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Original Research

Clinical features of patients who are admitted under different criteria of the Irish Mental Health Act 2001: a retrospective cohort study

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Abstract

Objectives: To examine the criteria utilised for detaining individuals under the Irish Mental Health Act 2001 (MHA 2001) and their association with clinical features.

Methods: Demographic and clinical data of 505 involuntary admissions under the MHA 2001 between 2013 and 2023 were attained. Data included criteria utilised for detention and renewal, sociodemographic and clinical features associated with these criteria, and the use of coercive practices, such as seclusion and restraint.

Results: The majority of patients who were involuntarily admitted (61.4%), or had their admission order affirmed by tribunal (78.2%), were not judged to pose an immediate risk to themselves or others. Patients admitted under the "impaired judgement criterion" were less likely to be secluded ($\chi^2 = 15.8$, $p < 0.001$) or restrained ($\chi^2 = 11.6$, $p < 0.01$). Patients admitted under the "risk criterion" were younger (KW = 12.7, $p = 0.02$), and less likely to have a psychotic disorder ($\chi^2 = 5.9$, $p = <0.001$) or have a previous involuntary admission ($\chi^2 = 7.7$, p = 0.02). Patients who were subject to coercive care were younger (U = 12739, $p < 0.001$), more likely to be male ($\chi^2 = 4.6$, $p = 0.03$), and have prolonged involuntary admissions (U = 18412, $p = 0.02$).

Conclusions: Currently, the majority of the involuntary care provided for patients under the MHA 2001 is not related to the risk criterion of causing immediate and serious harm to themselves or others, but rather to the criterion of impaired judgement. Patients admitted under the risk criterion are more often subjected to restrictive practices, but are less likely to suffer from psychosis, than those receiving involuntary care due to their impaired judgement.

Keywords: Coercion; health legislation; involuntary commitment; Mental Health Act; psychiatry

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Introduction

The use of involuntary detention and treatment in psychiatry is perhaps the most controversial aspect of the specialty, with critics declaring it an impingement on human rights (Kelly 2014) and proponents citing its necessity to facilitate an otherwise foregone beneficial treatment (Miller and Hanson 2016). Calls have been made to equivocate psychiatric patients with those in other branches of medicine by making decision-making capacity the sole criterion for detention, thereby ending the explicit discrimination, according to the United Nations Convention on the Rights of Persons with Disabilities, whereby only those suffering from the psychosocial disability of a mental disorder can be detained under such legislation (Szmukler 2015). Criteria required for the detention of psychiatric patients vary across countries but generally comprise a requirement that the person has a mental disorder and that compulsory treatment is necessary for their health or safety, with countries varying greatly in relation to the emphasis placed on dangerousness (Zhang *et al*., 2015). The most appropriate criteria for involuntary detention is subject to ongoing debate, with proponents arguing whether a mentally disordered person should be required to present an acute risk or have impaired capacity to be admitted without their consent (Szmukler and Kelly 2016).

Irish Mental Health Act

In the Republic of Ireland, the involuntary hospitalisation of patients on psychiatric grounds is regulated by the Irish Mental Health Act 2001 (MHA 2001), which was enacted on 1 November 1 2006. This Act allows people suffering from a 'mental disorder' to be detained if 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'; 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 an appropriate treatment that could be given only by such admission; and (ii) the reception, detention, and

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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 c) both a) and b).

A person, who it is believed should be subject to an involuntary psychiatric admission, is nominated by a third party to be assessed by a registered medical practitioner (RMP). If this RMP judges that the subject of this application fulfils criteria a), b), or c), they can recommend that the patient be admitted to an 'Approved Centre' for assessment within 24 hours by a consultant psychiatrist. The psychiatrist then decides if the patient fulfils criteria a), b), or c), thereby completing or terminating the involuntary admission. Patients who have been admitted voluntarily to an Approved Centre can also be detained under the MHA 2001 should they indicate a desire to leave and fulfil one of the above criteria for 'mental disorder'. Any involuntary admission decision is subject to a second opinion by a consultant psychiatrist and review by a mental health tribunal (comprising an independent psychiatrist, a barrister/solicitor, and a layperson) within 21 days. Should the involuntary admission be affirmed by this tribunal, the treating psychiatrist may make a renewal order, which lasts up to 3 months. This order will also be reviewed by a tribunal within 21 days, and the order can be extended for further periods of up to 6 months.

Implicit in criterion (a) is that a significant risk of harm to self or others is posed, and we interpret this as a mental disorder plus 'risk criterion' for the current paper. Implicit in criterion (b) is that the person's judgement is so impaired by their mental disorder that they cannot believe the information or weigh up the risks and benefits of admission and treatment sufficiently for capacity to enable consent to a clinically recommended voluntary admission, and we interpret this criterion as mental disorder plus 'impaired judgement criterion'.

