Involuntary admission from the patients’ perspective

Brian O’Donoghue · John Lyne · Michele Hill · Conall Larkin · Larkin Feeney · Eadbhard O’Callaghan

Received: 16 December 2008 / Accepted: 15 July 2009 / Published online: 11 August 2009 © Springer-Verlag 2009

Abstract

Background Involuntary admission legislation and rates differ greatly throughout the European Union Member States. In Ireland, the Mental Health Act 2001 has introduced significant changes in the care for patients admitted involuntarily, including mental health tribunals that review the involuntary admission orders.

Aims To investigate (1) people’s perception of the involuntary admission, (2) awareness of legal rights and perception of tribunal, (3) the impact of being admitted involuntarily on the relationship with their family, consultant psychiatrist and prospects for future employment.

Methods Over a 15-month period patients admitted involuntarily to a Dublin Hospital were interviewed using a semi structured interview.

Results Eighty-one people participated in the study. Seventy-two percent of patients believed that their involuntary admission was necessary at the time and this was associated with greater insight into illness. A total of 77.8% of patients felt that the treatment they received had been beneficial. A total of 86.4% of patients were aware that they had been admitted involuntarily and 45.5% of patients found it easier to accept that they had been admitted involuntarily as their case was reviewed by a tribunal. A total of 27.5% experienced a negative impact upon the relationship with their family as a result of the involuntary admission, while for 15% there was a positive impact. For 26.6% of patients the doctor-patient relationship was negatively impacted upon and a third felt their prospects for employment could be affected.

Conclusion The majority of patients reflect positively on their involuntary admission and this opportunity should be used to engage patients in follow-up treatment.

Keywords Coercion · Involuntary admission · Mental Health Act · Insight · Schizophrenia

Introduction

Throughout European Union Member States, the criteria, procedures and legislation for involuntary admission for
people affected by psychiatric illness differ greatly [1], as do the involuntary admission rates and quotas [2, 3]. However, all member states share the common objective to comply with the European Convention for the Protection of Human Rights and Fundamental Freedom (1950) which specifies that a person detained against their will should have a judicial review [4]. The new mental health act in Ireland was implemented in 2006 but prior to this there was no statutory provision for an independent review of the decision to admit a person involuntarily for treatment [5]. Under the new legislation, the Mental Health Act 2001, the patient receives legal representation, an independent psychiatric assessment and the involuntary admission is reviewed by a Mental Health Tribunal.

The aim of this study is to investigate patients’ perception of their involuntary admission and we hypothesised that the patients’ perception of whether the involuntary admission was necessary would be associated with the level of insight into their illness. We also sought to investigate if demographic factors, diagnosis and the use of physical coercive measures had an influence on how patients perceive the necessity of their involuntary admission. We also sought to investigate patients’ perception of the Mental Health Tribunals and the patient’s knowledge of their legal rights. We examined the impact of the involuntary admission on the relationship with the patients’ family and whether this was influenced by a family member being the applicant for the Involuntary Admission Order. We examined the impact of the involuntary admission on the relationship with the treating consultant psychiatrists and whether being detained after a voluntary admission had an impact on the relationship. We also examined the perceived impact of the involuntary admission on prospects for future employment.

**Subjects and methods**

**Setting**

The study was set in a 183 bedded psychiatric hospital in Dublin (St John of God Hospital), which receives admissions from the local catchment area of Cluain Mhuire Psychiatric Services, in south Dublin, Ireland serving a population of 172,000. St John of God Hospital is also an independent private hospital and receives admissions from all over Ireland.

