Outcomes of inpatients detained under holding powers in an Irish Psychiatric Hospital

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A Comparative Case-Control Study

A thesis submitted to Trinity College Dublin, the University of Dublin for the degree of

Doctor of Medicine

Thesis presented by

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Declaration

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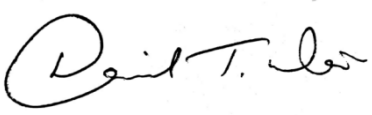
Signature: 

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First and foremost, I wish to acknowledge the patients of St Patrick's Mental Health Services. It is hoped that the findings in this study will form a meaningful contribution to the discussion around the use of holding powers in Irish psychiatric hospitals.

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Summary

This thesis comprises two research studies.

Study 1: Predictors and outcomes of detention under psychiatric holding powers

Objective: We aimed to characterise the use of the psychiatric holding power provided for in S.23(1) Mental Health Act 2001 (S.23(1)), investigate predictors for its initiation, and describe clinical outcomes for this patient group.

Methods: This retrospective case-control study characterised all voluntarily admitted patients (N=167) held under S.23(1) between January 2018 and December 2020 across two psychiatric hospitals in Dublin, Ireland. These patients were compared with a voluntarily admitted, never-held control group (N=334) with a one-year follow-up post-discharge.

Results: The use of the S.23(1) holding power was rare, occurring in approximately 2% of total admissions over the study period. Groups were similar with no significant difference in sociodemographic characteristics. The held group was more severely unwell on admission as measured by Clinical Global Impression – Severity scores ($P < .001$). Multivariable analysis demonstrated that detention under holding powers was more likely in the presence of impaired insight (OR 4.135; 95% CI, 2.46-6.94), psychotic symptoms (OR 7.56; 95% CI, 3.53-16.22), suicidal ideation (OR 2.58; 95% CI, 1.50-4.44) or diagnosis of bipolar disorder (OR 2.5; 95% CI, 1.34-4.46). Median length of stay (days) was longer for held patients (81.37 v. 45.74, $Z=-7.42$, $P < .001$), but Clinical Global Impression – Improvement scores did not differ between groups at discharge. There was no significant difference in one-year readmission rates between the groups.

Conclusions: Voluntarily admitted patients that become subject to S.23(1) present more severely unwell than those never held, with the likelihood of being held increasing in the presence of impaired insight, psychosis, bipolar disorder and suicidal ideation. Notwithstanding, the results suggest that outcomes for both groups are similar.

Study 2: Use of S.23(1) MHA 2001 and predictors for regrading to involuntary status

Objective: We aimed to describe the overall use of the psychiatric holding power provided for in S.23(1) Mental Health Act 01 (S.23(1)) over a three-year period, investigate the predictors for its regrading to involuntary status, and describe the clinical outcomes for this patient group.

Methods: This retrospective comparative cohort study described all initiations of S.23(1) on patients voluntarily admitted to two psychiatric hospitals in Dublin from January 2018 to December 2020. We then compared patients held under S.23(1) who were subsequently regraded to involuntary status (N=77) with those who were not (N=90), with a one-year follow-up post-discharge.

Results: S.23(1) was initiated 205 times across 167 admissions, with multiple uses occurring during a single admission in 27 instances. The majority of S.23(1) initiations (72.7%) were made by nursing staff, 53% occurred outside of normal working hours, and the median time between admission and initiation was 10 days. The median time to review by a consultant psychiatrist was 14 hours 59 minutes. 111/205 (54.1%) of initiations of S.23(1) were regraded to involuntary status. Of those 94 that were not, on 91 (96.8%) occasions the patient chose to remain in hospital voluntarily. Illness severity

at admission and the demographic and clinical characteristics of regraded versus non-regraded admissions were similar, with the only significant difference being age (*P* = .017). Multivariable analysis indicated that S.23(1) detention was more likely to be regraded when initiated during working hours (OR 3.95; 95% CI, 1.82-8.58), by a consultant psychiatrist (OR 3.67; 95% CI, 0.39-34.63) or if the patient had a diagnosis of bipolar disorder (OR 3.27; 95% CI, 1.19-8.99). There were no significant differences in total length of stay (days) or illness improvement scores between the groups at discharge, nor were there differences in one-year readmission rates.

Conclusions: Patients held under S.23(1) MHA 2001 are more likely to be regraded to involuntary status if diagnosed with bipolar disorder, if held during working hours, or if the S.23(1) initiation is made by a consultant psychiatrist. However, the results indicate that outcomes for both regraded and non-regraded groups are similar.

Output

Poster Presentations

"*Detention of voluntary patients to a university psychiatric hospital*" (Data from Study 2) presented at College of Psychiatrists of Ireland Spring Conference 2021.

Submitted papers:

"*Predictors and outcomes of detention under psychiatric holding powers*" (Study 1) submitted to *Psychiatric Services*. Revisions requested and manuscript resubmitted – January 2025.

Table of Contents

List of Tables

Table of Figures

List of Case-Law

1. *AC v CUH* [2018] IECA 217
2. *AS v The Clinical Director of St. Michael's Psychiatric Unit and HSE [2021] IEHC 447*
3. *E.H. v Vincent's Hospital & Ors [2009] IESC 46*
4. *Kavanagh v Governor of Mountjoy Prison [2002] 3 IR 97*
5. *Olaniran & Ors v Minister for Justice Equality and Law Reform [2010] IEHC 83*
6. *K.C. v Clinical Director of St. Loman's and HSE [2013] IEHC 310*
7. *PL v. Clinical Director of St. Patrick's University Hospital [2019] 2 IR 266*

List of Abbreviations

CGI	Clinical Global Impression Scale
CGI-I	Clinical Global Impression Improvement Scale
CGI-S	Clinical Global Impression Severity Scale
CSO	Central Statistics Office
EHR	Electronic Health Record
HSE	Health Service Executive
ICD-10	International Classification of Disease, 10th Revision
LOS	Length of Stay
MHA	Mental Health Act
MHC	Mental Health Commission
SPMHS	St Patrick's Mental Health Services

Chapter 1 : Introduction

1.1. Background

Admissions to psychiatric hospitals are typically classified dichotomously by their legal status: voluntary or involuntary (Poulsen, 1999). In Ireland, the difference between a voluntary and involuntary patient is prescribed by the Mental Health Act 2001 ("MHA 2001"). As per the MHA 2001, a "voluntary" patient means a person receiving care and treatment in an approved psychiatric hospital who is not the subject of an admission order or a renewal order. However, the narrow focus of existing research on voluntary and involuntary admissions has been criticized for overlooking that cohort of patients who are initially admitted voluntarily but are subsequently detained *during* their hospital stay (Nicholson et al., 1996).

The legislative processes by which voluntarily admitted psychiatric patients may be subsequently detained varies from jurisdiction to jurisdiction (see paragraph 1.7). In Ireland, the relevant legislative provision is S.23(1) of the MHA 2001 ("S.23(1)"). S.23(1) provides a legal mechanism for the temporary detention of voluntary patients who wish to discharge themselves from approved psychiatric hospitals against medical advice in specific circumstances, namely that the staff of that hospital are of the opinion that the person is suffering from a mental disorder. Under S.23(1), a patient may be temporarily detained for up to 24 hours pending review by their responsible consultant psychiatrist. If this consultant and another consultant psychiatrist both agree that the patient should continue to be detained involuntarily, an order is issued for their involuntary admission. However, not all patients temporarily detained under S.23(1) are regraded to involuntary status and those that are not may choose to discharge from hospital or remain voluntarily.

In England and Wales, similar provisions for the temporary detention of voluntary patients are established in the amended Mental Health Act 1983 and are commonly referred to as "holding powers". In the absence of a formal legislative descriptor for the temporary detention powers provided for by S.23(1), this thesis proposes to refer to these powers generally as "holding powers" and to patients temporarily detained under them as being "held" or

subject to a “hold". The duration permitted under these provisions will be referred to as the “holding period”.

Holding powers are prevalent worldwide. While the statutory language varies across jurisdictions, many, including Ireland, are activated where there are concerns regarding the presence of a mental disorder when a patient wishes to discharge against medical advice. Despite the extensive research on predictors and outcomes for involuntarily detained patients (Karasch et al., 2020; Katsakou & Priebe, 2006; van der Post et al., 2014; Walker et al., 2019) there is relatively little understanding about voluntarily admitted patients who become subject to holding powers as a distinct population and the outcomes associated with this group.

1.2. Current Irish Mental Health Legislation

In November 2006, the Mental Health Act 2001 (Approved Regulations) 2006 brought into force the provisions of the MHA 2001. The MHA 2001 replaced the involuntary admission procedures provided for by the Mental Treatment Act 1945 as well as several other Acts of the Oireachtas including the Mental Treatment (Detention in Approved Institutions) Act 1961, the Mental Treatment Act 1961 and the Health (Mental Services) Act 1981.

The MHA 2001 provides a legislative framework for the admission, detention and treatment of persons with a mental disorder in designated psychiatric hospitals (referred to as approved centres) around Ireland. It contains provision for the independent psychiatric assessment of these involuntarily detained patients as well as Mental Health Tribunals to review the legality of their detention. Section 33 MHA 2001 further provides for the establishment of the Mental Health Commission (“MHC”), a statutory body whose primary functions are to “*promote, encourage and foster the establishment of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres*”.

1.2.1. Section 23(1) MHA 2001

S.23(1) MHA 2001 provides for the temporary detention of voluntary adult patients treated in approved centres under specified circumstances. This provision may be invoked by certain categories of staff at the approved centre, including a consultant psychiatrist, registered medical practitioner or registered nurse, to prevent a voluntary patient from leaving where they have indicated a wish to do so. If the member of staff is *of the opinion* that the voluntary patient is suffering from a *mental disorder* (as defined by the MHA 2001), the patient may be temporarily detained for up to 24 hours pending review by their responsible consultant psychiatrist.

"Mental Disorder" is defined under the MHA 2001 to mean mental illness, severe dementia or significant intellectual disability where –

(a) Because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons,

OR

(b) (i) Because of the severity of the illness, disability or dementia, the judgment of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission

AND

(ii) the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent.

1.2.2. Outcomes of S.23(1) Orders

When a person is detained pursuant to S.23(1), S.24(2) MHA 2001 stipulates that the consultant psychiatrist responsible for the patient's care must either (a) discharge the patient or (b) arrange for the patient to be examined by another consultant psychiatrist (see Figure 1-1).

In the first instance, if the decision is made to discharge the patient in accordance with their wishes, the responsible consultant psychiatrist completes the relevant Clinical Practice Form (*Form: Power to Prevent Voluntary Patient (Adult) From Leaving an Approved Centre*) (see Appendix A). This form is then filed in the patient's clinical file at the approved centre. The Clinical Practice Form indicates that it *may* be required for inspection at a future date by the Inspector of Mental Health Services, a Mental Health Tribunal or the MHC. However, there is no statutory obligation for approved centres to notify the MHC of initiations of S.23(1) following the completion of this form.

In the second instance, if the responsible consultant psychiatrist is of the opinion that the patient should remain in hospital against their wishes, they must complete Part 1 of Form 13 (*Certificate and Admission Order to Detain a Voluntary Patient*) (see Appendix A). Additionally, they are required to request the opinion of a second consultant psychiatrist, who will then complete Part 2 of Form 13. There are two potential outcomes following this review by the second consultant psychiatrist review:

(1) Where the second consultant psychiatrist is *satisfied* that the person is suffering from a mental disorder, they shall certify, under Subsection 24(2)(a) MHA 2001, that it is their opinion – based on the presence of such a mental disorder – that the person should be detained in the approved centre. The responsible consultant psychiatrist must then complete Part 3 of Form 13, which serves as an admission order for the reception, detention and treatment of the person in the approved centre. Once the admission order is complete, the person becomes an involuntarily admitted patient (MHC, *Reference Guide to MHA 01*) (MHC, 2005). Additionally, within 24 hours of completing Form 13, this form must be notified to the MHC.

(2) Alternatively, if the second consultant psychiatrist is *not satisfied* that the individual is suffering from a mental disorder, the person should be immediately discharged from the hospital. However, they may choose to remain in the approved centre as a voluntary patient if they wish. In this case, Part 3 of Form 13 (the admission order) is not completed, and this form is filed in the patient's clinical notes. As no admission order is completed, there is no statutory requirement on the approved centre to notify the MHC of the holding period that was not progressed to involuntary.

Thus, an involuntary admission order under Part 3 of Form 13 can only be issued when both consultant psychiatrists agree that the person held under S.23(1) is suffering from a mental disorder. This admission order must then be notified to the MHC.

In cases where a patient is detained under S.23(1) but no subsequent involuntary admission order is issued – due to either the first or second consultant psychiatrist being unsatisfied that the person is suffering from a mental disorder – there is no statutory obligation notify the MHC of that period of detention. Instead, there is a directive to retain these records in the patient's file at the local level, with the understanding that it may be requested for review at a future date.

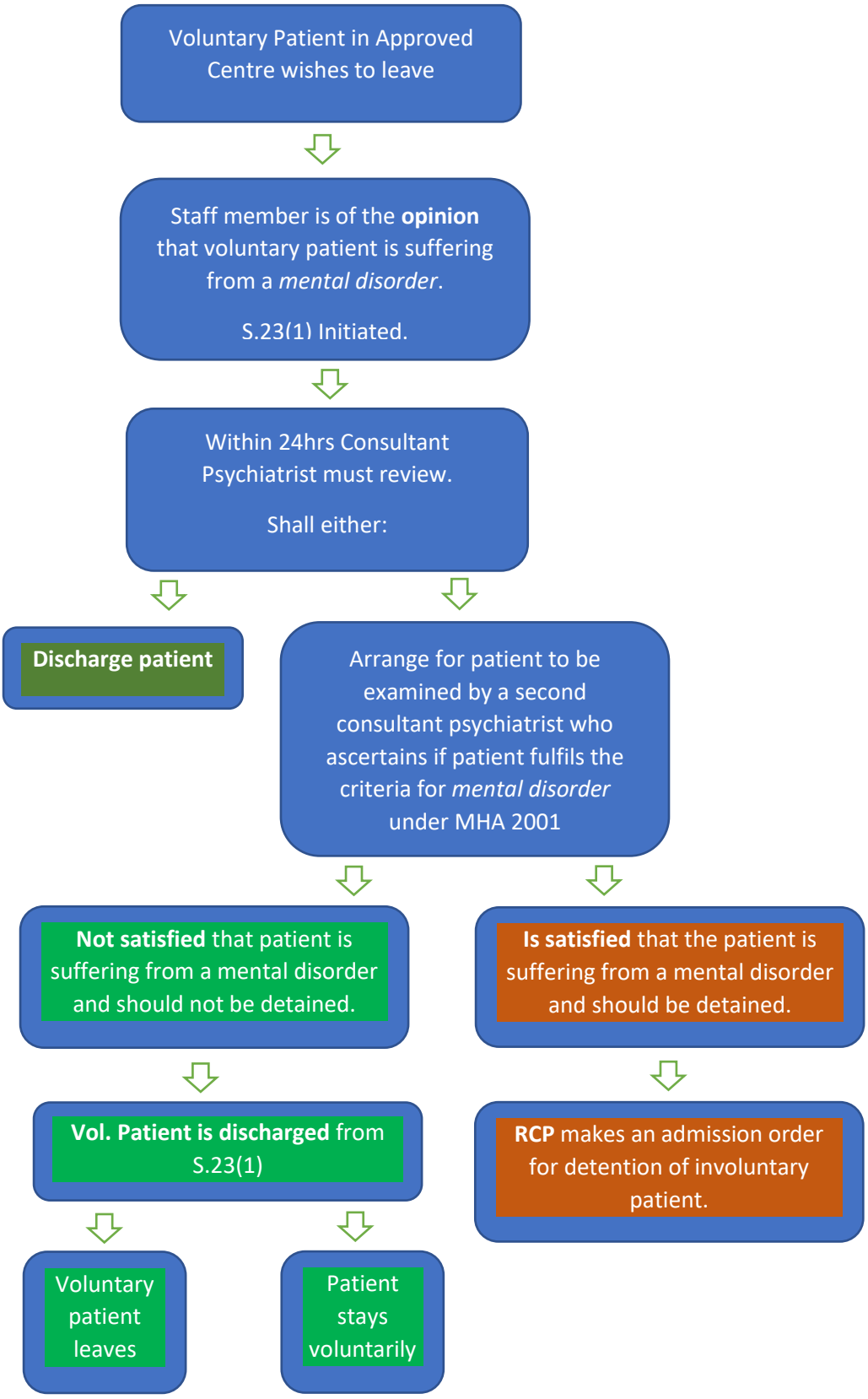


Figure 1-1 Flow chart describing the operation of Ss. 23 and 24 of MHA 2001

Adapted from Reference Guide to Mental Health Act 2001 (Mental Health Commission).

1.2.3. Threshold for detention under S.23(1) MHA 2001

For a voluntarily admitted patient to be held under S.23(1) MHA 2001, a consultant psychiatrist, registered medical practitioner or registered nurse must be "*of the opinion*" that the person is suffering from a mental disorder. For this temporary hold to be regraded to an involuntary admission order, a different threshold exists. In such circumstances, the consultant psychiatrist must be "*satisfied*" that the person is suffering from a mental disorder (Section 24(2) MHA 2001).

In the High Court case of *AS v The Clinical Director of St Michael's Psychiatric Unit and HSE [2021] IEHC* 447, the relevance of differing thresholds for mental disorder assessments was examined. In this case, the applicant was a voluntarily admitted patient at the respondent hospital. The applicant had requested discharge from hospital and was subsequently reviewed by the non-consultant hospital doctor (NCHD) on duty. The NCHD, being "*of the opinion"* that the applicant was suffering from a mental disorder at the time of the discharge request, detained the patient pursuant to S.23(1). However, the consultant psychiatrist who later reviewed the applicant under S.24 MHA 2001 was not satisfied that the applicant was suffering from a mental disorder and subsequently discharged them.

The applicant sought to judicially review the original S.23(1) Order made by the NCHD. Among the applicant's arguments was the assertion that the consultant psychiatrist differed from the NCHD regarding the presence of a mental disorder. Legal counsel for the respondent hospital, noting the different language between S.23 and S.24 of MHA 2001, argued that the threshold for forming an *"opinion"* under S.23(1) was lower than the requirement for a consultant psychiatrist to be "*satisfied*" under S.24. It was contended that this difference in language had been chosen with care by the Oireachtas when drafting these provisions.

Mr Justice Barr refused the applicant leave for judicial review. While the Court was not asked to interpret specifically whether different thresholds exist between S.23 and S.24 MHA 2001, Mr Justice Barr referenced the opinion of Mr Justice Hogan in the case of *PL v. Clinical Director of St. Patrick's University*

Hospital [2019] 2 IR 266, that the language of S.23(1) is "*deliberately broader and more extensive than that of S.24*", being designed "*to deal with a short-term exigency*". He continued that "*provided that the opinion is formed bona fide, is not unreasonable and is factually sustainable, then the power of detention under S.23 will have been lawfully exercised*".

It is logical and proportionate to require a higher threshold of consultant psychiatrists when assessing whether to regrade a temporary hold to involuntary status, compared to the threshold required of other hospital staff who may temporarily detain the patient pending review by a consultant psychiatrist. As noted by Mr Justice Barr in the *AS* case, the fact that the consultant psychiatrist reached a different conclusion from that of the NCHD who initiated the S.23(1) hold does not invalidate the NCHD's opinion.

1.3. Voluntary vs Involuntary Status under the MHA 2001

The MHA 2001 was introduced as "*an act to provide for the involuntary admission of persons suffering from mental disorders…[and] the independent review of the involuntary admission of such persons"*. As such, the Act is not concerned with the treatment of voluntary patients per se. The term "*voluntary patient*" is defined in Section 2 MHA 2001 as a person "*receiving care and treatment in an Approved Centre who is not the subject of an admission order or a renewal order*". Outside of this definition, the term only appears in four other sections of MHA 2001; Sections 23 and 24 (relating to powers to prevent voluntary patients from leaving approved centre and to subsequently detain them), Section 55 (relating to the power of the MHC to inquire into the care and treatment provided to a specified patient or a specified voluntary patient) and Section 69 (which includes voluntary patients in the definition of patient vis-à-vis the rules relating to bodily restraint and seclusion).

Thus, there is a lack of clarity as what constitutes a "*voluntary patient*", with such patients being defined by what they are not, rather than what they are. The Irish courts have been called upon in the past to interpret this lacuna in the legislation.

In the case of *EH v St Vincent's Hospital &* Ors, the High Court found that the definition of *"voluntary patient*" could not, on the basis of the wording of the MHA 2001, be interpreted as describing "*one who freely and voluntarily gives consent to an admission orde*r". This understanding emphasizes that neither consent nor capacity are relevant factors in determining the status of a voluntary patient, a decision that was upheld in the appeal to the Supreme Court.

Through its silence, the MHA 2001 imposes no statutory obligations or restrictions on approved centres regarding persons admitted voluntarily (Mental Health Commission, 2005). In contrast to involuntary patients, voluntary patients do not have their admissions reviewed independently, nor do they have access to free legal aid as provided under S.33 MHA 2001 for involuntary patients.

The statutory notification provisions of Section 16 MHA 2001, which apply to both admission and renewal orders, do not extend to voluntarily admitted patients. Consequently, there is thus no legal basis under the MHA 2001 requiring approved centres to inform voluntary patients of their rights upon admission. However, Regulation 20 of the MHC Judgment Support Framework mandates that residents of approved centres, both voluntary and involuntary, must receive comprehensive information at the time of admission (Mental Health Commission, 2005, 2020b). This information should cover housekeeping arrangements, complaints procedures, treatments, and diagnoses. Notably, neither the MHA 2001 nor the MHC Judgement Support Framework explicitly requires that voluntary patients be informed about the potential application of S.23(1) MHA 2001 if they later seek discharge.

The Irish Human Rights and Equality Commission (2010) has acknowledged the differing approaches to safeguards for involuntary versus voluntary admissions, aligning with the common-sense perspective that individuals who have voluntarily consented to admission and treatment do not require independent protective mechanisms. However, the MHA 2001 has faced criticism for meeting only one of five WHO criteria (2005) regarding "*voluntary treatment and admission*" (Kelly, 2011).

The distinction between voluntary and involuntary status is crucial in the context of S.23(1) MHA 2001. Patients detained under S.23(1) are not subject to an "*admission order*" or "*renewal order*" as defined by the Act, and therefore do not qualify as involuntary patients under its provisions. As they do not meet the criteria for involuntary status, they lack the protections afforded to involuntary patients under MHA 2001. However, neither can they be considered truly voluntary patients, given that they are not at liberty to self-discharge.