The rates of involuntary admissions have increased steadily in Ireland since the Act's introduction: from 37.3 involuntary admissions per 100,000 population in 2007 to 56.7 in 2021 (Walsh 2008, Craig 2014, Craig 2017, Craig 2020, Daly and Craig 2021, Craig 2022). Despite this trend, rates of involuntary admissions are almost half that of England, a comparable jurisdiction (Conlan-Trant and Kelly 2022), and significantly less than that of many other European countries (Rains *et al.*, 2019).

Proposed changes to the Irish Mental Health Act

The recent Mental Health Bill 2024 (MHA 2024), as currently drafted, contains multiple reforms to the 2001 Mental Health Act including revising the two criteria for involuntary detention which are now worded:

(a) the person has a mental disorder, the nature and degree of which is such that:

(i) the life of the person, or that of another person, is at risk, or the health of the person, or that of another person, is at risk of immediate and serious harm, **and**

(ii) if the first-mentioned person were to be admitted to and detained in a registered acute mental health centre

(I) his or her admission and detention would be likely to reduce the risk he or she poses to himself or herself or others due to his or her mental disorder

(II) he or she would be likely to benefit from care and treatment that cannot be given to that person other than in a registered acute mental health centre, **or**

(III) his or her admission and detention would be likely to benefit the condition of that person;

or

(b) the person has a mental disorder, the nature and degree of which is such that:

(i) he or she requires care and treatment immediately,

(ii) the care and treatment required to be given to the person cannot be given to that person other than in a registered acute mental health centre, **and**

(iii) the reception, detention and care and treatment of the person concerned in a registered acute mental health centre would be likely to benefit the condition of that person.

Thus the 'risk criterion' in (a) has been adapted to include a treatability component and the 'impaired judgement' criterion in (b) has been removed completely, although a lack of capacity is still implied in this criterion, since the person in question would presumably be consenting to a clinically recommended voluntary admission for their mental disorder were they able to do so.

Whether this legislative change will lead to a change in involuntary admission rates is unclear. In a review of the rates of involuntary admissions across EU states, De Stefano and Ducci (2008) argued that the rates of involuntary hospitalisation differed between countries that allow for involuntary hospitalisation on the basis of patient's need for treatment and those requiring a justification on grounds of risk (de Stefano and Ducci 2008), while others cast doubt that any single difference in legislation can account for the nearly 20-fold difference in these rates between European countries (Salize and Dressing 2004, Rains *et al.*, 2019). In the USA, Lee and Cohen (2021) have noted a nearly 30-fold difference in involuntary hospitalisations between states (Lee and Cohen 2021), despite these states (Connecticut and Florida) both having criteria for involuntary hospitalisation, which broadly resemble criterion a) of the MHA 2001 as necessary conditions (Reinhart 2002, Lemieux 2020). A complicating factor is that clinicians in front-line services can be expected to have different interpretations of how criteria should be applied. Many patients in different sociocultural settings may also be subject to various forms of involuntary care and coercion without actually being subject to the application (and therefore potential protection) of a specific legislation (Hotzy and Jaeger 2016).

The 'impaired judgement' criterion in the current MHA 2001 accounts for 68% of involuntary admissions under the Act in 2022 (personal communication from the Mental Health Commission). Limited research has been conducted to date to evaluate and compare the demographic and clinical characteristics of individuals detained under the different criteria of the MHA 2001 (Kelly *et al.*, 2018), and no research (to our knowledge) exists examining the criteria of extension orders under the Act.

Aims

We aimed to compare involuntary patients detained under different criteria ('risk criterion' and 'impaired judgement criterion') of the MHA 2001 in relation to:

1. Fulfilling criteria at different stages of the involuntary care pathway
2. Their sociodemographic and clinical characteristics and
3. Their exposure to coercive interventions, such as seclusion and restraint.

We also aimed to investigate the sociodemographic and clinical characteristics of patients who were subject or not subject to coercive measures.

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Methods

We identified patients using a database of involuntary admissions in the Department of Psychiatry, Adult Acute Mental Health Unit, University Hospital Galway (henceforth called AAMHU), a 50-bed psychiatric unit attached to a tertiary referral academic hospital. This unit serves a catchment area of over 230,000 people, with a mixture of urban and rural areas. This database contained hard copy files recording patients admitted to the AAMHU under the MHA 2001. It did not include individuals who were held under MHA 2001 while awaiting assessment by a consultant psychiatrist for involuntary admission but subsequently were not detained. The files of identified patients were requested from medical records to allow for further data extraction. Ethical approval was obtained from the Clinical Research Ethics Committee for Galway University Hospitals (C.A. 3085) prior to study commencement.