**Patient population**

Patients admitted involuntarily in St John of God Hospital, from the local catchment area or privately from throughout Ireland, in a 15 month period between 01/04/2007 and 30/06/2008 and over the age of 18 years were included in the study. Patients who were initially admitted voluntarily but were then subsequently detained under the Mental Health Act 2001 were also included in the study. Patients who were transferred to and from the only dedicated forensic psychiatric hospital in Ireland, the Central Mental Hospital, were excluded from the study. In Ireland, patients that are detained within the criminal justice system and who require psychiatric inpatient treatment are transferred to the Central Mental Hospital under the Criminal Law (Insanity) Act 2006 and are not routinely treated in the acute ward of the local psychiatric services [6]. Patients with a diagnosis of dementia or intellectual disability assigned by their treating Consultant Psychiatrist from ICD 10 Classification were excluded from the study [7]. Patients were invited to participate when the involuntary order had been revoked and a discharge date had been agreed. Therefore, patients who were still involuntary at the end of the study period or who were transferred to another hospital, while still involuntary, were not included in the study. Prior to inviting patients to participate, the treating Consultant Psychiatrist was consulted with to determine if it would be appropriate to include the patient in the study. A chart of all involuntarily admitted patients is presented in Fig. 1. Ethical approval was granted by the local ethics committee.

**Instruments**

Three psychiatrists (B. O’Donoghue, J. Lyne, M. Hill) interviewed the patients using a semi structured interview designed to investigate patient’s experiences and attitudes towards their Involuntary Admission, the Mental Health Tribunal and their knowledge of legal rights. Dichotomous answers were obtained from questions, e.g. patients answered that they perceived the involuntary admission to be necessary or unnecessary. The authors were not aware of any validated and reliable tool to investigate people’s perception of the necessity of admission. The interviewing psychiatrist was never a member of the patients treating team. Patients were given an information sheet about the study and signed a consent form if they wished to participate. Interviews were recorded on audio tape to facilitate measuring inter-rater reliability. Insight was assessed by an abbreviated version of the Scale to Assess Unawareness of Mental Disorder (SUMD) [8]. The general items questions were used because the study included patient groups with psychotic and non-psychotic illnesses. The SUMD addresses awareness of psychiatric illness, awareness of achieved effect of medication and the social consequences of psychiatric illness. The scale was scored out of a total of 15 with 0 representing present insight and 15 representing absent insight. Inter-rater reliabilities were measured from ten interviews for the SUMD and the measure of agreement, kappa, was 0.85 (P < 0.001).
Clinical information

Diagnoses were assigned by the treating consultant psychiatrists and coded from the ICD-10 Classification of Mental and Behavioural Disorders [7]. The use of restraint was determined by the “Clinical Practice Form for Physical Restraint” and the use of seclusion was determined from the “Register for seclusion.” These registers contain forms which are completed at the time of restraint or seclusion and are kept in the patient file and separately for review by the Mental Health Commission. Mechanical means of restraint was defined as the use of devices or bodily garments for the purpose of preventing or limiting the free movement of a patient’s body [9]. Seclusion was defined as the placing or leaving a person in any room alone with the exit door locked or held in such a way as to prevent the person from leaving [9]. Information on whether the assisted admissions team or the police brought the patient to the hospital was obtained in the clinical notes. The assisted admission team provide assistance in transferring patients to the approved centre (hospital) if it is required and consists of three nurses and a driver. Social and demographic information was obtained from the patient’s case notes.

Statistical analysis

Data were entered into SPSS version 15 for Windows. The demographic and clinical information of the patients who were interviewed and not interviewed were compared in Table 1 to investigate if they differed significantly, using t-tests and Chi-squared tests as appropriate. Spearman’s test was used to measure for correlations between non-parametric data and multi-dimensional Chi-square tests were used to measure associations between nominal data. The outcome of perceived necessity was dichotomous (necessary or unnecessary) and logistic regression was used to determine predictive factors for dichotomous category membership.

Results

Eighty-one patients were interviewed. Information on participants’ characteristics and demographics is presented in Table 1 and this contains comparisons with the patients who were eligible for the study but were not interviewed and those that were interviewed. There was no significant difference between the patients interviewed and not interviewed in any of the variables examined. Table 2 contains comparative data between the patients in this study and all involuntary admissions in Ireland. A flow chart of all patients involuntarily admitted within the study period is shown in Fig. 1. Participants were interviewed a median of 35 days (range 3–212 days) after they were admitted and a median of 6 days (range 1–85) after their Involuntary Admission Order had been revoked.