1.4. Holding Powers as Threat - Unwilling Voluntary Patients

Although a clear legal distinction exists between voluntary and involuntary admissions to psychiatric hospitals, the same clarity is not always shared by patients (Sørgaard, 2007). Studies indicate that both voluntary and involuntarily admitted patients often lack awareness of their legal status (Rooney et al., 1996; Tuohimäki et al., 2001). Additionally, there is a cohort of patients who are aware of the potential ramifications of choosing to discharge themselves voluntarily, which complicates the boundaries between voluntary and de facto involuntary admissions. While understanding one's voluntary status is crucial for making informed decisions about discharge from hospital, some patients may feel pressured or persuaded to remain voluntarily admitted out of fear that choosing to leave could result in the initiation of a hold or involuntary detention. This phenomenon, where patients recognise their voluntary status but choose to continue treatment due to concerns about their legal status changing, is referred to as the 'Breggin gap' (Breggin, 1964). These patients may experience what is known as 'hidden coercion', defined as "*being subject to compulsory admission and/or coercion without a formal treatment/detention order as provided in relevant law"* (Zinkler & Priebe, 2002).

Poulsen investigated perceived coercion between three groups of psychiatric inpatients: (i) 47 individuals (mean age 42 years) admitted involuntarily (ii) 48 individuals (mean age 36 years) admitted voluntarily but subsequently involuntarily detained, and (iii) 48 individuals (mean age 39 years) admitted voluntarily without any deprivation of liberty, serving as the control group

(Poulsen, 1999). The study was conducted through semi-structured interviews with patients admitted to five closed wards at Aarhus University Hospital in Denmark. Researchers assessed perceived coercion using a 5-item version of the Admission Experience Scale (AES), which measures perceived coercion on a scale from 0 (no perceived coercion) to 5 (maximum perceived coercion), as well as a Visual Analogue Scale (VAS) which ranges from 1 (no perceived coercion) to 10 (maximum perceived coercion). The results indicated significantly higher perceived coercion among involuntarily admitted patients compared to those voluntarily admitted and subsequently detained, with AES scores of 3.5 versus 2.1, ($P < 0.05$) and VAS scores of 7.5 versus 6.1 ($P < 0.05$). Among the voluntarily admitted groups, those who were subsequently detained reported a statistically significant higher perception of coercion than the control group, with VAS scores of 6.1 versus 2.8 ($P < 0.05$). While the AES also showed higher perceived coercion between these two voluntarily admitted groups (2.1 v. 1.7) this was not a statistically significant ($P > 0.05$).

Thus, the legal status of patients admitted to psychiatric hospitals is not always synonymous with the perceived coercion experienced by them. In an Irish study, 22% of voluntarily admitted patients reported levels of perceived coercion similar to that of the majority of involuntary patients (O'Donoghue et al., 2014).

Involuntary hospitalization is often associated with feelings of shame and self-contempt and it has been argued that patients may acquiesce to an unwanted voluntary admission to avoid the stigma associated with an involuntary admission (Bingham, 2012; Rüsch et al., 2014). Several studies highlight the perceived negative consequences of involuntary admission from the perspective of detained patients.

An Irish study by O'Donoghue at al. investigated the perspectives of 81 patients who were involuntarily detained, including 29% who had been re-graded from voluntary status (O'Donoghue et al., 2010). The authors found that while 72% of participants believed that their involuntary detention was necessary, 27.5% reported experiencing a negative impact upon their relationships with family, and 26.6% felt that the doctor-patient relationship was adversely affected.

Additionally, one-third of participants felt that their future career prospects could be negatively impacted due to their involuntary admission.

In a study by Murphy et al., 38% of 50 participants interviewed after an involuntary admission reported that the experience had a detrimental and prolonged negative impact on their mental health. Involuntary detention can have lasting implications for patients (Murphy et al., 2017). For instance, in Germany, individuals who are been involuntarily admitted are required to undergo fitness-to-drive testing upon their release (Zinkler & Priebe, 2002). More practically, voluntarily admitted patients have been demonstrated to maintain better therapeutic relationships with their mental health teams compared to involuntarily admitted patients, even where both groups have reported perceived coercion during their psychiatric admission (O'Donoghue et al., 2015).

Given the potential adverse effects of involuntary detention, it is foreseeable that patients may opt to remain voluntarily, albeit unwillingly, where the alternative is the possibility of a temporary holding power and subsequent involuntary status. In such cases, voluntary patients – who arguably should be afforded the protections provided by the review and notification provisions of the MHA 2001 do not receive these safeguards.

1.4.1. Treatment under S.23(1) MHA 2001

As previously discussed, patients held under S.23(1) do not qualify as "*involuntary patients*" under the MHA 2001. Consequently, in the absence of specific provisions addressing the treatment of this particular group of detained patients, it must be assumed that they are treated on the same footing as all other voluntary patients. Unfortunately, the MHA 2001 is silent regarding the treatment of voluntary patients. References to the treatment of "*patients*" – which specifically pertains to involuntary patients subject to an admission order – only appear in Section 57 MHA 2001 which states that "*the consent of a patient shall be required for treatment*". This provision does not apply to voluntary patients.

This interpretation is supported by the MHC (Mental Health Commission, 2005) which states that individuals detained under S.23(1) MHA 2001 are not subject to the Act's provisions regarding treatment, and there is no statutory right to administer treatment against their consent. The MHC clarifies that, in the absence of consent, treatment *may* be provided under common law principles of necessity where it is deemed to be in the best interests of the patient. When consent is obtained, it must adhere to common law principles. According to common law, effective consent is constituted of three parts: that the individual has the *capacity* to consent, that such consent is *voluntarily provided* and that it is *informed* (Casey, 2010).

1.5. Alternative Mechanism for Detention of Voluntary Patients

Part 4 MHA 2001 provides specific provisions for the treatment of involuntary patients who are unable or unwilling to give consent under certain circumstances. However, there are no equivalent provisions for the treatment of voluntary patients. Consequently, voluntary patients cannot be treated without their consent. This raises concerns that patients who agree to voluntary admission but refuse treatment may deteriorate or fail to improve. They may miss out on essential interventions, including medication that could be considered beneficial if administered involuntarily.

Currently, the only statutory pathway for a voluntarily admitted patient to be regraded to involuntary status is through S.23(1), which applies only when the patient indicates a desire to leave the hospital. If voluntary patients refuse treatment but do not indicate a desire to leave, there is no alternative mechanism within the MHA 2001 to regrade these patients for involuntary treatment.

This gap has been addressed in the Irish courts. In the case of *K.C. v Clinical Director of St. Loman's & HSE* [2013] a voluntarily admitted patient began to deteriorate and was unwilling to consent to treatment recommended by her doctors. The provisions of S.23(1) were unavailable to the doctors, as the patient did not express a wish to leave hospital. Considering it was in the best interests of the patient to receive medication on an involuntary basis, the

medical team initiated an involuntary admission of the patient under Sections 9 and 14 of the MHA 2001, despite her initial voluntary admission. In this case an application was made by an Authorised Officer under Section 9 MHA 2001. Following this, the patient's general practitioner assessed her at the hospital and made a recommendation for her involuntary detention under Section 10 MHA 2001. Subsequently, an admission order was completed by the doctors responsible for her care under Section 14 MHA 2001.

The patient who was detained challenged the above application of MHA 2001 arguing that S.9 MHA 2001 could only be invoked when a person had not yet been admitted to the hospital. The Court rejected this argument, deeming it irrelevant and affirming that the concept of an involuntary patient is a legal one. Additionally, the Court dismissed arguments that Sections 23 and 24 MHA 2001 represented the sole circumstances under which voluntary patients could be detained in approved centres. In this case, the use of Sections 9 and 14 MHA 2001 to involuntarily admit a patient who was already voluntarily admitted effectively bypassed the mechanism provided by S.23(1), which could not be applied due to the patient's willingness to remain voluntarily admitted.

1.6. Common-Law Power to Detain – The Doctrine of Necessity

The power to detain voluntary patients in approved centres under S.23(1) MHA 2001 is a unique statutory authority granted to doctors and nurses in psychiatric hospitals, a power that does not exist in any other medical setting in Ireland. Recent case-law has examined the issue in the context of the common-law Doctrine of Necessity.

In the case of *AC v Cork University Hospital (CUH)* [2018], a patient suffering from dementia sought to be discharged against the advice of the hospital's medical staff. The hospital refused her discharge, and the matter subsequently came before the courts to determine whether her detention was lawful.

In the Court of Appeal, Mr Justice Hogan found that the patient's detention in the medical hospital was unlawful, despite the valid concerns expressed by her treating medical team. He ruled that there is no legislative power equivalent to

S.23(1) MHA 2001 that medical hospitals can invoke to prevent a patient discharging themselves. Additionally, the Court determined that there was no general common law authority allowing hospitals to prevent patients effecting their own discharge. It further noted that any such common-law power, if it were to exist, would raise constitutional concerns.

The case was appealed to the Supreme Court by the Health Service Executive (HSE), challenging the Court of Appeal's ruling that the patient had been unlawfully detained by the hospital. The Supreme Court held that the patient's detention was lawful on the basis of the Doctrine of Necessity. While the Supreme Court clarified that hospitals do not possess a general power of detention akin to S.23(1) MHA 2001, it found that they may detain incapacitated patients for no longer than is necessary to ensure their safety while appropriate legal applications are pursued. Consequently, S.23(1) remains a unique legislative power without parallel in the general medical setting.

1.7. Detention of voluntary patients (The International Perspective)

Research comparing the mental health legislation across different jurisdictions has primarily focussed on the process of involuntary admission (Cronin et al., 2017; Fistein et al., 2009; Sheridan Rains et al., 2019). However, an extensive search has uncovered a lack of similar studies addressing the use of holding powers or legislative provisions analogous to S.23(1) MHA 2001. Nonetheless, a first principles analysis of selected international legislation concerning the detention of voluntarily admitted patients in England and Wales (1983), Norway (1999), New South Wales (2007), Western Australia (2014), British Columbia (1996), Ontario (1990), and New York State (2023) allows for several points of comparison.

First, not all jurisdictions have legislative provisions that allow for the conversion of a patient's voluntary status to involuntary status. For example, the Mental Health Act of British Columbia (1996) states that voluntary patients who request discharge *must* be released by the director of the psychiatric hospital upon notification.

Secondly, among the jurisdictions that permit the conversion of voluntary to involuntary status, not all utilize temporary 'holding powers' to facilitate the completion of an assessment as is the case under the MHA 2001. For example, the Ontario Mental Health Act (1990) allows for the filing of a certificate of involuntary admission, provided the patient meets the relevant criteria. However, the legislation does not address the patient's status during the period between their request for discharge and the subsequent certification. This practice in Ontario resembles the approach taken by the hospital in *K.C. v Clinical Director of St. Loman's & HSE* [2013] where S.23(1) MHA 2001 was by-passed, and the detention process commenced on-site despite the patient had expressing a desire to leave the hospital.

Among the jurisdictions that make provision for holding powers, the timeframes during which these powers are valid vary significantly: two hours in New South Wales (Section 10(3)) (2007), six hours in Western Australia (Section 34) (2014) and 72 hours in both England (in the case of a doctor's holding power - Section 5(4)) (1983) and New York State (Chapter 27, Article 9.13) (2023).

In jurisdictions where holding powers exist, some are only activated when the patient requests discharge (England, New York State), while the Western Australian Mental Health Act (2014) allows for the initiation of holding powers either upon the patient's request for discharge or when there is reasonable suspicion that the patient requires an involuntary order. In New South Wales and Ontario, the legislation is sufficiently broad to encompass both scenarios.

The Norwegian Mental Health Care Act, Sections 3-4, was implemented in 2007 to allow for the conversion of a patient's voluntary status to involuntary status if directed by a specialist in circumstances where is imminent danger to the patient or others (Hustoft et al., 2018). Similar to Ontario, the Norwegian legislation does not include provisions for the use of holding powers. The language of the Act is sufficiently broad to permit the direction of a specialist's opinion regardless of whether the patient has requested discharge from hospital.

1.8. Human Rights Considerations - Right to Liberty

In cases where S.23(1) is initiated, patients are deprived of their freedom and their fundamental right to liberty. This right is protected by various national, European and international legal instruments to which Ireland is a signatory. Specifically for individuals experiencing mental illness, the right to liberty is articulated in Article 14 of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) (UN General Assembly, 2006), ratified by Ireland in 2018. This convention explicitly includes individuals with "*long-term mental impairments"* within its definition of disability.

The UNCRPD does not grant an absolute right to liberty; rather, it allows for limitations that are "*in conformity with the law"*. However, the Convention explicitly states that the "*existence of a disability shall in no case justify a deprivation of liberty*". This raises concerns regarding the MHA 2001, which associates detention with the presence of a "*mental disorder*", potentially infringing upon Article 14 UNCRPD (Kelly, 2014). Szmukler, Daw, and Callard (2014) reference the interpretation of Article 14 by the United Nations High Commissioner for Human Rights (2009), arguing that a violation could occur even if "*mental disorder*" is just one of several criteria – such as posing a risk to oneself or others – used to justify involuntary detention. This highlights the tension between mental health legislation and international human rights standards, suggesting the need for reform to ensure compliance with the UNCRPD.

While mechanisms are in place to monitor Ireland's compliance with international instruments, these instruments do not grant direct rights to Irish citizens. As a "dualist" State, Ireland requires that international agreements – except for those under European Union law, which have direct effect – be explicitly incorporated into domestic law through an Act of the Oireachtas. Consequently, these international agreements are binding on Ireland as a state entity but do not automatically confer rights within the domestic legal framework.

This dualist approach implies that individuals cannot invoke international treaties directly in Irish courts; rather, any rights or obligations stemming from such treaties must first be integrated into national legislation. In the case of *Kavanagh v Governor of Mountjoy Prison* [2002] a decision of the UN Human Rights Committee tasked with monitoring state adherence to UN treaties was found not to represent a legally binding decision on the Irish State. The point was emphasised by Mr. Justice Clark in the case of *Olaniran & Ors v Minister for Justice Equality and Law Reform* [2010], where he found that, despite Ireland's status as a signatory to a UN human rights instrument, this conferred "…*no rights on individuals to rely on its provisions before the domestic courts*".

In Ireland, the primary source of rights is the Irish Constitution, which guarantees in Article 40.4 the "*right to liberty and freedom, except in accordance with law*" (Bunreacht na hEireann, 1937). Additionally, the right to liberty is protected under Article 5 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (Council of Europe, 1950) ("ECHR"). The ECHR allows individual litigants to bring complaints to the European Court of Human Rights after exhausting all domestic remedies. This convention has been indirectly incorporated into Irish law through the European Convention of Human Rights Act 2003. However, the right to liberty as outlined in the ECHR is qualified by subsection 1(e) of Article 5, which permits the lawful detention of persons of "*unsound mind*".

Thus, the right to liberty is not absolute and may be circumscribed in accordance with Irish law. The European Convention of Human Rights Act 2003 explicitly acknowledges the potential for the detention of individuals deemed to have unsound mind. S.23(1) MHA 2001 imposes such limitations on the right to liberty for individuals with a mental disorder under specified circumstances. However, it is important to note that the impact of the UNCRPD has yet to be fully assessed in relation to Ireland's mental health legislation.

1.9. Experience of Holding Powers (Ireland)

There are scarce Irish data specifically characterising patients temporarily detained under mental health holding powers. One Irish study by Masood et al. examined the predictors of involuntary detention among voluntary patients at a large voluntary hospital (Masood et al., 2015). It describes a cohort of 49 patients detained under S.23(1) MHA 2001 in 2011. Among these patients 49% were male and 51% were female. 63% of those detained were employed and their mean age on admission was 42.6 years (SD = 16.8). Additionally, 43% were married or cohabiting. The most prevalent psychiatric disorders identified in this cohort were mania with or without psychosis (35%), depression with or without psychosis (31%), schizophrenia (24%), and schizoaffective disorder (2%). Co-occurring substance misuse was also significant, with 39% of patients misusing alcohol, 19% using cannabis, and 19% misusing codeine. Furthermore, 63% had at least one previous admission to a psychiatric hospital, and 49% had experienced an illness duration of over ten years. Among those detained under S.23(1), 12% were assessed as being at high or moderate risk of suicide. At the time of detention, 79% of patients exhibited agitation, while 12% were at moderate to high suicide risk.

In the study, 74% of patients had S.23(1) Orders initiated once during their inpatient stay, while 16% had them initiated twice, and 10% three times. Notably, 70% of patients were not regraded to involuntary status after their hold. Just over half (52%) of the initiations of S.23(1) took place out-of-hours, and 43% took place within one week of admission. Furthermore, 30% of initiations of S.23(1) were carried out by a consultant psychiatrist.

1.9.1. Experience of Holding Powers (England and Wales)

Section 5(2) of the Mental Health Act 1983 grants doctors the authority to detain voluntary psychiatric patients in hospital for up to 72 hours for the purposes of an assessment to determine whether ongoing detention under the Mental Health Act is necessary. A review conducted by Najim & Shaik (2013) characterised a cohort of 44 patients detained under these holding powers at

an English psychiatric hospital. Among those detained, 40% of were male, and 65% were above the age of 50 years. The study reported that 68.5% exhibited threatening behaviour, while 13% were assessed as posing a risk to others. 60% were found to have a moderate to severe suicidal risk, and 26% were identified as having a risk of deliberate self-harm. Just over half (52%) of the holds occurred out-of-hours or during weekends.

While S.5(2) allows for temporary detention of up to 72 hours – compared to 24 hours under S.23(1) MHA 2001 – 60% of patients were assessed during the first 24 hours. Notably, 60% of patients were regraded from voluntary to involuntary status following their hold.

1.9.2. Characteristics of Patients Detained under Full Involuntary Orders

There is a wealth of studies characterising patients admitted involuntarily to psychiatric hospitals. However, as previously discussed, an involuntary admission under the MHA 2001 may occur either at the point of initial admission under S.14 (where the patient is literally admitted involuntarily), or subsequent to a voluntary admission via S.24(3) following detention under S.23(1). Unfortunately, the existing literature does not generally clarify whether the characterised involuntary admissions refer solely to those involuntarily admitted *ab initio* or if they also include data on patients who were admitted voluntarily and regraded to involuntary status later. Nonetheless, this research provides valuable insights for comparison in the context of the present analysis.

A meta-analysis conducted by Walker et al. examined the factors that increase the risk of involuntary psychiatric hospitalisation (Walker et al., 2019). The review included 77 studies from 22 countries. The studies were from 18 high-income countries (Australia, Canada, Israel, Taiwan, USA and 13 European nations) and four middle-income countries (Brazil, China, India and Turkey). The studies represented a total of 975,004 psychiatric patients, of whom 23% were involuntarily admitted. Most of the studies included were retrospective cohort studies. The primary aim of the meta-analysis was to identify potential

risk factors for involuntary admission so that these groups could be targets for future preventative interventions, such as crisis planning. The authors calculated odds ratios for all studies and separately for high-quality studies. Specific risk factors identified in both the full meta-analysis and the high-quality analysis included:

- male gender (odds ratio 1.23, 95% CI 1.14-1.32; p<.001),
- unemployment (1.43, 1.07-1.90; p=.020),
- a diagnosis of psychotic disorder (2.18, 1.95-2.44; p<.001),
- a diagnosis of bipolar disorder (1.48, 1.24-1.76; p<.001), and
- previous involuntary hospitalisation (2.17, 1.62-2.91; p<.001).

The same study utilised narrative synthesis to report associations between involuntary psychiatric hospitalisation and several factors, including perceived risk to others, non-adherence with treatment prior to hospitalisation, reduced insight into one's condition, and the necessity for police involvement during the admission.

A Dutch study by van der Post et al., part of the Amsterdam Study of Acute Psychiatry (ASAP) series, sampled 252 patients from a total of 2,682 who interacted with two psychiatric teams in Amsterdam between 2004 and 2006 (van der Post et al., 2014a). This prospective observational cohort study aimed to establish a predictive model to account for the highest percentage of variance in civil detention during the two-year observation period, using the fewest possible variables.

Of the sample, half were detained involuntarily following psychiatric contact, while the other half were either voluntarily admitted, directed to out-patient care or discharged. The authors collected clinical and demographic data, as well as information regarding the size of patients' social networks using the Dutch 10-item Social Network Structure Questionnaire (van Sonderen, 1991). They also assessed qualitative aspects of social interaction through the 13-item Social Resources Questionnaire (Ruehlman et al., 1999). Patient insight was assessed using Birchwood's eight-item Insight Scale (Birchwood et al., 1994), and satisfaction with previous mental health care was measured using the Verona Service Satisfaction Scale (VSSS) (van Sonderen, 1991).

The study found no significant differences between detained and non-detained groups regarding gender, age, country of origin, quantitative and qualitative aspects of social support, mean total of people involved in the patient's social network, or diagnosis. However, detained patients were significantly more likely to live alone (P = .006), and one-third of those in the detained group had experienced a previous civil detention or court-ordered detention within the year prior to the study's commencement. A significant association was also identified between satisfaction with previous mental health care (as measured by the VSSS score) and detention status (P = .004). No significant difference in insight was observed between the groups (P = .997).

Stepwise logistic regression analyses revealed a final model identifying predictors for civil detention over the two-year follow-up period: (i) prior involuntary admission (OR 9.4, 95% CI 3.6–24.7, P < .001), (ii) living alone (OR 4.5, 95% CI 1.9–11.0, P = .001), and (iii) a 'satisfactory' VSSS score (OR 0.2, 95% CI 0.0–0.8, P = .030).

A systematic review and meta-analysis conducted by Barnett et al. examined compulsory detention in black, Asian and minority ethnic (BAME) and migrant groups in the UK and internationally, encompassing 71 studies with a total of 1,953,135 participants (Barnett et al., 2019). The authors found that these minority groups are at a greater risk of psychiatric detention compared to majority groups. The most common explanations for this greater risk included: increased prevalence of psychosis, increased perceived risk of violence, increased police contact, absence of or mistrust of general practitioners, and ethnic disadvantages.

A recent study by Schmitz-Buhl et al. retrospectively analysed the records of 5,764 inpatients across four German hospitals in 2011 (Schmitz-Buhl et al., 2019). The authors included all 1,773 patients admitted involuntarily that year, along with a random sample of 3,991 voluntarily admitted patients as controls. The authors aimed to identify factors associated with a higher risk of involuntary admission. In addition to descriptive statistics, the authors employed a prediction model using chi-squared, automatic interaction detection (CHAID). Their results indicated that, organic mental disorders (ICD-10: F0), as well as schizophrenia and other psychotic disorders (ICD-10: F2),

were overrepresented among the involuntarily admitted cohort. CHAID analysis confirmed that primary diagnosis was the strongest predictor of subsequent involuntary admission. The study also revealed a greater representation of older patients, retired individuals, and migrants in the involuntary cohort. Other predictive factors identified through CHAID analysis included the absence of out-patient treatment prior to admission, admission outside of normal working hours, and having a migratory background.