We collected data on sociodemographic and clinical features, criteria for involuntary admission by different assessors across the involuntary care pathway, and the extent of coercive measures employed during admissions (see Appendix 1 for the full list). Statistical analysis was performed using the Statistical Package for Social Sciences 27.0 for Windows. We utilised the Student's *t* test for parametric data, the Pearson's chi-square test (or Fisher's exact test, where appropriate) for categorical data and the Mann–Whitney *U* or Kruskal–Wallis tests for nonparametric data. A statistical threshold of $p < 0.05$ was considered significant in the analyses.

Results

We collected data from 505 admissions, of 341 patients, dating from 2 May 2013 to 25 November 2022. Medical notes were unavailable for 76 admissions who were then excluded from the statistical analyses of outcomes. There was no significant difference between patients whose medical notes were available *versus* not available in age, detention criteria, or involuntary admission length. Demographic details are listed in Table 1.

Table 1. Demographic and clinical data of involuntary patients

Gender	N (% of all patients, $N = 505$)
Male	293 (57.8)
Female	212 (42.2)
Age	
Mean (SD)	42.9 (16.5)
Median (IQR)	41 (29–53)
Homeless	**50 (9.9)**
Nationality	**N (% of included, $N = 429$)**
Irish	448 (88.7)
Other European country	31 (6.1)
African	13 (2.6)
Asian	6 (1.2)
North American	5 (1.0)
Other	3 (0.6)
Primary diagnosis on discharge	**N (% of included, $N = 429$)**
Schizophrenia	98 (22.8)
Schizoaffective	62 (7.5)
Delusional disorder	12 (2.8)
Drug-induced psychosis	25 (5.8)
Other psychosis	38 (8.8)
Bipolar disorder: mania	95 (22.1)
Depressive disorder	28 (6.5)
Personality disorder	24 (5.6)
Dementia/intellectual disability	13 (3.1)
Traumatic brain injury	6 (1.4)
Adjustment disorder	11 (2.2)
Other	17 (4.2)
Medical notes not available	76
Previously admitted to AAMHU	285 (66.4)
Previously involuntarily admitted to AAMHU	183 (42.7)

AAMHU, Adult Acute Mental Health Unit.

Criteria for detention

Of patients admitted from the community (414 total admissions), the applicant for the involuntary detention was most often a family member of the patients ($n = 166$, 40.1%), followed by a member of the Gardaí ($n = 163$, 38.9%), an authorised officer ($n = 44$,10.6%), and 'Any Other Persons' ($n = 43$, 10.4%).

Criteria for community-based involuntary admission, as recommended by the RMP, were relatively equal in proportion; 155 (37.4%) deemed to fulfil criterion a), 144 (34.8%) criterion b), and 118 (28.5%) criterion c). By contrast, a large majority of patients (284 [68.6%]) were deemed by consultant psychiatrists, within 24 hours of admission to only fulfil criterion b), with only 19 patients (4.6%) of patients deemed to fulfil criterion a), and 111 (26.8%) criterion c) ($\chi 2 = 570.0$, $p < 0.001$). Criteria judgements by RMPs (form 5) and consultant psychiatrists (form 6) are illustrated in Fig. 1 for all community admissions and those initiated by Gardaí.

Ninety-one involuntary admissions resulted from a voluntary patient seeking discharge from the inpatient unit and is deemed by a consultant psychiatrist to fulfil the criteria for detention. Fifty-three (58.2%) of these 91 patients were female, a significantly larger proportion than those (38.4% female) admitted from the community ($\chi^2 = 12.1$, $p < 0.001$). Of the 91 previously voluntary patients who were detained, 8 (8.8%) were held under criterion a), 50 (54.9%) were held under criterion b), and 33 (36.3%) were held under criterion c). There was a 97.8% agreement on criteria between the two consultant psychiatrists who assessed the patient within a 24-hour period.

Thirty-seven (7.3%) of admissions resulted in the patient being transferred to a different Approved Centre prior to the end of their involuntary admission, one person was sent to the Central Mental Hospital, and the other 36 were sent either due to their local psychiatric unit or to a private hospital.

When their involuntary admission order was revoked, 34.4% of patients were discharged from the hospital on the same day. For those who continued as voluntary patients, those admitted under criterion a) or c) had significantly longer periods of voluntary admission than those admitted under criterion b) ($U = 5596$, $p = 0.017$). One-hundred and thirty-five (34.9%) patients were re-admitted within 1 year of discharge and 75 (14.9%) had a subsequent involuntary admission within 1 year of discharge.