Necessity of involuntary admission

A total of 72% (n = 58) of patients reflect that their involuntary admission was necessary prior to discharge. A total of 77.8% (n = 35) of patients with a diagnosis of schizophrenia or schizoaffective illness report that their involuntary admission was necessary and 67.9% (n = 19) of patients with a diagnosis of an affective illness report...
that their involuntary admission was necessary. A total of 77.8% (n = 63) of patients feel that the treatment they received was beneficial to their mental health.

There was a strong correlation between the level of insight of patients and whether they perceived that the involuntary admission was necessary \[ r = 0.67, \ n = 80, \ P < 0.001, \text{two tailed}. \]

We performed a logistic regression, with perceived necessity of involuntary admission as the dichotomous outcome variable. Age, gender, martial status, diagnosis, whether the patient was admitted from the catchment area or privately, whether it was their first admission, length of involuntary admission, level of insight and use of physical coercive measures (i.e. police being involved, assisted admission, restraint, seclusions) were used as predictor variables. We had complete data for 80 participants. The model was significant \[ \chi^2 = 52.31, \ df = 10, \ P < 0.0005 \] and accounted for between 48 and 69.4% of the variance in perceived necessity, with 95% of “necessary” predictions correct and 82% of “unnecessary” predictions correct, overall 91% of predictions were correct. Two factors reliably predicted perceived necessity; the level of insight and length of time as an involuntary patient. An increase in the SUMD insight score of 1 (indicating less

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Patient demographics and comparison with patients not interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>Interviewed \ n = 81 (%)</td>
</tr>
<tr>
<td>Sex</td>
<td>Male (%)</td>
</tr>
<tr>
<td></td>
<td>Female (%)</td>
</tr>
<tr>
<td>Mean age</td>
<td>Males, years (range)</td>
</tr>
<tr>
<td></td>
<td>Females, years (range)</td>
</tr>
<tr>
<td>Admission source</td>
<td>Catchment area (%)</td>
</tr>
<tr>
<td></td>
<td>Private (%)</td>
</tr>
<tr>
<td>Type of admission</td>
<td>Admitted involuntary</td>
</tr>
<tr>
<td></td>
<td>Detained after a voluntary admission</td>
</tr>
<tr>
<td>Martial status</td>
<td>Single (%)</td>
</tr>
<tr>
<td></td>
<td>Married (%)</td>
</tr>
<tr>
<td></td>
<td>Separated, divorced, widowed (%)</td>
</tr>
<tr>
<td>Employment</td>
<td>Employed (%)</td>
</tr>
<tr>
<td></td>
<td>Unemployed (%)</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>Schizophrenia/schizoaffective disorder (%)</td>
</tr>
<tr>
<td></td>
<td>Affective disorders (%)</td>
</tr>
<tr>
<td></td>
<td>Other (%)</td>
</tr>
<tr>
<td>Admission details</td>
<td>Tribunal occurring (%)</td>
</tr>
<tr>
<td></td>
<td>Median length of admission (SD)</td>
</tr>
<tr>
<td></td>
<td>Median length of involuntary order (SD)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 2</th>
<th>Comparisons between study setting and Ireland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study setting</td>
<td>Ireland (10)</td>
</tr>
<tr>
<td>Rate of involuntary admission—2007 (per 100,000 pop)</td>
<td>48.3</td>
</tr>
<tr>
<td>Involuntary detentions during a voluntary admission 2007 (%)</td>
<td>43</td>
</tr>
<tr>
<td>Diagnosis—schizophrenia and schizoaffective disorder (%)</td>
<td>55</td>
</tr>
<tr>
<td>Diagnosis—affective illness (%)</td>
<td>36</td>
</tr>
<tr>
<td>Patients order being reviewed by a Tribunal (%)</td>
<td>48</td>
</tr>
</tbody>
</table>

\( Soc \ Psychiat \ Epidemiol \) (2010) 45:631–638
insight) was associated with an increase in the odds that the involuntary admission will be perceived as having been unnecessary by a factor of 2.1 (95% CI 1.4 and 3.05). An increase in the time of the involuntary admission by 1 day is associated with an increase in the odds that the involuntary admission will be perceived as being unnecessary by a factor of 1.02 (95% CI 1.0 and 1.04) (Table 3).

