



## Experiences of involuntary admission in an approved mental health centre

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### **Abstract**

The aim of this qualitative study was to gain an understanding of what it means to have an involuntary hospital admission. A sample of six people who were detained at an approved Irish mental health centre and consented to recount their experiences were interviewed. The interview transcripts were analysed using Interpretative Phenomenological Analysis. Three super ordinate themes were identified: 'The early days', 'Experiences of treatment' and 'Moving on?'. 'The early days' represented participants' initial feelings and opinions of the experience of coming into the approved centre. 'Experiences of treatment' refers to participants' experiences of medication and relationships with staff. Finally, the theme 'Moving on?' represented participants' views on how they adjusted to involuntary admission. 'Learning the way' was central to the participants' notion of moving on. The findings suggest that the meaning of detention is a varied one that evokes an array of emotional responses for participants and highlights the need for a renewed way of thinking and doing concerning those subject to involuntary admission.

**Key words:** involuntary hospital admission, coercion, police, interpretative phenomenological analysis.

## **Introduction**

Involuntary hospital admission is concerned with balancing the rights of the individual with the desire to protect the community, and the paternalistic impulse to protect the individual from harming themselves (Stauch *et al.* 2002). The involuntary admission of a mentally ill person can be a contentious issue especially if the person is subjected to perceived coercive measures, such as police involvement, restraint, seclusion and forcible administration of medication. The experience can be a humiliating and deprives the individual of their liberty and basic human rights.

A number of clinical and demographic characteristics are frequently found in subjects who have multiple involuntarily admissions. In Ireland, of data relating to 121 individual classified as having multiple involuntary admissions, 59% were male who often lived in rural counties, 57% had a diagnosis of schizophrenia, or mania 20%, and most were in the age band of 22-64 (80%) (Mental Health Commission (MHC), 2010). Similarly, a French study also found that being male, having a diagnosis of schizophrenia and absence of depressive or anxiety symptoms was independently predictive of compulsory admission (Cougnard *et al.* 2004).

Internationally, legislation determines that patients who have a mental disorder or considered to be risk to themselves and/or others can be admitted involuntarily (Priebe *et al.* 2011). The Irish Mental Health Act (MHA) (Department of Health and Children 2001) sets clear, objective criteria for the determination of mental illness and review mechanisms and procedural safeguards to protect the rights of mentally ill persons.

Driven by the Green paper (Department of Health 1992) there was an emphasis to narrow the criteria for detaining a mentally disordered patient in Ireland. This was done by replacing the Mental Health treatment Act (1945) with the Mental Health Act 2001 (MHA 2001). A person can be admitted to hospital and treated against their will if they are found to have a mental disorder (i.e. mental illness, severe dementia or significant intellectual disability) and fulfils the criteria set out in the Act. According to the Act, spouses, relatives, Gardai (Irish Police), authorised officers and other person(s) can apply to a registered medical practitioner for a recommendation that a person be admitted involuntarily. This legislation has also entitled each involuntarily admitted individual to the right for independent legal advice, a second independent review by a consultant psychiatrist and a mental health tribunal within 21 days of admission (Kelly 2007). Since the introduction of the MHA in 2001, Ireland has seen an 8.9% decrease in the involuntary admission rate from 2007 to 2010 (MHC 2010). However, involuntary admissions continue to count for 10% for all psychiatric admissions (MHC 2010). Mental health professionals therefore need to continually enhance their skills in order to therapeutically engage with those involuntarily admitted to hospital and help them foster a sense of ownership for their illness on discharge. Whether involuntary detention is justified or necessary (right or wrong), the way in which it is handled can impinge in a positive or negative way and potentially hinder or enhance a person's engagement with services.

A recent review of qualitative studies on patients' experience of involuntary hospital admission and treatment selected five studies for consideration (Katsakou & Priebe 2007), two from Sweden and three from the UK. All five studies used semi-structured interviews to assess the patients' opinions on various aspects of involuntary treatment with sample sizes varying from 4-18 participants. Across the five studies, experiences

varied substantially amongst patients, with both positive and negative themes towards their detention and treatment highlighted. Negative themes included restrictions in autonomy, no participation in decisions for treatment, quality of care, not being cared for, emotional impact of the involuntary treatment and feeling devalued. On the other hand, positive themes included respect-autonomy and being cared for and treatment benefits.

