Irish Journal of Psychological Medicine (2017), **34**, 13–18. © College of Psychiatrists of Ireland 2015 doi:10.1017/ipm.2015.32

ORIGINAL RESEARCH

Clinical predictors of involuntary detention among voluntary inpatients in St Patrick's University Hospital (SPUH)

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Background. Few studies have described clinical characteristics of patients subject to an involuntary detention in an Irish context. The Irish Mental Health Act 2001 makes provision under Section 23(1), whereby a person who has voluntary admission status can be detained.

Aims. This study aimed to describe all involuntary admissions to St Patrick's University Hospital (SPUH) (2011–2013) and to evaluate clinical characteristics of voluntary patients who underwent Mental Health Act assessment during 2011 to determine differences in those who had involuntary admission orders completed and those who did not.

Methods. All uses of Mental Health Act 2001 within SPUH 2011–2013 were identified. All uses of Section 23(1) during 2011 were reviewed and relevant documents/case-notes examined using a pro forma covering clinical data, factors recognized to influence involuntary admissions and validated scales were used to determine diagnoses, insight, suicide and violence risk.

Results. Over 2011–2013, 2.5–3.8% of all admissions were involuntary with more detained after use of Section 23(1) than Section 14(2). The majority of initiations of Section 23(1) did not result in an involuntary admission (72%), occurred out of hours (52%) and many occurred early after admission (<1 week, 43%). Initiation of Section 23(1) by a consultant psychiatrist ($p = 0.001$), suicide risk ($p = 0.03$) and lack of patient insight into treatment ($p = 0.007$) predicted conversion to involuntary admission.

Conclusion. This study predicts a role for patient insight, suicide risk and consultant psychiatrist decision making in the initiation of Mental Health Act assessment of voluntary patients. Further data describing the involuntary admissions process in an Irish setting are needed.

Received 17 October 2014; Revised 30 January 2015; Accepted 25 June 2015; First published online 10 September 2015

Key words: Capacity, insight, involuntary detention, involuntary detention predictors, Irish Mental Health Act 2001.

Introduction

There are few published demographic or epidemiological studies of the involuntary admission process in Ireland, especially since the introduction of the new Mental Health Act 2001 in November 2006. Psychiatric admissions across Ireland since 2007 have been decreasing, yet involuntary admissions have remained at around 10% of all admissions, ranging from 46.7 to 50.1 per 100 000 persons (2007–2012) (Mental Health Commission, 2007–2013).

The Mental Health Act (2001) in Ireland makes provision for involuntary admission to approved centers from the community and a process, whereby a person who is under care voluntarily can be detained for up to 24 hours for assessment by two consultant psychiatrists (Section 23.1) (Mental Health Act, 2001). Voluntary patients must meet statutory criteria for Mental Disorder, that is, there must be a serious likelihood of immediate harm to the patient or others, or the judgment of the person must be so impaired by mental illness that treatment in the approved center is required. This study described all uses of the Mental Health Act 2001 within St Patrick's University Hospital (SPUH) between 2011 and 2013 and, in particular, evaluated demographic and clinical factors, particularly around insight, and their impact on the operation of Section 23(1). A sub-aim of this study was to determine whether there were any significant differences between voluntary patients who subsequently had involuntary admission orders completed and those who did not have admission orders completed.

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https://doi.org/10.1017/ipm.2015.32 Published online by Cambridge University Press

Methods

All uses of the Mental Health Act 2001 within SPUH between January 1, 2011 and December 31, 2013 were prospectively identified and recorded. Uses of the Mental Health Act 2001 including Section 23(1) use, recorded in the Mental Health Commission (MHC) code of practice log, were identified prospectively from all available sources and clinical case records including MHC Forms [Section 23(1) Clinical Practice Form, Recommendation for Admission Order Form, Independent Opinion Psychiatrist Form, Mental Health Tribunal findings], and clinical case records were subsequently examined.