Perception of tribunal and awareness of legal rights

A total of 86.4% (n = 70) of patients were aware that they were admitted involuntarily under the Mental Health Act 2001. A total of 63% (n = 51) of patients stated that their treatment was discussed with them and 76.5% (n = 62) consented to taking medication if it was prescribed.

Of the sample of 81 patients interviewed, 48.1% (n = 39) of patients had their case reviewed by a Tribunal as their involuntary admission order lasted longer than 21 days. This is representative of involuntary admissions throughout Ireland in 2007, in which 47% of patients had a Tribunal [10].

A total of 54.1% (n = 20) could identify the three different roles in the Tribunal Board, i.e. solicitor, psychiatrists and lay person. A total of 56.8% (n = 21) felt that their case was adequately presented by their Solicitor and 73% (n = 27) were aware that they could appeal the decision to the circuit court. A total of 56.8% (n = 21) disagree with the findings of the Tribunal at the time of discharge. A total of 45.5% (n = 15) found it easier to accept that they had been admitted involuntarily as their case was reviewed by a Tribunal. A total of 52.8% (n = 19) believe that the Mental Health Tribunals are a fair system in which to review involuntary admissions.

Implications of involuntary admission

The Involuntary Admission Order was initiated by a family member or partner in 49.4% (n = 40) of cases. When it was a family of origin member who initiated the involuntary order, 65% (n = 26) of patients were aware of this, while 10% (n = 4) believed that a doctor had commenced the order and 17.5% (n = 7) were not aware of who initiated the Order. Only 4% (n = 3) of patients incorrectly believed that a family member had commenced the involuntary admission order.

For 27.5% (n = 22) of patients, the involuntary admission had a negative impact on the relationship with their family, while for 15% (n = 12) there was a positive impact. We found no relationship between the family being involved in the commencement of the involuntary order and a negative impact occurring on the relationship with the family and the patient [χ²(2, n = 77) = 0.35, P = 0.55]. Similarly, we found no association between the patient perceiving the family to be involved in initiating the Admission Order and impacting on their relationship with the family [χ²(1, n = 78) = 1.28, P = 0.26].

There was a negative impact on the relationship with the consultant psychiatrist in 26.6% (n = 21) of cases and a positive impact in 7.6% (n = 6) of cases, similar to the family, there was no association between the consultant psychiatrists initiating the Order and an impact on the therapeutic relationship [χ²(1, n = 79) = 0.14, P = 0.71] 33.3% (n = 26) of patients expect that the involuntary admission will have a negative impact on their employment prospects.

Discussion

This study suggests that the majority of patients reflect positively on their involuntary admission and this is associated with greater insight into their illness. Since the introduction of the Mental Health Act 2001, the majority of patients are aware of their legal rights, however just over half of patients feel that the mental health tribunals are a fair system to review an Involuntary Admission Order. For
over one-quarter of patients, there was a negative impact on the relationship with their family or the consultant psychiatrists as a result of the involuntary admission.

Strengths and limitations

In a literature review on outcomes of involuntary hospital admissions specific criteria were identified to categorise studies to low, medium or high quality. Eight criteria were defined and included study design (prospective or retrospective), clarity of inclusion criteria, sample size >50, attrition rates >50%, reporting of differences between eligible patients who did not participate and those that did, differences in the patients who dropped out of the study and involvement of the interviewers (i.e. whether the interviewer was independent or involved in the patients care) [11]. The authors believe that this study satisfies six of the above criteria and of note, no study in the literature review achieved over six of the eight criteria.

A potential limitation to the study is that participants may have been inclined to give a more positive account of the experience because a discharge date had been set and participants did not want to jeopardise this. However, throughout the interviews, the researchers emphasised that they were independent of the clinical service providing care. This was also stated in a letter of information on the study and on the consent form, which every participant received. Another limitation to this study is that the two constructs of perceived necessity of the involuntary admission and insight were self reported and measured at the same time. Also, severity of symptomatology or global functioning were not measured or controlled for.