1.10. Rates of involuntary admission in Ireland

In Ireland, the rate of involuntary admissions to approved centres was 51.7 per 100,000 population in 2020, 49.4 per 100,000 in 2019 and 46.7 per 100,000 in 2018 (Daly & Craig, 2021). In the first year following the enactment of MHA 2001 in 2006, the rate of involuntary admission was 50.14 per 100,000. Since then, the rate has remained relatively stable, fluctuating between a low of 46.0 in 2010 and a high of 52.6 in 2016 (MHC Annual Reports, 2007-2020).

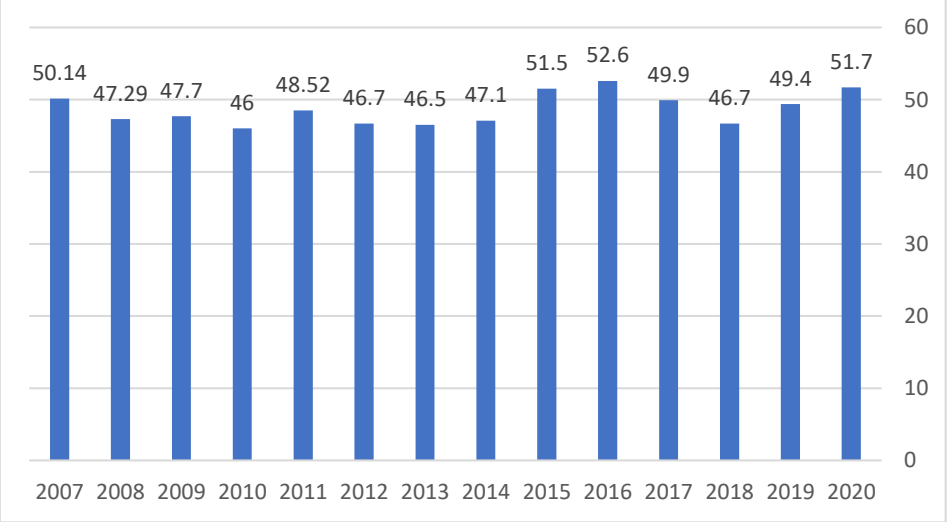


Figure 1-2: Ireland's Involuntary Admission Rates per 100,000 of total population for years 2007-2020 (Compiled from MHC Annual Reports 2007 - 2020).

The rates mentioned above include patients who were (i) admitted involuntary under Sections 4 and 9 MHA 2001 and (ii) those who were initially admitted voluntarily but subsequently regraded to involuntary status under Sections 23 and 24 MHA 2001.

As approved centres are required to report admission orders under both Sections 9 and 24 MHA 2001, it is possible to distinguish between the total number of involuntary admissions and those patients who were regraded to involuntary status. In 2020, there were 513 patients who were re-graded from voluntary to involuntary status following a S.23(1) Order as compared to a total of 1,919 involuntary admissions (MHC, 2020). This means that those initially held under S.23(1) and later regraded accounted for nearly 22% of all admission orders for that year. In previous years, the number regraded from voluntary to involuntary status were 565 in 2019 (representing 23.6% of the total involuntary admission rate for that year) and 610 in 2018 (accounting for 25%).

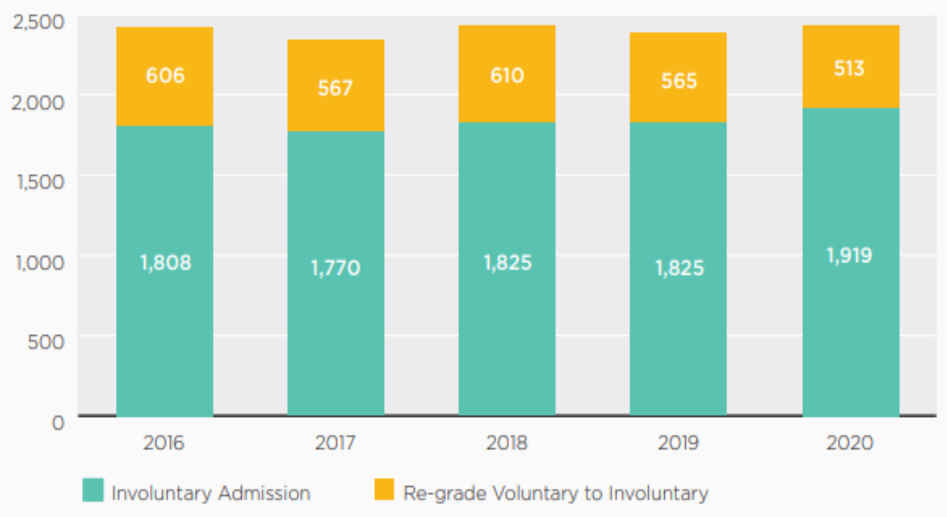


Figure 1-3: Comparisons of total involuntary admissions 2016-2020 (Source: MHC Annual Report 2020).

1.11. Oversight of Involuntary Detention Powers

Under Section 33 MHA 2001, the Mental Health Commission (MHC) is mandated to "*promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services and to take all reasonable steps to protect the interests of persons detained in approved centres under the Act*".

Regarding involuntary detention under the MHA 2001, there are specific statutory forms that must be submitted to the MHC in specified circumstances. For example, the MHC must be notified of the issuance of an admission or renewal order within 24 hours, as stipulated in Section 16(1)(a) of the Act. In the context of detentions under S.23(1), these only become notifiable to the MHC when patients are regraded to involuntary status by way of an admission order (Form 13) as per S.24(b)(2) of the Act.

Under the MHA 2001 there is no obligation for approved centres to notify the MHC about S.23(1) Orders that are not regraded to involuntary status. Consequently, there is no national record of the total use of S.23(1) across approved centres. While local data may be available, there is no effective means to ascertain the overall use of S.23(1) in Ireland, nor to determine the proportion of these orders that are not regraded.

Additionally, gaps in the data include information on the proportion of patients who, having been held under S.23(1) but not regraded to involuntary status, choose to either discharge from hospital or remain on as voluntary patients. Given that detention under S.23(1) can last up to 24 hours - even in cases where subsequent discharge occurs – the absence of national data on the overall use of S.23(1) represents a significant knowledge gap.

1.12. Mental Health Bill 2024 and reform of MHA 2001

The reform of MHA 2001 is (at the time of writing) at an advanced stage, with the Mental Health Bill 2024 having passed the Second Stage in Dail Eireann. This Bill aims to replace the existing MHA 2001 and introduces changes to the involuntary admission and detention processes. Several aspects of the Bill are noteworthy in relation to the overall operation of holding powers.

First, the Mental Health Bill 2024 maintains the power to detain voluntarily admitted persons who fulfil the criteria for involuntary admission, as outlined in S.37(1) of the Bill. The power is broader than that under S.23(1) MHA 2001. It permits a consultant psychiatrist – or another qualified mental healthcare professional – who is "*of the opinion that the voluntarily admitted person fulfils the criteria for involuntary admission*" to "*take charge of the person*" and "*detain him or her for a period not exceeding 24 hours*". Importantly, it is not required for the patient to express a desire to discharge from the hospital. This provision aligns with similar holding power legislation in New South Wales and Ontario, as previously discussed in Section 1.7. It effectively gives statutory backing to the use of S.23(1) in the case of *K.C. v Clinical Director of St. Loman's and HSE* [2013].

Second, whereas previously either a consultant, registered doctor or a registered nurse on the staff of the hospital could invoke S.23(1), the new Bill provides that either the patient's responsible consultant psychiatrist or other "*mental healthcare professionals*" (defined as nurses, social workers, occupational therapists or "*such other designated profession…as the Minister considers appropriate*") involved in the care of a patient may initiate the holding power in S.37(1). On the face of it, this section precludes doctors other than the patient's treating consultant from invoking the holding power.

Third, S.37(11) of the Bill provides that the MHC shall be notified of "*any decision to detain or the decision not to detain a patient*" in accordance with S.37. This requirement to report all instances of detention under S.37 would rectify the gap in national data that has been alluded to in 1.11 above.

Fourth, S.41 of the Bill introduces new obligations regarding the provision of information to voluntarily admitted patients following their admission, a requirement that was not explicitly present in the MHA 2001. This information must include a clause informing the patient that they may leave the hospital at any time subject to the holding powers in S.37(1). However, as this information is to be provided as soon as practicable *after* admission, its utility may be limited in practice.

Fifth, the Bill introduces new provisions regarding consent to treatment in Sections 42 to 51. While the MHA 2001 allowed for the administration of treatment to involuntary patients without their consent if deemed incapable of providing it due to their mental disorder, the new Bill establishes more stringent criteria and processes aligned with the Assisted Decision-Making (Capacity) Act 2015. However, similar to the MHA 2001, the Bill does not address the treatment of voluntarily admitted patients.

The Mental Health Bill 2024 has not, at the time of writing, been enacted into law in Ireland. It proposes changes regarding who may initiate holding powers and the procedures associated with that initiation, as well as introducing new mandatory reporting requirements. Furthermore, the Bill aims to formalize current practices concerning the involuntary detention of voluntary patients suffering from a mental disorder but not seeking discharge. However, for the analysis that follows, only the existing legal framework pertaining to the temporary detention of voluntarily admitted patients under S.23(1) MHA 2001 will be considered.

1.13. Aims and Hypotheses

The aim of this research is to evaluate the use and outcomes of S.23(1) MHA 2001 in a large Irish psychiatric hospital. The research comprised two related studies.

Study 1 aims to characterise a group of voluntary admissions held under S.23(1) during their admission (cases) in comparison to a control group of voluntary patients never held during their admission. In characterising all cases and controls by reference to demographic and clinical factors, the study shall assess whether there are significant differences between the groups. Additionally, it will investigate whether any patient-factors may be considered predictive of a S.23(1) initiation.

Hypothesis 1: Patients who are held pursuant to S.23(1) will have a greater burden of mental illness than those who are not held.

Study 1 shall also assess whether the outcomes for the held (case) and non-held (control) groups differed based on length of stay, Clinical Global Impression scores at discharge, and readmission rates.

Hypothesis 2: There is no difference in the overall outcomes for both held and non-held groups.

Study 2 will describe the outcomes for the held (case) group from Study 1. It will identify whether these patients' status was regraded to involuntary status after their S.23(1) hold and, if not regraded, whether those patients chose to remain in hospital as voluntary patients. In characterising those regraded to involuntary status (regraded group) and those not regraded (non-regraded group) by reference to demographic and clinical factors, Study 2 shall assess whether there are significant differences between the groups and will examine potential risk factors associated with the regrading to involuntary status for those held under S.23(1). Study 2 shall also assess whether the outcomes for the regraded and non-regraded groups differed based on length of stay, Clinical Global Impression scores at discharge, and readmission rates.

Hypothesis 3: That the group held under S.23(1) who are regraded to involuntary status will have a greater burden of mental illness than those held under S.23(1) and not regraded.

Objectives:

To perform a retrospective case control study (Study 1) to:

1. Compare the baseline clinical features of those held under S.23(1) with a control group who were not,
2. Compare the outcomes of those held under S.23(1) with regards length of stay, overall clinical outcomes, and readmission rates with a control group who were not, and

To perform a comparative cohort study (Study 2) to:

3. Compare the clinical features of a group held under s.23(1) and regraded to involuntary status to a group that were held under S.23(1) but not regraded and to compare the outcomes of these groups with regards length of stay, overall clinical outcomes, and readmission rates over 12 months post-discharge.

Chapter 2 : Materials and Methods

2.1. Overview of Study 1

This study was a retrospective, case-control study comparing voluntarily admitted psychiatric patients detained under S.23(1) MHA 2001 (referred to as "cases") with patients who remained voluntary throughout their hospital admission (referred to as "controls"). It employed a quantitative study design. The main purpose of this study was to evaluate the risk factors for and outcomes of S.23(1) initiation in a large psychiatric hospital in Ireland.

The cases comprised all voluntarily admissions to two adult psychiatric inpatient units in Dublin – St Patrick's University Hospital and St Edmundsbury Hospital (collectively referred to as "St Patrick's Mental Health Services" or "SPMHS") – between 1st January 2018 and 31st December 2020 (the study period) who were subsequently detained under S.23(1). This information was obtained from the Clinical Governance Department of SPMHS. Controls were defined as voluntary patients admitted immediately before and after each case during the study period. A chronological admission list, from the Clinical Governance Department of SPMHS, was used to identify both cases and controls.

2.2. Overview of Study 2

This study was a retrospective, comparative cohort study. The case cohort from Study 1 (i.e., all voluntarily admitted patients to SPMHS between 1st January 2018 and 31st December 2020 that were subsequently held under S.23(1)) comprised the cohort of interest. The first part of Study 2 described the overall use and outcomes of S.23(1) during the study period. The second part compared the admissions that were held under S.23(1) and subsequently regraded to involuntary status with those held under S.23(1) who were not regraded. The main purpose of Study 2 was to describe the use of S.23(1) and to evaluate the risk factors associated with individuals held under this provision who may be at risk of reclassification to involuntary status.

Clinical records for all subjects (cases and controls) were accessed through the SPMHS electronic health record (EHR) with no other source of information used. Data extracted from the EHR consisted of existing routine data, and patient contact was not necessary for this study. I collected all data and analysed the resulting data set using an authorized encrypted laptop provided by SPMHS.

2.3. Study Setting

This study was carried out across SPMHS's two adult psychiatric inpatient units. SPMHS offers multidisciplinary adult inpatient mental health care through a 241-bedded inpatient unit in Dublin 8 (St Patrick's University Hospital) and another 52-bedded inpatient unit in Co. Dublin (St Edmundsbury Hospital). Both are voluntary psychiatric hospitals operating in the independent sector and accept referrals on a national basis from General Practitioners or HSE Community Mental Health Teams. Inpatient services are also provided to the HSE mental health services via HSE service agreements.

Patients of SPMHS are admitted to multidisciplinary general adult, addiction, dual diagnosis, eating disorder and old age psychiatry teams. SPMHS provides mental healthcare to adults (aged 18 years or over) including voluntary and involuntary admissions under the MHA 2001.

Following the outbreak of Covid-19, SPMHS commenced a Homecare Service to patients in March 2020, offering remote access to their services through video, phone and online (Fearon, 2020b). The MHA 2001 only applies to patients physically admitted to approved psychiatric hospitals. Thus, Homecare admissions to SPMHS during the study period were excluded for research purposes.

Given the relative size of the inpatient units at SPMHS (293 beds in total) and the national catchment base, these sites provided a large sample size that was geographically diverse.

2.4. Ethical Approval

Ethical Approval was obtained from the St Patrick's Mental Health Services Research Ethics Committee ("REC") in August 2020. As per the Data Protection Act 2018 (Section 36(2)) (Health Research) Regulations 2018 (S.I. No. 314/2018), as amended by the Data Protection Act 2018 (Section 36(2)) (Health Research) (Amendment) Regulations 2021, patient consent was not required for this wholly retrospective review of patient charts. It was concluded that the study posed a low risk to the patient (data subject) and this was confirmed by the REC. Annual progress reports were filed with the REC.

2.5. Data Collection

2.5.1. SPMHS Electronic Health Record

All data were accessed electronically. In October 2017, SPMHS introduced an EHR system called "eSwift" that replaced the previous paper-based patient charts. The EHR contains all relevant patient clinical information, including psychiatric assessments, progress notes, letters and legal/statutory forms. Access to the EHR is password-protected, with different levels of access are granted to authorised staff based on their clinical responsibilities. Users access the EHR through dedicated electronic hardware provided by SPMHS. This research was conducted entirely using the EHR; paper-based charts were not reviewed. All data collection was performed by the author, who was granted access to the EHR through an honorary research contract with SPMHS.

2.5.2. Inclusion Criteria

The cases in this study comprised all voluntary adult admissions to either St Patrick's University Hospital or St Edmundsbury Hospital between 1st January 2018 to 31st December 2020 who were subsequently detained under S.23(1) MHA 2001.

For each case, two controls were selected. These comprised (i) the voluntary adult admission immediately before and (ii) the voluntary adult admission immediately after the admission of each case that remained as voluntary patients throughout their inpatient stay and at no time became subject to S.23(1) MHA 2001.

'Admissions' were the unit of study. Cases voluntarily admitted *and* detained more than once over the study period were examined as separate admissions. For example, if a patient was voluntarily admitted on two separate occasions between 2018 and 2020 and was detained under S.23(1) during each admission, each admission was analysed independently. No control patient was admitted more than once throughout the study period, and no admission identified as a case who was also classified as a control.

2.5.3. Exclusion Criteria for Cases and Controls

i. Patients admitted involuntarily to either St Patrick's University Hospital or St Edmundsbury Hospital under MHA 2001.
ii. Patients admitted to either hospital as Wards of Court.
iii. Patients under the age of 18 years.

2.5.4. Additional Exclusion Criteria for Controls

i. Patients admitted during 2020 on a Full Homecare Admission (see 2.5.3 below). (Cases were physically admitted to SPMHS sites).

2.6. Admission & Discharge Data

Admissions to SPMHS were considered to begin at the date and time recorded by the admitting doctor in the EHR. Discharge dates were defined as those documented on the Discharge Summary for each admission following the patient's discharge.

2.6.1. Transfers between St Patrick's University Hospital and St Edmundsbury Hospital

Transfers between St Patrick's University Hospital and St Edmundsbury Hospital were not considered to constitute a 'break' in a patient's admission. Such transfers may occur in routine clinical practice for two primary reasons. First, the Dean Swift ward, which includes the Special Care Unit, provides a higher level of observation and therapeutic security compared to the general wards at both St Patrick's University Hospital and St Edmundsbury Hospital. This unit is designated for acutely unwell patients and is located at St Patrick's University Hospital. Patients may be admitted directly to this ward or transferred from the general wards of either hospital. Secondly, during the Covid-19 pandemic, St Edmundsbury Hospital served as the isolation hub for patients treated at SPMHS who tested positive for Covid-19. Consequently, transfers between these two hospital sites can occur within a single episode of hospital treatment for mental illness, depending on the severity of the patient's condition, or their physical health status.

2.6.2. Transfers to hospital for treatment of a physical health condition

Transfers from SPMHS to a tertiary hospital for the treatment of physical health conditions were not considered a break in a patient's admission to SPMHS, provided that the patient was subsequently readmitted to SPMHS after being medically cleared. Although such transfers are technically classified as a discharge followed by a subsequent readmission for administrative purposes, these two admissions are considered as a single admission for the purposes of this study, as both occur within the same episode of mental illness. In routine clinical practice, the liaison psychiatry department at the receiving hospital is contacted to ensure the continuity of essential psychiatric care, including medication management, during the patient's medical admission.

2.6.3. Homecare Admissions in 2020

At the onset of the Covid-19 pandemic in March 2020, SPMHS introduced a Homecare Service (Fearon, 2020a). This service aims to provide a level of care comparable to that offered in inpatient settings, with patients receiving intervention in their own residence. Consultations with healthcare staff are conducted online, and medications are delivered where required. Suitability for the Homecare Service, which addresses the same mental health conditions that are treated by way of physical admission, is determined on a case-by-case basis following an evaluation by a consultant psychiatrist and a team of mental health clinicians.

From March 2020, when the Homecare Service at SPMHS was commenced, there were three potential admission pathways for patients:

1. Full Inpatient Admissions: patients physically admitted to and discharged from SPMHS. In 2020 there were 2369 such admissions to SPMHS.
2. Full Homecare Admissions: patients admitted to and discharged from Homecare services who were never physically admitted to SPMHS at any point of their treatment. In 2020 there were 667 such admissions to SPMHS.
3. Hybrid Admissions: patients who spent part of their admission in hospital at SPMHS and part receiving care at home through the Homecare service. In 2020 there were 61 such admissions to SPMHS.

S.23(1) MHA 2001 may only be initiated on voluntarily admitted patients to an approved psychiatric hospital. Therefore, all cases identified in Study 1 were by definition physically admitted to SPMHS at the time of their S.23(1) hold during either a full inpatient admission, or, in 2020, during the inpatient portion of a hybrid admission.

In Study 1, two controls for each case were selected. These were the admission immediately before and immediately after the admission of each case. From March 2020, when Homecare Services commenced, only full inpatient admissions or hybrid admissions were considered when choosing controls. Full homecare admissions were excluded. The rationale for excluding full homecare

admissions was that this cohort of patient could never become subject to detention under S.23(1) as they were not physically admitted to SPMHS at any point. For cases and controls, the Homecare portion of an admission was ignored when calculating length of stay (see 2.10.1).

2.7. Participant demographic data

Demographic data were extracted from the SPMHS EHR. These data included age, gender, ethnicity, level of educational achievement, employment status and marital status.

2.7.1. Age

Age was recorded as that documented for each case and control at the time of their admission.