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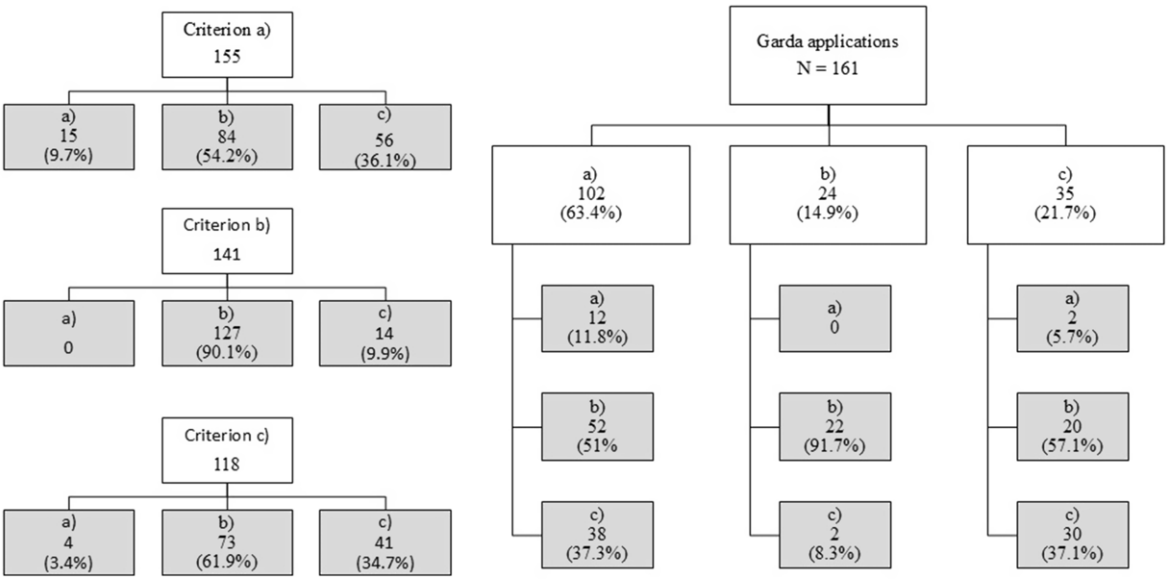

Figure 1. Community application criteria used: registered medical practitioner assessment (top row) and psychiatrist assessment (bottom row, shaded).

