stigmatised identity

Participants’ sense of being stigmatised and ‘other’, as discussed previously, was further exacerbated when friends and family treated them differently post discharge. Some participants disclosed that they had even lost friends as a result of their involuntary admission and the extent of their mental health difficulties being publicly known post-hospitalisation;

I had been to a birthday party to a sister-in-law in [PLACE] who is a teacher and she kept saying are you okay, are you okay? So, I suppose when you tell
family members and that, people look at you differently when they realise where you’ve been. You know. Well, I felt that anyway. They were like you know she must have been very bad if she had to be signed in. (Female, 42, 200)

I do in a sense. I feel I lost a lot and an awful lot of friends and stuff like that because there’s a lot of people judge you as well on that actual admission or involuntary admission. There’s a stigma with it no matter what anybody says. Neighbours and friends, you know, kind of... It’s very painful [...] (Female, 42, 200)

I ended up in the hospital only for three weeks or something like that and when I came back none of my friends would speak to me or anything like that once they found out I had schizophrenia. Like, people when they find out things like that, they just turn against you [...] (Female, 41, 27)

The public and subsequently stigmatising nature of some of the participants’ admission procedures, alongside the subsequent treatment they received from friends and family post discharge, appeared to have induced a sense of self-stigmatisation in many. In these cases, participants described the shame and embarrassment they felt about their involuntary admission;

I was embarrassed, really embarrassed because I was picked up in front of people I knew and it was really humiliating. I’m still humiliated by it, deeply humiliated by it. I haven’t gotten in contact with some people. I haven’t... I’m just... It was really humilitating. (Female, 36, 59)

In some cases, the self-stigmatisation manifested into self-directed anger and self-directed blame, with some participants noting that they shouldn’t have allowed their mental health to deteriorate as much as they had or for risking admission by discontinuing their medication;
In the first few days, I suppose I felt kind of regretful and a sense of shame that I had had to go in and you know maybe I slated myself a little bit the first few days but also kept very quiet and stuff. [...] I suppose I was just yeah, a bit, I suppose regretting that I got to that stage and a little bit of shame or whatever. (Female, 42, 200)

Of course I’m blaming myself because I had stopped taking my injection. If I had continued to take my injection, it might not have happened, you know. So, it's all my own fault [...] I was very angry with myself for allowing it to happen in the first place. You feel very vulnerable. Your self-esteem is on the floor. Everything, you know, you don’t feel good about yourself so you need a lot of after-care. You need reassurance and kind words but you don’t always get that. (Female, 48, 208)

5. Person centred encounters

In addition to the challenging aspects previously described, participants’ narratives were also interspersed with instances wherein they encountered individuals who endeavoured to provide compassionate, collaborative and humanising care. For example, a number of participants recounted that their admission process in particular had been handled in a calm and considerate way. They recalled that they felt actively included in the admission process. Specifically, their perception was that they were being listened to and made to feel like their opinion and perspective was respected. It appeared from the participants’ narratives that such an approach facilitated increased comfort with and acceptance of the hospital admission;

I suppose it started off with the Gardaí and they took a very caring attitude. They seemed concerned. They... while I was there like they [Gardai] couldn’t do enough for me like, you know. Even down to making sure I had tea and something to eat. You know, just something as basic as that. When I got here then, it was the nurse that actually brought me in, that kind of ran me through everything that kind of signed me in to the ward. It was caring as
well. She was actually talking to me. I guess initially I thought she was talking to me as though she believed what was going on in my thoughts so she was in agreement with me and she understood where I was coming from and all of that and I certainly remember thinking that nobody else believes me but the nurse can see. Now, not that she was... everything I was saying, she was saying yes to or whatever, but she was also asking me questions that were trying to make me think introspectively about what was going on with me and I just think that engagement in itself helped relax me. It took my mind off of what was really going on. You know, where my mind was at the time. It just gave me a different focus (Male, 37, 114)

To be honest it was just like me walking in myself. That’s how it felt. It didn’t feel bad. It really didn’t in fairness. I was treated just like any other person that would walk in off the street, I’d say. They weren’t bad-minded to me or talk down to me or, they just treated me like a normal person, which was good, do you know (Female, 44, 9)

The nurses was helpful. I’m not saying anything about the nurses’ job. They do as best as they can, but they were helpful to me and they tried to comfort me as much as they could. I was very distressed going into the hospital because I didn’t want to go in against my will. So, they were good.

**INT: What did they do? Can you give an example of how..?**

Just asking did you want tea or coffee, trying to relax you that you’d be talking to the doctor tomorrow and that things, you know, would be all right, that it was only out of the best for your health they’re doing it for. (Female, 24, 15)

Equally, and contrary to the reports of limited engagement and support evident in many participants’ narratives, a number of participants recalled many positive encounters and experiences which occurred during their hospital stay. This cohort of participants noted that they received plentiful information explained in an accessible way throughout;
She [Doctor] helped me, she was helpful as in explaining what’s going to happen and why I was here and she said how long I was going to be here and they're going to put me on these tablets and she just says that the drink was making me depressed (Male, 49, 10)

Nurses would be like explaining to you all the time what was happening. They would come and say don't worry, I'm just going to [inaudible]. You are okay, I can see that. Some people [Nurses] would really understand what’s going on. Really understand who I was. (Female, 30, 214)

No, I was given plenty of information. I had somebody come to me and talk to me. They gave me the mental health booklet. Somebody talked to me about the tribunal. Nurses came over to me regularly and asked me what was going on. They were very insightful at the time, I found regarding what was happening to me and what would possibly happen next. (Male, 37, 114)

Alongside receiving adequate information, some of the participants also recalled that they felt listened to and supported throughout their hospital stay. In such cases, individual doctors and nurses were perceived to offer comfort and meaningful support delivered in a compassionate and approachable manner;

And then she said “if you ever need to talk, just get the nurses to get me and I’ll talk to you” like, you know. She’s very down-to-earth. Very civil and everything like, you know. [...] Because she’d talk to you like she was a friend of yours like, you know (Male, 47, 39)

And they’re willing to listen and even though they go by the book as well, they’re willing to adjust. They’re willing to say, well I think he’s good today and I think he’s okay and I think he’s improving. Whereas the older ones don’t really want to get involved in that kind of… they just go about whatever the doctor says, you know (Male, 39, 3)
The nursing staff were just more there to console and be gentle and I found [NAME] as well, Dr. [NAME] very genuine and very, you know, just gentle (Female, 40, 23)

Yeah, she kind of held my hand. She said you’re only here for a rest. You know, you’re only here for a rest. That was after the first week with Dr. [NAME]. She was really nice. [...] So, she was nice. [...] Yeah. It's nice to have somebody that would be a little bit compassionate. (Female, 42, 200)

The inclusion of these positive encounters is not intended to minimise the challenging experiences reported in the preceding four themes. Instead, they are included to highlight that it was the distinct aspects of participants’ positive experiences (i.e. receiving explanations, being listened to and feeling supported) which many participants identified as being absent in their experiences, and which they believed needed to be enhanced and demonstrated consistently by every member of the team across the whole trajectory of involuntary and voluntary hospital admissions in the future, as the following comments suggest;

I think I would have liked to have somebody try to approach me in some other way rather than coming into a public restaurant. That was very... looking back on it, I’m very embarrassed about it. It was very public and I think unnecessary. [...] it would have been nice if somebody gentle, I think, had come and just said you know, you need to do this or you need to do this. That’s all it requires. A gentle voice. A gentle person a lot of the time, but you get force and aggression. (Female, 46, 63)

Hopefully it won’t happen again but if in some other bodies, someone with enough intelligence and enough, you know, to talk to someone and explain properly and an independent, not a GP. If they didn’t like their GP, somebody independent to come and speak to them and explain and talk it out and see where you go from there. (Male, 56, 230)
In addition to their desires for greater explanatory and compassionate support, some participants also expressed their wish for increased psychological support at each stage of their involuntarily detention including their initial admission, for the duration of their hospitalisation including during the tribunal and at discharge. For example, one participant proffered the recommendation of increasing the input of a psychologist in the tribunal process. He felt this would assist to counteract what he, and many of the other participants, felt was an over medicalised tribunal process. Whether it be in person and/or by submitting a psychological report, he felt it would offer some middle ground between the service users’ point of view and that of the treating and independent psychiatrist;

"It’s the psychiatrists and it’s the second psychiatrist who gives the opinion will never disagree with the main psychiatrist. Maybe they did in my case. I don’t know, but just ask a psychologist to do that process or to have a psychologist’s report put before the tribunal because it’s very lopsided. The tribunal is quite lopsided because the psychiatrists give all this type of you know, in my medical opinion this man should be detained and then they say what is that medical opinion? And then she rattles off some medical speak. That’s useless to me. Whereas, if the psychologist was there, the psychologist might offer some form of middle-ground. I suppose middle-ground really is what’s missing from the whole thing. (Male, 32, 162)"

The support of a psychologist was also specifically named as being a desirable source of support to be offered to the service users not just during the tribunal but also before and after;

"[…] the input of a psychologist. Not that the input of a psychologist is bizarre. Even to have some type of support while you’re going through the process which is quite a traumatic process to put yourself before a tribunal. […] (Male, 32, 162)"
Grounded theory analysis

A further more in-depth analysis of the data was undertaken using Grounded Theory methodology. The aim of this analysis was to develop a theory to understand service users experiences before, during and after involuntary admission under the MHA 2001. The data were analysed using the Straussian method of Grounded Theory (Corbin and Strauss, 2008), which builds theory from the data employing a constant comparative method of concurrent data collection and data analysis.

The data analysis revealed a theory of Preserving Control (Figure 4.2) which encapsulates service users experience before, during and after involuntary admission under the MHA 2001. The theory of Preserving Control consists of three themes: ‘Losing Control’, ‘Regaining Control’ and ‘Maintaining Control’. ‘Losing Control’ describes the loss of autonomy that service users experienced before and during involuntary admission. ‘Regaining Control’ describes the restoration of autonomy and liberty that service users experienced during admission. ‘Maintaining Control’ describes the impact that an involuntary admission had for the service users and the strategies that people used to deal with this and their mental well being on discharge.

‘Losing Control’ consists of three subthemes: ‘Diminishing Self-mastery’, ‘Feeling Violated’ and ‘Being Confined’. ‘Diminishing Self-mastery’ refers to the decline in mental well-being that some service users experienced before and in some instances during hospitalisation. ‘Feeling Violated’ refers to the lack of dignity and respect that service users experienced at the time the involuntary admission procedures were being implemented. ‘Being Confined’ refers to the negative feelings that service users experienced regarding their care and treatment during hospitalisation.

‘Regaining Control’ consists of four subthemes: ‘Resisting the System’, ‘Encountering Humanising Care’, ‘Gaining Perspective’ and ‘Playing Ball’. ‘Resisting the System’ refers to services users’ verbalisation of their
disagreement with involuntary admission and hospitalisation and the active pursuit to regain control. ‘Encountering Humanising Care’ refers to the encounters that services users had with professionals (Gardai, members of the assisted admission team, nurses and psychiatrists) that enabled the service user to feel more in control. ‘Gaining Perspective’ refers to the information, explanation that services users were provided that assisted the service user to feel more in control. In addition, it refers to service users’ cognitive appraisal of the reason for admission that enabled them to make sense of what was happening. ‘Playing Ball’ refers to the ‘compliance’ strategies that service users adopted to assist in a restoration of their liberty.

‘Maintaining Control’ consists of two subthemes ‘Maintaining Mental Health’ and ‘Preserving Sense of Self’. These two strategies were employed in the context of ‘Living with the Consequences of Involuntary Admission’. ‘Maintaining Mental Health’ refers to the strategies that service users employed to assist in managing their recovery. ‘Preserving Sense of Self’ refers to the strategies that service users employed to protect themselves from being seen as a person that has a ‘mental illness’ and requires readmission to hospital. Services users employed these strategies whilst also living with the longer-term emotional impact of being involuntary admitted - ‘Living with the Consequences of Involuntary Admission’.
Figure 4.2 Diagrammatic representation of the Theory of Preserving Control.
Discussion

The findings of this study indicate that participants’ principal concerns regarding their involuntary admission to hospital were about violations of their autonomy, the limited provision of information and support, and the detrimental impact that the involuntary admission process had on their psychological well-being. These qualitative findings, garnered from a descriptive analysis of 50 participants’ narratives, help to further elucidate the diversity of experience suggested by the quantitative findings in study 1. Notably, when examining subcategories of the Attitudes questionnaire in that study, those scale items which related to information provided, assessment prior to admission, medication usage and mental health tribunals, around 50% of this epidemiological sample ratified negative experiences. Similarly, and in keeping with other previously published research (Katsakou and Priebe, 2007; Wyder et al., 2013; Van den Hooff and Goossenson, 2014; Seed, 2014), participants’ qualitative narratives revealed both positive and challenging experiences over the course of their involuntary admission.