To further evaluate the use of Section 23(1) during 2011, a pro forma template was generated to include demographic data, details of incidents leading to use of Section 23(1) and predictive variables from published literature known to predict involuntary admission. Standardized internationally validated rating scales were used to determine diagnosis, insight, suicide risk and risk of violence from case-notes. Standardized Assessment of Personality Scale (SAPAS) was used to decide likely presence or absence of co-morbid personality disorder (Moran *et al.* 2003) Opcrit for Windows (v4) tool was used to predict diagnosis (Craddock *et al.* 1996). The Admission Risk Assessment Tool, used in the SPUH services to evaluate known current and historical risk factors that is known to predict suicide and violence, was used to determine level of suicide and violence risk. Insight was assessed using a modified Schedule for the Assessment of Insight scale – the presence or absence of acceptance of mental illness as a cause of symptoms, the presence or absence of willingness to engage in treatment and also the presence or absence of willingness to take medication (David, 1990). Decision-making ability was judged on four criteria according to the Mental Capacity Act 2005 (UK): the ability to communicate a decision, the ability to receive information, the ability to weigh up the pros and cons of any decision and not to be suffering from the effects of a mental illness that would impair decision-making ability (Grisso & Appelbaum, 1998). The Crisis Prevention Institute guidelines on non-violent crisis intervention were used to define 'agitation,' 'physical act' (violent) and 'verbal act' (violent) (Crisis Prevention Institute, 2011). 'Agitation' was present when there were signs of the person being upset or distressed without the person needing to verbalize this or even being given physical form. A 'physical act' was any act that caused action to occur such as the throwing of a chair, or harm to self or others. A 'verbal act' was deemed to be a verbal action indicating distress that was either loud, intimidating or language that was profane. Information was collected with regard to the initiator of the Section 23(1) process, the first consultant review and the second consultant review. The main predictive variables used in the pro forma showed excellent inter-rater reliability for 10 case-notes, subsequently assessed independently by a second rater (NK).

The clinical characteristics of Section 23(1) patients were also compared with the characteristics of Section 14(2) patients. Section 14(2) applies to patients admitted directly from the community with an application and recommendation for involuntary admission to hospital.

For Section 23(1) patients during 2011, case records and incidents were divided into an involuntary detention group and a non-detained group based on whether or not an admission order (Section 24) had been completed. An admission order requires that two psychiatrists, one of who must be the consultant responsible for the care of the patient, are of the opinion that the person ought to be detained involuntarily. Review points and end points were assigned to the presence of a Mental Health Tribunal; to the presence of granting of a second admission order; to the revocation of the admission order and the lapsing of the admission order period.

Involuntary detention and non-detention groups were compared using variables such as mental state, risk of violence, suicide risk, insight and impairment of judgment at the time of the incident; consultant as initiator, previous admissions, length of mental illness, time of days at initiation and 'out of hours' initiations. 'Out of hours' was defined as 05:00 p.m. to 09:00 a.m. (Monday to Friday), and all day Saturday and Sunday. Demographic and clinical details such as diagnosis, co-morbid personality disorder and substance misuse were also compared. χ^2 and Student's *t*-tests were used to test statistical significance. Ethics approval was obtained from the SPUH Audit Committee.

Results

Within SPUH, there were 58 involuntary admission orders completed during 2011, rising to 81 in 2012 and 96 in 2013, respectively, namely, 2.5%, 3.5% and 3.8% of all admissions. Over the 3-year period, there were more uses of Section 23(1) and more involuntary admissions than with Section 14(2) (see Table 1). A higher proportion of patients were likely to be admitted involuntarily after Section 14(2) compared with Section 23(1) (see Table 1), with <50% being detained involuntarily after initiation of Section 23(1), between 2011 and 2013.