Patients involuntarily admitted experience few clinical and social benefits (Preibe *et al.* 2011). However, a review notes that there is no evidence for the assumption that involuntary patients showed a homogenous pattern of worse clinical outcome (Katsakou & Priebe 2006). Outcomes for those admitted involuntarily when compared with those admitted voluntarily reveal that length of stay, re-admission risk and risk of involuntary readmission are at least equal or greater for involuntary patients (Kallert *et al.* 2008). Kallert *et al.* (2008) also report that patients admitted involuntarily expressed higher levels of dissatisfaction with staff care and often believed that their admission was not justified. Moreover, patients admitted involuntarily who perceived less coercion on admission and while receiving treatment in hospital, reported to be more satisfied with their treatment (Katsakou *et al.* 2010). The usefulness of involuntary admission is questioned when more negative than positive experiences of coercion are reported (Sibitz *et al.* 2011). Involuntary admission can also impact negatively on the therapeutic relationship with the person's consultant, relationships with their family and employment conditions (O'Donoghue *et al.* 2010).

The importance of satisfaction with treatment is highlighted by Fitzpatrick (1991), who states that there is a growing body of research which suggests that if satisfaction with

treatment outcomes is not present, then cooperation with community services after care will be impeded. This is illustrated by Priebe *et al.* (2009) who found that service users who expressed dissatisfaction with treatment at baseline showed greater statistical inclination towards subsequent involuntary admission and that a positive perception of the admission and care received, within the first week of admission, was critical to their overall perspective of the involuntary hospitalisation. In a recent study O'Donoghue *et al.* (2010) computed a logistic regression to investigate if age, gender, marital status, diagnosis, length of involuntary admission, level of insight and use of coercive measures predicted necessity of involuntary admission. The results showed that two factors predicted perceived necessity, i.e. the level of insight and the length of time as an involuntary admission.

The police hold certain powers with respect to the involuntary admission of persons to approved centres in Ireland. An approved centre is one approved by the Mental Health Commission. The MHA (2001) gives the police the power to take a person into custody and, if need be, enter a dwelling or other premises by force. This can conjure up the notion of a criminal act being committed, further highlighting stigma and distress and perhaps excessive use of force. The exercise of these powers is subject to the belief that there is a real possibility that the person may cause serious harm to him/herself or another person. However, a group of UK patients (n=16) (admitted both voluntarily and involuntarily), expressed a general dissatisfaction with quality of care and treatment from both police and professionals. Nevertheless, Priebe *et al.* (2009) report that 40% of patients admitted involuntarily when followed up considered their original admission justified. Similarly, the experience of involuntary hospital admission can be viewed by people as necessary with hindsight (Sibitz *et al.* 2011).

## **Aims and objectives of the research.**

The purpose of this study was to explore the impact of involuntary hospital admission upon a sample of people admitted to an approved Irish mental health centre and illuminate their lived experience of involuntary admission. This topic is of importance to mental health professionals, particularly in light of the literature that suggests that negative experiences of involuntary detention may impinge on persons' subsequent engagement with mental health services

The research to date on patients' perspectives and perceptions of involuntary admission in Ireland has been quantitative in focus (O' Donoghue *et al.* 2010, 2011). To date, no known phenomenological study in Ireland has interviewed people in relation to their experiences of involuntary detention.

## **Methods**

### ***Interpretative phenomenological analysis (IPA)***

This study adopted Interpretative Phenomenological Analysis (IPA) (Smith *et al.* 1999). Using IPA allows for greater detail of participants' experience and understanding of the topic in question to emerge (Smith *et al.* 1999). Illuminating the experience of involuntary detention using IPA recognises what it means to be a person in that situation and 'gives voice' to the way a person interprets their experience.