For many of the participants, a sense of coercion and disempowerment characterised each stage of their involuntary admission into hospital. The service users transferred to an approved centre reported that a firm and sometimes physically forceful stance pervaded their initial encounters with the assisted admissions team. In some cases, participants’ transfers to hospital were also publicly demarcated by an overwhelming presence of numerous unfamiliar stakeholders, including what was perceived as the criminalising involvement of the Garda Siochana. Such an approach informed service users’ reports of feeling coerced, criminalised and undermined.

The subsequent hospital experience, rather than being a place of refuge and compassion, was likened by some service users to imprisonment due to the perceived curtailment of their movements, impingements of their rights, discounting of their perspective, and their perception of being coerced into treatment adherence. The feelings and concerns identified by many of the
service users in this study are in line with those reported in qualitative reviews on this topic (Wyder et al., 2013; Katsakou and Priebe, 2007; Seed, 2014). Katsakou and Priebe (2007) reported that one of the most commonly mentioned issues by service users was experiencing involuntary admissions as a violation of autonomy and personal integrity. In each of Katsou and Priebe’s (2007) included studies, service users admitted on an involuntary basis had perceived a diminution of their rights and reported feeling coerced into treatment adherence. Later reviews conducted by Wyder et al (2013) and Van den Hooff and Goossenson (2014) also concluded that involuntary treatment was often experienced by many service users as a violation of their personal integrity and a loss of their basic human rights.

Further, the feelings of being coerced and disempowered over the trajectory of their involuntarily admission was, for many, intensified by a perceived lack of emotional and informational support and a limited facilitation of their active involvement in decision making. This was most frequently described during service users’ initial transfer to and detention in hospital, as well as at critical times during their hospitalisation including before, during, and after their mental health tribunal. Similarly, feelings of not being listened to, cared for and/or being actively involved in decision making are commonly reported by service users in other published qualitative studies, irrespective of country or legal framework (Katsou and Priebe, 2007; Wyder et al., 2013; , Van Den Hooff and Goossenson, 2014; Chambers et al., 2014; Seed, 2014). A lack of information in relation to one’s involuntary admission order, reasons for hospitalisation, treatment options and legal rights has been described previously by service users (Wyder et al. 2013; Van den Hooff and Goossenson 2014) and has been reported to exacerbate service users’ sense of lacking control during their involuntary hospitalisation.

It is worth noting that the Principles set out in section 4 of the 2001 Act are intended to influence the interpretation of the Act, but could be used more effectively having regard to the research findings on lack of communication and information. In particular, on the issue of both participation and information,
section 4(2) of the 2001 Act, underpins the requirement to enable the participation of the person concerned through consultation regarding decisions about admission and treatment. Unfortunately, this important human rights provision is not monitored although it has the potential to ensure the concerned person is communicated with and given information at an early stage of an intervention leading to detention. This failure is stark when compared with the principles under Scottish legislation that include participation (Mental Health Care and Treatment (Scotland) Act, 2003; Mental Health Scotland Act, 2015).

The right to information in clear language centres on the legal basis or reasons for detention in order to facilitate the right to challenge the detention based on Article 5(2) of the ECHR requirements. Information and communication are fundamental elements of participation. The 2001 Act does not specifically require that the reasons for detention are provided to the person concerned. The lack of information was highlighted as a key finding in this study, particularly prior to transfer for inpatient assessment. These deficiencies need to be addressed and may not need reform in primary legislation, but rather in its application and implementation through codes of practice or training.

The important right to review of the initial and continuing detention is included in the 2001 Act in keeping with Article 5(4) of the ECHR requiring an independent, speedy and regular review of the decision to detain and continuing detention. Mental Health Tribunals carry out this function and the research findings point to the need for reform of a number of elements of the workings of this review body. The findings of a Scottish study indicate some concerns similar to findings in this research about the need to make the tribunal hearings more accessible and service user focused and ensuring the person felt listened to and heard even if the outcome affirmed the detention (Dobbie et al., 2009).

Despite the aforementioned challenges, many of the participants also identified times when they encountered individuals along the way who endeavoured to initiate a collaborative, informative and compassionate approach. For some participants, their transfer to approved centre/hospital was conducted in a calm
and considerate manner wherein they felt actively included, listened to and cared for. In particular, service users valued the support and humanising treatment by members of An Garda Síochána during their transfer to the approved centre. Similarly, during their time in hospital, some service users recalled that they felt supported and that they received adequate information which was explained in an accessible way. It was these aspects of participants’ positive experiences (i.e. receiving explanations, being listened to and feeling supported) that many other service users identified as being absent in their experiences, and which they believed should be demonstrated consistently by every member of the team across the whole course of their admission. For those who did encounter instances of humanising care, their descriptions echo those identified in some previous studies (Katsou and Priebe, 2007; Wyder et al., 2013), wherein respectful, humanising and informative care reportedly facilitated autonomy and meaningful collaborative involvement with their treating team.

However, whilst the instances of compassionate interactions in this study are encouraging, not least because they demonstrate that a humanising approach can be achieved in the pressured and difficult context of an involuntary admission, unfortunately they were not demonstrated consistently across the involuntary admissions of the service users interviewed. Rather than reflecting a systemic culture, these exposures to humanising care appeared to depend upon the particular staff member encountered. Indeed there is evidence that the core experience of feeling genuinely listened to by supportive staff are associated with an increased acceptance of compulsory treatment, feelings of empowerment, and restored self-value and self-worth (Van den Hooff and Goosensen, 2014). In addition, the fact that the same participants recounted both positive and negative caring encounters with staff, adds validity to their accounts of both types of experiences, as opposed to the interpretation that negative descriptions are merely a reaction toward being restricted or due to low levels of insight.
One notable finding in this study was the traumatising effect of the involuntary admission process on many individual service users. This effect was not singly linked to the potential traumatising interventions involving physical contact, such as restraint, seclusion or coercive administration of intramuscular medication as has been noted in previous studies (Andreasson and Skarsater, 2012; Georgieva et al., 2012; Huber et al., 2012), but to the entire process of involuntary admission. Some service users likened the manner in which they perceived their admission to be handled to that of enduring a trauma; and one which continued long after they returned home. In these cases, service users described the long-term deleterious effects of their post-discharge anxiety with features of post-traumatic stress disorder, including panic attacks and flashbacks, and with the potential severity and persistence of these effects reflected by some reporting that they felt worse than they did prior to their admission.

In the context of risk categorisation, the traumatic effect of coercive treatments on people has been described as a health care induced risk (Stastny, 2000; Higgins et al., 2015; Light et al., 2015), requiring additional attention, with some arguing that future responses to emotional induced harm during hospitalisation should be aligned with other patient safety concerns, such as physical induced harm (Sokol-Hessner et al., 2015; Usher, 2016; Watson et al., 2014). In this study however, there was little evidence to suggest that the participants encountered therapeutic interventions which were targeted at coming to terms with the additional trauma of coercive admission and treatment on top of their existing mental health difficulties. The open acknowledgement and discussion of the person’s experience, which is increasingly advocated as a means to mitigate the potentially traumatising nature of involuntary admissions (Andreasson and Skarsater, 2012; Ling et al., 2015; Muskett, 2014), may have benefited participants. Many service users identified a desire for someone to talk to regarding their experience of involuntary admission and hospital stay throughout their involuntary admission and post discharge. Such open discussion about their experience and emotional response to involuntary admission, as distinct from their illness and its management, might reduce
additional deleterious effects endured by service users that are specifically related to the experience of coerced care, including their compromised sense of self-identity, self-confidence and familial relationships. It may also enable service users’ to develop strategies to minimise the state of apprehension and self-surveillance which permeated people’s lives long after their discharge from hospital. This finding also points to the need for further research into support strategies and the most effective and cost effective interventions which might reduce the negative emotional impact of involuntary admission.

The grounded theory analysis identified the theory of preserving control as a central process describing service users’ experience of coercive care and interactions with professionals. If professionals can limit the extent to which control is threatened by using persuasion and employing a maximally humanising approach to care and proactive efforts to maximise the service users’ control despite their involuntary admission, then outcomes and engagement after involuntary admission may be more favourable.

Conclusion of Study 2

Despite the potential beneficial effects that hospital admission can have on mental well-being, this qualitative study of service users views across the entire trajectory of their involuntary admission identified a number of factors that impacted negatively on their psychological well-being and left them feeling traumatised by the process of admission. These included disempowering and controlling practices, feeling uninvolved in decision making, and a lack of accessible information and emotional support. Many of these issues are targetable and can be addressed and potentially ameliorated. Indeed some participants identified instances of collaborative and autonomy-enhancing practice, which indicates that a person-centred approach can be achieved in the pressured and difficult context of involuntary admission. However, consistently applying such an approach across the entire trajectory of involuntary admission is challenging, and will require a multi-faceted strategy, inclusive of ongoing education and training of all stakeholders in the principles and practices of
humanising person-centred care, with a focus on optimising service users’ pathway towards regaining and preserving the control that was lost in the process of coercive care.
Chapter 5. Qualitative Exploration of Professionals & Carers Perspectives on Involuntary Admission (Study 3)

Introduction

This chapter outlines the findings from Study 3, which used questionnaire based and focus group methodologies to explore the attitudes and experience of stakeholders other than service users towards the involuntary admission process under the MHA 2001. Firstly, the findings of the descriptive survey are provided, followed by the findings of the focus groups analyses. The chapter concludes with a discussion on the study findings.

Findings - Descriptive survey

Participant profile

The sample comprised 503 respondents, including 397 paper respondents and 106 online respondents. Stakeholders’ demographic details are described in Table 5.1. There were significant differences between stakeholder groups for age ($\chi^2 = 201, df = 24, p < 0.001$), gender ($\chi^2 = 39, df = 6, p < 0.001$), number of involuntary admissions that they had experience of ($\chi^2 = 171, df = 12, p < 0.001$) and years of professional experience ($\chi^2 = 51, df = 10, p < 0.001$).

Findings

Stakeholders’ responses are outlined in Table 5.2. Stakeholders generally expressed the view (agreed or strongly agreed) that patients benefit from the care they receive (79%) and that the MHA 2001 ensures an independent and fair review of the person’s detention (65%). However only a minority were satisfied (agreed or strongly agreed) with the clinical assessment procedures (37%), with the implementation of the MHA 2001 in practice (36%) and with the level of information available (34%). The process of transfer of patients to the inpatient
unit demonstrated the lowest satisfaction rates (23%) with 63% of participants expressing dissatisfaction (disagreed or strongly disagreed).

Cumulative odds ratios to compare differences in responses between the stakeholder groups (with Gardai as the reference group) are presented in Table 5.3, with a selection of responses displayed graphically in Figure 5.1. Family members and Gardai were most dissatisfied regarding the MHA 2001 operating well to ensure patients receive the treatment they require, regarding the clinical assessment working well under the legislation and regarding the availability of information about MHA 2001. Gardai were also the most dissatisfied group with the practical implementation of the legislation and with the process of transfer of patients to approved centres, although high levels of dissatisfaction were also expressed by psychiatrists and family members. There was no significant difference among stakeholders’ views regarding the MHA 2001 supporting patients’ right to consent or refuse treatment.

**Free-text responses**

There were 421 free-text responses, with the greatest number of these from family members (n=114). Regarding paper data, 130 respondents (36% of participants) gave 184 free text responses. Two-hundred and thirty seven free text responses were attained from the 106 online respondents. Ten themes emerged from the free-text responses (Table 5.4). Themes associated with the greatest free text response included 1) the transfer of patients to approved centres under the MHA 2001 legislation (n = 84), 2) the clinical assessment for involuntary admission under the MHA 2001 (n = 70) and 3) that the MHA 2001 ensures treatment for individuals requiring involuntary admission (n = 63). Of the 381 free-text responses, only 25 (6.6%) were positive in relation to the operation of the MHA 2001, with the others either clearly negative or partially negative.

The process of transferring patients to approved centres was associated with 82 critical comments. These comments (particularly from consultant psychiatrists,
GPs, Gardai, CMHNs and family members) highlighted concerns regarding delays in the transfer of patients to approved centres, the lack of local mental health teams to assist with the transfer of patients to approved centres, and the traumatic impact of the transfer process on both patients and family members.

The clinical assessment for involuntary admission under the MHA 2001 was associated with 64 comments that expressed concern particularly from Gardai and family members in relation to the time required to organise a clinical assessment, the difficulty in correctly completing MHA 2001 Forms 1-5 with some respondents querying the appropriateness of undertaking a clinical assessment in a Garda station.

There were 50 comments predominantly from Gardai, inpatient unit psychiatric nurses and family members expressing concern regarding the capacity of the MHA 2001 to ensure treatment for individuals that require involuntary admission. Particular concerns related to patients such as those in an intoxicated state from alcohol misuse not meeting criteria for involuntary admission when in distress, that certain patients were admitted for treatment unnecessarily and that the MHA 2001 should facilitate treatment outside of a hospital setting. Several positive comments from psychiatrists, family members and tribunal members indicated that they believed the MHA 2001 succeeded in ensuring treatment for individuals requiring involuntary admission.
Table 5.1 Response rates and demographic characteristics of the stakeholder groups.