During 2011, there were 67 uses of Section 23(1) involving 49 patients, which resulted in 30% of uses of Section 23(1) and 41% of patients being involuntary detained. In total, 36 (74%) patients had Section 23(1) initiated only once, eight (16%) twice and five (10%) had the process initiated three times. Of these, 24 (49%) patients were male and 25 (51%) female. Of those who

https://doi.org/10.1017/ipm.2015.32 Published online by Cambridge University Press

Table 1. *Involuntary admissions to St Patrick's University Hospital (2011–2013)*

Category of involuntary admissions	2011 [*n* (%)]	2012 [*n* (%)]	2013 [*n* (%)]
Total and % involuntary admissions	58	81	96
Involuntary admissions as % of total admissions	2.5%	3.5%	3.8%
Total S23(1)	67	94	107
Total S23(1) subject to S24	20 (30%)	43 (46%)	40 (37%)
Total S14(2)	32	35	46
Total S14(2) subject to S14/S15	23 (72%)	30 (86%)	35 (76%)
Total S21 transfers in to SPUH	15	8	21

SPUH, St Patrick's University Hospital.

had Section 23(1) initiated 31 (63%) were employed. Mean age at admission was 42.6 years (S.D. = 16.8). In total, 21 (43%) patients were married or cohabiting. The main Opcrit ICD-10 diagnoses ($n = 49$) were mania + / − psychosis (17, 35%), depression + / − psychosis (15, 31%), schizophrenia (12, 24%) and schizoaffective disorder (1, 2%). Only eight patients (16%) were diagnosed with a co-morbid personality disorder. Co-morbid alcohol misuse was present in 19 (39%), cannabis misuse in eight (19%) and codeine misuse in eight (19%) patients.

During 2011, most patients where Section 23(1) was used were agitated (79%), and a minority were at moderate or high suicide risk (12%). The majority of uses of Section 23(1) during 2011 did not result in an involuntary admission (70%), occurred out of hours (52%) and a substantial minority early in the admission (<1 week = 43%). In total, 24 (49%) patients described >10 years duration of illness with 10 (20%) having a duration of <1 year. In total, 31 (63%) patients had been admitted previously.

Absence of insight into need for treatment strongly predicted involuntary detention ($p = 0.007$) as did the initiator of Section 23(1) being a consultant ($p = 0.001$) and suicidal ideation ($p = 0.03$) also predicted detention (see Table 2). Mood symptoms, psychosis, agitation or violence risk, were not associated with involuntary detention. Of the 47 uses of Section 23(1) from 67 that did not result in involuntary detention, 38 (81%) patients agreed to stay voluntarily after consultation with the team consultant and treatment team. The other nine (19%) agreed to stay voluntarily after further consultation with the team, after the second opinion independent psychiatrist was satisfied that the person was suffering from a mental disorder and should be detained. Time of initiation after admission,

Table 2. *Clinical characteristics of involuntary detained and non-detained groups in St Patrick's University Hospital after Section 23(1) during 2011*

Variable	Involuntary ($n = 20$)	Non-detained ($n = 47$)	p (χ^2)
Wish to leave	18	45	0.36
Mood symptoms	6	21	0.26
Delusions	7	16	0.52
Hallucinations	3	2	0.12
No insight into illness	6	13	0.84
No insight into need for treatment	7	4	0.007*
No insight into need for medication	5	6	0.21
Agitation	17	36	0.43
Physical Act (violent)	4	10	0.85
Verbal Act (violent)	3	10	0.55
Impaired judgment	2	4	0.84
<7 days admission at initiation	8	21	0.72
<28 days admission at initiation	12	33	0.41
Consultant as initiator	9	11	0.001*
'Out of hours' initiation	9	26	0.43
Medium or high suicidal ideation	5	3	0.03*

$n = 67$; *$p < 0.05$.

'out of hours' use of Section 23(1), co-morbid personality disorder or alcohol/drug misuse previous admissions or length of mental illness did not predict involuntary detention.

