Has the Mental Health Act 2001 altered the clinical profile of involuntary admissions?

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Abstract:

Objectives: To assess whether transition from the Mental Treatment Act (MTA), 1945 to the Mental Health Act (MHA), 2001 has had any impact on the clinical profile of patients in the West Galway Mental Health Services who are admitted on an involuntary basis.

Methods: Data were collected from clinical records in relation to all those individuals residing in the West Galway Mental Health Services who were admitted involuntarily in the 12 months prior to and subsequent to the introduction of the MHA 2001.

Results: A total of 175 individuals were included in this study (n = 91– MTA 1945; and n = 84 – MHA 2001). No significant differences were found between the two groups in relation to demographic data, rates of involuntary detention or duration of involuntary detention. The applicant was less likely to be a family member under the MHA 2001 (54%) than the MTA 1945 (85%).

Conclusions: Transition from the MTA 1945 to the MHA 2001 has had minimal impact on the admission rates, clinical profile or duration of detention of patients admitted involuntarily in the West Galway Mental Health Services.

Key words: Mental Health Act; Mental Treatment Act; Involuntary detention.

Introduction

The Mental Health Act (MHA) 2001,[1] was implemented in full on November 1, 2006 replacing the existing Mental Treatment Act (MTA) 1945.[2] Concerns had been expressed by the Council for Civil Liberties,[3] and the Law Society of Ireland,[4] that the MTA 1945 was excessively and inappropriately utilised with involuntary detention rates in Ireland noted to be higher than those in England and Wales and almost three times higher when compared to Italy.[5] Concerns had also been expressed that patients requiring involuntary detention might not be admitted as readily in the initial period following the introduction of the MHA 2001.

The catalysts for the introduction of the MHA 2001 included the publication of the United Nations paper on the *Protection of Persons with Mental Illness and the Improvement of Mental Health Care* (United Nations 1991)[6] and the incorporation by the Republic of Ireland of Article 5 of the European Convention for the Protection of Human Rights and Fundamental Freedoms (1954)[7] into the subsequent European Convention on Human Rights Act (2004).[8]

Accordingly, the MHA 2001 provides a legislative framework within which a person with a mental disorder can be admitted, detained and treated involuntarily in approved centres with formal review of their detention and treatment at regular intervals.[9,10]

In this study we examined the involuntary detentions of all patients over the age of 18 years residing in the West Galway Mental Health Service catchment area who were admitted from November 1, 2005 to October 31, 2006 under the Mental Treatment Act 1945 and from November 1, 2006 to October 31, 2007 under the Mental Health Act 2001. Our objective was to assess whether this transition had any impact on the clinical profile of involuntarily detained patients.

Methods

Catchment area characteristics

This catchment area covers Galway City and the western section of the county including Connemara and comprises a population of approximately 120,000.[11] The majority of information in relation to involuntarily detained patients in this study was attained in relation to the two approved centres in the West Galway region – an acute inpatient unit in University Hospital, Galway and a rehabilitation unit based in Merlin Park Hospital, Galway.

Three other hospitals to which patients from the catchment area are admitted (St Brigid's Hospital, Ballinasloe; St Patrick's Hospital, Dublin and St John of God's Hospital, Dublin) were also contacted to ensure complete information was collected on all patients residing within the catchment area.

Data collection

Data was collected retrospectively from all consecutively admitted individuals under the MTA 1945 from November 1, 2005 to October 31, 2006 and was compared with data from all consecutively admitted individuals under the MHA 2001 from November 1, 2006 to October 31, 2007 residing in the West Galway Mental Health Services.

This data was collected from both approved centres in the West Galway region, on 15 individuals on whom Person of Unsound Mind (PUM) forms (section 172 of the Mental Treatment Act, 1945) had been completed and who had been admitted to the regions only 'Authorised Institution' (St Brigid's Hospital, Ballinasloe) and on one individual who had

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been admitted involuntarily under the MTA 1945 to one of the countries private hospitals (St Patrick's Hospital, Dublin).