<table>
<thead>
<tr>
<th>Variables</th>
<th>General Practitioners n = 82 (%)</th>
<th>Consultant Psychiatrists N = 53 (%)</th>
<th>Tribunal Members n = 37 (%)</th>
<th>Gardai n = 207 (%)</th>
<th>Acute Psychiatric Unit Nurses n = 44 (%)</th>
<th>Community Mental Health Nurses n = 37 (%)</th>
<th>Family Members n = 43 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Response Rate</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paper Version</td>
<td>82 (40)</td>
<td>11 (55)</td>
<td>35 (64)</td>
<td>207 (34)</td>
<td>30 (42)</td>
<td>16 (53)</td>
<td>16 (48)</td>
</tr>
<tr>
<td>Online Version*</td>
<td>-</td>
<td>42</td>
<td>2</td>
<td>-</td>
<td>14</td>
<td>21</td>
<td>27</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 30</td>
<td>1 (1)</td>
<td>0 (0)</td>
<td>1 (3)</td>
<td>24 (12)</td>
<td>11 (28)</td>
<td>2 (6)</td>
<td>3 (7)</td>
</tr>
<tr>
<td>30-39</td>
<td>13 (17)</td>
<td>2 (4)</td>
<td>3 (9)</td>
<td>96 (48)</td>
<td>8 (20)</td>
<td>17 (50)</td>
<td>10 (24)</td>
</tr>
<tr>
<td>40-49</td>
<td>23 (30)</td>
<td>33 (63)</td>
<td>12 (34)</td>
<td>54 (27)</td>
<td>11 (28)</td>
<td>9 (26)</td>
<td>4 (10)</td>
</tr>
<tr>
<td>50-60</td>
<td>22 (29)</td>
<td>16 (31)</td>
<td>11 (31)</td>
<td>27 (13)</td>
<td>9 (22)</td>
<td>6 (18)</td>
<td>9 (21)</td>
</tr>
<tr>
<td>Over 60</td>
<td>18 (23)</td>
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<td>8 (23)</td>
<td>1 (0)</td>
<td>1 (2)</td>
<td>0 (0)</td>
<td>16 (38)</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>32 (41)</td>
<td>29 (55)</td>
<td>17 (46)</td>
<td>61 (14)</td>
<td>29 (66)</td>
<td>22 (61)</td>
<td>28 (65)</td>
</tr>
<tr>
<td>Male</td>
<td>47 (59)</td>
<td>24 (45)</td>
<td>20 (54)</td>
<td>141 (86)</td>
<td>15 (34)</td>
<td>14 (39)</td>
<td>15 (35)</td>
</tr>
<tr>
<td><strong>Number of experienced involuntary admissions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-10</td>
<td>42 (60)</td>
<td>0 (0)</td>
<td>2 (6)</td>
<td>77 (46)</td>
<td>2 (6)</td>
<td>7 (21)</td>
<td>21 (78)</td>
</tr>
<tr>
<td>11-20</td>
<td>15 (21)</td>
<td>2 (4)</td>
<td>2 (6)</td>
<td>48 (28)</td>
<td>6 (16)</td>
<td>9 (26)</td>
<td>1 (4)</td>
</tr>
<tr>
<td>21+</td>
<td>13 (19)</td>
<td>48 (96)</td>
<td>31 (88)</td>
<td>44 (26)</td>
<td>29 (78)</td>
<td>18 (53)</td>
<td>5 (18)</td>
</tr>
<tr>
<td><strong>Years of professional experience</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-10</td>
<td>13 (18)</td>
<td>0 (0)</td>
<td>4 (12)</td>
<td>55 (32)</td>
<td>15 (41)</td>
<td>9 (25)</td>
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<tr>
<td>11-20</td>
<td>24 (32)</td>
<td>27 (54)</td>
<td>10 (29)</td>
<td>79 (45)</td>
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<td>21+</td>
<td>37 (50)</td>
<td>23 (46)</td>
<td>20 (59)</td>
<td>42 (24)</td>
<td>15 (41)</td>
<td>14 (39)</td>
<td></td>
</tr>
</tbody>
</table>

Significant differences between the groups after performing post-hoc analyses are indicated in bold font, p<0.05.

Some responders did not provide complete demographic data. * Response rates were only available for the paper version of the survey.
Table 5.2 Opinions of all stakeholders regarding the Mental Health Act 2001.

<table>
<thead>
<tr>
<th>Questionnaire Items</th>
<th>N</th>
<th>Strongly disagree N (%)</th>
<th>Disagree N (%)</th>
<th>Neither agree or disagree N (%)</th>
<th>Agree N (%)</th>
<th>Strongly agree N (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1: The legislation operates well in ensuring treatment for persons that require involuntary admission</td>
<td>493</td>
<td>46 (10)</td>
<td>110 (22)</td>
<td>73 (15)</td>
<td>224 (45)</td>
<td>40 (8)</td>
</tr>
<tr>
<td>Q2: The clinical assessment in order to meet the criteria for involuntary admission works well under the legislation</td>
<td>493</td>
<td>76 (15)</td>
<td>162 (33)</td>
<td>75 (15)</td>
<td>160 (33)</td>
<td>20 (4)</td>
</tr>
<tr>
<td>Q3: People admitted without their consent generally benefit from the care received</td>
<td>447</td>
<td>11 (3)</td>
<td>30 (7)</td>
<td>55 (12)</td>
<td>236 (53)</td>
<td>115 (26)</td>
</tr>
<tr>
<td>Q4: Where possible the legislation supports the persons’ right to consent or refuse treatment</td>
<td>451</td>
<td>9 (2)</td>
<td>64 (14)</td>
<td>120 (27)</td>
<td>227 (50)</td>
<td>31 (7)</td>
</tr>
<tr>
<td>Q5: The legislation ensures an independent and fair review of the person’s detention</td>
<td>395</td>
<td>7 (2)</td>
<td>41 (10)</td>
<td>89 (23)</td>
<td>186 (47)</td>
<td>72 (18)</td>
</tr>
<tr>
<td>Q6: The legislation is difficult to implement in practice**</td>
<td>488</td>
<td>86 (18)</td>
<td>143 (29)</td>
<td>85 (17)</td>
<td>160 (33)</td>
<td>14 (3)</td>
</tr>
<tr>
<td>Q7: Information about the legislation is not readily available**</td>
<td>493</td>
<td>42 (9)</td>
<td>127 (26)</td>
<td>71 (14)</td>
<td>217 (44)</td>
<td>36 (7)</td>
</tr>
<tr>
<td>Q8: The way in which people are transferred to the inpatient unit works well under the legislation</td>
<td>302*</td>
<td>83 (28)</td>
<td>107 (35)</td>
<td>43 (14)</td>
<td>58 (19)</td>
<td>11 (4)</td>
</tr>
<tr>
<td>Q9: People admitted without their consent receive the least restrictive and the most effective care available under the circumstances</td>
<td>226*</td>
<td>14 (6)</td>
<td>43 (19)</td>
<td>70 (31)</td>
<td>81 (36)</td>
<td>18 (8)</td>
</tr>
</tbody>
</table>

* Item added after questionnaire distributed to GPs and Tribunal Members. ** Reverse coding was used for these items.
Figure 5.1 Cumulative odd ratios of stakeholders regarding views of MHA 2001.

Adapted from Georgieva et al, Irish Journal of Psychological Medicine, DOI: 10.1017/ipm.2016.6, and reprinted with permission.
Table 5.3 Proportional odds model providing cumulative odds ratios for each stakeholder group compared with the Gardai reference group for each questionnaire item in Table 5.4.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Q5</th>
<th>Q6</th>
<th>Q7</th>
<th>Q8</th>
<th>Q9</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R² = 0.26</td>
<td></td>
<td>R² = 0.223</td>
<td></td>
<td>R² = 0.05</td>
<td>R² = 0.19</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Practitioners</td>
<td>3.4***</td>
<td>1.5</td>
<td>3.9***</td>
<td>1.4</td>
<td>2.4*</td>
<td>2.4**</td>
<td>1.3</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>7.4***</td>
<td>5.8**</td>
<td>9.3***</td>
<td>2.1</td>
<td>7.2***</td>
<td>10.6***</td>
<td>1.8</td>
<td>2.4*</td>
<td>5.4***</td>
</tr>
<tr>
<td>Tribunal members</td>
<td>19.4***</td>
<td>11.0***</td>
<td>3.2**</td>
<td>1.4</td>
<td>8.2***</td>
<td>11.6***</td>
<td>3.4**</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Family members</td>
<td>2.1</td>
<td>1.2</td>
<td>1.7</td>
<td>1.9</td>
<td>2.4</td>
<td>4.2*</td>
<td>0.4</td>
<td>3.3*</td>
<td>3.4*</td>
</tr>
<tr>
<td>Inpatient unit psychiatric nurses</td>
<td>8.0***</td>
<td>3.4**</td>
<td>3.5**</td>
<td>0.9</td>
<td>2.3</td>
<td>7.0***</td>
<td>1.8</td>
<td>11.8***</td>
<td>16.7***</td>
</tr>
<tr>
<td>Community Mental Health Nurses</td>
<td>12.9***</td>
<td>8.8**</td>
<td>7.9***</td>
<td>1.7</td>
<td>6.3***</td>
<td>7.7***</td>
<td>1.7</td>
<td>7.4***</td>
<td>4.1**</td>
</tr>
</tbody>
</table>

Model controls for gender, age, number of experienced involuntary admissions and type of data collection (paper vs online).

*p < .05; **p < .01; ***p < .001.
<table>
<thead>
<tr>
<th>Theme</th>
<th>Consultant Psychiatrists</th>
<th>Inpatient Psychiatric Nurses</th>
<th>Tribunal Members</th>
<th>Gardai</th>
<th>CMHNs</th>
<th>Family Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensures treatment for individuals requiring involuntary admission</td>
<td>4</td>
<td>6</td>
<td>11</td>
<td>7</td>
<td>19</td>
<td>63</td>
</tr>
<tr>
<td>Clinical assessment for involuntary admission</td>
<td>7</td>
<td>12</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>40</td>
</tr>
<tr>
<td>Involuntary treatment is beneficial and as least restrictive as possible</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>22</td>
</tr>
<tr>
<td>Supports a persons’ right to consent or refuse treatment</td>
<td>1</td>
<td>4</td>
<td>6</td>
<td>3</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Independent and fair review of the person’s detention</td>
<td>4</td>
<td>6</td>
<td>5</td>
<td>1</td>
<td>7</td>
<td>34</td>
</tr>
<tr>
<td>Transfer of patients to approved centres</td>
<td>19</td>
<td>12</td>
<td>12</td>
<td>10</td>
<td>10</td>
<td>134</td>
</tr>
<tr>
<td>Information and training availability</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>5</td>
<td>32</td>
</tr>
<tr>
<td>Impact on workload and/or relations with other stakeholders</td>
<td>9</td>
<td>5</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>40</td>
</tr>
<tr>
<td>Effects on (therapeutic) relationship</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Comments unrelated to operation of MHA 2001</td>
<td>6</td>
<td>0</td>
<td>2</td>
<td>6</td>
<td>3</td>
<td>40</td>
</tr>
</tbody>
</table>

*CMHNs = Community Mental Health Nurses; GPs = General Practitioners.*
Findings – Focus groups

Participant profile

Focus group sizes ranged from 5 to 14 participants. Eight focus groups were conducted and there were 62 participants in total (Table 5.5). Gender was equally divided and most participants were aged over 40 years. Professional participants were very experienced in their field, with 90% (n = 26) of healthcare professionals (GPs, CMHNs and psychiatrists) and 64% (n = 9) of Gardaí having 11+ years of experience. Professional participants had extensive involvement in involuntary admissions under the Act with 18 (37%) having been involved on more than 21 occasions. Family members experienced their relative being hospitalised under the Act on a number of occasions: three on one occasion, four on three occasions and one on more than four occasions. Four family members (50%) were the applicant for their relative’s involuntary hospitalization. Four service users had been admitted under the Act on one occasion, one had been admitted on more than four occasions.
Table 5.5 Focus Group Demographics.

<table>
<thead>
<tr>
<th>Focus Group (By stakeholder group)</th>
<th>n</th>
<th>Gender</th>
<th>Age (In Years)</th>
<th>Experience (In Years)</th>
<th>Involuntary admissions (No. of cases involved in)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>M</td>
<td>F</td>
<td>&lt;30</td>
<td>30-39</td>
</tr>
<tr>
<td>Fg1: Relatives</td>
<td>8</td>
<td>4</td>
<td>4</td>
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<td>2</td>
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<tr>
<td>Fg2: General Practitioners</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Fg3: General Practitioners</td>
<td>8</td>
<td>2</td>
<td>6</td>
<td>0</td>
<td>3</td>
</tr>
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<td>Fg4: Community Mental Health Nurses</td>
<td>8</td>
<td>1</td>
<td>7</td>
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<td>2</td>
</tr>
<tr>
<td>Fg5: Consultant Psychiatrists</td>
<td>8</td>
<td>2</td>
<td>6</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Fg6: Tribunal Members/Solicitors</td>
<td>6</td>
<td>2</td>
<td>4</td>
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<td>0</td>
</tr>
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<td>Fg7: Police</td>
<td>14</td>
<td>12</td>
<td>2</td>
<td>1</td>
<td>8</td>
</tr>
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<td>Fg8: Service-users</td>
<td>5</td>
<td>2</td>
<td>3</td>
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Data analysis of the focus group transcripts revealed three categories: “Getting Help”, “Detention under the Act”, and “Experiences of the Tribunal Process”.