Discussion

Few studies have been published relating to the implementation of the Irish Mental Health Act 2001 in clinical settings, particularly in relation to the involuntary admission process. In this setting, there was a relatively low percentage of involuntary admissions (<4%) compared with other Irish Approved Centres (>10%) (Mental Health Commission, 2007–2013). This may reflect the higher proportion of patients treated with ICD-10 mood disorders, anxiety disorders and substance misuse disorders, 55%, 15% and 14% of all admissions to SPUH during 2013, respectively, compared with higher proportions admitted with ICD-10 schizophrenia in other approved centers (Health Research Board, 2010). Furthermore, some patients are admitted for specialized treatments involving programmatic care after initial stabilization in the local area. Similarly, over the 3 years of the study more patients became involuntary after use of Section 23(1) than 14(2), which may also reflect diagnostic

https://doi.org/10.1017/ipm.2015.32 Published online by Cambridge University Press

differences. During 2011, two-thirds of patients where a Section 23(1) was initiated had a diagnosis of depression or mania. Such patients are likely to be admitted voluntarily, but may need an involuntary admission if their mental state deteriorates or are at high suicide risk during admission in contrast to patients with schizophrenia who because of psychotic symptoms, particularly paranoia, may not engage with services and may need involuntary admission from the community.

In contrast to Section 14(2) admissions, the majority of uses of Section 23(1) did not lead to involuntary admission, 30–46% over 2011–2013 in SPUH. This is likely to reflect good practice and patient autonomy, thus is in keeping with the aims of the Act as advocated by the MHC (Mental Health Act, 2001). The 2011 data showed that only 20 of 67 Section 23(1) initiations resulted in involuntary detention with 38 agreeing to stay voluntarily after discussion with their multidisciplinary team (MDT) and a further nine deciding to stay voluntarily after further review by their MDT, even after a recommendation of detention was made by the second opinion psychiatrist. These data suggest that the least restrictive option remained available to the patient with attempts being made to engage the patient in voluntary treatment at each step of the detention process.

Where Section 23(1) was used, most were suffering from acute ICD-10 psychiatric disorders, many had severe impairment of judgment, as highlighted by little insight into need for treatment and a minority were at significant suicide risk suggesting that Section 23(1) was being appropriately used and patients not being inappropriately detained. However, on a less positive note, the majority of uses of Section 23(1) (52%) occurred 'out of hours.' The high proportion of uses out of hours may represent a way of dealing with crises and as such may represent a mechanism to detain to allow time to better manage or treat the patient in such a situation. It would be preferable from the perspective of patient autonomy and continuity of care if uses of Section 23(1) could be considered by the treating team and planned ahead in Care Plans. Such an approach would be consistent with the aims of the MHC (Mental Health Act, 2001). On the other hand, many of the uses of Section 23(1) could not be avoided as they occurred early in admission before adequate care planning could have taken place.

When examining the clinical data from Section 23(1) uses during 2011, lack of patient insight into treatment, a consultant initiating the Section and suicide risk predicted involuntary detention. In keeping with other studies, psychiatrists are reluctant to detain involuntarily except to protect health and welfare of patients, particularly where there is a high risk of self-harm or risk of deterioration in the absence of insight into treatment, which suggests an 'only when necessary' attitude to treatment (Luchins *et al.* 2004; Tan *et al.* 2008). We were unable to find comparable studies in an Irish context but Dunne and Moloney, reviewing uses of Section 14(2) from the community, found that the majority (71%) of all involuntary admissions occurred outside of working hours similar to our study. They also found that those who were not subsequently detained were more likely to have applications made by the Gardai and recommendations made by someone other than the patients' local general practitioner (GP). Similarly, in this study they also found that there were significant differences in understanding what constituted risk to self and others between GPs and consultant psychiatrists with GPs tending to have a lower threshold for risk and use of Section 14(2). Consultant psychiatrists agreeing with GPs on the appropriateness of involuntary admissions in only two-thirds of cases (Dunne & Moloney, 2012).