2.7.2. Marital Status

Marital status was recorded by reference to the Central Statistics Office of Ireland ("CSO") classification system. The classification categories described are:

- Single - Never married
- Married / Civil Partnership
- Separated
- Divorced
- Widowed
- Unknown

2.7.3. Level of Educational Achievement

The level of educational achievement for each case and control was recorded by reference to the CSO classification system. The categories of educational achievement described by the CSO are:

- No formal/Primary
- Lower Secondary
- Upper Secondary
- Third Level Non-Degree
- Third Level Degree
- Postgraduate

2.7.4. Ethnicity

Ethnicity was recorded by reference to the CSO classification system:

- White Irish
- White Irish Traveller
- Any other white background
- Black or black Irish - African
- Black or black Irish – Any other black background
- Asian or Asian Irish – Chinese
- Asian or Asian Irish – Any other Asian background
- Other including mixed background

2.7.5. Employment Status

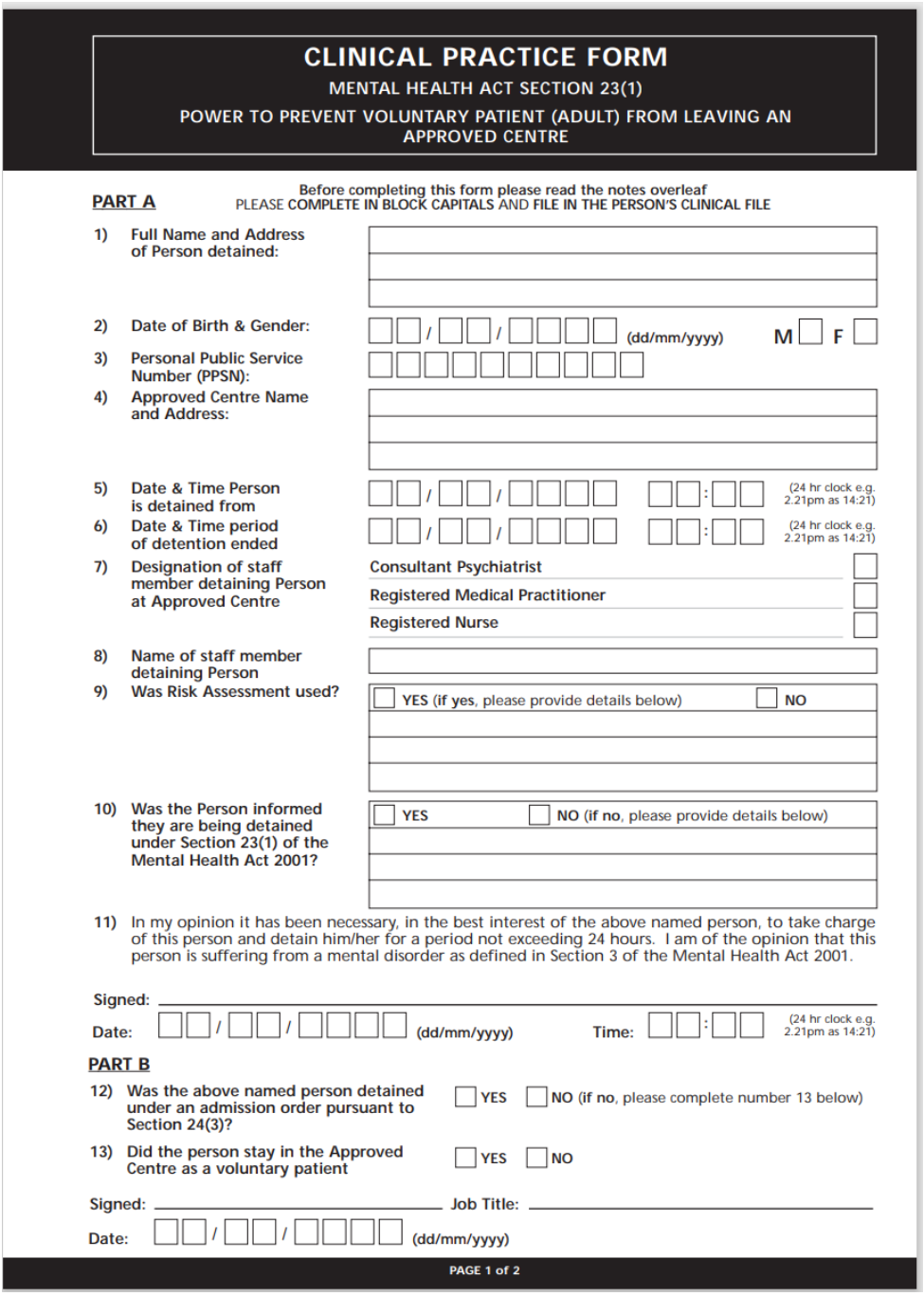
Employment status was recorded and categorised by reference to the CSO Principal Economic Status classification:

- Employed (working for payment or profit)
- Unemployed, seeking employment
- Student
- Looking after home/family
- Retired
- Unable to work due to permanent sickness or disability

2.8. Section 23(1) (and MHA 2001) Data

Data for the study related to the MHA 2001 were sourced from the EHR and the relevant Clinical Practice Form for S.23(1) Orders (See Figure 4 below). Scanned copies of these forms were accessible through the EHR, facilitating the extraction of necessary information. This information comprised:

i. The time elapsed between admission and the subsequent initiation of a S.23(1) Order;
ii. Whether the S.23(1) Order was initiated during normal working hours (9 AM – 5 PM Monday to Friday) or 'out-of-hours', i.e., during weekends (5 PM Friday to 9 AM Monday) or during a Bank Holiday;
iii. The role of the member of hospital staff who initiated the S.23(1) Order (either registered nurse, consultant psychiatrist or another registered medical practitioner);
iv. The time elapsed between initiation of a S.23(1) Order and subsequent review by a consultant psychiatrist;
v. The outcome of each S.23(1) Order – whether the patient was regraded to involuntary status or not;
vi. In circumstances where a patient's status was not regraded to involuntary status:
    a) whether that patient agreed to remain as a voluntary patient in hospital; and
    b) the duration of that subsequent voluntary admission.
vii. Where a patient's status was regraded to involuntary status:
    a) the duration of that involuntary admission;
    b) whether the detention was reviewed by a Mental Health Tribunal and the number and outcome of these; and
    c) whether the involuntary order was ultimately revoked by a Mental Health Tribunal or the Responsible Consultant Psychiatrist.



CLINICAL PRACTICE FORM

MENTAL HEALTH ACT SECTION 23(1)

POWER TO PREVENT VOLUNTARY PATIENT (ADULT) FROM LEAVING AN APPROVED CENTRE

PART A

Before completing this form please read the notes overleaf
PLEASE COMPLETE IN BLOCK CAPITALS AND FILE IN THE PERSON'S CLINICAL FILE

1) Full Name and Address of Person detained:

2) Date of Birth & Gender: ☐☐/☐☐/☐☐☐☐ (dd/mm/yyyy) M ☐ F ☐

3) Personal Public Service Number (PPSN): ☐☐☐☐☐☐☐☐☐☐

4) Approved Centre Name and Address:

5) Date & Time Person is detained from ☐☐/☐☐/☐☐☐☐ ☐☐:☐☐ (24 hr clock e.g. 2.21pm as 14:21)

6) Date & Time period of detention ended ☐☐/☐☐/☐☐☐☐ ☐☐:☐☐ (24 hr clock e.g. 2.21pm as 14:21)

7) Designation of staff member detaining Person at Approved Centre
- Consultant Psychiatrist ☐
- Registered Medical Practitioner ☐
- Registered Nurse ☐

8) Name of staff member detaining Person

9) Was Risk Assessment used? ☐ YES (if yes, please provide details below) ☐ NO

10) Was the Person informed they are being detained under Section 23(1) of the Mental Health Act 2001? ☐ YES ☐ NO (if no, please provide details below)

11) In my opinion it has been necessary, in the best interest of the above named person, to take charge of this person and detain him/her for a period not exceeding 24 hours. I am of the opinion that this person is suffering from a mental disorder as defined in Section 3 of the Mental Health Act 2001.

Signed: _____

Date: ☐☐/☐☐/☐☐☐☐ (dd/mm/yyyy) Time: ☐☐:☐☐ (24 hr clock e.g. 2.21pm as 14:21)

PART B

12) Was the above named person detained under an admission order pursuant to Section 24(3)? ☐ YES ☐ NO (if no, please complete number 13 below)

13) Did the person stay in the Approved Centre as a voluntary patient ☐ YES ☐ NO

Signed: _____ Job Title: _____

Date: ☐☐/☐☐/☐☐☐☐ (dd/mm/yyyy)

PAGE 1 of 2

Figure 2-1 Clinical Practice Form – Mental Health Act Section 23(1)

2.9. Clinical Data

Clinical data obtained through the EHR comprised primary psychiatric diagnosis, personal and familial past psychiatric history, past medical history, alcohol and substance dependency history, suicidal risk, violence risk, clinical symptoms at point of admission and initiation of S.23(1), length of stay, and discharge outcomes.

2.9.1. Primary psychiatric diagnosis

The primary psychiatric diagnosis for each Case and Control was extracted from the Discharge Summary Report which is completed at a patient's point of discharge. During the study period, SPMHS used the ICD-10-CM (International Classification of Diseases, Tenth Revision, Clinical Modification) (WHO, 1992) to classify and code all diagnoses of admitted patients. The ICD-10 is a diagnostic tool, maintained by the World Health Organisation that is used globally. Chapter V of the ICD-10 classifies mental and behavioural disorders. There are ten main groupings (with additional subcategories):

i. FO: Organic, including symptomatic, mental disorders
ii. F1: Mental and behavioural disorders due to use of psychoactive substances
iii. F2: Schizophrenia, schizotypal and delusional disorders
iv. F3: Mood [affective] disorders
v. F4: Neurotic, stress-related and somatoform disorders
vi. F5: Behavioural syndromes associated with physiological disturbances and physical factors
vii. F6: Disorders of personality and behaviour in adult persons
viii. F7: Mental retardation
ix. F8: Disorders of psychological development
x. F9: Behavioural and emotional disorders with onset usually occurring in childhood and adolescence

Primary diagnoses were recorded by reference to the ICD-10 classification system and then re-categorised as follows:

i. "Organic Disorders" referencing all primary diagnoses recorded under F0
ii. "Substance Use Disorders" referencing all primary diagnose recorded under F1
iii. "Psychotic Disorders" referencing all primary diagnoses recorded under F2
iv. "Depressive Disorders" referencing all primary depression-related diagnoses recorded under F3
v. "Bipolar Disorders" referencing all primary bipolar-related diagnoses recorded under F3
vi. "Anxiety Disorders" referencing all primary diagnoses recorded under F4
vii. "Eating Disorders" referencing eating disorder diagnoses recorded under F5
viii. "Personality Disorders" referencing all primary diagnosis recorded under F6

The rationale for this re-categorisation was to simplify the language used to describe the ICD-10 diagnoses and to distinguish depressive and bipolar/manic presentations which under ICD-10 are considered together under the F3 category *Mood Disorders*.

2.9.2. Substance use

The presence of problematic alcohol and/or substance use on admission is documented for all admissions to SPMHS and was extracted from the EHR, regardless of whether it was subsequently classified as a primary substance use disorder diagnosis. The assessment of whether the alcohol and/or substance use of a patient prior to admission is deemed problematic is a clinical decision, made by the admitting doctor and recorded on a designated page of the electronic admission document.

2.9.3. Psychiatric history

Data related to a patient's psychiatric history were extracted from the EHR. This included information on whether the recorded admission represented the patient's first psychiatric episode and the number of previous recorded inpatient admissions, either at SPMHS or another Approved Centre. However, it was not possible to accurately determine the number of past involuntary admissions for these patients. Further data relevant to suicidal risk and psychiatric history were obtained from the risk assessment tools used internally at SPMHS (see 2.9.5).

2.9.4. Clinical Data at time of S.23(1) initiation

Clinical data relevant to the initiation of S.23(1) were extracted from the electronic clinical notes of each case and included:

i. The requirement for mechanical restraint around the time of the S.23(1) Order initiation. This information is centrally recorded by way of an "Incident Form";
ii. The requirement for intra-muscular medication administration (known as rapid tranquilisation) at the time of the S.23(1) Order;
iii. The requirement for a transfer to another ward following the initiation of S.23(1);
iv. The presence of psychotic or manic symptoms at the time of the S.23(1) Order; and
v. The presence of suicidal risk at the time of the S.23(1) Order.

2.9.5. Internal SPMHS risk assessment tools

2.9.5.1. *Longitudinal assessment of suicidal risk*

A longitudinal assessment of suicidal risk is conducted for every patient admitted to SPMHS using an internally developed assessment tool. This tool is completed at the point of admission for all patients and prompts admitting doctors to provide binary yes/no responses to a series of questions related to suicidal risk. It serves as a guideline only and does not yield a composite score or value for suicide risk upon completion. Clinical data extracted from these admission assessments included the presence (or absence) of:

i. A five-year history of treatment for their presenting illness OR at least two previous admissions to psychiatric hospital;
ii. A previous significant suicide attempt;
iii. A family history of completed suicide in first- or second-degree relatives;
iv. Whether the patient had been referred from a tertiary service provider;
v. The presence of a mood disorder on admission;
vi. The presence of impaired insight on admission;
vii. The presence of psychotic features on admission;
viii. Whether the patient lived alone or was socially isolated; and
ix. Previous engagement in self-harming behaviours.

2.9.5.2. *General risk assessment tool*

A general risk assessment tool, also developed internally for use within SPMHS, is completed by the admitting clinician for all patients upon admission and may be updated as necessary during the inpatient stay. This tool addresses various aspects of violence and suicide risk, prompting patients to respond to a series of binary yes/no questions to record the presence or absence of both current and historical features (see Figure 2-2, 2-3). The responses contribute to formulating an overall risk impression, that is categorised as Low, Medium or High based on the clinical judgement of the assessing clinician. For suicide risk, this overall risk impression is evaluated in conjunction with the longitudinal assessment tool mentioned above.

The overall risk impressions, recorded on admission, along with specific data pertaining to suicide and violence risk, were extracted for analysis for each case and control. Specifically, for suicide risk, whether the patient expressed suicidal communication at the point of admission was documented. For violence risk, the presence of a history of violence was recorded.

V: VIOLENCE RISK – (Brief Risk Screen)	
Historical Items	
Violent act(s)	☐
Violence before the age 15	☐
History of previous violence	☐
Weapon use	☐
Conviction(s) for violence	☐
Probably personality disorder	☐
Alcohol / drug misuse	☐
Prior supervision failure	☐
Current Items	
Intoxicated	☐
Active psychosis	☐
Violent ideation	☐
Identified target	☐
Access to weapons	☐
An expression or concern from others about the risk	☐
Violence Risk Score	☐ Low / Medium / High

Figure 2-2 General Risk Assessment Tool - Violence Risk

S: SUICIDE RISK – (Over last week period: Brief Risk Screen Rated in Conjunction with LASR)	
An expression of concern from others (incl. family and staff) about suicide	☐
Suicidal ideation, communication or intent	☐
Hopelessness	☐
Ongoing psychosocial stress within the last week (e.g. relationship, work, financial or physical illness)	☐
Problem solving deficits in suicide risk	☐
Alcohol / substance misuse over the last week	☐
Significant change in mental state (worsening depression, agitation, or psychosis over the last week)	☐
Recent poor treatment adherence	☐
Suicide Risk Score	☐ Low / Medium / High

Figure 2-3 General Risk Assessment Tool – Suicide Risk

2.9.6. Discharge Data

Data pertaining to discharges from SPMHS were extracted from the Discharge Summaries of each case and control and included:

i. Whether the patient discharged from SPMHS against medical advice; and
ii. To where they were discharged, i.e., home or another hospital, psychiatric or physical.

2.10. Outcome Assessments

2.10.1. Length of Stay

The inpatient length of stay (LOS) may be defined as the period during which a patient is confined to a hospital or any other health care establishment (Chazard et al., 2017). Only the physical inpatient portion of an admission was counted towards calculating the LOS of any case or control. LOS was therefore measured as the difference between the date on which a patient was physically admitted to SPMHS and the date on which they were either discharged home, discharged to SPMHS Homecare services, or discharged to another hospital. Patients who commenced their care under Homecare arrangements at SPMHS and were then transferred to a physical admission at SPMHS were considered to have their LOS commence at the point of this physical admission.

2.10.2. Clinical Global Impression Scale

The Clinical Global Impression Scale (CGI), originally developed for assessing the relative cost-benefit of treatment in psychiatric patients (Guy, 1976) is a standardized clinician-rated mental health assessment tool, commonly used for evaluating psychiatric treatment in patients. The CGI enables clinicians to provide an overall summary assessment of a patient based on all available information including their history, psychosocial circumstances, symptoms, behaviour and the impact of symptoms on the patient's ability to function

(Busner & Targum, 2007). The CGI is comprised of two one-item measures. The GGI-Severity (CGI-S) Scale evaluates the severity of illness in a patient at the point of their initial assessment while the CGI-Improvement (CGI-I) Scale evaluates change in the severity of that illness following the initiation of treatment or intervention.

2.10.2.1. CGI-Severity (CGI-S)

The CGI-S asks the clinician: "*Considering your total clinical experience with this particular population, how mentally ill is this patient at this time?*" (Guy, 1976). The CGI-S provides a baseline evaluation of illness severity and considers the patient's presentation (in terms of symptoms, behaviour and function) in the preceding seven days. In SPMHS the CGI-S is completed at a patient's first multi-disciplinary team meeting post-admission. The clinician response is rated on a 7-point scale:

1 = normal, not at all ill

2 = borderline mentally ill

3 = mildly ill

4 = moderately ill

5 = markedly ill

6 = severely ill

7 = amongst the most extremely ill patients

2.10.2.2. CGI-Improvement (CGI-I)

The CGI-I enables clinicians to track a patient's progress following the initiation of their treatment. At each clinician assessment following their initial (baseline) assessment, the clinician answers the question "*Compared to the patient's condition at baseline, this patient's [average] condition has…?*" (Guy, 1976). In SPMHS, the CGI-I is completed weekly at a patient's multi-disciplinary meeting. Again, the clinician response is rated on a 7-point scale:

1 = Very much improved

2 = Much improved

3 = Minimally improved

4 = No change

5 = Minimally worse

6 = Much worse

7 = Very much worse

2.10.3. Time-to-Readmission

The outcome variable *time-to-readmission* was defined as the number of days following hospital discharge to the first psychiatric readmission at SPMHS within 12 months.

2.11. Data Quality Assurance

All required data were extracted from the EHR by the primary researcher. As the study was retrospective, all data were available at the time of commencement of the study. All data were factual and required no clinical interpretation. All data were checked twice by the primary researcher. To mitigate the possibility of collection error, data relating to 10% of all cases and controls were independently checked by a clinician authorised to access the SMPHS EHR for research purposes. To identify the 10% of data to be independently verified all cases and controls were separately assigned random numbers in Excel (Microsoft) using the [=Rand()] function. This function assigned random values between 0 and 1 to each case and control. These random numerical values were then sorted from largest to smallest using the Sort and Filter function. Through this sequence, the cases and controls were randomly shuffled. The first 17 shuffled cases and the first 35 shuffled controls were taken to represent a random 10% sample.

2.12. Statistical Analysis

Statistical analyses were performed using IBM SPSS Statistics (V.22). Data were normally distributed unless otherwise specified. Comparative analysis between the groups were performed using chi-square tests for categorical data and Mann-Whitney U test for continuous non-parametric data.

Binary logistic regression was used to analyse (i) the relationship between demographic and clinical characteristics and case-control status (Model A – Study 1) and (ii) the relationship between demographic and clinical characteristics and non-regraded and regraded status following detention under S.23(1) (Model B – Study 2).

Covariates entered into the Model A included those variables found to be statistically significantly different (at $P < .05$) following univariate analysis as well as others, not significantly different, but identified in the literature as risk factors for involuntary hospitalisation including sex and social isolation (van der Post et al., 2014a; Walker et al., 2019).

Covariates entered into Model B included those variables found to be statistically significantly different (at $P < .05$) following univariate analysis as well as others, not significantly different on univariate analysis, but identified as a statistically significant risk factor for S.23(1) detention by Model A. Odds ratios and 95% confidence intervals were calculated for each variable.

The regression models were tested for multicollinearity which is where two or more independent variables are highly correlated. Multicollinearity was assessed using Variance Inflation Factor (VIF) statistics and a cut-off value of 10 was used, above which it is generally accepted that an inflation in variances is potentially caused by correlated predictors (O'Brien, 2007).

LOS tends to be distributed as heavy tailed with values concentrated around the median and may contain outliers with extremely high values (Chazard et al., 2017; Gardiner et al., 2014). Therefore, Mann-Whitney testing was used for comparing mean LOS between cases and controls (Chazard et al., 2017).

Kaplan-Meier life tables were used to compare time-to-readmission between groups over a 12-month period following discharge. The Kaplan-Meier curve demonstrates the probability of "survival", i.e., of not being readmitted for both groups at a series of time-points post-discharge. Log-rank analysis was used to determine statistical significance between groups in terms of cumulative time to readmission. Patients not readmitted during the 12-month period following their discharge from hospital were treated as censored and coded as 0. The significance level was set at 5% ($P < .05$) for all analyses.

Chapter 3 : Results - Predictors and outcomes of detention under psychiatric holding powers

3.1. Introduction

There is scarce literature, in Ireland or internationally, that characterises individuals detained under psychiatric holding powers as a discrete population.

In the first part of this chapter, cases detained under S.23(1) holding powers and those never detained (controls) are compared using demographic data, diagnosis, prescribed medication, historical characteristics, psychiatric symptoms at admission and CGI-Severity scores at admission. By characterising cases and controls by reference to demographic and clinical factors, this study aims to evaluate whether significant differences exist between the two groups and whether any patient-factors may be considered predictive of future detention under S.23(1). It is hypothesised that patients detained under S.23(1) will exhibit a greater burden of mental illness compared to those who are not detained.

In the second part of this chapter, outcomes for cases detained under S.23(1) and controls, who were never detained, are compared to evaluate if there are any differences between the groups. Outcomes in this study are measured by reference to total length of stay (LOS), Clinical Global Impression – Improvement (CGI-I) score at discharge and readmission rates within 12 months of discharge. Readmissions from both groups are also explored through survival analysis. It is hypothesised that there is no difference in the overall outcomes for both detained and non-detained groups.

3.2. Comparative analysis and predictors of detention under S.23(1)

3.2.1. Demographic Data

Between 1st January 2018 and 31st December 2020 there were 167 voluntary admissions during which S.23(1) was initiated at least once. These 167 admissions comprised 162 patients: there being five readmissions during the study period. 334 controls were included for comparative analyses.

The groups were compared by reference to sex, age, ethnicity, marital status, occupational status, educational status and determination of social isolation. Across all demographic variables, there were no statistically significant differences between the groups (Table 3-1).

Table 3-1 Demographic data by case-control status

	Case (n = 167)		**Control (n = 334)**		***U* or χ^2**	***P***
Characteristic	**N**	**%**	**N**	**%**		
Sex						
Female	108	64.7	209	62.6	0.21	.646
Male	59	32.1	125	37.4		
Age, median (IQR), y	52 (34-65)		50 (33-65)		0.35	.779
Ethnicity						
White Irish	162	97	316	94.6	1.46	.265
Marital Status						
Single	86	51.5	146	43.7		
Married / Civil Partnership	64	38.3	142	42.5		
Separated	8	4.8	21	6.3		.215[a]
Divorced	0	0.0	7	2.1		
Widowed	9	5.4	18	5.4		
Occupational Status						
Employed	65	38.9	141	42.3		
Unemployed	31	18.6	58	17.4		
Student	23	13.8	25	7.5	5.89	.207
Retired	42	25.1	99	29.7		
Looking after the home	6	3.6	11	3.3		
Educational Attainment						
Third level	91	57.6	202	61.0	0.53	0.469
Social Isolation/Living Alone	54	32.3	87	26.1	2.12	0.146

Abbreviation: IQR, interquartile range; [a]Values determined using Fisher's exact χ^2 test

3.2.2. Diagnosis

Table 3-2 describes the diagnoses of cases and controls as recorded at discharge. Unipolar depressive disorders were the most commonly diagnosed mental illness amongst all patients (31.3%) but the proportions did not differ between the groups. Bipolar disorders and psychotic disorders were more commonly diagnosed among cases compared to controls and this was statistically significant (29.3% *v.* 11.7%, *P* < .001 and 17.4% *v.* 4.8%, *P* < .001, respectively). Anxiety disorders and substance use disorders were more commonly diagnosed in the control group (3.6% v. 18%, *P* < .001 and 4.8% v. 19.5%, *P* < .001, respectively) as were eating disorders. Personality disorders were diagnosed in 7.8% of cases and 9.6% of controls, and organic disorders were diagnosed in 3.6% of cases and 0.9% of controls but these differences were not statistically significant findings (*P* = .507 and *P* = .660, respectively).