1. Getting help

The category “Getting Help” describes the experiences of involuntary admission across stakeholder groups from the time of recognizing that a person in distress was unwell and needed help, through to instigating admission and getting the person to hospital. It refers to stakeholders’ frustration with the admission process and the perception of many stakeholders that they were often left in isolation in dealing with issues.

Family members and police were the two stakeholder groups who most frequently sought to initiate admission. The challenges described by family members were in relation to help after they became aware that the service-user was acutely unwell and needed urgent care.

\textit{This night we brought him to the hospital, we locked, we child locked the 2 doors because we were afraid he’d jump out of the car. Because he’d already gone out the window at home. Brought him down to A&E, into A&E, we were left sitting there for, I don’t know, it felt like hours but it wasn’t particularly long that particular night. We were afraid he was going to make a run for it out the door. I kept saying to the receptionist please get us in to the place where he couldn’t get out (FG1FM).}

They termed this period as a “time of despair and extreme stress”, particularly when the service-user themselves did not recognise that they needed care.

\textit{my mum and dad would have known that I wasn’t well and they would have told me...listen, your behaviour is kind of, there’s something wrong like, are you okay or whatever, but I’d dismiss it completely and tell them I’m fine... you put the hard face (FG8SU)}
and could respond aggressively to the suggestion that they needed help.

... so I went out to see him and I signed the form and the poor wife was left with this really psychotic man, he’s three times her size, a really dangerous man, and she, you kind of feel guilty for her. So we called the guards and the guards were out at the house, he had gone. So they had another call and had to leave...so we ended up having to ring that national ambulance. Now when they arrived he was gone again (FG3 GP).

For other service-users it was the police who were initially alerted to problems when the service-user was presenting with odd behaviours, acting dangerously, or a initiating a disturbance in public.

I did let him out (after GP assessment) and he went up X Street and there was two guys painting a shop in X Street and there was one guy up a ladder and that particular patient took a run at the ladder and knocked your man off the ladder, and I was in the public office and the two painters came in with him physically restrained, back in to the Police Station. And that was, that was one of my first experiences of, of the Act and the service we were getting and I felt utterly and completely and utterly frustrated and let down by the system and for the people who were availing of the service, and the people were being placed in danger and I don’t think it has changed and that’s my view. (FG7GA).

During this time, it was reported by some service-users that the Gardaí treated them with respect and care and described acts of compassion for which they were very appreciative.

You know, the way you were treated and the way things were done and the way, you know, the guards talked to you and talked you in the station and all that... when I look back on that I think I was treated very respectfully and with great care. (FG8SU).
Nonetheless, some service-users experiences were frightening particularly when they were being taken from their home or public place by the Gardaí. Some described at the time that they felt they were under arrest; they described fear around the use of physical force to hold them and described the lasting impact of this.

*I was terrified, it was just the thought of, I felt like a criminal in handcuffs in the backseat of a squad car… I see those same guards every day around the town and I’m ...mortified and it still affects me because I see those guards and I know they know me...and I feel ugly (FG8SU).*

One service-user, in hindsight, acknowledged that the police had no option but to forcibly restrain the person in order to get them admitted to the hospital.

*The only way I was brought in was... they sat on top of me in the back of the squad car because they couldn’t hold me down and they couldn’t get me in to the car, so I had to be forced in. I went to thank them for what they did like, you know, and I said sorry if I hurt you or anything, and he said you’re all right, it’s part of the job. (FG8 SU).*

Sometimes when an admission for a service-user was initiated, it was needed ‘out of hours’ and many stakeholders described that it was challenging to get help at these particular times.

*You could imagine that...you have to get your son, a form signed on your son who’s psychotic upstairs in the bedroom and three days later you’re still waiting for somebody...you can’t even imagine what that would be like... awful. (FG1FM).*

Many family members reported not knowing where to get information and help from and described that this was a stressful time for them. There was also a perception across the key stakeholders (GPs, mental health nurses, family
members and Gardaí) that at this early point you were “on your own”, struggling to encourage others for help and assistance. These stakeholders described feelings of abandonment as they were left to deal with very challenging circumstances alone. In addition, for mental health nurses and GPs on occasions, this meant ‘going on your own’ into a persons’ home and into potentially unsafe situations.

*There’s a definite issue of safety for the GP... I was called out to a house once where even the relatives were afraid to go in there apparently, and me naively went in anyway to find the man almost naked in the kitchen with a whole load of knives sticking in to the lino [floor covering] in a semi-circle...I didn’t know what to do...I didn’t run because I thought if I ran he might pick one up and throw...*(FG3GPs).

GPs reported difficulties when they had to call to a person’s home unexpectedly in an acute crisis. This meant that this unplanned visit was challenging for them and potentially unsafe, as they often had to leave very busy surgeries with unknown levels of acuity.

*But I think the timeframe involved, I think the fact that we’re not paid to do it has become a bigger and bigger factor because we’re kind of not paid to do very much these days and the fact that you could be two hours missing. So that’s one part of it, but, you know, you’re also possibly on your own with a busy waiting room full of patients, you’re not quite sure how sick they are and how safe is it to abandon ten people for one person who you might be chasing (FG3 GP)*

The Gardaí also felt abandoned by GPs and mental health services. They described situations when they were extremely concerned about a person’s wellbeing, had information that indicated the person was at grave risk, but were unable to seek medical help that they believed necessary.
We brought her to the [police] Station, we weren’t able to get a doctor that night... three days beforehand she was found by a farmer inside in a field, she’d parked her car and she’d an exhaust going...it was only by chance a farmer ... found her inside in the car. And we went to A&E and we’d to sit with her, we were there till five o’clock in the morning... So without a system that supports the person then it’s really very difficult. We just feel unsupported. (FG7GA).

They highlighted their duty of care to the public and described their feelings of vulnerability when left with people who they believed were at serious risk of harm, but were unable to persuade the on call GP of what they perceived as high risk.

It’s drilled in to us since we joined An Garda Siochana is we can’t walk away from those situations because it’s provided for in the Garda Siochana Act, the protection of life and property... so we’re very, very reluctant and very worried to walk away from that situation, even where X says there, the doctor says that person’s okay, we’ve, we feel that if we let them out that door that they’re going to go in the river and we’re going to have to answer to some, some parent somewhere along the road and the Garda ombudsman and the .....So without a system that supports the person then it’s really very difficult. We just feel unsupported. (FG7GA)

Many Gardaí were concerned about the time the process of involuntary admission took, they sometimes found themselves waiting in hospitals with service-users, while medical help was accessed.

It’s a lot about time as well like, I mean you want, it’s only such a small part of our job but it takes up such a big time – I’m not saying that in a negative way – but we could be half a night or a night or sometimes more dealing with somebody... you know, it’s down to time also because as the time is ticking on you’re getting further and further away and, you know, it’s a losing battle essentially (FG7GA)
They were concerned about the impact their prolonged absence had on already overworked colleagues. They also reported times when they had to hold a service-user within the police station for many hours while waiting for the on-call GP. It was often the case that the service-user was kept in a cell due to no other alternative accommodation for them, and police and GPs felt strongly that detaining service-users in the police station was not appropriate and were concerned that the experience could exacerbate levels of distress.

*From your talking to service users, that probably what you heard more than anything else – I know it’s what I hear more than anything else – is in relation to the whole patient situation is that they feel that the system is far too much based on drugs and not, and not enough talking. (FGT).*

GPs reported that there is sometimes a fine line between a public disorder issue and mental health problems, believing that at times the MHA 2001 was used inappropriately to deal with behaviours that were drug or alcohol related rather than mental ill health.

*I’ve just have the sense that…it’s easier have them sectioned than deal with them…And it’s an easy out for them (the Police) because if, if they’re committed then…They’re out of their hands. (FG2GP).*

Relatives also reported that the response time to access professional help was often overly long and particularly difficult when the person was perceived to be experiencing psychotic or manic episodes. They reported that they had to wait for hours, if not days, to get the person admitted to hospital.

*You could imagine that…you have to get your son, a form signed on your son who’s psychotic upstairs in the bedroom and three days later you’re still waiting for somebody…you can’t even imagine what that would be like…awful. (FG1FM)*
My mother had basically rang everyone to see, along the way, doctor, mental health team and then the Guards came ...then they sort of forced me in to the back of the squad car and brought me in to the hospital... and then I was held down and gave an injection and previous to all of this, six months before I’d given up my medication and I wasn’t on any medication and that’s part of the reason I went downhill as well ... (FG8 SU)

GP stakeholders were concerned about out of hours cover; nights and weekends were frequently the times when individuals most often became distressed and required admission. It was often the case that the GP on-call did not know the person, adding to the trauma for service-user and GP. Likewise, GPs responsible for the assessment reported that this component was the least time consuming aspect of the process; they were more concerned by the amount of time it took to access the relevant personnel and organise the transfer of the person in distress to hospital.

The actual assessment...that can only take five or ten minutes...It’s the logistics of getting...the patient to you – from that first phone call heart sink, saying ‘we think this person needs to be signed in’, you just know you’re whole day is ruined and the outcome may not be good for you or the patient or anybody else and it’s just that whole uncertainty. (FG3GP).

Transfer to hospital was an issue of concern across all stakeholders groups, including service users. The time for transfer could be 8 hours or more, and this added considerably to the stress on relatives.

The fact that it takes so long to get a company like X to be freed up and to travel that long distance to maybe a remote area in the west of Ireland ...It has been up to two or three days, not in all circumstances, but it has been that long...it’s always hours, it’s always hours and hours (FG4 MHN).
Service-users were often upset by the how public the transfer from their home was, by the number of people who arrived to get them to hospital, by the use of force, and lack of information available for family members.

Across stakeholder groups, there was a general frustration about how challenging it was for them to enact the admission process, get the person in distress to the hospital, find a relevant doctor, organise the transfer process and the responsiveness of the transfer team. Most stakeholders believed that a team approach to managing involuntary admission would be best, where GPs, Gardaí, mental health nurses, psychiatrists and a local admission team worked together to coordinate the transfer and admission process more effectively. Some stakeholders were able to describe instances when a team approach had been possible because of co-operation of local staff, and how it had enabled more timely and appropriate care for the person.

*a defined protocol around assessment...especially community assessment patients...obviously by definition, unstable patient...I think there should be resources in place where...it doesn’t have to be a team of six people...even if it was two (FG2GP).*

2. Detention under the Act

“Detention under the Act” describes stakeholders’ experiences of detention and has three sub-categories; 1) signing the application and the perceived impact on relationships, 2) information about the detention process and 3) the need for therapeutic care.

**Signing the application and the perceived impact on relationships**

The first sub-category describes stakeholders’ views on who should be the signatory to the application for admission. GPs, service-users, psychiatrists and family members all believed that being a signatory could impact negatively on relationships.
I was the one to go to sign the form because X was coping better with my son that particular night. And I remember thinking it was the end of the world that I had to sign my son into a psychiatric ward and I was very upset...Now when our son was still manic, he blamed me for putting him into the psychiatric ward. (FG1FM)

There are times then when the trust has just gone ... in that therapeutic relationship and it’s very difficult...where you’ve been the one to bring them in to hospital and to recover from that sometimes, that trust is gone (FG4CMHN),

Even when the service-user understood that the person signing the application cared about them and was doing this for their own good, these stakeholders expressed concerns about signing the application form and felt it would be best if done by someone else. Some GPs reported that being a signatory had sometimes resulted in the service-user changing GP on discharge and that this was more likely if the service-user did not believe the admission was required.

Service-users described the anger they felt towards the signatory even when they knew this was not justified.

Sometimes when people sign you in it has been... some people get angry with that person, if it’s your relative or if it’s... the Guards or if it’s the GP or whatever. (FG8SU)

In addition, this feelings of anger against a prior signatory had continued over time and family members, aware of this, were cautious of taking the responsibility of the role of signatory because of the apparent consequences.

I didn’t want to sign the form because I knew from a previous experience that she doesn’t talk to her father for this reason. And I was put under pressure to sign the form and I was destroyed, I couldn’t sign it because I knew that she would actually hate me for the rest of her life. (FG1FM).
It was evident from the descriptions given by service-users and family members, that the admission process for involuntary detention was very distressing. Some family members described being so traumatized by the experience that, when asked if they had been the signatory to the application, they really could not remember if they were or not.