IPA is both phenomenological and interpretive. Central to IPA is the individual's personal perception of an event. Moreover, the interpretive element of IPA's 'double hermeneutics' acknowledges the researcher's attempt to make sense of the experience

related by the study participants (Smith *et al.* 2009, p. 3). Importantly, the researcher's pre-understandings are viewed as '...necessary precondition for making sense of another person's experience' (Willig, 2008, p. 69). However, researchers using IPA are advised to 'park or bracket...pre-existing concerns' to allow them focus on the study participants' accounts of their lived experience (Smith *et al.*, 2009, p. 64). IPA is also idiographic in that the researcher must initially engage deeply with each study participant's transcript before later integrating analysis of all the study transcripts (Willig, 2008).

### ***Participants and setting***

The study was conducted in an approved mental health centre, which is part of a broader mental health service in a regional health authority of the Irish national health system. The approved centre is primarily treatment focused and provides a service for those with acute mental health difficulties, mainly depression and severe mental illness. The number of involuntary admission orders to the approved centre in 2010 was 64 (MHC 2008).

Participants were purposefully selected on whether they were detained under the MHA (Department of Health and Children 2001). People 18 years of age and over who had their status revoked to a voluntary patient between 28 November 2010 and 30 April 2011 and a planned discharge had been agreed were only eligible to be included. Persons involuntary detained may be considered a vulnerable population, but would have their detention revoked at tribunal or by the treating psychiatrist, where they are (mentally stable) in the recovery/recovering stages of an illness and yet are in a safe and therapeutic environment. Permission was also sought from the treating consultant regarding the person's suitability for interview. Prior to planned discharge, each person

on the identified sample was approached by the first author and provided with written information on the study and asked to contact the first author if they wished to be interviewed. A total of six people (four men and two women) agreed to be interviewed (Table 1).

### ***Ethical considerations***

Ethical approval for the study was granted by the university's ethics committee. Each participant was provided with written information and signed a consent form before being interviewed. All identifying information was omitted and each participant was given a number and pseudonym, for later reference. The first author, a registered psychiatric nurse and assistant psychologist at the approved centre, approached and interviewed each participant. This may have influenced participants' willingness to be interviewed. In addition, it is acknowledged that this may also have been perceived by participants as coercion to participate in the study.

### ***Data collection***

The first author undertook all six interviews at the centre. All participants were interviewed within 1 week of their involuntary status being revoked.

A semi-structured interview guide was used. All interviews were tape recorded and transcribed verbatim. The interviews lasted between 8-43 minutes.

### ***Data analysis***

The first author undertook the data analysis following the principles for analysing phenomenological data proposed by Smith *et al.* (2009). Each transcript was analysed

case by case, as outlined in IPA (Smith *et al.* 2009). Sub themes were then identified prior to the development of an overall group analysis. Interpreted themes were then discussed with the third author and agreement was reached regarding the sub themes and super-ordinate themes. The final stage of analysis resulted in the collapse of sub themes and identification of three super-ordinate themes reflecting the participants' experiences.

## **Findings**

Three super ordinate themes emerged from the data as follows: 'The early days'; 'Experiences of treatment'; 'Moving on?'

### **Super ordinate theme 1: 'The early days'**

This theme represents participants' initial feelings and opinions of the experience of coming into the approved centre. Central to the early days were the difficulties in knowing "what's going on". This was due to a lack of information and explanation of what was happening.

The 'journey' to the approved centre was a significant aspect of each person's narrative. Brid recalled how she came to the centre voluntarily but then the admission became involuntary.

*Brid 3.3.3 "I was very tired and eh...rather hyper and the family noticed the change and eh...I wasn't aware of it but that first evening a member of the family stayed with me through the night but I didn't realise that I was that bad but apparently I was and then they brought me into hospital, they realised I needed hospitalisation"*

Brid 3.1.8 *"I refused to take an injection apparently and I was very difficult and therefore I became involuntary"*

Typically, the police (Garda Síochána or Gardaí) assisted participants to the approved centre and some participants discussed their experiences of being taken from their homes.