Table 3-2 Diagnosis by case-control status

	Case (n = 167)		**Control (n = 334)**		χ^2	***P***
Characteristic	**N**	**%**	**N**	**%**		
Diagnostic (ICD-10) group						
Bipolar Disorders (F30-F31)	49	29.3	39	11.7	23.99	<.001
Psychotic Disorders (F20-F29)	29	17.4	16	4.8	21.53	<.001
Depressive Disorders (F32-F39)	55	32.9	102	30.5	0.30	.586
Anxiety Disorders (F40-F48)	6	3.6	60	18.0	20.10	<.001
Substance Use Disorders (F10-F19)	8	4.8	65	19.5	19.25	<.001
Personality Disorders (F60-F69)	13	7.8	32	9.6	0.44	.507
Organic Disorders (F00-F09)	7	4.2	3	0.9		.660[a]
Eating Disorders (F50)	0	0.0	16	4.8		.002[a]

Abbreviation: ICD-10, International Classification of Diseases 10th Revision; CGI-S, Clinical Global Impression Severity Scale.

[a] Values determined using Fisher's exact χ^2 test

3.2.3. Historical Characteristics

Cases were more likely than controls to have had a history of suicide attempt (38% *v.* 27.5%, *P* = .02) or a history of violence (9% *v.* 2.7%, *P* = .002) (Table 3-3). Approximately two thirds of all patients (66.9%) had a prior psychiatric admission and this differed significantly between cases and controls (74.4% *v.* 63.8%, *P* = .02). No significant differences were found in comparisons of previous psychiatric episode (84.4% *v.* 85.6%, *P* = 0.73), family history of psychiatric illness (51.9% *v.* 53.2%, *P* = 0.79), family history of suicide (14.1% *v.* 13.2%, *P* = 0.77) or past history of self-harm (25.8% *v.* 21.6%, *P* = 0.30).

Table 3-3 Historical characteristics by case-control status

	Case (n = 167)		**Control (n = 334)**		χ^2	***P***
Characteristic	**N**	**%**	**N**	**%**		
Historical characteristics						
Past psychiatric episode	141	84.4	285	85.6	0.12	.732
Past psychiatric admission	122	73.0	213	63.8	5.63	.018
At least five years tx for this illness prior to admission or at least two prior admissions	120	71.9	216	64.7	2.60	.107
Past suicide attempt	62	37	92	27.5	5.64	.018
History of self-harm	42	25.8	72	21.6	1.10	.295
History of violence	15	9.0	9	2.7	9.65	.002
Family history of psychiatric illness	82	51.9	176	53.2	0.07	.792
Family history of suicide	23	14.1	44	13.2	0.08	.774
Substance use on admission						
Alcohol	16	9.6	67	20.1	8.85	.003
Illicit substances	17	10.2	29	8.7	0.30	.584

Table 3-3 also describes substance use on admission identified as problematic on admission assessment. Problematic alcohol consumption was more commonly identified in controls than cases (20.1% *v*. 9.6%, *P* = .003). Problematic illicit substance use was identified in 10.2% of cases and 8.7% of controls and this difference was not statistically significant.

3.2.4. Psychiatric Symptoms at Admission

On admission, cases more commonly demonstrated psychotic symptoms (31% *v.* 3.9%, *P* < .001), impaired insight (52.1% *v.* 13.9%, *P* < .001) and suicidal ideation (28.3% *v.* 18%, *P* = .008) (Table 3-6).

Table 3-4 Psychiatric Symptoms at Admission by case-control status

	Case (n = 167)		**Control (n = 334)**		χ^2	***P***
	N	**%**	**N**	**%**		
Psychiatric symptoms at admission						
Psychotic symptoms	52	31.1	13	3.9	73.20	<.001
Suicidal ideation	47	28.3	60	18	6.93	.008
Impaired insight	87	52.1	45	13.9	81.84	<.001

3.2.5. CGI-Severity Score on Admission

Baseline illness severity, measured using the CGI-Severity Scale differed between the groups (*P* < .001) (Table 3-7). Cases were more commonly represented towards the more unwell end of the illness severity spectrum with 4.4% of cases and 9.1% of controls presenting as “mildly ill”, 18.1% of cases and 37.4% of controls presenting as “moderately ill”, 31.9% of cases and 40.3% of controls presenting as “markedly ill” and 40% of cases and 11.3% of controls presenting as “severely ill”.

Table 3-5 CGI-Severity score by case-control status

	Case (n = 167)		Control (n = 334)		χ^2	*P*
Characteristic	**N**	**%**	**N**	**%**		
CGI Severity (CGI-S) score						
Normal	0	0.0	1	0.3		
Borderline ill	1	0.6	3	0.9		
Mildly ill	7	4.4	29	9.1		
Moderately ill	29	18.1	119	37.4		<.001[a]
Markedly ill	51	31.9	128	40.3		
Severely ill	64	40.0	36	11.3		
Extremely ill	8	0.5	2	0.6		

[a] Values determined by Fisher's exact χ^2 test.

3.2.6. Risk Factors for detention under holding powers

Table 3-8 outlines the risk factors for detention of a voluntary patient under S.23(1).

Detention was significantly associated with the presence of impaired insight (OR 4.135; 95% CI, 2.46-6.94), psychotic symptoms (OR 7.56; 95% CI, 3.53-16.22) and suicidal ideation on admission (OR 2.58; 95% CI, 1.50-4.44). It was also significantly associated with a diagnosis of bipolar disorder (OR 2.5; 95% CI, 1.34-4.46) but not that of a psychotic disorder (OR 2.27; 95% CI, 0.98-5.26). S.23(1) detention was not associated with sex (OR 1.18; 95% CI, 0.73-1.91), social isolation (OR 1.05; 95% CI, 0.63-1.72), a history of violence (OR 2.09; 95% CI, 0.68-6.39), past significant suicide attempt (OR 1.32; 95% CI, 0.80-2.17) or past psychiatric admission (OR 1.10; CI, 0.66-1.84).

Variance inflation factor (VIF) values were below the cut-off of 10, demonstrating no significant problem with multicollinearity (O'Brien, 2007). The overall regression model was statistically significant when compared to the null model, (χ^2 (12) =145.055 $P < .001$). Modelling explained 36% (Nagelkerke R^2) of the variation in detention under S.23(1) holding powers and correctly predicted 77.8% of cases.

Table 3-6 Risk factors for detention under S.23(1)

Variables	β	**SE**	**Wald**	***P***	**OR**	**95% CI**	**VIF**
Sex	0.164	0.247	0.442	.506	1.18	0.73-1.91	1.057
Past psychiatric admission	0.096	0.262	0.136	.713	1.10	0.66-1.84	1.117
Past significant suicide attempt	0.276	0.254	1.178	.278	1.32	0.80-2.17	1.126
Impaired insight at admission	1.419	0.263	28.830	<.001	4.14	2.46-6.94	1.284
Psychotic at admission	2.023	0.389	27.014	<.001	7.56	3.53-16.22	1.280
Suicidal ideation at admission	0.946	0.278	11.615	.001	2.58	1.50-4.44	1.125
History of violence	0.736	0.571	1.664	.197	2.09	0.68-6.39	1.068
Social Isolation or living alone	0.044	0.255	0.030	.762	1.05	0.63-1.72	1.032
Diagnosis of psychotic disorder	0.820	0.429	3.656	.056	2.27	0.98-5.26	1.250
Diagnosis of bipolar disorder	0.915	0.296	9.579	.002	2.50	1.40-4.46	1.195

Abbreviation: β, regression coefficient; SE, standard error; 95% CI, 95% confidence interval of odds ratio; VIF, variance inflation factor.

3.3. Comparison of outcomes following detention under S.23(1)

3.3.1. Length of Stay

Length of stay (LOS) data did not follow a normal distribution and therefore median and interquartile ranges were compared between the groups with the Mann-Whitney U Test to evaluate for statistical significance (see Table 3-9). The median LOS was longer for detained cases (67 days) than controls (39 days) and this differed significantly between the groups (U = 16840.5, P < .001).

Table 3-7 Length of stay by case-control status

Outcome	**Case (n = 167)**	**Control (n = 334)**	**U**	***P***
Length of stay, median (IQR), days	67 (40-100)	39 (24.75-59)	16840.5	<.001

Abbreviation: IQR, interquartile range;

3.3.2. GGI-Improvement Score

Illness improvement at discharge, measured using the CGI-Improvement Scale did not differ significantly between the groups at discharge (Table 3-10). Both cases and controls were most likely to be rated as "much improved" (51.6% *v.* 46.5%) or "minimally improved" (30.1% *v.* 37.7%) while similar proportions were recorded as "very much improved" (9.8% *v.* 9.4%) or demonstrating "no change" in their presentation (7.8% *v*. 5.4%).

Table 3-8 CGI-Improvement score by case-control status

	Case (n = 167)		**Control (n = 334)**		χ^2	***P***
Outcome	N	%	N	%		
CGI Improvement (CGI-I) Score[a]						
Very much improved	15	9.8	28	9.4	Fisher Ex.	.555[b]
Much improved	79	51.6	138	46.5		
Minimally improved	46	30.1	112	37.7		
No change	12	7.8	16	5.4		
Minimally worse	1	0.7	2	0.7		
Much worse	0	0.0	1	0.3		

[a]Clinical Global Impression – Improvement Score allocated by treating clinical team within one week of discharge.
[b] Values determined using Fisher's exact χ^2 test.

3.3.3. Readmission within 12 months of discharge

24% of cases and 29.3% of controls were re-admitted to SPMHS within 12 months of discharge. There were no significant differences in the readmission rates between the groups (Table 3-11).

Table 3-9 Readmission within 12 months of discharge

	Case (n = 167)		Control (n = 334)		χ^2	*P*
Outcome	N	%	N	%		
Re-admission within 12 months	40	24.0	98	29.3	1.62	.203

Figure 3-1 demonstrates adjusted Kaplan-Meier survival curves for days-to-readmission for cases and controls within 12 months of discharge. For those readmitted, the cumulative survival was similar for cases (156.3 days +/- SE 14.74, CI 95% = (127.41-185.19)) compared to controls (148.5 days +/- SE 9.5, CI 95% = (129.83-167.09)). Log-rank analysis indicated that this difference was not statistically significant (χ^2 (1) = .001, *P* = .980) and the shape of the curve illustrated a similar pattern of readmission for both groups that is consistent over time.

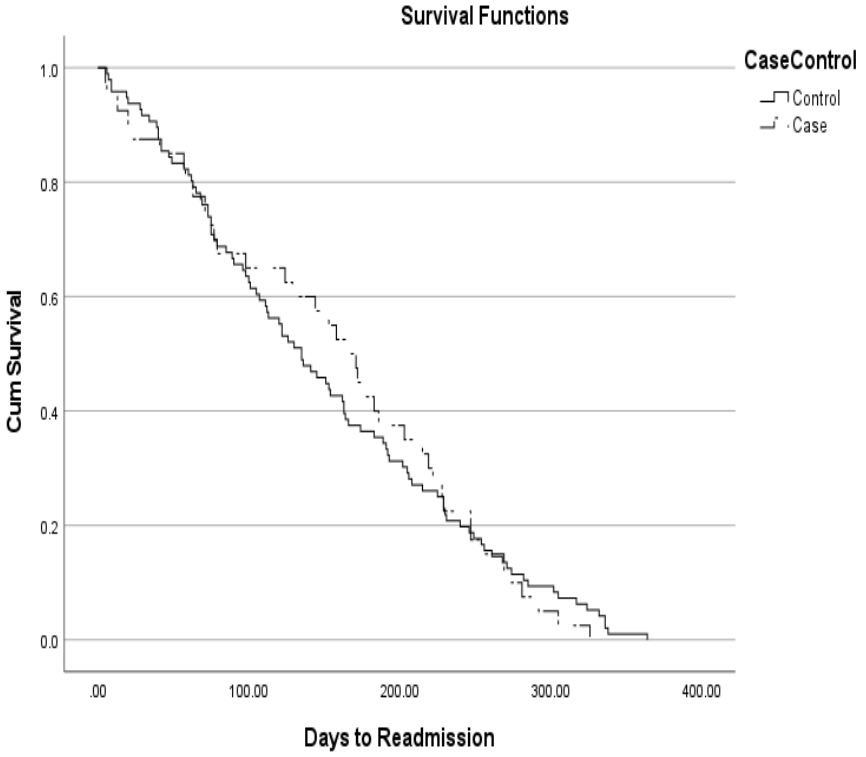


Figure 3-1 Kaplan-Meier curve showing cumulative survival of patients by case-control status

Cumulative survival represents chance of not being readmitted over 12-month period for cases (n= 40) and controls (n = 98).

3.4. Discussion

3.4.1. Descriptive analysis of cases and controls

167 cases and 334 controls were characterised. Controls were strategically chosen and comprised the voluntary admission preceding and proceeding each case. Across all demographic data collected, there were no significant differences between cases and controls (Table 1). For this reason, matching was not undertaken, it being unlikely in the presence of similar demographic characteristics to provide additional benefits to statistical analysis (Pearce, 2016).

Although not statistically significant, a point of interest is the ratio of female to male admissions. While females accounted for 65% of cases and 63% of controls, these figures were reflective of the ratio of female to male admissions to SPMHS between 2018-2020 where 62% (n=5510) of total admissions were female and 38% (n=3383) were male. This proportion is mirrored in 2020 national data across all independent/private and private charitable centres (including SPMHS) where 61% of admissions were female and 39% were male (Daly & Craig, 2021). This contrasts to admissions to general hospital psychiatric units and psychiatric hospitals/continuing care units where the proportion of females admitted were 47% and 45% respectively. There is no clear reason for the greater number of female admissions to independent/private and charitable centres. A review by Archer et al. (2016) on the characteristics and needs of females admitted to acute psychiatric inpatient services (in UK and Europe) highlighted a lack of gender-sensitive care in acute psychiatric inpatient settings. In these conditions, the review reports that females may experience feelings of powerlessness and considerations such as these may prompt referral to private over general psychiatric settings.

The median ages of subjects in this study (52 years for cases and 50 years for controls) also reflected national admissions data for 2020 where the age for admission to independent/private centres had a higher median age on admission of (52 years) compared to admissions to general hospital psychiatric units (44 years). Again, there is no obvious reason for this difference in median age of admissions to private and public psychiatric hospitals. One possibility is

the lack of suitable inpatient psychiatric beds for older adults in the public setting. In 2020 the Mental Health Commission reported that there were only 56 beds for older adults (out of a total of 1050 adult beds) meaning that older-age individuals presenting with mental illness requiring admission are being admitted to general acute mental health units alongside working-age adults (Mental Health Commission, 2020a).

This lack of inpatient beds, coupled with the fact that older adults have high health insurance coverage (Health Insurance Authority, 2020), (particularly those aged 50-84) increases the likelihood that older individuals requiring inpatient psychiatric care may utilise their health insurance to facilitate admission to independent/private psychiatric care.

3.4.2. Risk factors for detention under holding powers

The findings of this retrospective case-control study show that the risk factors most strongly associated with detention under S.23(1) following voluntary psychiatric admission are the presence of psychotic symptoms or impaired insight. Although an infrequent event, patients admitted with these features were seven-times and four-times more likely, respectively, to becoming detained under S.23(1) during their psychiatric admission than those admitted without.

To our knowledge, there is no other research (national or international) focussing solely on predictors for detention under holding powers such as S.23(1). Notwithstanding this gap, as holding powers are a potential (but not inevitable) precursor to involuntary detention, points of comparison may be drawn against known predictors for involuntary admission generally.

A diagnosis of a psychotic disorder is a well-established risk factor for involuntary admission (Cunningham, 2012; Gilhooley et al., 2017; Silva et al., 2021). However, while the presence of psychotic symptoms at admission was significantly associated with increased risk of S.23(1) detention, a diagnosis of a psychotic disorder was not. This can be explained by the fact that psychotic symptoms are a feature of several mental disorders separate to psychotic disorders. In the present study, psychotic symptoms were identified among

cases in those diagnosed with bipolar disorders (10.2%), psychotic disorders (9.0%), depressive disorders (10.7%) and organic disorders (1.2%). Psychotic disorders were also present among the control group in those diagnosed with psychotic disorders (2.4%), depressive disorders (1.2%) and substance misuse disorders (0.3%) (see Table 4.1).

Bipolar disorders are a known risk factor for involuntary hospitalisation (Kelly et al., 2018) and this is reflected in the 2.4-fold increased risk of S.23(1) detention for this cohort.

As noted, a S.23(1) holding power may be initiated where an opinion exists that a patient seeking to leave a psychiatric hospital is suffering from a "mental disorder" such that there is a serious likelihood of that person causing immediate and serious harm to themselves or another. It is therefore unsurprising that the communication of suicidal ideation is a risk factor for the initiation of S.23(1). Impaired insight as a psychiatric symptom describes a person's incapacity to recognise that they are suffering from a mental illness, that their symptoms are pathological and that they require treatment (Beck et al., 2004). It is a known risk factor for involuntary hospitalisation (Kelly et al., 2004) and an expected risk factor for detention under a temporary holding power where a mentally unwell patient might otherwise seek to discharge themselves unsafely from hospital.

While inconsistent, the bulk of international literature associates the presence of male sex and unmarried status as risk factors for involuntary hospitalisation (Loyal et al., 2022), an association which has been reported in the Irish context in recent studies (Feeney et al., 2019; Gilhooley et al., 2017; Umama-Agada et al., 2018). In the present analysis neither male sex nor marital status was significant as between both groups.

That several predictors for temporary detention under holding powers mirror established predictors for full involuntary detention is expected: holding powers play a precursory role in converting a voluntary inpatient admission to an involuntary one. However, involuntary status is not an inevitable consequence of holding powers and it is noteworthy that in the present analysis 46% of cases were ultimately discharged from their psychiatric hold and nearly all agreed to remain in hospital. This cohort have to date been neglected in

research describing involuntarily detainees. Their inclusion here may explain why certain potential risk factors (including sex, marital status, and diagnosis of psychotic disorder) were not significant predictors in the current analysis. The precise reason for this is unclear but may reflect that patients admitted involuntarily *de novo* are at a more advanced stage of illness, whereas an evolving presentation may be present in those admitted voluntarily and subsequently detained under holding powers.

3.4.3. Comparison of outcomes following detention under holding powers

As might be expected, baseline illness severity (CGI-S) was significantly different between cases and controls, with the former presenting with a higher burden of illness on admission and requiring longer hospital stays (M=81.37 *v*. 45.74, F=63.95, *P* <0.001). Despite this, neither illness severity at discharge nor readmission rates over the 12-month period post-discharge were statistically different between the groups. In other words, those subject to psychiatric holding powers (regardless of whether this temporary detention was ultimately discharged or regraded to involuntary status) have similar outcomes to voluntary admissions never detained in terms of illness improvement and rates of readmission.

3.5. Strengths and Limitations

The existing literature describing involuntary admission of psychiatric patients omits those temporarily detained under holding powers but subsequently discharged. While time-limited, holding powers represent a limitation on the right to liberty and constitute an essential area of study. The present study provides novel insights regarding risk factors for detention under S.23(1) MHA 2001 that have not previously been described. A further strength of this study is the large data-set available detailing S.23(1) use on all admissions to SPMHS over a three-year period. The resulting data identify several discrete variables

that may aid clinicians in identifying those at greatest risk of detention under similar holding powers.

Limitations of the present study include, firstly, that the study setting, a voluntary psychiatric hospital operating in the private independent sector accepting referrals on a national basis, is not readily comparable to other approved psychiatric hospitals operating in the Irish public sector that accept referrals based on defined geographical boundaries. Secondly, SPMHS may also be differentiated in terms of its admission profile in that it likely has a lower proportion of involuntary admissions as compared to the non-independent sector. As against this, the present analysis was confined to the analysis of voluntarily admitted patients subsequently detained under S.23(1). As S.23(1) applies equally across all approved centres in Ireland irrespective of their status or general admission profile, its single clinical standard arguably calibrates and generalises the findings here. Thirdly, while holding powers similar to S.23(1) exist outside of Ireland, the provision as set out in the MHA 2001 may not be generalisable to other jurisdictions.

Fourthly, possible readmissions to other psychiatric hospitals are not considered. Fifthly, impaired insight and CGI scores are subjectively assessed by clinicians and this is a source of potential bias. Sixthly, 167 admissions detained under S.23(1) during the study period were analysed comprising five readmissions. As the primary focus of this study was on the experience of being detained under holding powers during a voluntary admission, we considered these five readmissions as separate events occurring at different times throughout the three-year period because the circumstances may have been different. Finally, as the study period partially overlapped with the emergence of COVID-19 in Ireland in March 2020, this may have impacted on the pattern of admissions after this.

Chapter 4 : Results - Use of S.23(1) MHA 2001 and predictors for regrading to involuntary status

4.1. Introduction

In this chapter, the use of S.23(1) is described by reference to frequency (including multiple initiations on a single admission), timing (in terms of days elapsed between admission and initiation, and whether initiations occurred within or without working hours), and the role of the initiating clinician. Risk identifiers including the presence of psychotic or manic symptoms, suicidal ideation and the requirement for emergency interventions, including rapid tranquilisation and physical restraint are also described at the time of S.23(1) initiation. Patients detained under S.23(1) must be reviewed by a consultant psychiatrist within 24 hours and this 'time to review' is examined. The outcomes of S.23(1) detention are described by reference to two groups: those subsequently regraded to involuntary status and those not so regraded.

In the second part of this chapter, the outcomes of S.23(1) detention during the study period are explored in greater detail. Patients detained under S.23(1) experience one of two outcomes: being regraded to involuntary status (the regraded group), or not being regraded and having the option to leave hospital or remain on a voluntary basis (the non-regraded group). In the analysis that follows, these regraded and non-regraded groups are compared by reference to demographic and clinical data to explore potential associations between the initiation of a S.23(1) hold and its regrading to involuntary status. Based on this analysis, logistic regression was performed to ascertain the effects of identified variables on the likelihood of such regrading. Outcomes are also compared between the regraded and non-regraded groups by reference to length of stay (LOS), Clinical Global Impression – Improvement (CGI-I) scores and readmission rates.

It is hypothesised that the group who are regraded to involuntary status will have a greater burden of mental illness with regard to baseline Clinical Global Impression scores on admission, presence of psychosis and insight.

4.2. S.23(1) initiation, outcomes and risk factors for regrading to involuntary status

4.2.1. Overall use of S.23(1) during study period

S.23(1) was initiated 205 times during 167 voluntary admissions to SPMHS over the study period. These 167 voluntary admissions comprised 162 patients: there being five readmissions during the study period. Of these 167 admissions, 58 were admitted during 2018, 53 in 2019 and 56 in 2020 (Figure 3-2).