*Because you’re in such a state. I remember being shown the Act, I remember hearing the word Act, section but I don’t know if I signed it or not (FG1FM).*

**Information about the detention process**

The second sub-category describes stakeholders understanding of detention. Some stakeholders, GPs, tribunal members, mental health nurses were more informed than others and a lack of information was a particular problem for relatives and service-users, who found the whole process confusing and ‘akin to struggling in the dark’. The stress of the process resulted in both the service-user and relative having problems in processing and remembering information.

*I’d say you are so traumatised by the admission and the first realisation that this [mental health problems] is now in your family. That you need to be told it a few times for it to go in. (FG1FM).*

For service-users this was sometimes compounded by cognitive dysfunction associated with mental illness resulting in a reduced ability to process information and understand what was actually happening.

*When you’re in a psychosis things start to, time starts to move very fast sometimes, then sometimes...Going through that intervention – I didn’t really understand it...(FG8SU).*

Some family members described how difficult it was to get information about the process and duration of involuntary detention and they stressed how important it was to know what was happening and what was likely to happen.
It’s not about support, it’s just about somebody actually explaining to you what’s happening...but to me it would have helped because it always seemed like everybody was just waiting to see, they knew the next steps, I didn’t and they were always waiting to see would they go and then all of a sudden you’re off on this rollercoaster and you’re going where did this come out of (FG1FM)

In terms of information it’s fragmented. Completely fragmented, there’s nowhere to go. I googled everything, I couldn’t find out anything...Give relatives some information or even to know where to turn to for help. (FG1FM)

Moreover, information at the time of admission was felt very important for some service-users. This would have lessened anxieties for them.

    I think what would have helped me was just maybe if there was a little more information about what the next step was, I know it can be traumatic for people sometimes when they hear it, to think oh my God are we going there. But for me it would have helped I think just to have known that ... this is a possibility because that was never really presented to me... (FG8SU)

Relatives were concerned that, due to patient confidentiality issues, they were not given full information about the person’s progress in hospital. They felt that they had an important perspective regarding the person’s illness and, as mental health issues affect the whole family, they believed that the sharing of information relating to the person’s condition is important but was not adequately addressed.

    Families are given no information because I completely understand that the person is the person they’re treating and they’re the patient. But it’s not like a normal illness. Everybody is affected by it. The whole family, not just the person that’s suffering (FG1FM).
They described the despair they felt when they could not get information.

_In the end in desperation I went to his GP ... and I said 'I just don’t know what to do because nobody is giving me any information, he’s informed them not to speak to me and they’re respecting his wishes’, which I understand, but he is in a psychotic state that really doesn’t make much sense (FG1FM)._ 

In addition, some stakeholders perceived that information sharing between GPs and psychiatrists was poor.

_I think there’s very poor communications between the psychiatrists and GPs. And I think now they’re not and now I’d know the primary care teams are not working but the psychiatric section do not sit on primary care teams, or have any input there at all. They, we as GPs and I suppose this is getting a little bit off it like. Certainly in our own area, the psychiatrists send out prescriptions which we are, well I don’t know if we’re obligated to fill them. Because it’s becoming more of an issue all the time, so we’re here with these patients and we know them and they spend two minutes in front of a psychiatrists (FG2 GP) _

_Well it comes down again to communication, that if you do sent somebody in who’s terribly unwell and their not kept, or sent out again. You may not know about it because they can go to the chemist and they can get enough medication to do them for a week. You’re not necessarily going to know they’re out again, unless somebody tells you, or you spot them in passing. (FG 2 GP)._ 

**The need for therapeutic care**

The third sub-category describes stakeholders’ perspectives of care while detained. Many stakeholders reported that the focus of care during the detention period was on medical management and expressed concern about the lack of talking therapies for the service-user.
... from your talking to service-users, that probably what you heard more than anything else – I know it’s what I hear more than anything else – is in relation to the whole patient situation is that they feel that the system is far too much based on drugs and not, and not enough talking. (FGT).

The days of detention under the MHA 2001 were described as long and boring with little to do.

when you were in hospital – one of the impressions that we get when we talk to people is really of not very much happening from week to week...The only thing I found was if you’re told the doctor is coming, the doctor is coming and the doctor sometimes doesn’t come like and it could be the weekend and you’re waiting on a Friday evening to see a doctor and maybe they’re just plámáising you or something to keep you quiet... to tell you the truth and not be telling you the doctor is coming on Friday when he actually doesn’t come to you... day is quite long ... (FG SU)

Given the impact of the loss of freedom had on the service-user, stakeholders agreed that it was essential that care focused on strategies for maintaining well-being with additional resources dedicated to facilitate therapeutic interventions.

Where on a practical level our activities in the acute unit are put to a halt when there is insufficient staffing. Staff to cover them. And I think I mean also when someone hasn’t their [own] clothes ... they can’t go to some of the activities ...they can’t. So they’re so, there needs to be some monies for those activities for, for people ... so I think there’s a number of resource issues .... I’m just thinking of, working in a kind of, well from forensic service in the past where there was a sort of an art therapist, drama therapist, music therapist ... every type of kind of therapy going...you compare it with an acute ward where you’d be lucky if you have any... They need something...(FG5 PSY)
Across stakeholder groups, there was a belief that some cases of involuntary detention could have been averted with better (or more appropriate) community support, if more resources were provided within the community for distressed people

_You were asking what could be done, I don’t really know what could be done but I just know from other situations, like in cancer care there’s always a liaison nurse that you have a nurse you can speak to._ (FG1 FM).

### 3. Experiences of the tribunal process

The category, “experiences of the tribunal process” focuses on the stakeholders’ experiences’ of the tribunal process and need for enhanced community resources. All stakeholders welcomed the opportunity for an independent review of a person’s involuntary detention by a tribunal and were of the opinion that the process in itself contributed, on the whole, to protecting human rights. There was consensus among stakeholders that the MHA 2001 did make it less likely that people who did not require detention, would be held against their will.

_(The Act) has definitely ensured that people’s human rights have been addressed and that we’re, we’re doing what we can to make sure that nobody is detained, incorrectly._ (FG5PSY)

_The new Mental Treatment Act was put in place... like it’s all about the patients’ rights and freedoms... their right to recourse to have what’s right done (FG4CMHN)._ 

Also, the psychiatrist stakeholders reported that tribunals had enhanced respect for the right to freedom, but highlighted that there were circumstances when the presence of a person at the tribunal was not appropriate, because the person did not have the capacity to understand what was happening due to cognitive dysfunction or psychosis.
I would have patients with dementia who would have sat next to me bewildered..., I would have maybe potentially have said in advance, ‘is it an essential that the patient attends’? And that, that depends very much on the Chairperson on the day (FG5PSY).

(the Tribunal) it’s very traumatic, exhausting, potentially bewildering for a paranoid patient, potentially frightening. (FG5PSY)

In addition some family members questioned the extent to which the tribunal process was working in the best interest of the service-user, when, in their opinion, the tribunal revoked the order before the service-user was well enough for discharge.

He (the Solicitor) was trying his best to get her off. Because he’s there for her rights. He doesn’t care, I said to him one day, I said to him why are you doing this, I said, sure you know well she’s not well. And he said it’s not about her being well, it’s about her rights. (FG1 FM).

Some tribunal members believed that the renewal period specified within the MHC 2001 shaped the period of detention rather than clinical necessity, as there was a tendency to use the maximum detention period once the detention period was confirmed.

I think the kernel of the issue is that once we are compelled to sign the renewal order, which could be for up to twelve months, whether we’re comfortable about it or not, if the evidence points to the fact that we have to sign it the nub of the problem is that nobody, and I mean nobody, except the treating psychiatrist can revoke it. (FG6TM)

Some stakeholder groups were also concerned about the impact of tribunals on service-user relationships with their treating psychiatrist, especially if the tribunal was conducted in an adversarial way. Stakeholders had experience of tribunals that worked positively for service-user and others that did not. Those
that did not were described as adversarial with solicitors setting out to “win a case”

*There are still some of our colleagues that take it, like you said earlier about winning and losing, like as if it’s trying to get someone off a drunk driving case. (FG6TM).*

*But the more adversarial they are, the more overt we have to be, the more you know, definite and strong... and that can be very distressing to patients. (FG5PSY).*

In these tribunals, a robust response from the psychiatrist was required and this was seen as sometimes damaging to the client-clinician relationship.

*And sometimes it can be quite destructive to the, and I suppose therapeutic relationship between the consultant and their patient where you have the legal rep in an adversarial way kind of challenging the consultant about decisions about treatment or about you know, an assessment they might have done on a particular day or whatever. So sometimes it can be quite, inappropriate and adversarial. And counter therapeutic to the whole, I suppose, the whole idea of the process you know, where it’s supposed to be affirming of the patient and what, you know, that it’s actually just been, sometimes mischievous almost (FG5PSY).*

There was a consensus across all stakeholders that training for tribunal members, solicitors and clinicians was a necessity. It was reported that there should be a review of performance of solicitors at tribunals and a careful choice of those with the skills to work in the best interest of service users. Other stakeholders suggested that the conduct of the chairperson of the tribunal was as important as the training of tribunal members.
The earlier point about the attitude of legal reps ... we’ll never be able to change that in training, probably never will but it’s how the Chair ... actually moderate the process and make those key decisions about what information is shared or who’s present. (FG6TM).

Some tribunal member stakeholders believed that the wording for revoking a detention order could be misleading for the service-user.

*We had a Tribunal yesterday and the interesting thing was that we revoked the Act, which is quite unusual but when we were filling out the form in order to say that we’d revoked the order we had to say this person does not have a mental illness. Whereas we weren’t saying that, we were saying that we were revoking this order because there was no need for the person to be involuntary...we had to explain to the patient well we know it says that you haven’t got a mental illness but that’s in terms of the legal definition of a mental illness, in fact you do have an issue. (FG6TM).*

In addition, across stakeholders a number also believed that tribunals should include the perspectives of other members of the multidisciplinary team (MDT) in order to get a more holistic perspective to support decision-making.

*I would love to see more personnel coming in to the tribunals. We only meet the treating psychiatrist...and yet we’re supposed to be dealing with a situation where there are a number of personnel involved, like the OT or the social worker or – I mean it would help us make decisions if we knew what... the care plan was going to be... and we don’t hear anything about the socio-economic supports. (FG6TM).*

Some professional stakeholders also suggested that tribunals should facilitate other members of the multidisciplinary team and family members to attend the tribunal hearing, citing positive experiences of this in other jurisdictions. Differences emerged around the appropriate number of days that a person should be detained before a tribunal is held. Psychiatrists and tribunal members
felt the time under the present MHA 2001 was too short, while service-user felt it was too long.

_Justify keeping them in involuntarily whereas at three weeks very often... it’s, sort of obvious that they still need further treatment... patients with no insight and they, play up, put on a show for the Tribunal and sometimes it’s very difficult to justify._ (FG5PSY)

_I feel that twenty-one days is a bit short, for the first Tribunal, that if it was twenty-eight, you know, that a patient might have a better chance._ (FG6TM).

Psychiatrist stakeholders suggested that the timeframe of assessment by a consultant within 24-hours of admission was difficult to meet.

_The 24 hour timeframe can be very difficult...it’s very tight...It is extremely tight._ (FG5PSY)

Psychiatrists and mental health nurses reported that there was no mechanism at present to compel a service-user to undergo treatment outside the hospital environment, and this was of concern because this sometimes prolonged detention. They highlighted the need for a legislative mechanism to enable this and some stakeholders suggested that the use of community treatment orders (CTOs) may be one way of dealing with this problem and could lessen the time that the service-user were detained in hospital. There was agreement across stakeholders regarding the lack of adequate services in the community, which impacted on the numbers of people involuntarily detained and contributed to increased duration of hospital stays. Furthermore, many stakeholders believed that without good community support services in place, including housing, relapse was more likely.
Discussion

Similar to previous research with service users, where the majority perceived their involuntary admission as justified and conferring benefit for their mental health difficulties (O ‘Donoghue et al., 2011), this study demonstrates that other groups of stakeholders involved in the process generally believe that involuntary admission of patients under the MHA 2001 confers benefit to patients. In addition, these stakeholders reported that the MHA 2001 ensures an independent and fair review of patients' detention and supports their right to consent or refuse treatment, which is in keeping with findings related to mental health legislation in other European countries (Fiorillo et al., 2011).

However across both descriptive and focus group investigations, the study identified substantial concerns that stakeholders had with the operation of the Act in practice. In particular stakeholders reported difficulties obtaining help at the early phases of the admission process. Relatives highlighted a lack of information and awareness as to where to go for support. Similar to some other studies (Jepsen et al., 2010; Kelly et al., 2011; Jankovic et al., 2011; Røtvold and Wynn, 2015), the involuntary detention process was reported to be complex, burdensome and associated with distressing time delays in organising the transfer and transport of service-users to hospital. A previous study reported concern from GPs in relation to the time required to organise service user transfer to approved centres under the MHA 2001 and the distress this can cause to service users (Kelly et al., 2011). In corroboration of this, service users in this study reported that being taken involuntarily from their homes or public areas was a particular distressing experience and had a long lasting negative impact. These findings reflect the international literature (Arrigo and Williams, 1999; Swartz et al., 2003; Van Dorn, et al., 2006). Concern in relation to the time required for service user transfer was shared across stakeholder groups. One potential contributory factor to the distress experienced by service users and the time delay in transferring patients to approved centres was the widespread use of out-sourced assisted admission teams rather than local staff, who are unfamiliar to the person and often require substantially more time to reach the
patient. This study suggests that the implementation of transfer of the individual to an approved centre by local mental health service staff familiar with patient, where this is possible, might ameliorate aspects of this distressing process.