Thermo 1.10.5: *"they [Gardaí] just handcuffed me like a dog, they fired me in the back of the van like a dog and they just left me in there".*

Betty 5.1.4 *"they [Gardaí] put me into a van, in a black box, you know the mariah vans, I've never been in one in my life, which was very, very scary 'cos I thought they were going to kill me 'cos I was so paranoid."*

Some participants remarked on a lack of understanding of what was 'going on'.

Gerry 6.1.4: *"....when I came in here I thought I was in here for another reason than I was in here for..."*

George 2.4.6 *"They brought me here and they left, that's all I remember, they brought me here, they dropped me here to the centre, they left me here then and they went home"*.

Betty recalled not being fully examined by the doctor when she arrived at the centre.

Betty 5.6.1 *"The doctor asked me how was I and I said I'm fine and then he just automatically signed me back in again [laughs] so I can't understand how he could... a strange man could know that I was not ok unless he spoke to me 'cos all I said was that I was fine..."*

In the following extracts, George and Christy recount how they were not aware of being detained under the Mental Health Act.

George 2.7.1: *"It was never explained to me why I was in the place at all. Just waiting... I only found out like the day before yesterday the reason I was*

*detained here was because of the Mental Health Act 2001. I never even realised that, I thought I was here because I was brought by the Guards [Police] and they thought it would be better for me... ”.*

*Christy 4.2.11- 4.3.14: “I never felt that I needed to be here.....I thought that my freedom was being robbed...That when I got here nobody actually listened to me... I was confused. I didn’t know what was happening.. They kept me locked up in the room for a couple of weeks... I wasn’t allowed walk around or anything... And I didn’t have my clothes or anything like that...”. I didn’t know why it was happening, nobody was so they wouldn’t have any clue of why I was being detained and the ones that got me here, they weren’t here, they weren’t feckin talking to me..explaining anything to me.....So I was left in limbo really, the people that were.. that ended up getting me signed in like my family and the Guards and different things, they weren’t here to say this is why it’s happened or whatever.*

Participants expressed a sense of the need for more information.

*Christy 4.9.1 “The one main thing for me is that nobody ever had a clue how long it was going to take, how long it was going to be before I got out, you know, there was no exit... ”.*

On one occasion Christy recalls his experience when he asked for information.

*Christy 4.2.1/2 “When I asked for information at about the drug itself they’d only give me the printed leaflet from the pharmaceutical company... I wanted more and I wanted access to some other form of info but I was never allowed it”.*

Conversely Brid makes the point in her case that it was difficult to remember information when she was unwell.

*Brid 5.7.7/8: “Well, I got information but I wasn’t well so I couldn’t understand what was going on...You know what it’s like...you know when you’re not well you just don’t know what’s being said to you or what it’s about.. I hadn’t a clue... ”.*

There is a strong sense that the early days are tainted with a lack of information on what was going on. The initial encounter appeared to be a critical period in setting the scene for the formation of the overall experience. After the 'early days', participants talked about their experiences of treatment.

### **Super ordinate theme: 'Experience of treatment '**

This theme refers to several aspects of treatment, particularly medication, seclusion, tribunals and relationships with staff.

Christy and Gerry recounted similar experiences with medication.

Gerry 6.4.8 *"it wasn't needed like, the injection, I would of actually taken them. I remember saying...them saying "do you refuse to take it orally?" but I didn't hear them properly and I just didn't know what to say and I was panicking, I said yeah I do refuse, I said yeah, and then I realised straight away and then the needle was in ...[laughs]"*.

Christy 4.1.4/6 *"and I eh refused to take it at first...And then they came round with their heavies to try and inject me and then I stuck out my hand and took it"*.

The importance attached to people's involvement in decisions about medication is suggested.

Christy 4.6.4 *"...They [staff] had their way. You know, it wasn't like...I didn't have a choice and that was made clear to me when the guys came to inject me. I didn't have a choice"*.

However, whilst medication was seen as the mainstay of treatment, the perceived benefits of interpersonal communication and interaction are highlighted. George relayed the importance of other interventions and relationships although he did say the

initial period was “groggy” he then goes on to talk about activities he partook in whilst in the centre.