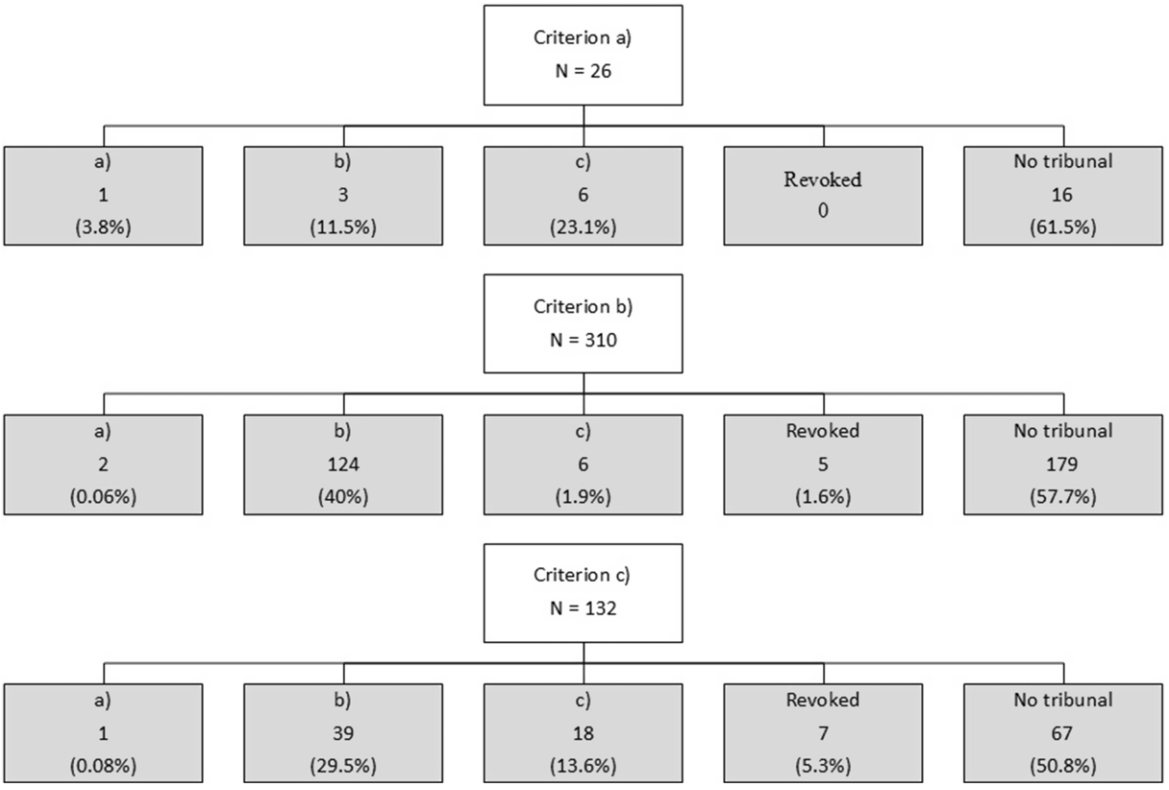

Figure 2. Criteria on application of form 6 or 13 (top row) and subsequent criteria for affirmation of the involuntary order at the first tribunal (bottom row, shaded).

The length of involuntary or total admission did not change based on patient age, gender, or detention criteria.

Criteria for continuation of involuntary treatment

Of those 206 involuntary admissions that were reviewed by the tribunal, 5.8% were revoked. The b) criterion was used to affirm 78.2% of involuntary admissions at the first tribunal and 81% at the second tribunal. Figure 2 shows the distribution of the decisions made at each patient's first tribunal, depending on the initial criterion under which they were detained.

Coercive treatments

Demographics, admission details, and outcomes grouped by criteria are shown in Table 2. Patients admitted under the impaired judgement criterion of the MHA 2001 were significantly less likely to be secluded, restrained, and coercively medicated. Patients

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Table 2. Comparison of patients admitted under different criteria of the Mental Health Act

	Criterion a)	Criterion b)	Criterion c)	Statistic (KW/χ^2), p-value
Total admissions	27	329	136	
Not transferred to a different Approved Centre	26	310	132	
Medical notes available and not transferred	24	261	102	
Demographics	**N (%)**	**N (%)**	**N (%)**	
Male (%)	13 (48.1)	178 (54.1)	96 (70.6)	**17.4, < 0.001**
Mean age (SD)	34.5 (14.9)	44 (16)	41 (17.5)	**12.7, 0.02**
Homeless	5 (18.5)	33 (10)	12 (8.8)	4.3, 0.24
Psychotic disorder†^	7 (29.2)	217 (83.1)	74 (72.5)	**37.7, < 0.001**
Personality disorder†^	7 (29.2)	8 (3.1)	8 (7.8)	**30, < 0.001**
Previous admission†*	17 (70.8)	191 (73.2)	74 (72.5)	0.13, 0.99
Previous involuntary admission†*	5 (20.8)	130 (49.8)	47 (46.1)	**7.7, 0.02**
Outcome	**N (%)**	**N (%)**	**N (%)**	
Secluded†*	7 (29.2)	25 (9.6)	24 (23.5)	**15.8, < 0.001**
Mean hours spent in seclusion†*#	47.9 (75.7)	23.5 (45.7)	29.6 (38.9)	
Median (range) hours spent in seclusion†*#	16 (0–214)	8 (0–218)	16 (0–138)	2.9, 0.23
Restrained†*	10 (41.7)	48 (18.4)	33 (32.4)	**11.6, < 0.01**
Median number of episodes of restraint†*#	3 (1–6)	1 (1–12)	1 (1-9)	3.8, 0.14
Coercively medicated†*	8 (33.3)	53 (20.3)	31 (30.4)	**5.9, 0.049**
Regular antipsychotic dose above BNF max†*	1 (4.2)	23 (8.8)	15 (14.7)	2.7, 0.26
Regularly prescribed two antipsychotics†*	7 (29.2)	57 (21.8)	30 (29.4)	1.8, 0.42
Received electroconvulsive therapy†*	0	13 (5)	3 (2.9)	1.9, 0.39
Discharged against medical advice†*	2 (8.3)	19 (7.3)	8 (7.8)	0.6, 0.97
Absent without leave†*	3 (12.5)	8 (3.1)	9 (8.8)	**6.7, 0.03**
Readmitted within 1 year of discharge†*	13 (54.2)	86 (33)	36 (35.3)	4.4, 0.11
Involuntary admission within 1 year†*	4 (16.7)	44 (16.9)	19 (18.6)	0.168, 0.92
Admission				
Median (range) involuntary admission length*	15 (2–108)	18 (1–997)	17 (2–301)	1.86, 0.35
Mean (SD) involuntary admission length*	26.1 (27.5)	40.3 (75.8)	35.6 (52.9)	
Median (range) total admission length†*	30 (2–407)	30 (1–997)	29 (2–403)	0.03, 0.98
Mean (SD) total admission length†*	62.7 (94.6)	48.9 (72.7)	49.6 (63.5)	
Median (range) days in hospital post-revocation	10.5 (0–327)	3 (0–145)	4 (0–119)	**7.3, 0.026**