In this study, and the study described earlier, a consultant initiator predicted of an involuntary detention. This may imply a more planned approach to treatment by the patient's consultant and multidisciplinary team, which is in accordance with best practice similar to findings of the above Irish study. Section 23(1) may sometimes be initiated in circumstances that are not appropriate such as in the case of dementia or substance misuse when a simple duty of care principle may be more suitable. A consultant may be more experienced and better informed about the appropriateness of a detention (Brooks, 2007). A stable doctor–patient relationship and good communication skills have been shown to minimize involuntarily detentions and improve treatment adherence (Appelbaum & Hamm, 1982; Kelly *et al.* 2009). With regard to seniority of training and involuntary detention, there is a suggestion that residents in years 1–3 of training seem to have less tendency to involuntary detain than senior residents in years 5+ of training (Sattar *et al.* 2006). Other factors that might influence a decision to involuntarily detain a patient could be a tendency to avoid, deny or minimize a patient's degree of risk (Litwack, 1994). There may be a desire to control behavior (Brown & Rayne, 1989). Psychiatrist exposure to malpractice lawsuits for detaining or not detaining involuntarily and/or consequent patient suicide may influence a psychiatrist's decision as two studies have shown, though another did not show this correlation (Appelbaum, 1995; Knapp &Vande Creek, 1997; Sattar *et al.* 2006).

In this study, impairment of judgment into need for treatment was common where Section 23(1) was initiated and predicted subsequent involuntary admission. However, in most cases, impaired judgment is likely to be temporary and related to the severity of illness, and a recent Irish paper showed that the majority of patients subsequently accepted the need for involuntary

https://doi.org/10.1017/ipm.2015.32 Published online by Cambridge University Press

admission and reflected positively (72%) on this experience (O'Donoghue *et al.* 2011). Furthermore, they acknowledged the need for the involuntary admission at the time, 1 year afterwards, which appeared to be associated with greater insight. However, a minority of patients reported a negative impact of their involuntary detention on their family relationships and an adverse impact on their doctor–patient relationship. Similarly, US research showed that the majority of patients reported positive views about their involuntary admission (Gardner *et al.* 1999), though a German study reported more negative experiences of involuntary admission particularly in terms of autonomy even though patients did stay in treatment after the involuntary admission was terminated and indicated that they would return to hospital in event of crisis (Langle *et al.* 2003).

Strengths of this study included the prospective identification of all uses of the Mental Health Act over a 3-year period in a large University Teaching Hospital. This allowed large numbers to be identified, which aids generalizability given that SPUH accounts for over 16% of national admissions, though proportion of involuntary admissions are likely to be lower than in other approved centers (Mental Health Commission, 2007–2013). The setting with a catchment area encompassing the whole country within the private Independent Health Sector as well as differences in diagnoses within inpatients may limit comparison with other approved centers. With regard to the clinical data pertaining to 2011, Section 23(1) uses, case records and all other available information was used rather than clinical interview. However, every attempt was made to gather information from a wide variety of sources and validated rating scales, such as Opcrit and SAPAS, were used for diagnostic and clinical purposes. All cases were identified and successfully followed up using a pro forma and satisfactory inter-rater reliability was established. Use of validated rating scales on patient insight and recovery will be considered in further studies within our service to ascertain patient views regarding their experiences of involuntary admission.

This study suggests that impairment of patients judgment into the need for treatment, risk and consultant initiation, predict detention of voluntary patients. This may in part be reduced by careful multidisciplinary team planning and good communication (Mental Health Commission, 2006). Communication skills and professional relationships on behalf of the clinician are integral to this process and reduce negative perceptions even when involuntary admission becomes necessary. These findings could be contrasted with findings from other Irish approved centers in different settings.

Acknowledgement

We wish to acknowledge the support of the Clinical Governance Committee of St Patrick's University Hospital in conducting this study.

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