Any individuals who were involuntarily detained prior to the commencement of this study were excluded from all analysis. The three individuals transferred from the MTA 1945, to the MHA 2001 (on form 24, Section 72 of the MHA 2001) were not considered as new admissions under the MHA 2001. In order to calculate the length of involuntary admission on all individuals, an arbitrary cut off date was chosen by the authors (March 14, 2008) for the one individual who remained involuntarily detained under the MHA 2001 at the conclusion of the study.

Clinical information was obtained from several sources including medical and nursing notes, prescription sheets, the community mental health nurses' notes and the mental health act administrator's database for all patients admitted involuntarily in the West Galway catchment area.

For each subject, demographic and clinical data was collected. Clinical data included diagnosis, length of involuntary detention, applicant for involuntary detention, type of risk necessitating admission (risk to self, risk to health, risk to others or mixed risk) and any change of detention status whilst an inpatient (voluntary to involuntary).

In addition information relating to patients discharged on a trial basis ('on trial' or 'absent with leave') as well as the length of time patients remained in hospital on a voluntary basis following discharge from either act was recorded. Under the MHA 2001, there is no provision for discharging patients 'on trial', however individuals can be given periods of extended leave.

Finally, in relation to the use of the MHA 2001, we collected information pertaining to the total number of Mental Health Tribunals (MHTs) convened and the number of revocations of both involuntary admission orders and of transitional patients prior to the first MHT. Data gathered also pertained to the number of MHTs held post revocation of the initial involuntary admission order.

Data analysis

All data were analysed utilising the Statistical Package for Social Services 15.0 for Windows (SPSS 15.0 for Windows, SPSS Inc., Chicago, Illinois, USA). Parametric data was analysed utilising the student t-test and means, medians and standard deviations were determined. Non-parametric data were analysed utilising either the Chi square test for categorical variables or the Mann Whitney U test for continuous variables.

Results

Patient characteristics

There were 175 patients included in this study with 91 individuals admitted on an involuntary basis under the MTA 1945 and 84 admitted under the MHA 2001. The mean age of individuals was older for the MHA 2001 (43 +/- 14.8 years) compared to the MTA 1945 (38.5 +/- 12.4 years) ($p = 0.018$). There were no significant statistical differences found between the individuals admitted under either Act in relation to other demographic data including gender, employment, status and ethnicity *(see Table 1)*.

There were no significant differences in the proportions of patients in the main diagnostic categories in both groups with psychotic and affective disorders accounting for 81.4% and 77.3% of individuals admitted under the MTA 1945 and MHA 2001 respectively *(see Table 2)*.

Detention characteristics

The most common risk factor necessitating admission was 'Risk to Health' which was present in 48.4% of individuals admitted under the MTA 1945 and 51.2% of individuals admitted under the MHA 2001 *(see Table 2)* and was not statistically significantly different between the two groups ($p = 0.722$). Family members were more likely to make the initial application for involuntary detention under the MTA 1945 compared with the MHA 2001 ($p < 0.0001$) *(see Table 2)*.

A similar number of individuals were admitted over each 12 month period under the MTA 1945 and the MHA 2001 ($p = 0.597$). This indicates a comparable incidence of involuntary admissions for both acts (no significant population shift occurred during the study period). In addition, no difference was found in relation to duration of detention in hospital or total duration of involuntary admission (which included inpatient detention and discharge 'on trial').

However when individuals detained involuntarily for less than one day were excluded from the analysis ($n = 11$ for the MTA 1945 and $n = 1$ for the MHA 2001), the total duration of involuntary admission ($p = 0.009$), but not the duration of detention in hospital *per se* ($p = 0.078$), was shorter for those admitted under the MHA 2001. Individuals detained under the MTA 1945 were more likely to be discharged 'on trial' (or extended leave), with 14 individuals kept on trial compared to three individuals under the MHA 2001 ($p = 0.002$). Individuals detained under the MHA 2001 remained in hospital as voluntary patients for a greater duration of time after being discharged from their detention order compared to those admitted under the MTA 1945 ($p < 0.001$).