(Statistically significant results in bold).
†* Percentage calculated using only patients for whom medical notes were available and who were not transferred to a different Approved Centre prior to discharge (N = 387, 76.6%).
^ Psychotic disorder refers to diagnoses falling under International Classification of Disease (ICD) 10 criteria F10.5–19.5 or F20–29 and F31.2.
#Median of patients in each criterion who were secluded.
BNF, British National Formulary; KW, Kruskal–Wallis; χ^2, Pearson chi-square.

admitted only under the risk criterion were significantly younger, more likely to have a personality disorder, and less likely to have a psychotic disorder or have a previous involuntary admission. Patients who experienced coercive care were significantly younger, more likely to be male, and had prolonged involuntary admissions. Patients deemed to fulfil both criteria, meanwhile, were more likely to be male.

The majority of patients who were secluded (64.8%, $n = 35$) or restrained (62.5%, $n = 55$) during their admission, were subject these coercive measures on only one occasion.

Table 3 shows the comparison between patients who experienced coercive practices (defined as seclusion, restraint, or being subjected to coercive intramuscular medication) and those who did not. Patients who experienced

Patients with a primary discharge diagnosis of personality disorder were more likely to be subject to seclusion or restraint than other patients (54.2% *v.* 24.5%, $\chi^2 = 6.2$, $p = 0.01$). Readmission rates of 43.5% to the AAMHU were noted within 1 year of discharge with 4 (17.4%) re-admitted under the MHA 2001.

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Table 3. Comparison of patients who were subjected to coercive practice

	Yes (N = 121, 31.3%) N (%)	No (N = 266, 68.7%) N (%)	Statistic (χ^2/U), *p*-value
Demographics			
Male[†*]	80 (66.1)	145 (54.5)	**4.6, 0.03**
Mean age (SD) [†*]	38.9 (15.3)	45 (17.3)	**12,739, < 0.001**
Previous admission[†*]	87 (71.9)	175 (65.8)	1.42, 0.23
Previous involuntary admission[†*]	56 (46.3)	112 (42.3)	0.55, 0.46
Outcome			
Regular antipsychotic dose above BNF max[†*]	16 (13.2)	19 (7.1)	**3.9, 0.049**
Regularly prescribed two antipsychotics[†*]	42 (34.7)	47 (17.7%)	**13.6, < 0.001**
Readmitted within 1 year of discharge[†*]	45 (37.2)	90 (33.8)	0.41, 0.51
Involuntary admission within 1 year of discharge[†*]	23 (19)	44 (16.5)	0.36, 0.55
Admission			
Median (range) involuntary admission length*	22 (1–997)	17 (2–369)	**18,412, 0.023**
Mean (SD) involuntary admission length*	56.6 (105.4)	28.8 (37.9)	

Coercive practices are defined as seclusion, restraint, or coercive administration of medication.
[†*] Percentage calculated using only patients for whom medical notes were available and who were not transferred to a different Approved Centre prior to discharge (N = 387).
χ^2, Pearson chi-square; *U*, Mann–Whitney U; BNF, British National Formulary.

Discussion

This study demonstrates that the large majority of patients admitted involuntarily in Ireland under MHA 2001, and of those who have their admission sustained for long enough to have a review by a mental health review tribunal, are considered by the assessing consultant psychiatrist to only meet the criterion of impaired judgement, rather than to pose an immediate and serious risk to themselves or others. We found that patients admitted under the impaired judgement criterion of the MHA 2001 were less likely to be secluded, restrained, and coercively medicated; while patients admitted under the risk criterion were younger, more likely to have a personality disorder, and less likely to have a psychotic disorder or have a previous involuntary admission. Additionally, patients who were subject of coercive care were younger, more likely to be male, and had longer involuntary admissions. Ireland already has a relatively low rate of involuntary psychiatric hospitalisation (Rains *et al.*, 2019), and it is unclear how in practice any shift in emphasis on risk or treatability in the proposed MHA 2024 legislation would be interpreted by front-line service providers in practice. It should also be noted that this current draft may yet be amended by the time it passes through the Irish governmental system.