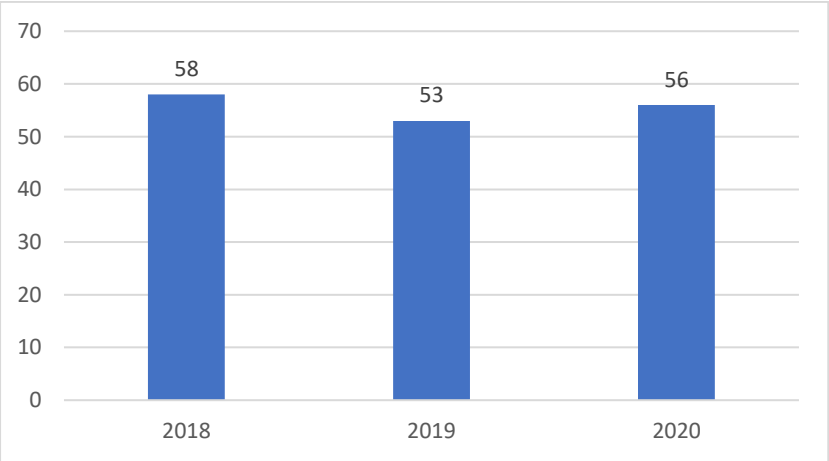


Figure 4-1 Admissions over study period during which S.23(1) initiated at least once

Of 205 initiations of S.23(1), the frequency of use in 2018 and 2019 was similar (62 *v.* 63). In 2020 there was a 28% increase in the use of S.23(1) compared to the average annual use across 2018 and 2019 (80 *v*. 62.5) (Figure 3-3).

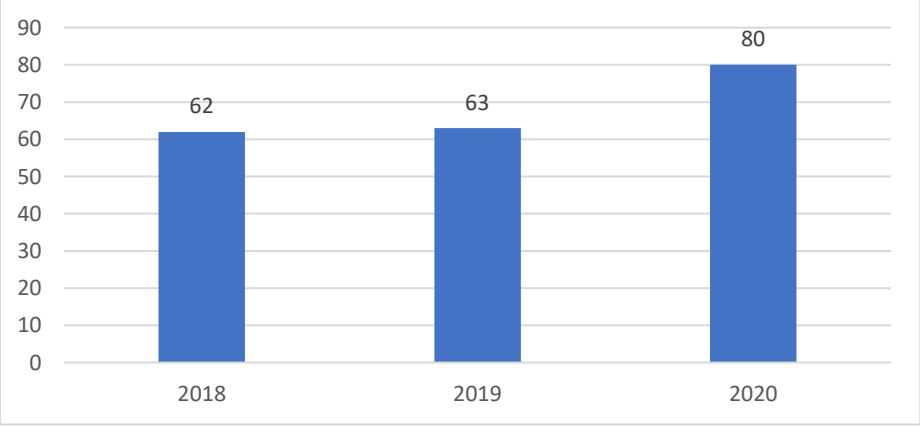


Figure 4-2 Total no. of initiations of S.23(1) by year

4.2.2. Use of S.23(1) as a proportion of total admissions

S.23(1) was initiated 62 times in 2018, 63 times in 2019, and 80 times in 2020. As a proportion of total admissions to SPMHS over the study period, S.23(1) occurred in 2% (2018), 2.2% (2019), and 2.6% (2020) of admissions (Table 3-12). However, this figure does not take of account multiple initiations of S.23(1) on the same admission.

Table 4-1 . Initiations of S.23(1) as a proportion of total admissions

	S.23(1) Initiations	**Total Admissions**	**% of Total Admissions**
2018	62	2953	2
2019	63	2887	2.2
2020	80	3075	2.6
Total	205	8915	2.3

4.2.3. Multiple initiations of S.23(1) during a single admission

S.23(1) may be initiated more than once on the same patient during the same admission. This may occur where either the initial S.23(1) detention is not progressed to an involuntary admission and is subsequently re-initiated on another occasion, or, in circumstances where the initial S.23(1) detention is progressed to an involuntary admission, where that involuntary admission is eventually extinguished and the patient is detained again under S.23(1) having been returned to voluntary status.

Table 4-2 No. of initiations of S.23(1) per admission

No. of initiations per admission	**Frequency**	**%**
S.23(1) initiated once	140	83.8
S.23(1) initiated twice	18	10.8
S.23(1) initiated thrice	7	4.2
S.23(1) initiated four times	2	1.2
Total	167	100

Over the study period, S.23(1) was initiated 205 times on 167 admissions. During 140 (83.8%) of these 167 admissions, S.23(1) was initiated once. During 27 (16.2%) of these admissions, S.23(1) was initiated more than once: twice on 18 (10.8%) admissions, thrice on seven (4.2%) admissions and four times on two (1.2%) admissions (Table 3-13 and Figure 3-7).

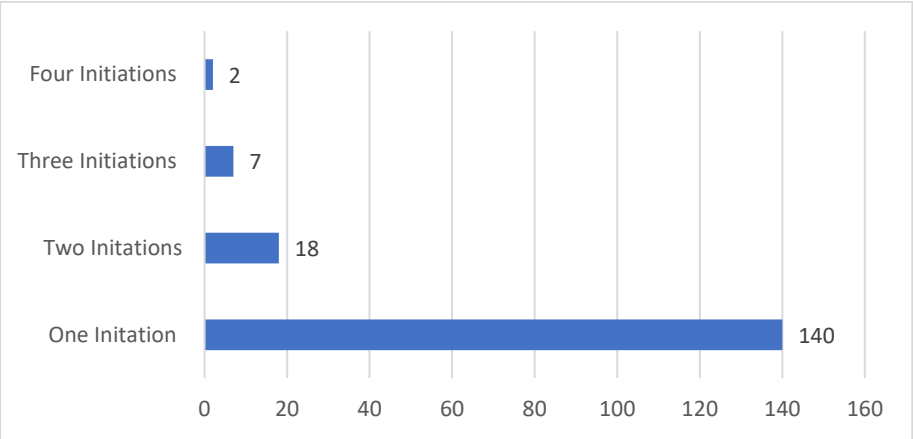


Figure 3-7. No. of Initiations of S.23(1) during a single admission during the study period

Details of the circumstances in which S.23(1) was initiated more than once during a single admission are described in Tables 3-14, 3-15 and 3-16. It is evident that there are various scenarios that contextualise the use of multiple initiations of S.23(1) on a single admission. For example, in one instance a patient was held under S.23(1). This hold was not regraded to involuntary status and the patient remained in hospital voluntarily. The patient was then subsequently detained for a second time under S.23(1) and on this occasion they were regraded to involuntary status. Then, following the revocation of that involuntary detention they were twice more held under S.23(1) but not regraded to involuntary status on either occasion (see Table 3-16, second example).

Table 4-3 Circumstances leading to two initiations of S.23(1) during a single admission

	Circumstances leading to two initiations of S.23(1) during same admission
Two initiations of S.23(1) during a single admission occurred 18 times.	• **Four** patients were twice regraded to involuntary status. • **Five** patients were twice not regraded to involuntary status. • **Two** patients were regraded to involuntary status on their first S.23(1) detention and were not regraded on their second. • **Seven** patients were not regraded to involuntary status on their first S.23(1) but were regraded to involuntary on their second.

Table 4-4 Circumstances leading to three initiations of S.23(1) during a single admission

	Circumstances leading to three initiations of S.23(1) during same admission
Three initiations of S.23(1) during a single admission occurred seven times.	**One** patient was thrice regraded to involuntary status. **Two** patients were thrice not regraded to involuntary status. **One** patient was not regraded to involuntary status on their first S.23(1) but was regraded to involuntary status on their second and third. **Three** patients were not regraded to involuntary status on their first or second S.23(1) but were regraded to involuntary on their third.

Table 4-5 Circumstances leading to four initiations of S.23(1) during a single admission

	Circumstances leading to four initiations of S.23(1) during same admission
Four initiations of S.23(1) during a single admission occurred two times.	**One** patient was not regraded to involuntary status on their first, second or third S.23(1) but was regraded to involuntary on their fourth. **One** patient was not regraded to involuntary status on their first S.23(1), was regraded on their second and was subsequently not regraded on their third and fourth S.23(1).

4.2.4. Timing of initiation of S.23(1)

Of 205 initiations of S.23(1):

- 97 (47%) took place during normal working hours (Monday-Friday, 9am-5pm), and
- 108 (53%) took place outside normal working hours.

Of 108 initiations taking place outside of normal working hours:

- 54 (26% of total) took place between Monday-Thursday, 5pm-9am, and
- 54 (26% of total) took place during the weekend or on a Bank Holiday.

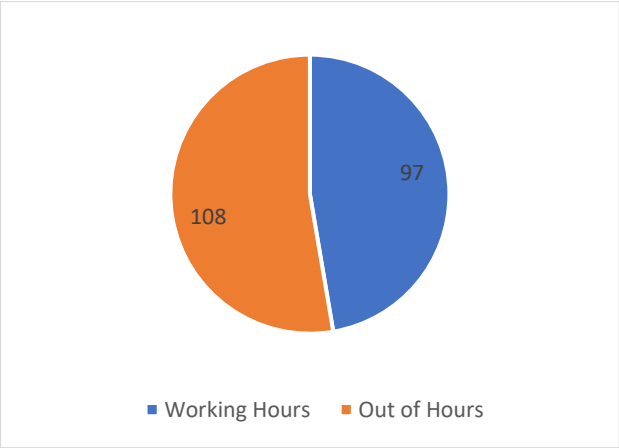


Figure 4-3 Timing of initiation of S.23(1)

4.2.5. Time to initiation of S.23(1) following admission

S.23(1) may be initiated on a voluntary patient in an approved centre following their admission, or in cases where that patient has been previously detained (either under S.23(1) or as an involuntary patient) and that period of detention has ended or been revoked. There is no minimum duration that must elapse from either the point of admission or revocation of a previous detention before S.23(1) can be initiated on a voluntary patient indicating a desire to leave hospital.

The median length of time between admission (or revocation of a previous detention) and initiation of S.23(1) was 10 days (IQR = 2-33 days). Of the 167 admissions detained under S.23(1) during the study period, 28 (17%) were detained within 24 hours of being admitted to hospital.

4.2.6. Time to review following initiation of S.23(1)

A patient detained under S.23(1) must be reviewed by the consultant psychiatrist responsible for the care and treatment of the person prior to his or her detention within 24 hours of the initiation of that detention (S.24 MHA 2001). The median time to review by a consultant psychiatrist following initiation of S.23(1) across 205 initiations was 14hrs 59mins (IQR = 5hrs 56mins – 20hrs 38mins).

4.2.7. Initiations of S.23(1) by role

S.23(1) may be initiated by a registered nurse, registered medical doctor or consultant psychiatrist on the staff of an approved psychiatric hospital (Table 3-17). Over the study period, nursing staff were responsible for 149 (72.7%) initiations of S.23(1), non-consultant hospital doctors for 45 (22%) initiations and consultant psychiatrists for 11 (5.3%) initiations.

Table 4-6 Initiations of S.23(1) by staff grade

	Detained under S.23(1) (n=205)	
Staff Grade	**N**	**%**
Consultant Psychiatrist	11	5.3
Non-Consultant Hospital Doctor	45	22
Nurse	149	72.7

4.2.8. Symptoms and risk at time of initiation of S.23(1)

Patient charts were examined for psychiatric symptoms and risk identifiers at or around the time (within 24 hours) of the initiation of S.23(1). Searched psychiatric symptoms included the recorded presence of manic/hypomanic symptoms, psychotic symptoms, and expressions of suicidal ideation. Other searched indicators of risk included the requirement for physical restraint and the requirement for rapid tranquilization.

94 (45.9%) of patients detained under S.23(1) were assessed as presenting with psychosis while 58 (28.3%) were assessed as manic/hypomanic. 46 (22.4%) patients had expressed suicidal ideation prior to the initiation of S.23(1). At the time of initiation of S.23(1), 50 (24.4%) patients required rapid tranquilization, and 28 (13.7%) required physical restraint (Table 3-18).

Table 4-7 Risk identifiers present at time of initiation of S.23(1)

	Detained under S.23(1) (n=205)			
	Present		**Not present**	
Risk identifier at initiation of S.23(1)	N	%	N	%
Manic or hypomanic symptoms	58	28.3	147	71.7
Psychotic symptoms	94	45.9	111	54.1
Suicidal ideation	46	22.4	159	77.6
Requirement for physical restraint	50	24.4	155	75.6
Requirement for rapid tranquilisation	28	13.7	177	86.3

4.2.9. Ward transfers following initiation of S.23(1)

Table 3-19 details the transfers between wards of patients following the initiation of S.23(1). 78 (38%) initiations of S.23(1) took place on open wards at SPMHS, 61 (29.8%) on the acute unit (locked ward with a higher level of observations than the open wards) and 66 (32.2%) in the special care unit (locked ward with the highest level of observations for the most unwell patients). Of those initiated on open wards, 12 (15.4%) were transferred to the acute unit and 46 (59%) to the special care unit. Of those initiated on the acute unit, 26 (42.6%) were transferred to the special care unit. Overall, of 139 initiations of S.23(1) outside of the special care unit, 72 (52%) required transfer into it. Not surprisingly, no patient detained on a holding power on the acute ward or the special care unit was transferred to a ward with less restrictions and lower level of observations.

Table 4-8 Ward transfers following initiation of S.23(1)

	Ward following S.23(1) initiation					
	Open ward		**Acute unit**		**Special care unit**	
Ward at S.23(1) initiation	N	%	N	%	N	%
Open ward (n=78)	20	25.6	12	15.4	46	59
Acute unit (n=61)	0	0	35	57.4	26	42.6
Special care unit (n=66)	0	0	0	0	66	100

4.2.10. Outcome of S.23(1) following consultant psychiatrist review

Of 205 initiations of S.23(1):

- 111 (54.1%) were regraded to involuntary status and
- 94 (45.9%) were not regraded to involuntary status, meaning that the patient was reverted to voluntary status and could either discharge from hospital or remain as a voluntary patient.

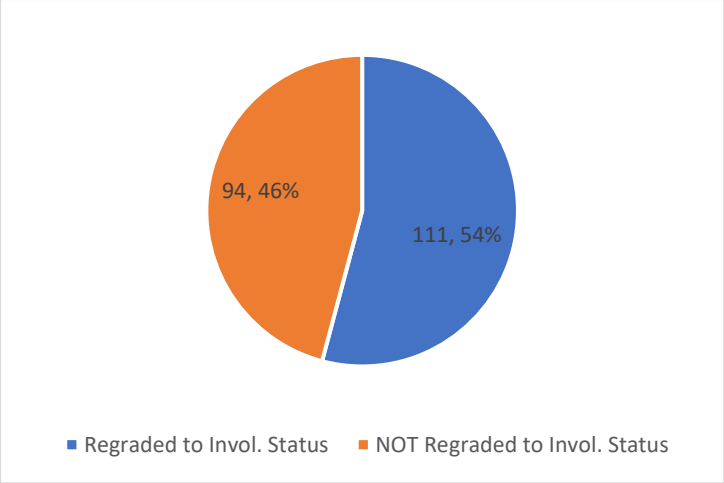


Figure 4-4 Outcome of S.23(1) following consultant psychiatrist review

4.2.10.1. S.23(1) hold regraded to involuntary status

Of the 111 initiations of S.23(1) that were regraded to involuntary status:

- 50/111 (45%) had their involuntary orders revoked prior to Tribunal, and
- 61/111 (55%) had their involuntary orders assessed at a Tribunal.

Of those 61 that went to Tribunal:

- 14/61 (22.9%) had their involuntary status revoked at Tribunal, and
- 47/61 (77%) had their involuntary status affirmed at Tribunal.

Of those 47 who had their involuntary status affirmed at Tribunal:

- 45/47 (95.7%) had their involuntary status discharged by their responsible consultant psychiatrist, and
- 2/47 (4.3%) were transferred to another approved centre under the MHA 2001 prior to the revocation of their involuntary orders.

Of those 61 patients that had their involuntary orders assessed at Tribunal, 18 (30%) had more than one Tribunal during their period of involuntary detention (see Table 3-20).

Table 4-9 No. of tribunals per period of involuntary detention

No. of detained patients who had a Tribunal (n=61)	Number of Tribunals
43	1
14	2
2	3
2	4

4.2.10.2. S.23(1) hold not regraded to involuntary status

Of the 94 initiations of S.23(1) that were not regraded to involuntary status, 91 (96.8%) chose to remain in hospital as a voluntary patient while three (3%) chose to take their discharge from hospital (see Figure 3-6).

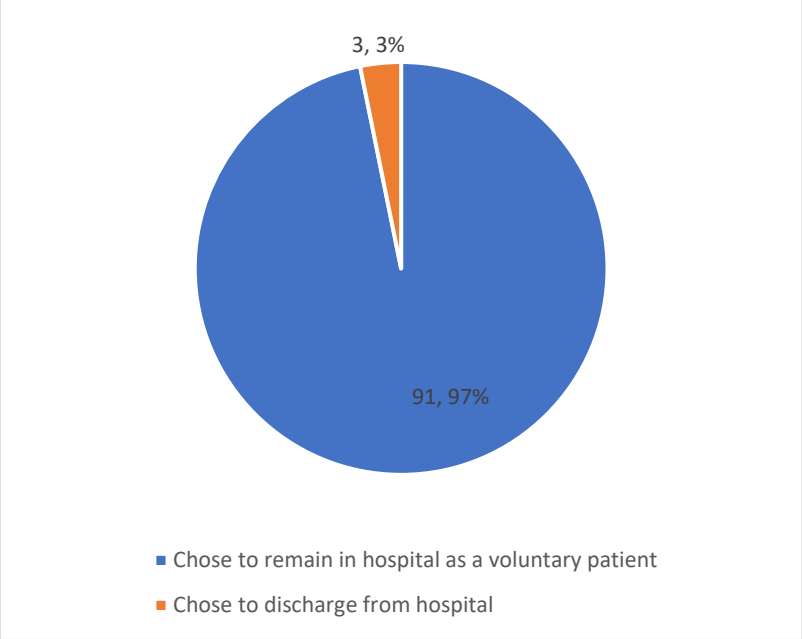


Figure 4-5 Outcome: S.23(1) not regraded to involuntary status

Figure 3-7 illustrates the outcomes following initiation of S.23(1) during the study period. The boxes highlighted in green describe the outcomes for those initiations of S.23(1) which were not regraded to involuntary and those highlighted in red describe the outcomes for those that were regraded including their Mental Health Commission Tribunal outcomes.

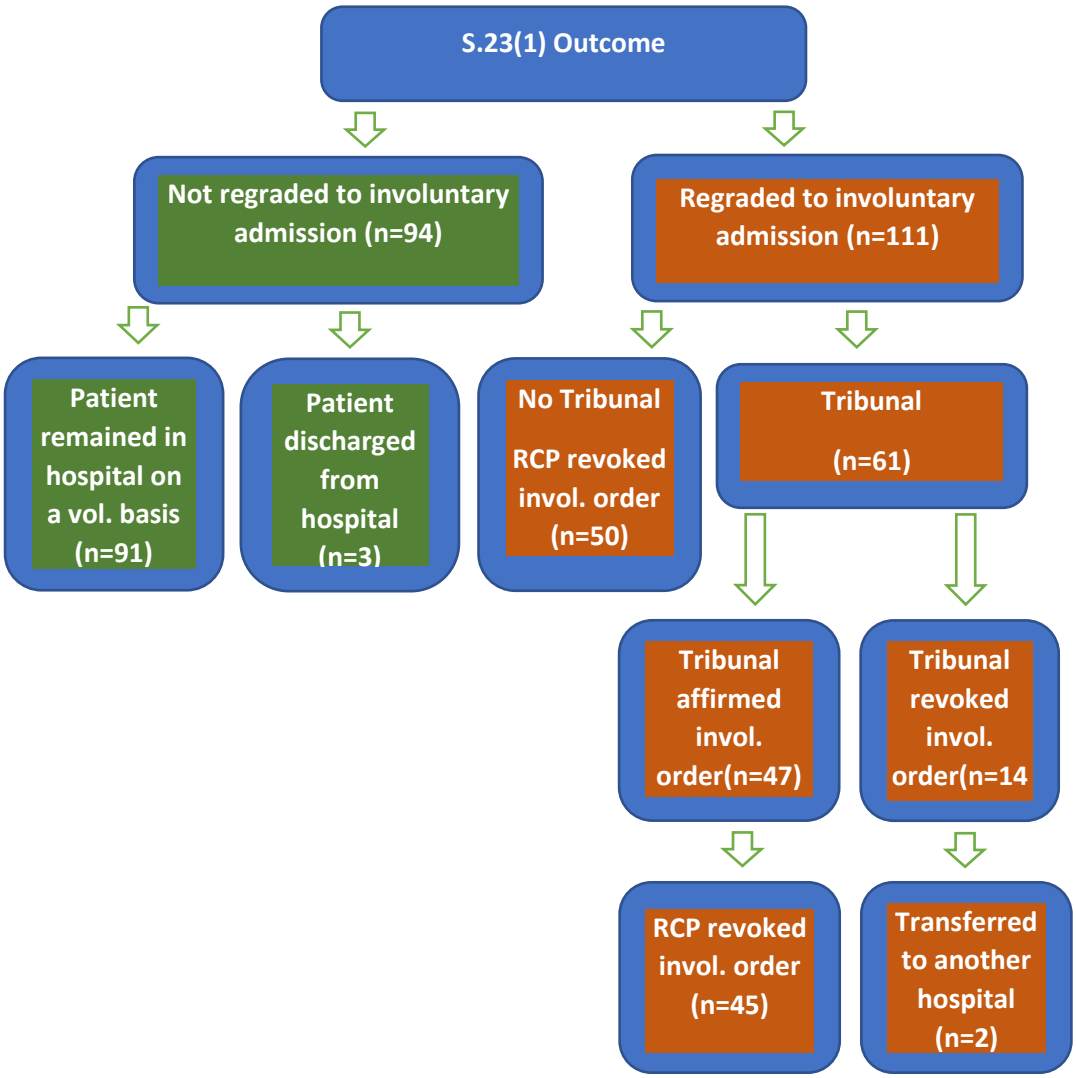


Figure 4-6 Flowchart of outcomes following S.23(1) detention

4.3. Comparative analysis and predictors for regrading to involuntary status

In the analysis that follows, regraded and non-regraded groups are compared by reference to demographic and clinical data to explore potential associations between the initiation of a S.23(1) hold and its regrading to involuntary status. Based on this analysis, logistic regression is performed to ascertain the effects of identified variables on the likelihood of such regrading. Outcomes are also compared between the regraded and non-regraded groups by reference to length of stay (LOS), Clinical Global Impression – Improvement (CGI-I) scores and readmission rates.

Between 1st January 2018 and 31st December 2020 there were 167 voluntary admissions during which S.23(1) was initiated at least once. In total, S.23(1) was initiated 205 times on these 167 admissions and 111 (54%) of these detentions were regraded to involuntary status. To control for multiple uses and outcomes of S.23(1) during a single admission, only data pertaining to the first initiation of S.23(1) for each admission was considered in the comparative analysis that follows.

4.3.1. Demographic data

On the first initiation of S.23(1) for all 167 admissions during the study period, 90 (53.9%) were regraded to involuntary status and 77 (46.1%) were not.