Tribunal outcomes

In relation to the MHA 2001, there were a total of 51 MHTs from November 1, 2006 to October 31, 2007, 42 of which related to patients admitted under the MHA 2001 and nine related to transitional patients initially detained under the MTA 1945. The involuntary detention order was revoked in four MHTs. In two of these cases the MHT cited a failure to fulfil the necessary criteria for major mental illness at the time of the tribunal and in the other two cases the MHT cited the unavailability of index patients for mental state examination (due to absconsion). Of the 57 individuals who had their involuntary detention status changed to voluntary within three weeks of admission and therefore prior to their first (automatic) MHT, no patient requested to have an (optional) MHT.

Discussion

There has been no significant reduction in the involuntary detention rates of individuals in the West Galway Mental Health Services with the introduction of MHA 2001. The Mental Health Commission (MHC) recently noted a national reduction of 25% in involuntary admissions since the introduction of the MHA 2001.[12]

It is possible that the small apparent reduction (91-84) would have reached statistical significance if the study had attained greater power by being held over a longer duration. However if involuntary detentions of less than one day's

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Table 1: Demographic data

	MTA 1945 (n = 91)		MHA 2001 (n = 84)				
	N	%	N	%	χ^2	df	p
Gender							
• Male	46	50.5	47	56.0	0.512	1	0.474
• Female	45	49.5	37	44.0			
Employment status							
• Employed	18	19.8	66	21.4	0.073	1	0.788
• Unemployed	73	80.2	18	78.5			
Civil Status							
• Single/Divorced/ Separated/Widow(er)	77	84.6	64	76.2	1.981	1	0.159
• Married/Cohabiting	14	15.4	20	23.8			
Nationality							
• Irish	82	90.1	74	88.1	2.086	3	0.555
• United Kingdom	4	4.4	2	2.4			
• Other European	3	3.3	3	3.6			
• Other							
Diagnosis							
• Schizophrenia/Schizoaffective/ Other Psychotic Disorders	35	38.5	37	44.0	1.695	2	0.428
• Affective Disorder	39	42.9	28	33.3			
• Other	17	18.7	19	22.6			
Risk							
• Risk to Self	13	14.3	15	17.9	1.331	3	0.722
• Risk to Health	44	48.4	43	51.2			
• Risk to Others	26	28.6	18	21.4			
• Mixed risk	8	8.8	8	9.5			
Change of Status from Voluntary to Involuntary							0.650
• Yes	17	18.7	18	21.4	0.206	1	
• No	74	81.3	66	78.6			
Applicant Data							
• Family	77	84.6	45	53.6	19.93	1	< 0.0001
• Non-family/Second Opinion (Form 23)	14	15.4	39	46.5			

duration are excluded from both Acts (MTA 1945, n = 11; MHA 2001, n = 1) the difference in detention rates under both Acts was clearly negligible (MTA 1945, n = 80; MHA 2001, n = 83). The absence of a period of observation under the MTA 1945 might account for a greater number of patients being detained for up to 24 hours in that group as a patient can be detained but not admitted under the MHA 2001 pursuant to section 14(2) of the MHA 2001 (24-hour holding power).

Interestingly the Mental Health Commission report,[12] noted that the 25% reduction in involuntary admissions nationally is due to a drop in the number of Involuntary Admission Orders (Form 6) rather than regrading from voluntary status (Form 13). It would be interesting to see whether this reduction nationally is entirely accounted for by a reduction in very brief involuntary admissions under MTA 1945, as suggested by the present study, since the national figures indicate a low proportion (5%) of admissions under MHA 2001 are for less than five days.[12]

Notwithstanding a minor difference in age, no other statistical differences were found in relation to demographic data, median duration of involuntary inpatient detention or median duration of total involuntary detention (inpatient and 'on trial' patients) between the two groups.