George 2.1.2: “...Within week 3 then em I began, I was mixed in with the other patients and I began attending different activities...they were well organised eh. The two nurses, female nurses [names nurses] were very helpful...just doing different things from relaxation to solutions to wellness to eh how to deal with anxiety and panic attacks ...so but em apart from that all I could say is that the past few weeks now from say week 4 onwards I’ve been just getting progressively better. My medication when I first began here was very high...eh my medication was reduced to half ...”.

Other participants also recounted positive experiences with staff.

Thermo 1.7.5: “The people here are just so professional, not attitude problems, they treat you with great respect. I just wouldn’t, I can’t say anything bad about it because there’s nothing to say bad about it, they’re just being professional at their job”.

Brid 3.9.8 “Well I mean the staff are fantastic now I found, they were all...you know they’re doing their work but they’re very helpful and friendly, I think the staff are fantastic”.

However, Gerry referred with frustration to the paternalistic position staff adopted to his care.

Gerry 6.7.1 “..they make you feel like, I dunno, treat you like child first of all and they treat you as if you’re totally mad in the head like”

Gerry also expressed the need for staff to see the person and not to be labelled.

Gerry 6.5.10 “She [doctor] just took me as a....an absolute looper”.

Christy also expressed some frustration with staff.

Christy 4.10.10 ”.... I just found them sort of ... the psychiatrist that they sent, he didn’t have enough time, he didn’t have enough time to assess me, he was busy, he had to go somewhere and the second one, I didn’t even know she was

*coming and she asked me the same question three times that I answered and then I just had enough and told her to leave [laughs]”*

George made reference to the passive interactions he had with the staff during his time in seclusion and the feeling that he was by himself:

*George 2.6.5 “just feeling paranoia and anxiety like I was saying to you and just feeling restless and just not being able to know what was going to happen to me tomorrow and like the meals being brought to you do you know and having the doctors coming into to you, in and out, checking on you, not even paying you a second notice, that kind of thing...”*

George also remarked on what he perceived as the current practice when someone is admitted, he then went on to outline how things could be done better.

*George 2.13.5 “and they come [patients] in here and when they’re brought in here they’re put- into a bed and prescribed medication and that’s wrong, what I feel should be done is brought in here, put in a bed and taken for a walk. Taken for a nice stroll around the hospital and just talking and just seeing what, what’s the problem, what’s the matter as opposed to just straight away prescribing medication upon medication upon medication and making them doped up”*

### **Super ordinate theme 3: ‘Moving on?’**

Moving on represented participants’ views on how they adjusted to involuntary admission, and processed oscillating feelings. All participants held varying perspectives on the necessity of detention.

*Thermo 1.4.3 “I didn’t feel there was anything wrong with me but the doctor told me that I was kinda being out of it”*

*Gerry 6.2.11 “I didn’t know what was wrong with me, I just knew there was something wrong with me”*

In Gerry's account below, he oscillates from thinking detention was necessary to thinking it may not have been.

Gerry 6.7.7 *"It had to be done [being detained]...well I don't know if it had to be done...someone coulda sat me down and told me I had to take my medication like and well then I think I could've got better without being in here"*.

Oscillating emotions can be a slow process of acceptance as outlined by George:

George 2.6.13 *"... when I'm thinking back at my own perspective now, I know that they were just looking out for me, making sure that I was doing ok. At that time if I was in that mindset I woulda been thinking...like I woulda been very paranoid that they were going to do something to me, that's how I felt at that time, but now that thought has changed from paranoia to acceptance, from acceptance to relief, from relief to normality"*.

Most participants gave examples of experiencing strong and varied emotional reactions to detention.

Christy 4.10.11/12: *"Well, anger, I was angry, I was angry.. I was just \*\*\* angry but I wasn't allowed show it, you know there's no sort of place to show anger...that means there is something wrong with you, but it doesn't mean there any thing wrong with you it means your normal but if you get angry it s like "he's angry" lets calm him down"*.