This is the first study to evaluate the opinions of the Gardai in relation to the operation of the MHA 2001 and demonstrates substantial dissatisfaction with several aspects of the operation of the MHA 2001. In addition to concerns regarding the transfer of patients to approved centres, Gardai consistent with other stakeholders, expressed frustration with "paperwork" or "excessive legalities" (Jabber et al., 2011; Doherty et al., 2014). They were concerned with the appropriateness of clinical assessments being undertaken in a Garda station and expressed dissatisfaction with the availability of information and training. The EUNOMIA study examined service user's perspectives of involuntary admission across eleven European countries (not including Ireland) and recommended police involvement only when all other alternatives have been exhausted and appropriate training for police regarding both clinical aspects of the main mental health disorders and concerning the legal and administrative aspects of mental health laws (Fiorillo et al., 2011).

Despite the presence of the authorised officers’ function in the MHA 2001, family members still initiate the majority of involuntary admission orders in the present study and this is reflected in the figures nationally where 47% of applicants are family members (Mental Health Commission, 2015). However relatives reported a lack of information and awareness as to where to go for support and advice. Many stakeholders also reported that detention under the MHA 2001 negatively impacted on relationships between the signatory and service user. This finding is similar to that found by O’Donoghue et al. (2010) who reported that more than 25% of people admitted involuntarily under the MHA 2001 felt the experience had negative consequences on relationships with families and health professionals. The quality of relationships between service users and treatment teams is crucial to care (Sheehan and Burns, 2011; O’Donoghue et al., 2011a). However in only 4 cases during the study period was the application made by an authorized officer. Although the use of authorized
officers is gradually being expanded and now accounts for 13% of applicants nationally (Mental Health Commission, 2015), it remains the least common applicant category. Of note, the Expert Group reviewing the operation of the MHA 2001 recommend that there should be a more expanded and active role for AOs, including accessibility to AOs 7 days a week (Department of Health, 2015). The current study provides further support from stakeholders’ views for much greater use of authorised officers as applicants.

Family members expressed greater dissatisfaction compared to other stakeholders regarding care in hospital benefiting service users and the review process of their relatives’ detention being fair. Potentially, this may reflect family members having limited involvement in their relative’s care after they are admitted to an approved centre and that they usually have no role in the tribunal process. Family members would like more information regarding the progress of their relative in hospital, a finding previously reported in the United Kingdom (Jankovic et al., 2011). This study supports the need for more extensive psycho-education and engagement of family members throughout their relatives’ admission and suggests that it might be desirable if family members were more regularly invited to attend mental health tribunals with the person’s consent.

Both service users and relatives perceived a lack of information regarding admission under the MHA 2001 whilst in hospital, a finding also previously reported in other jurisdictions (Olofsson and Jacobsson, 2001). Access to appropriate information is beneficial for self-management and recovery (Baines and Wittkowski, 2013) and thus ascertaining effective ways of providing this information should be identified.

Although stakeholders reported that the MHA 2001 ensured an independent and fair review of patients’ detention, some concerns were expressed about the conduct of mental health tribunals. Some stakeholders felt that the tribunal process could be confrontational and were concerned about the negative impact this had on service-user relationships with the treating psychiatrist, a finding previously reported (Jabber et al., 2010). Further training for all those involved in mental health tribunals might ensure that, as well as human rights being
upheld, the process should minimise any adversarial interactions, keep the focus on the best outcome for the service-user and present information in an understandable way for the service user.

Conclusions of Study 3

The study demonstrates that certain key components of the MHA 2001, providing care and respecting rights, are achieved in practice according to stakeholders. However, substantial process difficulties for stakeholders exist in the implementation of MHA 2001, particularly at that most distressing period of clinical assessment and transfer to hospital, with the stakeholders involved in this aspect of the process expressing highest levels of dissatisfaction. While no system will meet with universal approval across all stakeholders, additional service related supports are likely to improve the negative experiences, especially during the critical phase of assessment and transfer of patients to hospital. These include increased training and information, support and resourcing of local assisted admission services and carer support workers. Authorized officers should be the norm, rather than the exception, for completing the initial community assessment and application, and consequently providing this service 'out of hours' should be prioritized. It is also likely to have a beneficial effect on relations between the person and their families or carers. Such resources require no additional legislative change, but are of potentially of substantial benefit to patients and key stakeholders.

Education and information for the service user and carers should be provided throughout the different stages of involuntary admission and repeated as appropriate, given the likely impact that distress and cognitive dysfunction will have on absorbing and processing information which may be complex and difficulty to digest, for example relating to the powers and processes of mental health tribunals. The experience of mental health tribunals could be improved by training participants to minimize the adversarial nature and implementing more inclusive processes, where relatives and other members of the multidisciplinary team are invited to attend with the person’s consent. Better therapeutic
outcomes and community engagement with service users are more likely in a process that empowers people to take more control over their lives. The experiences of the stakeholder groups reported here suggest that such additional measures could be helpful to alleviate the distress associated with the traumatic process of involuntary admission, and further research should be conducted to identify the optimal supports which will facilitate this.
Chapter 6. Summary and Recommendations

Study summary

Coercive care through involuntary admission to an inpatient psychiatric ward and associated treatment, frequently without informed consent, is applied to over 2,000 service users nationally each year in Ireland. The intention of service providers is to reduce the immediate risk of harm and/or deliver care to those assessed as lacking capacity to consent to their admission and treatment. However the experience is often traumatic for service users who struggle to understand why they are being subjected to this deprivation of liberty and withdrawal of their autonomy over their bodily integrity and choice of care. The implementation of coercive care is also often difficult and distressing for relatives and carers and for the various professional stakeholders involved in the processes. The MHA 2001 introduced several reforms which brought Irish legislation into line with international human rights standards, including the automatic right to legal representation and independent review of detention. The current research programme assessed how the MHA 2001 actually operates in practice from the viewpoint of service users and other stakeholders involved in its implementation.

When assessed objectively using standard psychometric instruments approximately 3 months after involuntary admission, service users demonstrated substantial symptomatic and functional improvement since their inpatient admission. Most individuals viewed their involuntary admission as necessary in retrospect. Levels of satisfaction with care were moderate during involuntary admission and improve further by the time of symptomatic recovery. However attitudes towards care and treatment varied widely with many negative attitudes persisting, especially in relation to assessment in the community, the information provided about detention and medical treatment, and fairness of mental health tribunals. The strongest
predictors of more positive attitudes towards involuntary admission and treatment tended to be clinical factors such as level of awareness of illness, symptomatic improvement, diagnosis and absence of illicit substance misuse, as distinct from service related factors such as experience of actual coercive measures, whether an admission order was completed, length of involuntary admission and whether the admission order was reviewed by a mental health tribunal. Individuals who are likely to display these clinical features and have persistent negative attitudes can therefore potentially be identified and offered additional supports. One third of individuals transferred to or prevented from leaving inpatient psychiatric units under the MHA 2001 are clinically assessed by consultant psychiatrists as not detainable, but no information is systematically collected about these individuals despite having been subject to coercion.

Consistent across the studies was that substantial dissatisfaction with the processes were experienced by service users and stakeholders involved in the community assessment and transfer of individuals to hospital. Service users and other stakeholders identify lack of information and emotional support at critical points in the process as a major issue, including prior to admission, around treatment with medication and the tribunal experience. On top of their mental disorder, service users often suffer from the additionally traumatising impact of disempowerment throughout the process, which can contribute to persistent anxiety after the admission. The positive experiences during detention that were recalled by service users tended to centre around kind and humanising care experienced in interactions with professionals. A central theme encompassing the loss and regain of control was identified as characterising the service user experience of detention, and indicates that therapeutic efforts by professionals implementing the processes should, as well as providing care and treatment for the disorder, focus on supporting individuals in their efforts to regain and maintain control through acts of emotional support and compassion, enhanced accessible information provision and maximizing service user choice where feasible. Increased training and information for other
stakeholders, support and resourcing of local assisted admission services, authorised officers and carer support workers were identified as other key supports.

A summary of the study findings and preliminary recommendations were presented to a selected group of local and national stakeholder representatives at a seminar in Galway in October 2016, in order to garner initial feedback and refine the study recommendations. The following stakeholders and organisations were represented at this seminar and workshop: project steering group members, service users, consultant psychiatrists, general practitioners, psychiatric nurses, psychiatric social workers, occupational therapists, Community Health Organisation management, independent psychiatric hospital management, clinical governance representatives, authorised officers, an Garda Síochána, Irish Advocacy Network, Mental Health Reform, Grassroots Forum and the Mental Health Commission. After presentation of the study findings, the attendees at this seminar divided into workshops and discussed each recommendation in turn. The project steering group then refined the recommendations in the light of this initial feedback from key stakeholders and finalised the following 15 recommendations:

**Study recommendations**

1. **The Mental Health Commission should instigate a process to ensure that information is collected through each approved centre on all service users subject to MHA 2001, even when an involuntary admission is not completed.**

   Unlike those actually admitted involuntarily, about 30% of service users who are subject to coercive care under MHA 2001 for periods of up to 24 hours (commonly transferred to an acute inpatient unit by police or an assisted admissions team or prevented from leaving a ward by staff) have
no information about their presentation, clinical characteristics or experience of coercive practices systematically recorded.

2. **National agencies engaged in health services research, including the Health Service Executive and Health Research Board, should support research to assess the impact of any interventions on involuntary admission rates and on attitudes and experiences of service users and other stakeholders towards the involuntary admission process.**

   The studies conducted in the current research programme are entirely observational. It is unknown whether proposed interventions or alterations to resources and practices, even though apparently sensible and well meaning, will be effective at improving the experience and attitudes of service users and other stakeholders unless they are subject to systematic and high quality research. Unawareness of illness is an inherent component of many psychotic disorders, which are responsible for 80% of involuntary admissions, and was a predictor of negative attitudes to care in the current study. Some individuals with persistent unawareness of illness may have continued negative attitudes towards any coercive care despite the efforts of stakeholders to promote humanising care, accessible information and restore control; research is required to identify the characteristics of those individuals most likely to respond positively to interventions.

3. **The Mental Health Commission, with support from the Health Services Executive (HSE), should ensure that accessible information is made readily available for all stakeholders involved with the MHA 2001 processes, including service users/families/GPs/gardai, via website and training resources.**

   A consistent source of negative attitudes of service users and other stakeholders, especially those involved in the assessment and transfer process, was the difficulty in accessing information in a clear and readily accessible format.
4. Mental health service providers, including HSE and private services, should ensure that clinical staff are further trained to implement the most humanising and autonomy-enhancing care for service users at each stage of the involuntary admission process. Training should be mandatory and highlight the additional trauma that service users experience though care being provided coercively.

The qualitative research with service users highlighted the additionally traumatising impact of coercive care upon individuals already suffering an exacerbation of mental disorder, and its impact in loss of control and autonomy. Additional awareness of service providers about the often ongoing negative impact of coercion could help in the provision of more therapeutic care.

5. All clinical staff should focus on supporting service users to regain and maintain their autonomy and sense of control throughout the involuntary admission process.

Given the central theme of loss and regain of control that service users must navigate through an episode of coercive care, at the forefront of staff interactions should be assisting service users in this process, including through acts of emotional support and compassion, enhanced accessible information provision and maximizing service user choice where feasible.

6. All committees considering system reforms and staff training on the involuntary admission process should have adequate levels of representation by service users and family members who have experience of the involuntary admission process.

Representation by these key stakeholders, including those with positive as well as negative experiences of involuntary admission process, would help to inform the work of policy makers and service providers and enhance practical effectiveness.
7. **The HSE should ensure that authorised officers become the norm rather than exception for community assessments and are available at all times.**

The current situation where the most distressing and difficult component of the involuntary admission process, assessment and transfer to an approved centre, is performed by those stakeholders with the least experience of MHA 2001, family members and GPs, should be abandoned and the use of authorised officers should be greatly expanded. The authorised office should then liaise with an identified clinician coordinator in the approved centre regarding the optimal transfer process if an application for involuntary admission is made.

8. **Support available for service users at each stage of the involuntary admission process should include a support representative of their choice, such as an advocate or peer support worker.**

Service users subject to coercive care by Gardai or mental health service staff may be unable to accept emotional support from these same individuals, and their sense of control and autonomy could be enhanced by the offer of a support representative of their own choice.

