Information on the Mental Health Act 2001

The Mental Health Act (2001) strengthened legal oversight of the involuntary admission process and ensured that Ireland was on a par with international standards of human rights, by taking into account frameworks such as the European Convention for the Protection of Human Rights and Fundamental Freedom (1), and the United Nations Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (2). While previous legislation contained minimal provision for service users to have a right to second opinions and other protections against inappropriate detention, the MHA 2001 strengthened processes and included the automatic right to an independent review of involuntary admission by a Mental Health Tribunal. Individuals admitted under the MHA 2001 are required to have a mental disorder resulting in a serious likelihood of the person causing immediate harm to themselves or others, or because of the mental disorder, their judgement is so impaired that failure to admit would likely lead to a serious deterioration in the persons condition (3,4). Diagnoses of solely personality disorders or psycho-active substance misuse are insufficient for detention under the MHA 2001. An application form to a registered medical practitioner (usually a General Practitioner) can be completed by a number of different individuals including a family member, a member of the police or an Authorised Officer (4). The registered medical practitioner if they believe that the person fulfils criteria for detention under the MHA 2001 will complete a recommendation form and subsequently (where required) can request support from an Assisted Admission team for the person to be escorted to an acute psychiatric unit (4). The Assisted Admission team may comprise psychiatric nurses working in the acute psychiatric unit or be the National Assisted Admission team; a private company to whom transfer of service users to approved units is outsourced, with staff working in this company having no prior knowledge of the service

users. Within 24 hours of arrival, a consultant psychiatrist may complete an admission order for the involuntary detention of the person. The person can request voluntary admission or alternatively can be discharged from hospital if the consultant believes that admission is not merited (4).

References

1. European Union: Convention for the protection of human rights and fundamental freedoms. 1950. Available at http://www.coe.int/fr/web/conventions/full-list/-/conventions/treaty/005.

2. United Nations: The protection of persons with mental illness and the improvement of mental health care. 1991. Available at http://www.un.org/documents/ga/res/46/a46r119.html.

3. Office of the Attorney General: Mental Health Act 2001. (No. 25). Available at http://www.irishstatutebook.ie/eli/2001/act/25/enacted/en/print.html.

4. Mental Health Commission: Code of Practice on Admission, Transfer and Discharge to and from an Approved Centre. Issued Pursuant to Section 33(3)(e) of the Mental Health Act, 2001. Dublin: Mental Health Commission, 2009. Available at http://www.mhcirl.ie/File/COP_ATD.pdf.

Information on the research process, inclusion criteria and ethical procedures.

Recruitment and sampling

Participants were recruited from a larger cohort of individuals (n=156) who had participated in a quantitative prospective study of attitudes towards admission and care, which was conducted with a representative cohort of service users from three inpatient psychiatric in the ROI, encompassing urban and rural settings and attached to a tertiary referral academic hospital, a county hospital and a standalone psychiatric unit (1). During their involuntary admission, prospective participants were informed about the study and facilitated in meeting a researcher who provided further information. Three months post-revocation of the involuntary admission, potential participants were re-contacted by a member of the research team to ascertain their willingness to engage in the study. Individuals were excluded if they had an intellectual disability (intelligence quotient < 70) or dementia, were still receiving inpatient care (ie. voluntary status), did not feel well enough to partake or did not have the capacity to consent in the interview. The decision to exclude people who were in hospital was based on a desire to minimise risk of coercion associated with being in the hospital and maximise participants time to recover, whilst still being able to recall the details of their admission experience, thus we did not undertake interviews in a hospital setting. We also wanted to reduce bias by including individuals who had a similar trajectory in their recovery.

Ethics

Ethical approval for the study was attained from the Research Ethics Committees of National University of Ireland Galway, Galway University Hospitals Clinical Research Ethics Committee and Roscommon Hospital Ethics Committee. Written, informed consent was

obtained from all participants. Alongside the provision of written and verbal information about all aspects of the study, participants were informed they could have an advocate and or a family member accompany them to the interview and were provided with contact details for additional support services.

Data collection

Data were collected, during 2011 and 2014 using in-depth, semi-structured, audio-recorded face-to-face interviews guided by an interview schedule that had been developed by the research team and informed by the literature and aims of the study. The interview schedule included open-ended and focused questions relating to four general topics which were 'experience of transfer and detention', 'hospital experiences (e.g. non-consensual medication and seclusion)', mental health 'tribunal experience', and 'going home'. The schedule was piloted with 1 service user. As the study progressed, minor amendments were made to the schedule following review of the transcripts by members of the research team. Comparative questions to attain a deeper understanding of participants' experiences and to elicit commonalities and differences across participants were also utilised. The mean duration of the interviews, which were conducted by a member the research team (Author X), was 47 minutes (range 10-95 minutes).

In total 50 participants (29 males, 21 females) were interviewed. The sample size was determined by a desire to achieve maximum variation in the sample rather than providing an epidemiologically representative sample (see Table 1). To ensure maximum diversity, we included service users with a wide age range, included service users admitted to all three sites and included individuals who had their detention order revoked at mental health

tribunal. Service users' applicants included all potential options (family members, police members, authorised officers and "any other persons"). To reduce bias, we did however include service users where possible in similar proportion to national statistics (58% of participants were males, 54% of individuals were between 25 and 54 years, and 9% of those service users that had mental health tribunals had their involuntary status revoked). In addition, sampling continued until theoretical saturation of data was achieved.

Data analysis

Prior to entering data into Nvivo (2), all interviews were transcribed in full and identifying material was removed. Data were analysed using thematic analysis (3). Written transcripts were examined systematically, and coded line by line according to distinct stages of involuntary admission. Once all transcripts were coded, each code was examined to identify the relationships and connections between codes. Any overlapping codes were collapsed to form larger, more inclusive sub-themes. This initial analysis identified a number of sub-themes within each of the chronological stages of involuntary admission. A subsequent comparative analysis collated sub-themes evident across each of these stages of into four overarching themes. These themes were then cross-checked against the raw data by two members of the research team and consensus reached regarding interpretation, relationships and titles.

References

1. Bainbridge E, Hallahan B, McGuinness D, et al: A three-month follow-up study evaluating changes in clinical profile and attitudes towards involuntary admission. European Psychiatry 33:S477-S478, 2016

2. QSR International Pty Ltd: NVivo qualitative data analysis Software. Version 10, 2012.

3. Braun V, Clarke V, Terry G**:** Thematic analysis. In *Qualitative Research in Clinical Health Psychology* (ed. P. Rohleder and A. Lyons), pp. 95-114. Palgrave Macmillan: New York, 2014.