The groups were compared by reference to sex, age, ethnicity, marital status, occupational status, educational status and determination of social isolation (Table 3-21). Across all demographic variables except for age there were no statistically significant differences between the groups (Table 3-21). As age data were non-parametric, medians of the non-regraded and regraded were compared (years) (49 *v*. 54.5) and Mann Whitney U Test reported a statistically significant difference between the groups (P = .017).

Table 4-10 Demographic data by regraded and non-regraded status

	Not Regraded (n = 77)		**Regraded (n = 90)**		**U or χ^2**	***P***
	N	**%**	**N**	**%**		
Sex						
Female	50	64.9	58	64.4	0.004	.947
Male	27	35.2	32	35.6		
Age, median (IQR), y	49 (30-61.5)		54.5 (38.75-66.25)		2721.5	.017
Ethnicity						
White Irish	73	94.8	89	98.9	5.60	.133
Marital Status						
Single	43	55.8	43	47.8		.492[a]
Married / Civil Partnership	29	37.7	35	38.9		
Separated	2	2.6	6	6.7		
Divorced	0	0.0	0	0		
Widowed	3	3.9	6	6.7		
Occupational Status						
Employed	31	40.3	34	37.8		.988[a]
Unemployed	14	18.2	17	18.9		
Student	11	14.3	12	13.3		
Retired	18	23.4	24	26.7		
Looking after the home	3	3.9	3	3.3		
Educational Attainment						
Third level	41	57.7	50	57.5	.001	.972
Social Isolation/Living Alone	23	29.9	31	34.4	.40	.619

[a] Values determined using Fisher's exact χ^2 test.

4.3.2. Diagnosis

Table 3-22 describes the diagnoses of the non-regraded and regraded groups. Psychotic disorders, bipolar disorders and depressive disorders were more commonly diagnosed in the regraded groups but these were not statistically significant differences. Anxiety disorders, substance use disorders, organic disorders and personality disorders were more commonly diagnosed in the non-regraded groups and only the difference in personality disorder diagnosis was statistically significant between the non-regraded and regraded groups (15.6% *v.* 1.1%, *P* = <.001).

Table 4-11 Diagnosis by non-regraded and regraded status

	Not Regraded (n=77)		**Regraded (n=90)**		χ^2	***P***
	N	**%**	**N**	**%**		
Diagnostic (ICD-10) group						
Bipolar Disorders (F30-F31)	17	22.1	32	35.6	3.64	.057
Psychotic Disorders (F20-F29)	12	15.6	17	18.9	0.32	.574
Depressive Disorders (F32-F39)	23	29.9	32	35.6	0.61	.436
Anxiety Disorders (F40-F48)	3	3.9	3	3.3		.583[a]
Substance Use Disorders (F10-F19)	6	7.8	2	2.2		.060[a]
Personality Disorders (F60-F69)	12	15.6	1	1.1		<.001[a]
Organic Disorders (F00-F09)	3	3.9	3	3.3		1.00[a]
Eating Disorders (F50)	0		0		-	

[a]Values determined using Fisher's exact χ^2 test

4.3.3. Historical Characteristics

Across all historical characteristics compared between the non-regraded and regraded groups there were no statistically significant differences (Table 3-24).

Table 3-24 also describes problematic substance use on admission identified during the admission assessment for non-regraded and regraded patients. As regards problematic alcohol and illicit substance use, there were no statistically significant differences between the groups.

Table 4-12 Historical characteristics by non-regraded and regraded status

	Not Regraded (n = 77)		**Regraded (n = 90)**		χ^2	***P***
	N	**%**	**N**	**%**		
Historical characteristics						
Past Psychiatric Episode	68	88.3	73	81.8	1.64	.200
Past Psychiatric Admission	57	75.0	65	73.9	0.03	.868
At least five years treatment for this illness prior to admission or at least two prior admissions	57	74.0	63	70.0	0.33	.564
Past suicide attempt	30	39.5	32	36.8	0.13	.724
History of self-harm	24	31.6	18	20.7	2.52	.113
History of violence	9	11.7	6	6.7	1.28	.258
Family History of Psychiatric Illness	36	51.4	46	52.3	0.01	.916
Family History of Suicide	11	14.9	12	13.5	0.06	.801
Substance Use						
Alcohol	7	9.1	9	10.0	0.04	.842
Illicit substances	10	10.1	7	7.8	1.23	.267

4.3.4. Psychiatric symptoms at admission

On admission, regraded patients more commonly demonstrated psychotic symptoms and impaired insight (35.6% *v.* 26%), but these were not statistically significant differences between the groups (Table 3-26). The presence of suicidal ideation on admission differed significantly between groups and was more commonly demonstrated by the non-regraded group (37.7% *v*. 21.1%, *P* = .018)

Table 4-13 Psychiatric symptoms at admission by non-regraded and regraded status

	Not Regraded (n = 77)		**Regraded (n = 90)**		χ^2	***P***
	N	**%**	**N**	**%**		
Psychiatric symptoms at admission						
Psychotic symptoms	20	26.0	32	35.6	1.78	.183
Suicidal ideation	29	37.7	19	21.1	5.55	.018
Impaired insight	35	45.5	52	57.8	2.55	.112

4.3.5. CGI-Severity score on admission

Baseline illness severity for the non-regraded and regraded groups, measured using the CGI-Severity Scale on admission is outlined in Table 3-27. While the non-regraded group was more commonly represented in the "mildly", "moderately" and "markedly" ill categories and the regraded group was more commonly represented in the "severely" and "extremely" ill groups, these differences did not differ significantly between the groups (*P* = .365).

Table 4-14 CGI-Severity score on admission by non-regraded and regraded status

	Not Regraded (n = 77)		Regraded (n = 90)		χ^2	*P*
	N	**%**	**N**	**%**		
CGI Severity (CGI-S) score						
Normal	0	0.0	0	0.0		
Borderline ill	0	0.0	1	1.2		
Mildly ill	4	5.3	3	3.5		
Moderately ill	18	24.0	12	14.1		.365[a]
Markedly ill	25	33.3	25	29.4		
Severely ill	25	33.3	39	45.9		
Extremely ill	3	4.0	5	5.9		

[a]Values determined using Fisher's exact χ^2 test

4.3.6. Comparative analysis of S.23(1) initiation and review

Table 3-28 compares data related to the initiation of S.23(1), including timing considerations, the clinical role of the initiator and clinical and risk features.

Regraded patients were more likely than non-regraded patients to have been detained under S.23(1) during working hours (61.1% *v.* 32.5%) and this difference was statistically significant between the groups ($P < .001$).

90% of those patients who had their S.23(1) detention initiated by a consultant were regraded to involuntary status while the other 10% did not and this was statistically significant between the groups ($P = .021$). There was no significant difference in outcome between the non-regraded and regraded groups where either nurses (72.7% *v.* 67.8%) or NCHDs (26% *v.* 22.2%) initiated the S.23(1) detention.

There was no statistically significant difference between the non-regraded and regraded groups as regards the median time (days) elapsed from admission to S.23(1) detention (6 *v.* 7, *P* = .953) or the median time (hours:mins) elapsed from initiation of S.23(1) to consultant review (15:05 *v*. 14:42, *P* = .759).

At the time of S.23(1) initiation, the regraded group more commonly demonstrated symptoms of psychosis as compared to the non-regraded group (63.3% *v*. 31.2%, *P* < .001). Features of manic or mixed affective state were also more commonly described in the regraded group than the non-regraded group (33.3% *v*. 20.8%) but this difference was not statistically significant. Non-regraded patients more commonly expressed suicidal ideation at the time of initiation of S.23(1) (23.4% *v*. 17.8%) but this did not differ significantly between the groups.

There was no significant difference between the non-regraded and regraded groups as regards the requirement for rapid tranquilisation (10.4% *v*. 17.8%) or physical restraint (22.1% *v*. 21.1%) at the time of S.23(1) initiation.

Table 4-15 Comparative analysis of regraded and non-regraded initiations of S.23(1)

	Not Regraded (n = 77)		**Regraded (n = 90)**		**U or χ^2**	***P***
	N	**%**	**N**	**%**		
Timing of S.23(1) initiation						
Working Hours	25	32.5	55	61.1	13.64	<.001
Out of Hours	52	67.5	35	38.9		
Initiator of S.23(1) detention						
Consultant	1	1.3	9	10.0		.021[a]
NCHD	20	26.0	20	22.2	0.32	.571
Nurse	56	72.7	61	67.8	0.49	.503
Time from admission to S.23(1) detention, median (IQR), days	6 (1-20.5)		7 (2-28.5)		3446.5	.953
Time from S.23(1) detention to consultant review, median (IQR), hrs	15:05 (7:45-19:44)		14:42 (4:06-22:04)		3369.5	.759

Clinical features present at S.23(1)						
Psychosis	24	31.2	57	63.3	17.19	<.001
Manic/Mixed affective state	16	20.8	30	33.3	3.28	.083
Suicidal ideation	18	23.4	16	17.8	0.80	.442
Rapid tranquilisation required at S.23(1)	8	10.4	16	17.8	1.84	.192
Physical restraint required at S.23(1)	17	22.1	19	21.1	.02	1.000

[a]Values determined using Fisher's exact χ^2 test.

4.3.7. Risk Factors for S.23(1) detention being regraded

Table 3-29 outlines the risk factors for detention under S.23(1) being regraded to involuntary status.

Regrading to involuntary status was significantly associated with being detained under S.23(1) during normal working hours (OR 3.76; 95% CI, 1.75-8.08), demonstrating psychotic symptoms at the time of initiation of S.23(1) (OR 3.16; 95% CI, 1.46-6.85) and having a diagnosis of bipolar disorder (OR 3.60; CI 1.33-9.70). Regrading to involuntary status was not significantly associated with age, sex, consultant initiation of S.23(1), a diagnosis of a psychotic disorder, impaired insight on admission, a history of past psychiatric admission or social isolation.

Variance inflation factor (VIF) values were below the cut-off of 10, demonstrating no significant problem with multicollinearity (O'Brien, 2007). The overall regression model was statistically significant when compared to the null model (χ^2 (10) = 39.207 P < .001). Modelling explained 31.1% (Nagelkerke R^2) of the variation in detention under S.23(1) holding powers and correctly predicted 53.7% of cases.

Table 4-16 Risk factors for regrading to involuntary status following detention under S.23(1)

Variables	β	SE	Wald	*P*	OR	95% CI	VIF
Age	0.019	0.011	3.072	.080	1.02	1.00-1.04	1.181
S.23(1) during working hours	1.374	0.395	12.084	<.001	3.95	1.82-8.58	1.140
Consultant initiation of S.23(1)	1.296	1.147	1.277	.258	3.67	0.39-34.63	1.105
Psychotic at S.23(1)	1.083	0.394	7.536	.006	2.95	1.36-6.40	1.235
Diagnosis of bipolar disorder	1.186	0.516	5.291	.021	3.27	1.19-8.99	1.576
Diagnosis of psychotic disorder	0.466	0.571	0.665	.415	1.59	0.52-4.88	1.387
Impaired insight on admission	0.040	0.388	0.011	.918	1.04	0.49-2.23	1.194
Suicidal ideation on admission	-0.368	0.428	0.741	.389	0.69	0.30-1.60	1.195
Past psychiatric admission	-0.319	0.463	0.476	.490	0.73	0.29-1.80	1.228
Social isolation or living alone	0.102	0.396	0.066	.797	1.11	0.51-2.40	1.018

Abbreviation: β, regression coefficient; SE, standard error; OR, odds ratio; 95% CI, 95% confidence interval of odds ratio; VIF, variance inflation factor.

4.3.8. Comparison of outcomes for regraded and non-regraded admissions

4.3.8.1. Length of Stay

The median and interquartile ranges of LOS data for patients regraded and not regraded following detention under S.23(1) were compared and the Mann-Whitney U Test was used to evaluate for statistical significance (Table 3-30).

The median LOS (total) for all admissions detained at least once under S.23(1) during the study period was 67 days (IQR = 40-100). There was not a statistically significant difference between median LOS (total) for patients regraded to involuntary status compared to those not regraded (64.5 days *v*. 71 days).

Median LOS (post initiation of S.23(1)) was calculated for both groups and was longer for patients regraded to involuntary status than those not regraded (55.5 days *v.* 37 days, *P* = .003)

Table 4-17 Comparison of length of stay between regraded and non-regraded admissions

	Not Regraded (n = 77)	**Regraded (n = 90)**	**U**	***P***
LOS (total), median (IQR), days	71 (40.5-110)	64.5 (38.5-96.25)	3356	.728
LOS (post S.23(1)), median (IQR), days	37 (23.5-66.5)	55.5 (36-85.5)	2532	.003

Abbreviation: IQR, interquartile range;

4.3.8.2. CGI Improvement Score

Illness improvement at discharge, measured using the CGI-Improvement Scale did not differ between those not regraded to involuntary and those that were regraded (Table 3-31). Both groups were most likely to be rated as "much improved" (55.2% *v.* 49.5%) or "minimally improved" (34.5% *v.* 24.7%).

Table 4-18 CGI-Improvement score by regraded and non-regraded status

	Not Regraded (n = 77)		**Regraded (n = 90)**		χ^2	***P***
	N	**%**	**N**	**%**		
CGI Improvement (CGI-I) Score[a]						
Very much improved	4	5.6	44	13.4		
Much improved	36	50.7	43	52.4		
Minimally improved	24	33.8	22	26.8		.364[b]
No change	6	8.5	6	7.3		
Minimally worse	1	1.4	0	0		
Much worse	0	0	0	0		

[a]Clinical Global Impression – Improvement Score allocated by treating clinical team within one week of discharge.

[b] Values determined using Fisher's exact χ^2 test.

4.3.8.3. Readmission within 12 months of discharge

28.6% of those not regraded to involuntary and 20% of those regraded were re-admitted to SPMHS within 12 months of discharge. There were no differences in the readmission rates between the groups (χ^2= 1.67, *P* = .266) (Table 3-32).

Table 4-19 Comparison of regraded and non-regraded admission outcomes - length of stay

	Not Regraded (n = 77)		**Regraded (n = 90)**		**χ^2**	***P***
	N	**%**	**N**	**%**		
Re-admission within 12 months	22	28.6	18	20.0	1.67	.266

Figure 3-8 demonstrates adjusted Kaplan-Meier survival curves for days-to-readmission for non-regraded and regraded patients within 12 months of discharge. For those readmitted, the cumulative survival was similar for the non-regraded group (144.6 days +/- SE 21.05, CI 95% = [103.34, 185.85]) compared to the regraded group (170.61 days +/- SE 20.42, CI 95% = [130.59, 210.64]). Log-rank analysis indicated no difference between the groups (χ^2 (1) = 0.05, *P* = .822) and the shape of the curve illustrated a similar pattern of readmission for both groups that was relatively consistent over time.

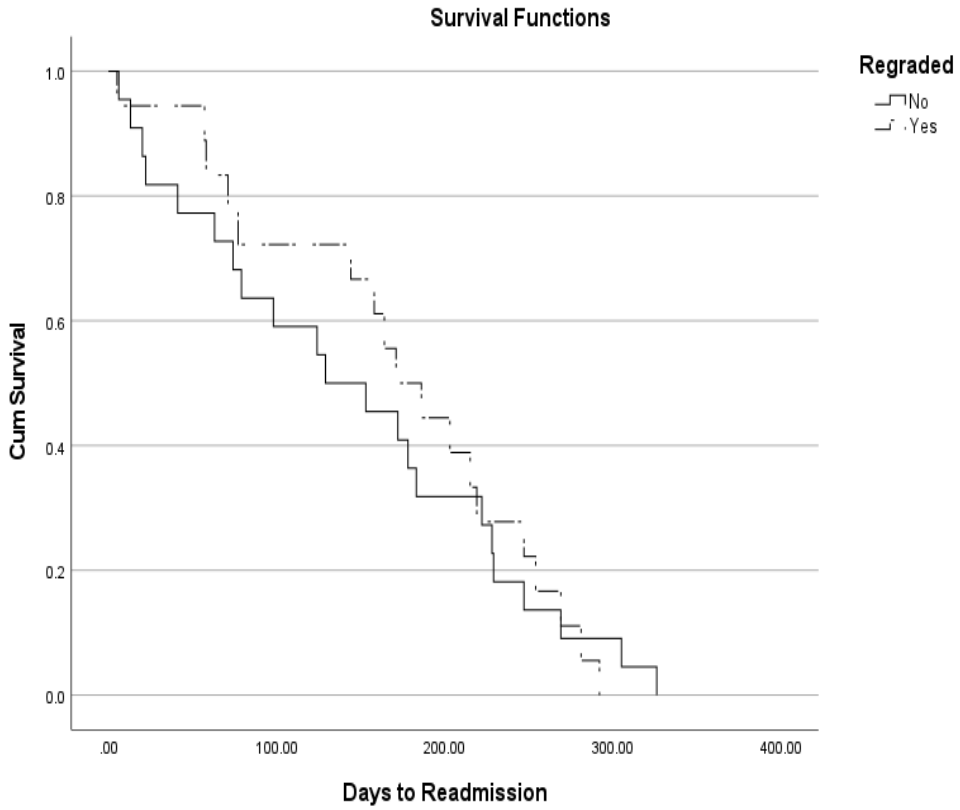


Figure 4-7 Kaplan-Meier curve showing the cumulative survival of patients by regraded to involuntary status

Cumulative survival represents chance of not being readmitted over 1-year period for non-regraded (n= 18) and regraded (n = 22) patients.

4.4. Discussion

4.4.1. Analysis of S.23(1) MHA 2001 initiation and outcomes (2018-2020)

There is limited knowledge regarding the overall use of S.23(1) MHA 2001 on voluntarily admitted patients to Irish psychiatric hospitals. This may be due to the lack of a statutory requirement for approved centres to inform the Mental Health Commission about the use of S.23(1) in instances where patients are not regraded to involuntary status. Instead, the relevant Clinical Practice Form (see Figure 2-1) on which S.23(1) is initiated states that the document *may* (at a future date) be required for inspection by the Inspector of Mental Health Services or a Mental Health Tribunal or by the MHC. Thus, while these data exist locally, there is no central register to support national comparative analysis. There is a notable absence of Irish literature that examines the overall use of S.23(1) in Irish psychiatric hospitals. One apposite study is that of Masood et al. (2015), also undertaken at SPMHS, with which some points of comparison may be made as regards risk factors for the regrading of a S.23(1) hold to involuntary status (see 4.4.2 below).

Over the period of the study presented in this thesis, S.23(1) was initiated on 2.3% of total admissions to SPMHS and its usage remained relatively stable as a proportion of total admissions from 2018 to 2020. However, in 2020, there was a 28% increase in the number of S.23(1) initiations compared to the average from the previous two years. This rise was associated with a higher frequency of S.23(1) use per individual admission. In 2020, there was an average of 1.43 initiations of S.23(1) per admission for patients held at least once that year, compared to an average of 1.19 in 2019 and 1.07 in 2018. While there is no clear explanation for this increase in S.23(1) usage in 2020, it may be hypothesized that the Covid-19 precautions implemented in Ireland in March 2020 influenced patients' willingness to remain in hospital.

During the study period, 140 admissions were held under S.23(1) only once, while multiple uses of S.23(1) on a single admission occurred 27 times (16.2%). As detailed in Tables 3-14 to 3-16 the circumstances surrounding these multiple uses varied. For instance, one patient was held under S.23(1) three times without ever being regraded to involuntary status, while another patient was regraded to involuntary status on three separate occasions. Although no two instances of S.23(1) initiation can be compared due to the dynamic presentation of mental illness in the hospital setting the utility of S.23(1) as a means of preventing mentally ill patients from prematurely discharging is recognized. However, the repeated initiation of S.23(1) during a single admission without it being regraded multiple raises ethical concerns, particularly regarding (i) the lack of oversight by the MHC for such detentions and (ii) the status of patients held under S.23(1).

Regarding the latter point, a patient held under S.23(1) does not qualify as an "*involuntary patient*" under the MHA 2001 and therefore lacks the protections that this status provides. Additionally, these patients cannot be classified as voluntary patients, as they are not free to leave. On the former point, in SPMHS, when S.23(1) is used multiple times without progressing to involuntary status, an internal oversight mechanism is activated. In such cases, the Clinical Governance Office requests a report from the relevant treating team to ensure that the use of S.23(1) has been inconsistent with the letter and spirit of MHA 2001.

S.23(1) becomes applicable at the point of admission for a voluntary patient or following the revocation of a previous detention. During the study period, the median time between either of these events and the initiation of S.23(1) was 10 days. Of the 167 admissions held under S.23(1), 28 patients (17%) were held within 24 hours of their admission. Importantly, all 28 patients detained within this timeframe had been assessed as having the capacity to accept voluntary admission to the hospital. However, these findings suggest that the transition to inpatient psychiatric care may present a destabilizing risk factor for patients, particularly during the initial 24-hour period post-admission.

47% of all initiations of S.23(1) occurred during normal working hours (Monday to Friday, 9 AM to 5 PM). The median time until their first review by a consultant psychiatrist was 14 hours and 59 minutes (IQR = 5hrs 56mins – 20hrs 38mins). The delay in review time may be attributed to the fact that 53% of initiations occurred outside of working hours, when consultant psychiatrists are generally not available on-site, resulting in assessments only taking place the following morning.

The typical working hours, responsibilities and general proximity of consultants, non-consultant hospital doctors and nurses to patients in day-to-day psychiatric care may also explain the distribution of S.23(1) initiations among these roles during the study period. Since S.23(1) is initiated in acute situations where patients indicate a desire to discharge themselves from hospital, it is not surprising that nursing staff, who are on-site 24 hours a day and work closely with patients, accounted for the majority of initiations at 72.7%. Non-consultant hospital doctors also maintain a 24-hour presence at SPMHS, which likely explains their involvement in 22% of initiations. In contrast, consultant psychiatrists only initiated 5.3% of S.23(1) holds.

Initiations of S.23(1) at SPMHS may take place in either open wards, the acute unit (a locked ward with a higher level of observation than open wards) or the special care unit (the locked ward with the highest level of observation). Among the 78 initiations of S.23(1) that took place on open wards, 58 patients (74.4%) required transfer to a ward with a higher level of observation. Notably, no patients held under S.23(1) were transferred to a ward with a lower level of observation.

Of the 205 initiations of S.23(1) during the study period, 111 (54.1%) were regraded to involuntary status. Surprisingly, in the 94 (45.9%) instances where S.23(1) was not regraded, 96.8% of the patients chose to remain in the hospital voluntarily after their temporary detention ended. This finding is unexpected, given that these patients had indicated a desire to leave the hospital within the previous 24 hours. It is hypothesized that the initiation of S.23(1) served as a last resort, occurring after attempts at verbal de-escalation had failed. Nonetheless, the fact that 96.8% of these patients changed their minds and agreed to remain as voluntary patients between the initiation of S.23(1) and

consultant psychiatrist's assessment is reassuring. This finding suggests that S.23(1) can effectively provide patients with time to recover from acute, but potentially transient deteriorations in their mental health, thereby preventing unsafe discharges.