However, when individuals involuntarily detained for less than 24 hours were excluded, the total duration of involuntary detention was greater for those admitted under the MTA 1945. In the MTA 1945 clear guidelines exist for discharging individuals 'on trial', however the MHA 2001 has no such provision although it does allow involuntary patients to be on approved leave from the hospital for extended periods within the duration of the order.

We also noted that more individuals remained as voluntary patients in hospital under the MHA 2001 after their involuntary status was discontinued.

More family members made the initial application for involuntary detention under the MTA 1945. This would seem to corroborate anecdotal evidence from families who welcome

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Table 2: Duration of detention

	MTA 1945 (n = 91)		MHA 2001 (n = 84)			
	Median No. of days	SD	Median No. of days	SD	z	p
Duration of inpatient detention	17.00	40.14	15.00	48.48	-0.314	0.754
Total duration on Act	21.00	50.40	15.00	49.34	-1.174	0.240
Duration of hospitalisation when status changed to Voluntary	0.00	58.25	3.00	35.55	-6.270	< 0.001

the ready availability of other sources of applicant facilitated under the MHA 2001 for fear of any negative consequences on their relationship with the patient. In addition, this data would further suggest that other sources of applicant feel both confident and legally protected under the current process.

We believe that our findings demonstrate a relatively seamless transition from the MTA 1945 to the MHA 2001 in the West Galway Mental Health Services suggesting that the MTA 1945 had been used appropriately.

However, unlike the MTA 1945, the MHA 2001 fulfils the requirements of the United Nations Principles for the Protection of Persons with Mental Illness (1991),[6] and the European Convention for the Protection of Human Rights and Fundamental Freedoms (1954),[7] and like similar mental health legislation in other jurisdictions, reflects a welcome societal shift in attitudes towards those suffering from major mental illness.[13,14]

It remains a possibility that some individuals from the West Galway Mental Health Services could have been missed due to detention in other 'catchment areas'. However this could have occurred equally for individuals detained involuntarily under either Act and given that information was attained in relation to admissions to the East Galway Mental Health Services as well as from the country's two main private hospitals (St Patrick's hospital and St John of Gods hospital, Dublin), it is unlikely to have significantly affected our results.

It is also possible that our results are not generalisable to other 'catchment areas' in the country and consequently we believe that similar audits in other regions would prove valuable in guiding the first governmental review of the MHA 2001, in its entirety, in 2012.

We compared individuals 'on trial' under the MTA 1945 and individuals on extended approved leave under the MHA 2001, however we acknowledge that these two concepts are not identical and that some consultants may not use the extended approved leave facility of the MHA 2001 in a similar fashion to 'discharging patients on trial' under the MTA 1945.

Conclusion

We found no significant differences in the rates of detention or in the clinical characteristics of involuntarily admitted patients with the introduction of the MHA 2001. We found some evidence for earlier discharge of patients under the MHA2001 – individuals were less likely to be discharged on approved leave than on the older act and the total duration of detention was shorter on the new act when brief (< 24 hours) admissions were excluded.

We believe our data demonstrates that the MTA 1945 was not inappropriately utilised in the 12 month time period prior to the introduction of the MHA 2001 in West Galway. We believe that further detailed regional auditing of the functioning of the MHA 2001 would help guide the first full governmental review of the MHA 2001 in 2012.

Declaration of Interest: None.

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While there was no specific safety signal in the 800 patients treated in combination with oestrogens, caution should be exercised when prescribing agomelatine with other moderate CYP1A2 inhibitors (e.g. propranolol, grepafloxacine, enoxacine) until more experience has been gained. In* vivo, agomelatine does not induce CYP450 isoenzymes. Agomelatine inhibits neither CYP1A2 in vivo nor the other CYP450 in vitro. Therefore, agomelatine will not modify exposure to medicinal products metabolised by CYP 450. **Adverse Events**: In clinical trials, over 3,900 depressed patients have received Valdoxan. Adverse reactions were usually mild or moderate and occurred within the first two weeks of treatment. The most common adverse reactions were nausea and dizziness. These adverse reactions were usually transient and did not generally lead to cessation of therapy. 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