9. **Use of national assisted admissions service should be minimised, so that it is a last resort in exceptional situations, and instead assisted admissions should be funded for implementation by staff familiar with the service user where this is possible.**

The sudden appearance of unfamiliar staff for the purposes of transfer to an approved centre tended to heighten the distress and powerlessness experienced by service users. An identified clinician coordinator from the local service should liaise with the applicant regarding the optimal transfer, which should be conducted with the assistance of familiar staff where possible.
10. Accessible information about involuntary admission and rights should be delivered in context and repeated as necessary to service users and family members by mental health service staff.
Service users and relatives are often in distress, suffering from cognitive dysfunction and unable to fully understand and absorb information. Information must be delivered over time and in a context appropriate manner to assist individuals in understanding the often complex information regarding their rights, the involuntary admission processes and safeguards.

11. Service users should be provided with the opportunity to discuss their experience of the involuntary admission process with members of the multidisciplinary team.
As well as providing care for the particular mental disorder, clinicians should be aware of the additional distress that being subject to coercive care imposes on service users and provide space and support for service users to discuss their concerns and reactions to this.

12. Chairpersons of Mental Health Tribunals should ensure that all reasonable steps are taken to minimise any adversarial elements of tribunal hearings.
An emphasis on inquisitorial rather than adversarial practices in mental health tribunals would help emphasise to all that the rights and best interests of service users are paramount, and protect the therapeutic relationship between service users and consultant psychiatrists, often already under strain due to the experience of care being delivered coercively.

13. The Mental Health Commission should instigate a process for feedback by service users and other stakeholders into their experience of Mental Health Tribunals.
At present there is no systematic way for service users or other stakeholders to feedback their experience of this process or any complaints they may have about the conduct of their tribunal.

14. **Mental Health Tribunals should welcome other stakeholders, such as a support person chosen by service user, family members or nonmedical clinical staff to attend tribunals, if requested by the service user.**

The presence of other clinicians, supportive individuals and a forum for carer concerns, could help dissipate any adversarial dichotomy between the service user/their solicitor and the consultant psychiatrist that may emerge at tribunals.

15. **Clinical teams should ensure that each service user subject to involuntary admission should have a documented multidisciplinary aftercare plan to include wellness maintenance and crisis intervention intended to reduce the likelihood of involuntary readmission, whilst maximising the individual’s efforts to maintain control and autonomy.**

Over half of the research participants had previously been subject to an involuntary admission and the experience of involuntary admission often brings additional challenges to service users engaging with community care, as they seek to regain autonomy after this distressing and disempowering experience. These additional factors flag individuals who have been detained as deserving individual aftercare plans, to be shared between clinical team members, service users and carers, that include steps to reduce the likelihood of recurrent involuntary admission.
References


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Lidz, C. W., S. K. Hoge, W. Gardner, N. S. Bennett, J. Monahan, E. P. Mulvey and L.


Appendix 1. Attitude scale (Study 1)

1. My admission to the psychiatry ward was necessary
   No, Definitely not-----No, Not really--------Yes, generally--------Yes, definitely

2. An adequate assessment about my need for hospitalisation was performed before my transfer to hospital
   No, Definitely not-----No, Not really--------Yes, generally--------Yes, definitely

3. My rights and dignity were respected during my transfer to hospital
   No, Definitely not-----No, Not really--------Yes, generally--------Yes, definitely

4. I felt safe during my transfer to hospital
   No, Definitely not-----No, Not really--------Yes, generally--------Yes, definitely

5. I felt my human rights and dignity were respected on arriving in hospital
   No, Definitely not-----No, Not really--------Yes, generally--------Yes, definitely

6. I felt safe in hospital
   No, Definitely not-----No, Not really--------Yes, generally--------Yes, definitely

7. I felt my human rights and dignity were respected during my involuntary admission on the psychiatry ward
   No, Definitely not-----No, Not really--------Yes, generally--------Yes, definitely
8. I felt that I was given adequate information about the legal process of involuntary admission and my rights under the Mental Health Act

No, Definitely not-----No, Not really--------Yes, generally-------------Yes, definitely

9. I did not feel threatened in any way during my admission

No, Definitely not-----No, Not really-------Yes, generally----------Yes, definitely

10. I felt I could talk to staff about my feelings regarding involuntary admission

No, Definitely not-----No, Not really-------Yes, generally----------Yes, definitely

11. I felt forced to take medication

Yes, definitely--------Yes, generally-----No, Not really------------ No, Definitely not

12. I felt that I was provided with adequate information about why I was given medication and its intended benefits

No, Definitely not-----No, Not really--------Yes, generally------------Yes, definitely

13. I felt I was listened to and given a fair hearing at my Mental Health Review Tribunal(s)

No, Definitely not-----No, Not really--------Yes, generally----------Yes, definitely

14. I felt my solicitor appropriately represented my case at my Mental Health Review Tribunal(s)

No, Definitely not-----No, Not really--------Yes, generally----------Yes, definitely
15. I believe the Mental Health Review Tribunal(s) acted independently and objectively in its review(s) of my involuntary admission

No, Definitely not------No, Not really-------Yes, generally---------Yes, definitely

COMMENTS

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## Appendix 2. Semi-structured interview guide (Study 2)

<table>
<thead>
<tr>
<th>PRE-ADMISSION</th>
<th>ADMISSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explore perceptions of what caused them to come into hospital</td>
<td>With regard to your recent admission, tell me of what happened to cause you to be admitted to hospital?</td>
</tr>
<tr>
<td>Reactions</td>
<td>How did you feel</td>
</tr>
<tr>
<td>Information</td>
<td>What did you think was happening</td>
</tr>
<tr>
<td>Information</td>
<td>What was it like for you when you first arrived at the hospital?</td>
</tr>
<tr>
<td>Understand what the initial admission felt like for the person</td>
<td>Who was there?</td>
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<tr>
<td></td>
<td>How did you feel?</td>
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<tr>
<td></td>
<td>Did you understand what was happening?</td>
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<td></td>
<td>Did you feel like you knew what was going on?</td>
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<td></td>
<td>Was there anyone or anything that</td>
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<tr>
<td>HOSPITAL STAY</td>
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<td>-----------------------------------------------------------------------------</td>
<td></td>
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<tr>
<td>Explore experiences of hospital stay</td>
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<tr>
<td>Identify the factors that impacted on experience:</td>
<td></td>
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<tr>
<td>People</td>
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<tr>
<td>Medication</td>
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<tr>
<td>Other treatments</td>
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<tr>
<td>Other patients</td>
<td></td>
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<tr>
<td>Relationships</td>
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<tr>
<td>To explore if admission affected their relationships with family, psychiatrists, staff and advocates</td>
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<tr>
<td>Feelings about the admission</td>
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<tr>
<td>What was your stay in hospital like?</td>
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<tr>
<td>Was there anyone or anything that was helpful?</td>
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<tr>
<td>What made it difficult?</td>
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<td>Did you feel you were involved in decisions about your treatment?</td>
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<td>Did you agree with the treatment given to you?</td>
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<tr>
<td>What do you think about it now?</td>
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<tr>
<td>Did staff involve you in your care?</td>
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<tr>
<td>Can you give me an example?</td>
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<tr>
<td>Looking back, how do you feel about your admission now?</td>
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<td>what was helpful?</td>
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<tr>
<td>What made it better?</td>
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<td>What made it worse?</td>
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<tr>
<td>Was there anything that made it more difficult?</td>
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<td>Was helpful?</td>
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<td>What made it better?</td>
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<td>Was there anything that made it more difficult?</td>
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<td>Was helpful?</td>
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<td>What made it better?</td>
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<td>What made it worse?</td>
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<td>Was there anything that made it more difficult?</td>
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<td><strong>TRIBUNAL</strong></td>
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<tr>
<td>Did you know what the tribunal was for?</td>
<td>Did you attend a tribunal?</td>
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<td></td>
<td>What do you think the tribunal was for?</td>
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<td>Can you tell me what it was like?</td>
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<td>What preparation did you get for attending the tribunal?</td>
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<td>Who gave it to you?</td>
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<td></td>
<td>Who was there?</td>
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<td></td>
<td>Did you feel your views were represented?</td>
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<tr>
<td></td>
<td>What would have made the process easier for you?</td>
</tr>
</tbody>
</table>

Do you still think it was (was not) needed.

Is there anything else you think I should understand?

In light of your experience is there any advice you would give us to help others in the same situation?
<table>
<thead>
<tr>
<th><strong>POST ADMISSION</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Explore the experiences of person when discharged home?</td>
<td>What was it like immediately after hospital?</td>
</tr>
<tr>
<td></td>
<td>What has it been like since you left?</td>
</tr>
<tr>
<td></td>
<td>What is life like now?</td>
</tr>
</tbody>
</table>
Appendix 3. Focus groups research proforma (Study 3)

Focus Group interview guide for Families

Introduction
Welcome and thanks. Review and check with participants re: consent and sign consent form.

Introduce and tell about yourself.

Explain the purpose/context of the Focus Group

Context: The Mental Health Commission is interested in hearing your views about the extent to which the current Mental Health Legislation met your needs/expectations when your family member/relative was admitted to hospital under the Mental Health Act. We want to talk to you therefore about your experiences, sources of information, explore if the mental health act worked for you or not. The focus group will ask a series of questions related to your experience of the Act and will focus in particular around your experiences prior to admission of your relative to hospital, making the application, the process of admission to hospital and the discharge experience. The information you give us is confidential and no one person or place will be identified. We are only interested in your point of view of how this process worked and in trying to get it better in the long term.

Before Admission

Can you tell us about your first experience or other experiences of what happened when you family member/relative was becoming unwell
Were you aware of what you needed to do to get help

- What were your sources of information (if any)?
- Did you understand the process of involuntary admission?
- How did you find out about the mental health act?
- Were your options explored and explained to you, if so, by who?
- What would have helped you at the point when you were concerned and before the decision to admit your relative was made?
- Is there anything else that anyone wants to discuss around the experience prior to admission?

Making the Application
Can you tell us what happened when it was decided that your relative required admission, (how the application for admission was enacted)

- To what extent were you aware of the process required to enact admission
- If you were an Applicant, can you tell us what the process of being an Applicant was like
- Did you feel supported during the application for admission, if so, by whom
- What helped most
- What could have been done differently
- Is there anything else that anyone wants to discuss around the making of the application?

Being Admitted
Can you tell us what the admission of your relative was like for you

- Who was involved in the admission process?
- At your house, in hospital
• What helped most?
• Thinking about your experience is there anything that could have been done differently?
• What would have helped you?
• Is there anything else that anyone wants to discuss around the process of the admission to hospital?
• Do you have any comments about the care they received when in hospital?
• During the admission, your relative may have had an independent review of their involuntary admission by a tribunal – were you aware of this? Do you think this review worked well?

Being Discharged
Can you tell us about your experience of your relative being discharged from their involuntary admission

• Were you aware when the involuntary admission of your relative ended
• Can you tell us what happened and what it was like
• Did you understand the process
• What there any supports or information offered to you as a family member/relative
• Is there anything else that anyone wants to discuss around the discharge experience?

Overall is there anything that you think the Mental Health Commission should know about how the Act is currently working

Overall is there anything that should be changed to make this process better for families
Closing

What one thing would you want us know to help make the experience better for families?

Are there any issues that we have not discussed that you would like to raise?
Focus Group interview guide for GPs

Introduction
Welcome and thanks. Review and check with participants re: consent and sign consent form.

Introduce and tell about yourself.

Explain the purpose/context of the Focus Group

Context: The Mental Health Commission is interested in hearing your views/experiences of enacting the current Mental Health Legislation. We want to talk to you therefore about how the mental health act worked for you or not and your sources of information/training in relation to the act. In this focus group you will be asked a series of questions related to your practical experience of the Act, in particular around: your experiences of initiating / using the Act, issues for you in making an application, how you have found the process of pre admission to hospital and the information about the discharge of patients. The information that you will give us is confidential and no one person or place will be identified. We are interested in your point of view and plan to feed these back to the Mental Health Commission.

Can you tell us about your experiences of using the current Mental Health Act?

1. Can you think of a patient that you dealt with who was admitted as an involuntary patient under the ACT to an approved centre?
2. Can you tell us about your experience of informing that person and/or their family about the assessment process and application?
3. Can you tell us about the process of making that application?
4. Can you tell us about the forms you had to use? Prompts - where did you get them (that's if you are looking at sources as you mentioned in the introduction) were they user friendly if yes
explain how so? Were they difficult or cumbersome? If yes, explain why?
5. Can you tell me if you received any particular training on the working of the Act, if so, by whom?
6. Did you give a copy of the recommendation form to the applicant; what was that like?
7. Have you ever had a situation where a family wanted a person admitted under the act but you did not support their request? What was that like for you?
8. Have you ever had a family member request a second opinion when you refused to make a recommendation to admit a patient involuntarily to an approved centre? What was that like for you?
9. What was your experience of arranging the transfer of the patient to the approved centre? What was your role and was there any one else involved?
10. What works well about the Act in terms of having a patient admitted? What difficulties did you encounter? What would help this process be smoother in your opinion?
11. Relatives of people admitted under the Act suggest that they lack information about the Act, have you any suggestions as to how information for relatives could be made easier to access?
12. What is your understanding of Mental Health Tribunals? Do you have any comments on the Tribunal process?
13. What comments, if any, do you have on the communication process between the hospital and GPs in relation to a patient’s discharge from hospital?
14. Thinking about your experiences of using the Act is there anything that you think that needs to be changed? If so what might that be?
15. What were your sources of information about the Act? Do you feel that you are well informed? If not, what would help to improve your access to information?
Overall is there anything that you think the Mental Health Commission should know about how the Act is currently working for GPs or is it being used by GP’s in practice?