4.4.2. Risk factors for regrading to involuntary following detention under S.23(1)

The findings of this study indicate that the risk factors most strongly associated with a S.23(1) hold being regraded to involuntary status include the initiation of the hold during working hours, the presence of psychotic symptoms at the time of the initiation, and a diagnosis of bipolar disorder.

Patients held during working hours were nearly four times more likely to be regraded to involuntary status than those held outside of these hours. This increased risk may be attributed to the likelihood of having their assessment by a consultant psychiatrist on the same day. In this scenario, the patient's condition may still be acute, whereas those detained in the evening typically do not have a consultant psychiatrist available on-site, resulting in their review being delayed until the following morning.

During the study period, consultants were responsible for ten initiations of S.23(1), 90% of which were regraded to involuntary status. Although there was a significant association on univariate analysis - consistent with previous research (Masood et al., 2015) - consultant initiation did not emerge as a predictor of regrading to involuntary status in regression analysis. This may be due to the relatively small sample size involved.

Nonetheless, when a Section 23(1) hold is initiated by a consultant psychiatrist, who is also responsible for the subsequent assessment of the patient's status, it is likely that the initial hold will progress to a second review by another consultant rather than resulting in discharge. Given their expertise, consultant psychiatrists are more likely than other roles to recognize the necessity of progressing a patient's status to involuntary where no other options are available. Therefore, patients held by consultants may represent cases that ultimately require involuntary admission. Additionally, the time to review

following the initiation of S.23(1) by a consultant psychiatrist is likely to be shorter - or even simultaneous if the consultant is also the patient's responsible consultant - meaning that the patient's acute presentation is unlikely to have changed.

Patients held under S.23(1) with a diagnosis of bipolar disorder or exhibiting symptoms of psychosis at the time of initiation were four times and nearly three times more likely, respectively, to being regraded to involuntary status than those without these conditions. Bipolar disorder is a known risk factor for involuntary hospitalisation (Kelly et al., 2018), so it is not surprising that it serves as a predictor for a S.23(1) hold being regraded to involuntary status.

The presence of psychotic symptoms, rather than the diagnosis of a psychotic disorder, was predictive of regrading to involuntary status. These findings align with the results presented in Section 4.1.2 "Risk factors for detention under holding powers". Psychotic symptoms can occur in various mental disorders beyond those classified as psychotic disorders, making this finding not unexpected. This is particularly relevant given that psychotic disorders are well-established risk factors for involuntary hospitalisation (Cunningham, 2012; Gilhooley et al., 2017; Silva et al., 2021).

Caution should be exercised when comparing these data to prior research on risk factors for involuntary hospitalisation. The cited studies typically compare risk factors between involuntarily admitted patients and those who have never been detained. Although not regraded, the comparative group to the regraded group in the present analysis consisted of patients who were nonetheless held under S.23(1) and were part of a cohort (including the regraded group) in Study 1 identified as having a greater burden of mental illness upon admission compared to a control group that were never held (see Section 3.2.5). This distinction is further emphasised by the finding that there was no significant difference in illness severity, as measured by Clinical Global Impression Severity (CGI-S) scores at admission, between the regraded and non-regraded groups.

A diagnosis of a personality disorder was significantly associated with patients being discharged from a S.23(1) hold. Specifically, 12 patients (92.3%) diagnosed with a personality disorder were ultimately discharged from their S.23(1) hold. This finding is expected, given that S.8 of the MHA 2001 specifically excludes the involuntary admission of individuals solely on the basis of having a personality disorder.

Although suicidal ideation at the time of admission was significantly associated with regrading to involuntary status following a S.23(1) hold, the presence of suicidal ideation at the time of initiation of S.23(1) was not. This paradoxical finding may be attributed to the relatively small sample size in this analysis or may reflect the transient nature of suicidal ideation in the context of acute mental distress. In their study, Masood et al. (2015) found that suicidal risk was significantly associated with regrading to involuntary status; however, it remains unclear at what point during the admission this risk was assessed.

That study also reported an association with impaired insight into the need for treatment and the regrading of a S.23(1) hold to involuntary status. However, because they assessed insight across separate domains (illness, treatment and medication) rather than globally, as was reported in the present analysis, their findings are not directly comparable.

4.4.3. Comparison of outcomes for regraded and non-regraded admissions

While there was no significant difference between the overall median length of stay (LOS) between non-regraded and regraded patients, the LOS post initiation of S.23(1) was significantly longer for regraded patients. This finding should be interpreted in the context of only 3% of non-regraded patients choosing to discharge themselves from hospital. For the overall LOS to be similar between groups, despite the significantly longer LOS post-initiation of S.23(1) for regraded patients, it suggests that those regraded to involuntary status were likely detained earlier in their admission than those whose detentions were not regraded.

If regraded patients were indeed detained earlier, it might be speculated that they presented with a greater burden of illness on admission, which required their temporary and subsequent formal detention. However, the findings indicate no significant difference in illness burden as measured by CGI-S scores on admission.

Clinical Global Impression Improvement scores at discharge were similar for both regraded and non-regraded patients, indicating that both groups demonstrated comparable clinical improvement in their symptoms. Additionally, rates of readmission within a 12-month period were not statistically different between the groups. Given these findings, the results suggest that after the initiation of S.23(1), patients regraded to involuntary status have similar outcomes to those held under S.23(1) but not regraded, in terms of illness improvement, total LOS, and rates of readmission.

4.4.4. Strengths and Limitations

There are few Irish studies describing the use of S.23(1), and it is noteworthy that one of these was also conducted at SPMHS. While the overall use of S.23(1) in Irish psychiatric hospitals remains unclear, the results presented here that its use is infrequent, at least within SPMHS. Nevertheless, given the SPMHS's capacity and the number of admissions per year, a key strength of this study was the large dataset collected over a three-year period, which allowed for a robust analysis of sufficient incidents of S.23(1). Furthermore, this study provides novel insights into the risk factors associated with regrading to involuntary status following detention under S.23(1) which have not been previously described.

The present study has several limitations. First, the study was conducted in a voluntary psychiatric hospital operating within the private independent sector, accepting referrals on a national basis. This setting is not readily comparable to other approved psychiatric hospitals in the Irish public sector, that typically accept referrals based on defined geographical boundaries. Secondly, the admission profiles at SPMHS may differ to hospitals operating in the Irish public sector; the independent sector has a lower proportion of involuntary

admissions as compared to public hospitals (Mental Health Commission, 2021). Notwithstanding, the present analysis was confined to the analysis of voluntarily admitted patients subsequently detained under S.23(1). As S.23(1) applies equally across all approved psychiatric hospitals in Ireland, irrespective of their status or general admission profile, its single clinical standard arguably calibrates and generalises the findings here.

Thirdly, in this study, a total of 167 admissions were analysed, during which patients were held under S.23(1) a total of 205 times. As a control measure to avoid duplication of data, only the first S.23(1) hold for each admission was included. However, this choice may overlook variations in patient experiences and outcomes that could arise from subsequent holds within the same admission.

Fourthly, possible readmissions to other psychiatric hospitals were not taken into account. Fifthly, the assessment of impaired insight and Clinical Global Impression (CGI) scores was conducted subjectively by clinicians and this is a source of potential bias. Sixthly, the analysis included 167 admissions detained under S.23(1) during the study period, which comprised five readmissions. Given that the primary focus of this study was on the experience of detention under holding powers during a voluntary admission, these five readmissions were treated as distinct events occurring at different times throughout the three-year period, as the circumstances surround each admission may have been different. Finally, the study period partially coincided with the onset of COVID-19 in Ireland in March 2020, this may have influenced admission patterns thereafter.

Chapter 5 : Conclusions and future directions

There has been limited national research focussed on the use of S.23(1) MHA 2001, particularly regarding the characteristics and outcomes of individuals temporarily detained under this provision in Irish approved centres. The authority granted to psychiatric staff to detain voluntarily admitted patients for up to 24 hours based on an opinion that that patient is suffering from a mental disorder while attempting to exercise their right to self-discharge, is a significant responsibility. Notably, patients temporarily detained under S.23(1) are not classified as "involuntary" patients under the MHA 2001. It is only if subsequently regraded, and their involuntary detention crystallised by an admission order, that the safeguards afforded by the MHA 2001 become applicable. For those who are temporarily detained and not regraded, there exists a legal gap for a duration of 24 hours during which they are afforded no statutory safeguards while being deprived of one of their most fundamental constitutional rights. At a time when Irish mental health legislation is being reformed, it is hoped that this research, characterising a cohort detained under S.23(1) over a three-year period, will highlight this lacuna in the law and the need to acknowledge and define the rights of those temporarily detained in Irish psychiatric hospitals.

The existing literature on involuntary detention often overlooks individuals who are initially detained under holding orders that are not progressed to involuntary status. While a significant proportion of those temporarily detained are eventually regraded to involuntary status (approximately half in the present study), this is not the case for all. The omission of this latter cohort from research may reflect a broader lack of scrutiny regarding their periods of detention within the healthcare system.

The current legal framework under the MHA 2001 does not require approved centres to notify the MHC about patients detained under S.23(1) who are not regraded to involuntary status. This lack of mandatory reporting creates uncertainty regarding the actual number of patients detained under this section in Irish approved centres annually. The forthcoming Mental Health Bill 2024 aims to address this gap by introducing mandatory reporting for all initiations of the holding powers it outlines. It is anticipated that this legislative

change will enhance transparency and accountability within mental health services, ensuring that the MHC receives comprehensive data on *all* patient detentions including holds not regraded to involuntary status. However, as of the current date, there is no specified timeline for when this Bill will be enacted into law, which means that until it is passed, the existing reporting deficiencies will persist

The present research aims to highlight the experiences of this group, thereby drawing attention to an area of study that has been largely overlooked. By describing their mental health journey following initiation of S.23(1), this study seeks to encourage further investigation in this area.

While there is limited national data on this topic, the results of this study indicate that S.23(1) was infrequently initiated over the study period at SPMHS. In most cases where it was initiated, S.23(1) was invoked only once; however, there were instances of multiple initiations during a single admission are described. Notably, just under half of all S.23(1) initiations analysed were not regraded to involuntary status. Furthermore, in nearly all cases, the patients held under S.23(1) chose to remain in hospital despite initially being prevented from discharging themselves. This finding is both reassuring and unexpected, supporting the potential ethical justification for S.23(1) mentioned earlier.

In Study 1, it was demonstrated that voluntary patients detained under holding powers differ from those voluntary patients who are never detained. Several risk factors for detention under S.23(1) were identified, including the presence of psychotic symptoms on admission, impaired insight, suicidal ideation, and a diagnosis of bipolar disorder. There is overlap between the predictors of detention under holding powers and those risk factors established in the literature concerning involuntary admission. However, certain points of comparison, such as a diagnosis of psychotic disorder and marital status – commonly accepted as predictors of involuntary admission – were not found to be significant predictors of a psychiatric hold in this analysis.

Despite presenting with greater severity of illness and having longer hospital stays, the outcomes for those held under S.23(1) were comparable in terms of illness improvement and readmission rates to those never held. These findings may assist clinicians in identifying voluntary patients at increased risk for potential detention under psychiatric holding powers at the time of admission.

Within the cohort held under S.23(1) that are described in Study 1, Study 2 compares all patients who were regraded to involuntary status with those who were not. The findings indicate that predictors for being regraded include the presence of a diagnosis of bipolar disorder, being held during working hours, and initiation of S.23(1) by a consultant psychiatrist. However, the results suggest that outcomes for both groups – measured in terms of overall length of stay, illness improvement scores and rates of readmission – are similar.

These findings may provide reassurance to clinicians who must consider the use emergency holding powers in acute psychiatric care and who are concerned the potential infringement on patients' rights. However, further research is necessary as there is currently a lack of literature – either nationally or internationally – with which to compare our findings. It is noteworthy and somewhat expected that the results of Study 1 align broadly with what is known regarding the risk factors for involuntary hospitalisation.

This study was conducted at a large university psychiatric hospital operating within the independent sector, that has a largely homogenous patient population. Therefore, there is a need to replicate the present study across Ireland and internationally with more diverse patient populations. Additionally, longer-term follow-up studies are required to better understand the implications of these findings.

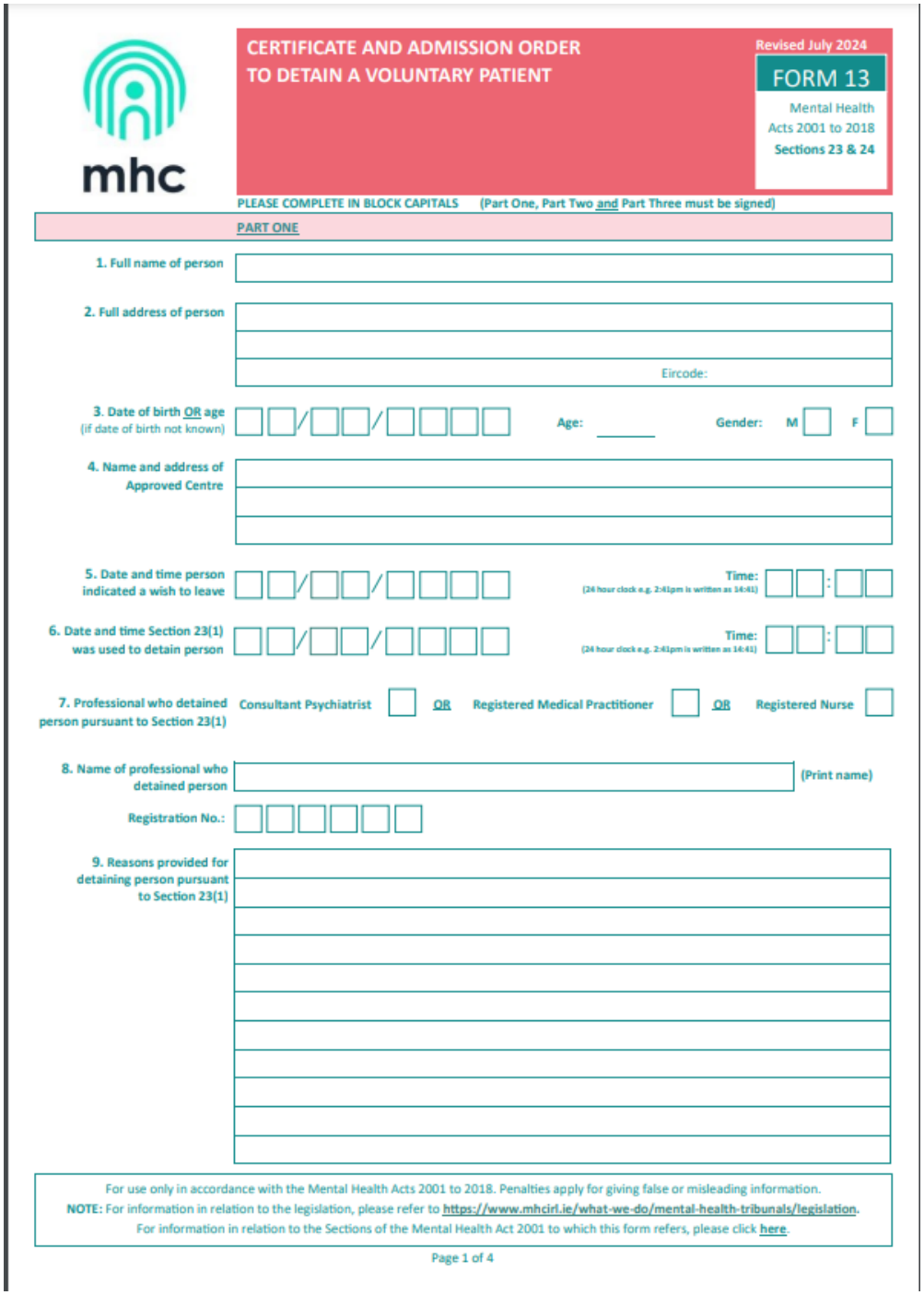
The ethical complexities surrounding the use of holding powers in mental healthcare necessitate qualitative studies that assess the attitudes and opinions of the clinical staff responsible for initiating such measures. This area of research is critical, as understanding the perspectives of those who utilise these powers can illuminate the moral dilemmas they encounter and the implications their decisions may have on patient care. Furthermore, the experiences of patients subjected to holding orders remain largely unexamined, representing a significant gap in the literature.

Notably, a substantial proportion of voluntary patients held under S.23(1) (but not regraded) chose to remain in hospital, even after having previously been held under a separate initiation of S.23(1) during the same admission. This phenomenon raises important questions about patient autonomy and decision-making in contexts where coercion is present. Exploring the attitudes of these patients could yield valuable insights into the ethical considerations that S.23(1) engenders, particularly regarding their perceptions of safety, agency, and the overall therapeutic environment. By examining both clinical staff and patient perspectives, researchers can foster a more comprehensive understanding of the ethical landscape surrounding holding powers.

The findings of this thesis illuminate a critical yet underexplored aspect of Irish mental health legislation and highlights the significant ethical implications surrounding the temporary detention of voluntary patients under S.23(1) in our psychiatric hospitals. Despite these concerns, the outcomes for patients detained under this provision indicate that holding powers can play an important role in managing acutely unwell individuals in the inpatient setting. However, to deepen our understanding on the use, outcomes and effects of S.23(1) initiation, it is essential to explore the experiences of other psychiatric hospitals, nationally and internationally, as well as the opinions of those staff and patients most impacted by them.

Chapter 6 : Appendix

6.1. Appendix A – Mental Health Commission Form 13



mhc

CERTIFICATE AND ADMISSION ORDER TO DETAIN A VOLUNTARY PATIENT

Revised July 2024

FORM 13

Mental Health Acts 2001 to 2018

Sections 23 & 24

PLEASE COMPLETE IN BLOCK CAPITALS (Part One, Part Two and Part Three must be signed)

PART ONE

1. Full name of person

2. Full address of person

Eircode:

3. Date of birth OR age (if date of birth not known) ☐☐/☐☐/☐☐☐☐ Age: _____ Gender: M ☐ F ☐

4. Name and address of Approved Centre

5. Date and time person indicated a wish to leave ☐☐/☐☐/☐☐☐☐ Time: (24 hour clock e.g. 2:41pm is written as 14:41) ☐☐:☐☐

6. Date and time Section 23(1) was used to detain person ☐☐/☐☐/☐☐☐☐ Time: (24 hour clock e.g. 2:41pm is written as 14:41) ☐☐:☐☐

7. Professional who detained person pursuant to Section 23(1) Consultant Psychiatrist ☐ OR Registered Medical Practitioner ☐ OR Registered Nurse ☐

8. Name of professional who detained person (Print name)

Registration No.: ☐☐☐☐☐☐

9. Reasons provided for detaining person pursuant to Section 23(1)

For use only in accordance with the Mental Health Acts 2001 to 2018. Penalties apply for giving false or misleading information.
NOTE: For information in relation to the legislation, please refer to https://www.mhcirl.ie/what-we-do/mental-health-tribunals/legislation.
For information in relation to the Sections of the Mental Health Act 2001 to which this form refers, please click here.

Page 1 of 4

mhc

CERTIFICATE AND ADMISSION ORDER TO DETAIN A VOLUNTARY PATIENT

Revised July 2024

FORM 13

Mental Health Acts 2001 to 2018
Sections 23 & 24

PLEASE COMPLETE IN BLOCK CAPITALS (Part One, Part Two and Part Three must be signed)

10. Criteria for Mental Disorder In my opinion this person has a mental disorder where:
(*PLEASE TICK ONE BOX ONLY*)

(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). ☐

11. Description of the person's mental disorder

My opinion above that the person has a mental disorder is based on the following grounds:

Signed: _____ (Responsible Consultant Psychiatrist)

Print name: _____ (Responsible Consultant Psychiatrist)

MCRN: ☐☐☐☐☐☐

Date: ☐☐/☐☐/☐☐☐☐ Time: ☐☐:☐☐
(24 hour clock e.g. 2:41pm is written as 14:41)

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CERTIFICATE AND ADMISSION ORDER TO DETAIN A VOLUNTARY PATIENT

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FORM 13

Mental Health Acts 2001 to 2018

Sections 23 & 24

PLEASE COMPLETE IN BLOCK CAPITALS (Part One, Part Two and Part Three must be signed)

PART TWO - SECTION 24 (2)(a) or (b) CERTIFICATE

This certificate is to be completed by another consultant psychiatrist following referral by the consultant psychiatrist responsible for the care and treatment of the person.

12. Name of person detained under section 23(1)

13. I am not a spouse or relative of the person.

14. I have examined the above person and I am of the opinion that the person has a mental disorder. Yes ☐ No ☐

My opinion above that the person has a mental disorder is based on the following grounds:

Note: Section 15 should only be completed if you have formed the opinion the person has a mental disorder.

15. Criteria for Mental Disorder

In my opinion this patient continues to suffer from a mental disorder where:

(PLEASE TICK ONE BOX ONLY)

(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). ☐

Signed: _____ (Consultant Psychiatrist)

Print name: _____ (Consultant Psychiatrist)

MCRN: ☐☐☐☐☐☐

Date: ☐☐/☐☐/☐☐☐☐ Time: (24 hour clock e.g. 2:41pm is written as 14:41) ☐☐:☐☐

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NOTE: For information in relation to the legislation, please refer to https://www.mhcirl.ie/what-we-do/mental-health-tribunals/legislation.

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CERTIFICATE AND ADMISSION ORDER TO DETAIN A VOLUNTARY PATIENT

Revised July 2024

FORM 13

Mental Health Acts 2001 to 2018

Sections 23 & 24

PLEASE COMPLETE IN BLOCK CAPITALS (Part One, Part Two and Part Three must be signed)

PART THREE - ADMISSION ORDER

16. A certificate has been issued under Subsection 24(2)(a) by a second consultant psychiatrist. In accordance with Section 24(3) and (4), I now make an admission order for the reception, detention and treatment of the above-named person, on that basis that they have a mental disorder, for a period of 21 days from the date of the making of this Order.

17. I am not a person disqualified from making this Order.

18. I shall within 24 hours of making this Order:

- Give to the patient a notice in writing as required by Section 16(1)(b) and 16(2) of the Mental Health Acts 2001 to 2018;
- Send to the Commission a copy of the Order as required by Section 16(1)(a) of the Mental Health Acts 2001 to 2018.

Signed: _____ (Responsible Consultant Psychiatrist)

Print name: _____ (Responsible Consultant Psychiatrist)

MCRN: ☐☐☐☐☐☐

Date: ☐☐/☐☐/☐☐☐☐ Time: ☐☐:☐☐ (24 hour clock e.g. 2:41pm is written as 14:41)

For use only in accordance with the Mental Health Acts 2001 to 2018. Penalties apply for giving false or misleading information.
NOTE: For information in relation to the legislation, please refer to https://www.mhcirl.ie/what-we-do/mental-health-tribunals/legislation.
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