A common pathway of involuntary admission (15% of recorded admissions) was of a patient being detained by the Gardaí (who the law states can only hold an individual who poses a serious likelihood of immediate and serious harm to themselves or to other persons), this patient being judged as fulfilling criteria a) or c) by the General Practitioner, before being judged as fulfilling only criterion b) by the consultant psychiatrist. Notably, whereas over 85% of Gardaí applications were judged by the assessing RMP to pose an immediate and serious risk to themselves or others, less than half of consultant psychiatrists deemed this to be the case when the patients were assessed within the subsequent 24-hour period. In addition, a previous study of involuntary admission applications, which included the same hospital as our study, reported that 22% of such applications were deemed by consultant psychiatrists to be ineligible for involuntary admission under any criterion (Bainbridge *et al.*, 2018). This disagreement would be additional to the already high rates of disparate assessments in our study, in that only 9.7% and 34.7% of patients judged by the RMP as fulfilling criteria a) and c) respectively were assessed by consultant psychiatrists as fulfilling these same criteria. Such disparate results of assessments of risk between consultant psychiatrists and Gardaí/other doctors may have a number of explanations. First, the acuity of the risk presensted by the patient in the community may have diminished, and/or the patients' mental state may have meaningfully changed in the time between their detention in the community and the consultant's review on the inpatient unit some hours later. Another possible explanation is that consultant psychiatrists may have a higher threshold for what constitutes 'serious and immediate risk', which would decrease their likelihood as deeming a patient as fulfilling criteria a) or c).

This increased propensity for use of the b) criterion was also evident in the decision of the mental health tribunals, who overwhelmingly used this criterion to affirm involuntary detentions. If the 'risk criterion' were the only one for involuntary detention only 6.7% of our study population would have their involuntary admission affirmed beyond 21 days, rather than the 39.4% who were affirmed. A recent Scottish study of 42,493 involuntary admissions showed that 61% of these admissions lasted over 27 days (Connolly *et al.*, 2023). The length of involuntary admission varies across European countries (Dimitri *et al.*, 2018, Hotzy *et al.*, 2018, Feeney *et al.*, 2019), which are likely due to a combination of legislative, demographic, and cultural differences. Patients in our study had longer inpatient admissions if they were given coercive medication or medication beyond BNF max-dose monotherapy. This likely indicates a more severe cohort of patients, and higher Brief Psychiatric Rating Scale (BPRS) scores have been shown to be correlated with the duration of admission (Kalisova *et al.*, 2014). A large multinational prospective study indicated that the use of seclusion, but not restraint, was predictive of a prolonged admission (McLaughlin *et al.*, 2016), while in our study, neither was predictive of a prolonged inpatient admission. We did not note any correlation between age and length of admission, as has been reported in other jurisdictions (Connolly *et al.*, 2023, NHS Digital 2020).

One previous paper has examined differences in the three criteria used in the Irish MHA (Kelly *et al.*, 2018). This paper similarly found schizophrenia to be the most common diagnosis among involuntary patients. The median duration of admission for involuntary patients was similar to that of our study (27 days *v.* 29 days in our study), and the length of admission was not different among the three criteria. One difference is that this study reported the admission criteria to make no difference in length of admission following revocation of an involuntary admission order, in contrast to our finding of a significant difference, in this admission length post-revocation, between the three criteria. Our study examined a greater number of outcomes, and found significant

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differences between the criteria in rates of both seclusion and restraint, use of coercive medication, and whether a patient went absent without leave during their involuntary admission. Each of these outcomes had the lowest proportion of patients admitted under the b) criterion, while the history of a previous involuntary admission was lowest in those admitted under the a) criterion. Such differences are to be expected, as patients detained under criteria a) or c) are, by definition, more likely to represent an acute risk to themselves or others, a requirement for any use of restraint or seclusion to be performed. Patients are often subjected to coercive medication because they are deemed to present a risk to themselves or others (Raboch *et al*., 2010), and so patients admitted for this reason would be expected to be more likely subjected to coercive medication. The increased rates of absence without leave in patients admitted under the risk criteria may be indicative of a more chaotic and unpredictable presentation or mental state. Such mental states, as well as patients who may have diminished impulse control, may be deemed by psychiatrists as inherently carrying more risk and also may have an increased risk of absconding.

Approximately one-third of involuntary psychiatric patients in our study were subject to coercive measures (defined as seclusion, restraint, or coercive medication). While the rates of coercive care have been shown to vary across countries (Bak and Aggernæs 2012) and within services of the same healthcare system (Husum *et al*., 2010), the most reliable results are likely to come from the multinational prospective EURONOMIA study, which also demonstrated large variations between countries (Raboch *et al*., 2010). The slightly higher rate (38%) in this study may be explained by our study not including 'medication given under strong psychological pressure (involving at least three members of staff)', as was done in the EURONOMIA study. As in previous literature, the majority of coercive measures in our study occurred early in the admission (Müller *et al*., 2023) and were associated with younger age (Way and Banks 1990, Hendryx *et al*., 2010, Beck *et al*., 2008). While we were unable to quantify illness severity, high scores in the BPRS (McLaughlin *et al*., 2016) and Health of the Nation Outcome Scales (Müller *et al*., 2023) have been shown to be correlated with the use of coercive measures.