Is there anything else you would like to add?

Closing
Focus Group interview guide for Mental Health Nurses

Introduction
Welcome and thanks. Review and check with participants re: consent and sign consent form, demographics

Introduce and tell about yourself.

Explain the purpose/context of the Focus Group

Context: The Mental Health Commission is interested in hearing your views/experiences of enacting the current Mental Health Legislation. We want to talk to you therefore about how the mental health act worked for you or not and your sources of information/training in relation to the act. In this focus group you will be asked a series of questions related to your practical experience of the Act, in particular around: your role in initiating / using the Act (community mental health nurses only), issues for you in admitting and treating psychiatric patients involuntarily, how you have found the process of pre admission and discharge of patients. The information that you will give us is confidential and no one person or place will be identified. We are interested in your point of view and plan to feed these back to the Mental Health Commission.

Can you tell us about your experiences of using the current Mental Health Act?

1. Can you think of a patient that you dealt with who was admitted as an involuntary patient under the ACT to an approved centre?
2. Can you tell us about your experience of informing that person and/or their family about the necessity to admit him/her to an Approved Centre (community nurses)?
3. Can you tell us to what extent you are involved in the assessment process and application? Do you feel that you should get less or more involved with these processes?
4. Can you tell me if you received any particular training on the working of the Act, if so, by whom?

5. Have you ever had a situation where a family wanted a person admitted under the Act but you did not support their request or vice versa? What was that like for you?

6. What was your experience of arranging the transfer of the patient to the approved centre? What was your role and was there any one else involved?

7. What works well about the Act in terms of having a patient admitted? What difficulties did you encounter? What would help this process be smoother in your opinion?

8. How do you experience the first 24 hours of admitting patients involuntarily to an approved centre, until patients get assessed by a psychiatrist? Are there things that could be improved regarding this stage?

9. How do you experience the collaboration with guards regarding involuntary admissions? What difficulties did you encounter? What would help this process be smoother in your opinion?

10. How do you experience the application of involuntary interventions / treatment (i.e. involuntary medication, seclusion and restraint) under this Act?

11. What is the impact of patients' involuntary status on care plan, and inpatients' willingness to cooperate with the treatment?

12. Relatives of people admitted under the Act suggest that they lack information about the Act, have you any suggestions as to how information for relatives could be made easier to access?

13. What is your understanding of Mental Health Tribunals? Do you have any comments on the Tribunal process?

14. What comments, if any, do you have on the communication process between the hospital, GPs and family members in relation to a patient's discharge from hospital?

15. How could we ensure an efficient collaboration and adequate exchange of information between all parties involved in the
admission process, including between approved centre staff and primary care/community mental health services, and other relevant agencies, in order to guarantee continuity of care from admission to aftercare?

16. Do you have any suggestions on how involuntary admissions of psychiatric patients could be reduced or become a less intrusive experience for patients and their relatives?

17. Are there issues which you would like to raise in relation to your or patients’ safety?

18. Does your centre have a protocol for dealing with urgent referrals? If so, are the procedures described in this protocol clear and do you find it useful?

19. How do you find the administrative work/duties related to involuntary admissions?

20. Thinking about your experiences of using the Act is there anything that you think that needs to be changed? If so what might that be?

21. What were your sources of information about the Act? Do you feel that you are well informed? If not, what would help to improve your access to information?

Overall is there anything that you think the Mental Health Commission should know about how the Act is currently working for GPs or is it being used by GP's in practice?

Is there anything else you would like to add?

Closing
Focus Group interview guide for Consultant Psychiatrists

Introduction
Welcome and thanks. Review and check with participants re: consent and sign consent form, demographics

Introduce and tell about yourself.

Explain the purpose/context of the Focus Group

Context: The Mental Health Commission is interested in hearing your views/experiences of enacting the current Mental Health Legislation. We want to talk to you therefore about how the mental health act worked for you or not and your sources of information/training in relation to the act. In this focus group you will be asked a series of questions related to your practical experience of the Act, in particular around: your role in using the Act, issues for you in admitting and treating psychiatric patients involuntarily, how you have found the process of discharge of patients. The information that you will give us is confidential and no one person or place will be identified. We are interested in your point of view and plan to feed these back to the Mental Health Commission.

Can you tell us about your experiences of using the current Mental Health Act?

1. Can you tell us about your experience of informing patients or their family about the necessity for admission to an Approved Centre?
2. Can you tell us to what extent you are involved in the assessment process and application for involuntary admission? Do you feel that you should get less or more involved with these processes?
3. Can you tell me if you received any particular training on the working of the Act, if so, by whom?
4. Have you ever had a situation where a family wanted a person admitted under the Act but you did not support their request or vice versa? What was that like for you?

5. What works well about the Act in terms of having a patient admitted? What difficulties did you encounter? What would help this process be smoother in your opinion?

6. What comments, if any, do you have on the communication processes between the hospital, nursing staff, GPs, Gardaí and family members in relation to a patient’s admission to the hospital?

7. How do you experience the collaboration with Gardaí regarding involuntary admissions? What difficulties did you encounter? What would help this process be smoother in your opinion?

8. What are your views about the “awaiting assessment by consultant psychiatrist” stage for up to 24 hours after transfer to an approved centre? Are there things that could be improved regarding this stage?

9. How do you experience the application of involuntary interventions / treatment (i.e. involuntary medication, seclusion and restraint) under this Act?

10. What is the impact of patients’ involuntary status on their care plan, and willingness to cooperate with the treatment?

11. Does the patient’s involuntary status affect your therapeutic relationship with them on the inpatient unit? Should an independent clinician be the one to provide information about their status and rights under the Act?

12. Relatives of people admitted under the Act suggest that they lack information about the Act; have you any suggestions as to how information for relatives could be made easier to access?

13. Do you have any comments on the Mental Health Tribunal process?
14. What comments, if any, do you have on the communication processes between the hospital, GPs and family members in relation to a patient's discharge from hospital?

15. How could we ensure an efficient collaboration and adequate exchange of information between all parties involved in the admission and treatment process, including between approved centre staff and primary care/community mental health services, and other relevant agencies, in order to guarantee continuity of care from admission to aftercare?

16. Do you have any suggestions on how involuntary admissions of psychiatric patients could be reduced or become a less intrusive experience for patients and their relatives?

17. Are there issues which you would like to raise in relation to your or patients’ safety?

18. Does your centre have a protocol for dealing with urgent referrals? If so, are the procedures described in this protocol clear and do you find it useful?

19. How do you find the administrative work/duties related to involuntary admissions?

20. Thinking about your experiences of using the Act is there anything that you think that needs to be changed? If so what might that be?

21. What were your sources of information about the Act? Do you feel that you are well informed? If not, what would help to improve your access to information?

Overall is there anything that you think the Mental Health Commission should know about how the Act is currently working for psychiatrists or is it being used by psychiatrists in practice?

Is there anything else you would like to add?

**Closing**
Focus Group interview guide for Tribunal Members

Introduction
Welcome and thanks. Review and check with participants: consent and sign consent form, compete demographics questionnaire

Introduce and tell about yourself.

Explain the purpose/context of the Focus Group

Context: The Mental Health Commission is interested in hearing your views/experiences of enacting the current Mental Health Legislation. We want to talk to you therefore about how the mental health act worked for you or not and your sources of information/training in relation to the act. In this focus group you will be asked a series of questions related to your practical experience of the Act, in particular around: your role in using the Act, issues for you in reviewing the involuntary admissions of patients to hospital or psychiatric units. The information that you will give us is confidential and no one person or place will be identified. We are interested in your point of view and plan to feed these back to the Mental Health Commission.

Can you tell us about your experiences of using the current Mental Health Act?

1. Could you describe how the Mental Health Act is operationalized in context of your role? Could you give me an example of a recent case in which you were involved? What did you find particularly challenging?

2. What are your views on the tribunals? Have you attended many? In what capacity? What is positive about the tribunals? Are there things about the tribunal process that you think need to change? Do you think your views are heard by other members of the tribunal?
3. I’m interested in your perspectives on how service users legal and human rights are upheld during the admission process. Who provides the service users with information about the process? What do you see as your role or responsibility? To what extent do service users understand the process and their rights? Who advocates for them? When? How useful is this? What changes would you make (if any) if you could?

4. Do you feel that you act ‘in the best interests of the client” at all times during Tribunals?

5. In context of your role, what factors facilitate the implementation of the Mental Health Act in practice? What are the barriers to its implementation?

6. Can you tell me if you received any particular training on the working of the Act, if so, by whom?

7. How could we ensure an efficient collaboration and adequate exchange of information between all parties involved in the Mental Health Tribunal process?

8. Do you have any suggestions on how involuntary admissions of psychiatric patients could be reduced or become a less intrusive experience for patients and their relatives?

9. Thinking about your experiences of using the Act is there anything that you think that needs to be changed? If so what might that be?

10. What were your sources of information about the Act? Do you feel that you are well informed? If not, what would help to improve your access to information?

11. Is there anything else I haven’t asked that you think is important?

Overall is there anything that you think the Mental Health Commission should know about how the Act is currently working for tribunal members or is it being used by tribunal members in practice?

Is there anything else you would like to add?

**Closing**
Focus Group interview guide for Gardai

Introduction
Welcome and thanks. Review and check with participants: consent and sign consent form, compete demographics questionnaire

Introduce and tell about yourself.

Explain the purpose/context of the Focus Group

Context: The Mental Health Commission is interested in hearing your views/experiences of enacting the current Mental Health Legislation. We want to talk to you therefore about how the mental health act worked for you or not and your sources of information/training in relation to the act. In this focus group you will be asked a series of questions related to your practical experience of the Act, in particular around: your role in using the Act, issues for you in transferring patients to hospital or psychiatric units or in relation to their involuntary admissions. The information that you will give us is confidential and no one person or place will be identified. We are interested in your point of view and plan to feed these back to the Mental Health Commission.

Can you tell us about your experiences of using the current Mental Health Act?

1. Could you describe how the Mental Health Act is operationalized in context of your role? Could you give me an example of a recent case in which you were involved? What did you find particularly challenging?
2. What was your experience of arranging the transfer of the patient to the approved centre? What was your role and was there any one else involved? Who provided the service users with information about the process?
3. At the police station, to what extent do service users understand the process and their rights? Who advocates for them? What changes would you make (if any) if you could?

4. What works well about the Act in terms of having a patient admitted? What difficulties did you encounter? What would help this process be smoother in your opinion?

5. Have you ever assisted with the application of involuntary interventions / coercive measures such as seclusion and restrain? What was your role and was there any one else involved? How was this for you?

6. Are there issues which you would like to raise in relation to your or patients' safety?

7. In context of your role, what factors facilitate the implementation of the Mental Health Act in practice? What do you see as your role or responsibility? What are the barriers to its implementation? What changes would you make (if any) if you could?

8. Can you tell me if you received any particular training on the working of the Act, if so, by whom?

9. How could we ensure an efficient collaboration and adequate exchange of information between all parties involved in the Mental Health Tribunal process?

10. Do you have any suggestions on how involuntary admissions of psychiatric patients could be reduced or become a less intrusive experience for patients and their relatives?

11. What were your sources of information about the Act? Do you feel that you are well informed? If not, what would help to improve your access to information?

12. Thinking about your experiences of using the Act is there anything that you think that needs to be changed? If so what might that be?

13. Is there anything else I haven’t asked that you think is important?
Overall is there anything that you think the Mental Health Commission should know about how the Act is currently working for gardai or is it being used by gardai in practice? Is there anything else you would like to add?

Closing
Focus Group interview guide for Service Users

I am interested in your experience of involuntary admission, what happened and how you felt about it.

• Can you tell us what led up to your admission?

• If you remember your admission, can you tell us What happened? How did you feel?

• Who was there? Did you understand what was happening and why? Did you get an explanation about what was happening? At that time did you think your involuntary admission was needed?

• Overall, how did your involuntary detention affect you? How did it affect your relationship with your GP, doctors that were looking after you? How did it affect your relationship with family/friends?

• Did you attend a tribunal? If yes can you tell me what that was like? What preparation did you get for attending the tribunal? Who gave it to you? Who was there? Did you feel you views were represented? Did you feel you got an opportunity to speak?

• What was your stay in hospital like? How did staff manage your care? Do you feel you got the care you required? What has helpful? What was not helpful? Who helped you, did you feel you had a voice.

• Have you concerns about people knowing that you were in hospital and involuntary detained?

• Thinking about your experience, what advice would you give in order to improve the experience for others
• What would you like us to tell the MHC about what needs changed in the act.

• Is there anything else you think I should understand? Is there anything else I haven’t asked that you think is important?