Perception of necessity of involuntary admission

Previous studies addressing the people’s perception of the necessity of their involuntary admission have produced different results. In the largest of these studies, Priebe et al found that at 1 year, 40% of patients considered that their involuntary admission had been justified and they also found a 15% involuntary readmission rate [12]. The proportion of patients that believed that their involuntary admission was necessary in the present study is consistent with results from other studies [11, 13, 14]. Also, in a study undertaken in Ireland under the previous legislation, 66% felt that their involuntary admission had been necessary [15]. Other researchers have tried to identify factors associated with attitudes to involuntary admission. Kjellin et al. reported that age, gender and diagnosis did not influence patients’ attitudes in Sweden [16]. In contrast, a study from the US found male gender and a greater number of previous admissions are associated with a negative perception of the involuntary admission [17]. Although clinically intuitive, to our knowledge this is the first study that clearly demonstrates the association between insight and the perception that the involuntary admission was necessary. The finding that a longer length of time as an involuntary patient is associated with the perception that the involuntary admission was unnecessary, while interesting, may be confounded by the severity of illness.

Asking patients about their attitudes to involuntary admission may help identify those at risk of not engaging in follow-up. Short insight-focused cognitive behavioural therapy intervention prior to discharge has been demonstrated to improve adherence to treatment and awareness of symptoms of psychiatric illness [18]. A trial of compliance therapy in patients with psychotic symptoms found an improvement in adherence [19], and also a reduction in readmission rates at 18 month follow-up [20]. However, this has not been consistently replicated [21] and it was observed that involuntary admission was a predictor of poor outcome in the study involving CBT.

Awareness of rights

Under the previous legislation in Ireland, 47% of patients were unaware that they had been admitted involuntarily on arrival to hospital and 37.5% remained unaware of their legal status [15]. On admission only 10% knew their legal rights and this finding has been replicated elsewhere [14]. This study has demonstrated that patients admitted under the new legislation are more aware of their legal status and rights under the MHA2001. In this study 86.4% of patients were aware they were admitted involuntarily, compared to 62.5% of patients from a different study ten years ago under the previous legislation. Patients also appeared to be well informed of specific rights such as their right to appeal the decision of the Mental Health Tribunal to the circuit court. Under the Mental Health Act 2001 patients are given an information booklet informing them of their legal rights and the procedures of involuntary admission and this appears to have had a positive impact [22]. However, there may be alternative explanations for this apparent increase in awareness of legal rights, including that the two studies involved two different patient populations.

Involvement of family

This study identified and quantified the impact the involuntary admission has on the relationship between the patient and their family but an investigation of the causes for this impact was beyond the scope of the study. There is a considerable burden of care on the family of a person affected by psychiatric illness and with the move from
hospital-based treatment to community care this burden is increasing [23, 24]. In cases of acute psychiatric admissions, relatives can be subjected to high levels of verbal and physical abuse [25]. Commonly, relatives and caregivers of patients admitted involuntarily do not feel involved in the care and treatment of their relative [26, 27], more so than relatives of voluntary patients [28].

Studies show that when families and caregivers of people affected by schizophrenia have been provided with psychoeducation the risk of readmission for the patient is reduced, as is the length of stay [29]. Also, families and caregivers have improved attitudes towards medication for people with schizophrenia following psychoeducation [30]. In this study, 15% of patients felt that the involuntary admission had a positive impact upon the relationship with their family. Further research is required to better understand the pathways to care for an involuntary admission, and the experience of the process from the family or caregiver’s perspective.

**Conclusion**

Involuntary admissions often represent a last and unwelcome resort for families, general practitioners and psychiatrists. However the majority of patients, prior to discharge, reflect that their involuntary admission was necessary and this positive perception could be used to engage the patient with follow-up care.

**Acknowledgments** The authors are grateful to Sandra Bollard, Mental Health Act administrator in St John of God Hospital and Dr Daria Brennan who provided invaluable assistance to the study. We are also grateful to the participants as well as the psychiatrists and nurses in St John of God Hospital and Cluain Mhuire Family Centre for facilitating this study.

**Conflict of interest statement** None.

**References**