Involuntarily admitted patients have previously been shown to have high readmission rates (Kallert *et al*., 2008, Müller *et al*., 2024), and there is limited evidence for interventions to avoid this negative outcome (Giacco *et al*., 2018). Such readmissions may lead to a deterioration in therapeutic rapport and trust in the psychiatric services (Mielau *et al*., 2018), potentially resulting in a greater requirement for further coercive practices and deterioration of the therapeutic relationship (Swartz *et al*., 2003). In our study, 15% of patients were involuntarily re-admitted within 1 year, which is similar to the 10% that has previously been reported nationally (Cunningham 2012).

Patients with a primary discharge diagnosis of a personality disorder warrant special attention. The MHA 2001 specifically excludes the involuntary detention 'by reason only of the fact that the person (a) is suffering from a personality disorder'. Previous research has shown patients with personality disorders to make up between 5% and 13% of involuntary admissions in Ireland (Ramsay *et al*., 2013, Feeney *et al*., 2019), similar to our finding of 5.6%. Patients with a primary diagnosis of personality disorder were more likely to be secluded or restrained compared to other involuntary patients, and patients with personality disorders have previously been noted to be at increased risk of such coercive practice (Beck *et al*., 2008, Knutzen *et al*., 2014). Not all countries exclude personality disorders from involuntary admissions (Zhang *et al*., 2015), and its exclusion is controversial (World Health Organization 2005). Their high rates of seclusion and restraint in our study may be explained by the increased impulsivity (Links *et al*., 1999, Swann *et al*., 2009) and acts of self-harm often present in individuals with a diagnosis of a personality disorder (Reichl and Kaess 2021). Patients with a primary diagnosis of personality disorder also often present with psychiatric comorbidities (Zanarini *et al*., 1998), which may themselves require such coercive measures. Thus, patients with a diagnosis of personality disorder may have been initially considered to have another Axis 1 disorder, for example, adjustment disorder or major depressive disorder, in order to justify their involuntary admission and treatment in an inpatient unit under MHA 2001.

Male patients have been found, across most countries, to make up the majority of involuntarily admitted psychiatric patients (Feeney *et al*., 2019), and our study is consistent with this literature. Interestingly, we found that females accounted for the majority of patients who were admitted voluntarily and subsequently detained under the MHA 2001. One possibility for our finding is that female patients may have been more likely to have been subjected to soft coercion prior to admission (before being subsequently involuntarily detained as an inpatient). Although not previously linked to gender, soft coercion has been shown to have been a factor in a significant minority of voluntary admissions (Bindman *et al*., 2005, O'Donoghue *et al*., 2014).

Our study has a number of limitations. First, this was a retrospective chart review and is subject to the limitations of studies of this nature, such as potentially missing data and heterogeneous documentation among clinical staff (Talari and Goyal 2020). Second, we were unable to access all medical notes for patients involuntarily admitted during this period, although there was no difference between patients whose medical notes were or were not available in age, detention criteria, or involuntary admission length. Third, this study identified patients in only one psychiatric inpatient unit; however, the AAMHU covers a wide catchment area, including urban and rural areas. Fourth, some patients with repeat involuntary admissions had different primary diagnoses for subsequent admissions, which may raise questions about the internal validity of the psychiatric diagnosis data collected in this study. Given the exploratory nature of this research, we did not explicitly correct for multiple testing as this is not indicated (Garcia-Perez, 2023). These limitations offer avenues for future research, which might include cross-centre comparisons of detention practices and more comprehensice longitudinal outcomes of patients detained under differing criteria.

Conclusions

Our results characterise the features of those admitted under different criteria of MHA 2001 and highlight that the majority of involuntary care under this Act, both by number and duration of admissions, is provided for those who lack the capacity to make decisions about their mental health care, rather than presenting an immediate and serious risk of harm. Patients with impaired judgement were also less likely to be subject to coercive measures than those who presented an acute risk of harm. Getting the balance right, between respecting and supporting those who do not wish to avail of inpatient care and providing such care for those who are unable to consent to it by virtue of the nature and severity of their illness, is likely to remain a contested area and require ongoing engagement by all relevant stakeholders in designing and implementing both legislation and service provision.

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