George 2.5.5- 13 *"...first few weeks it was def... it was definitely anxious, anxiousness. And then after the first four or five weeks it was a sense of relief... I was feeling like annoyed by the centre for having me here...Annoyed for being detained for such a long period, five weeks, but I didn't know I was going to say here for nine and a half weeks [laughs]."*

Gerry 6.3.9-11 *"...it wasn't too bad at the start but then I got very restless...Very restless...[long pause]...Restless to the point of...not quite despair but near enough like"*.

What is important at this stage is ‘emotional processing’ as it may lead to an acceptance of their condition and the promotion of recovery. Related to this is Christy’s description of how he “learned the way” in the context of taking medication.

Christy 4.6.8: *“I took it [medication] and I’ll take it in order to get myself out, I had to like comply”*.

There was a sense that some participants fought the system initially and with time they conformed and ‘learned the way’. Thermo talked about what he observed others in the centre were doing ‘wrong’.

Thermo 1.6.6 *“...I think what’s wrong with a lot of people who come in here sometimes, you know sometimes they might say too much, they’re not prepared to go with the staff and the staff is acting in their best interests and they kinda very much feel that what they think is right and what’s wrong with them is that they can’t see the light for the trees. These people here in this place are very professional, they treat you with great respect but what’s happening with a lot of them here I think from what I see is that they don’t go with the flow, people are trying to help them and they kinda like put up a barrier and they just don’t to the people in this place which is very wrong”*.

While ‘learning the way’, participants talked about making sense of their admission which occurred over time. There was a sense that some participants did not want to incorporate the experience into their sense of self and this can be related to their ‘sealing over’ style of recovery.

George 2.7.3 *“It’s very groggy, it really is like, and it’s a period of time when I know myself that I kinda wanna forget”*.

Brid talks about what she could have done to avoid her detention:

Brid 3.10.8 *“If I had been a bit smarter maybe I could have avoided...you know if I had known maybe a week before that it was getting hard and I think I hadn't been taking my tablets and eh, it could have been avoided maybe by myself. I don't know if I would have gone...”*.

In the following narrative George make sense of the experience of detention:

George 2.8.6: *“It coulda been...not good for the public, but good for myself that I didn't go outside and make a show of myself in front of people.... 'cos for all I know 'cos I was so spontaneous I woulda ended up in maybe [names park] taking my clothes off or something like, something as wicked and ludicrous as that like. But I mean I woulda come to those conclusions maybe a few weeks ago when I realised that, you know, that my detention here is for my own good myself and the good of my family, do you know what I mean?”*.

Christy talked about being labelled and others' perception of him and 'moving on' was seen as difficult.

Christy 4.7.8 *“It's in the past, I have to move on. Whatever things people think on the outside, I just have to ignore. I'm now labelled as a feckin psycho”*.

Brid referred to other people's perceptions' of her illness in a more positive light as she tries to integrate her experience.

Brid 3.5.1 *“I need help and I get the help and if other people can't deal with that.. you know what I mean, they have to learn to deal with it and that's the way it is...”*.

## **Discussion**

The study findings highlight participants' perceived lack of information, particularly in the early days of their admission process. All but one of the participants said that the information and explanation of the reasons why they were subject to a detention were inadequate. Experiences during this period of time are under-represented in the

literature. Previous literature has examined experience whilst being in hospital (Johansson & Lundman 2002) and patients' experience of coercion (Olofsson & Jacobsson 2001, Sibitz *et al.* 2011). However, consistent with the findings reported here, Jones and Mason (2002) also found an overall dissatisfaction with the quality of care and treatment offered by the police.

The emphasis of being involved in the decision making process and having a choice was highlighted by three participants. Detained patients have limited involvement in their own care (Johansson & Lundmen 2002). Nevertheless, O'Donoghue *et al.* (2010) found that 76.5% of involuntary patients reported that their treatment was discussed with them.

For some participants there was a gradual realisation that they were actually mentally ill and a relief to have at last found help: a notion that may be likened to the acceptance phase in grieving. Participants commented that seeking to understand the experience of detention brings an array of feelings, as individuals begin to conceptualise what has happened to them. One explanation for this may come from the theoretical notion of emotional processing of normal and abnormal emotions (Jackson & Birchwood 1996). In this staged theory, people are thought to go through a process which begins with an awareness of emotional disturbance, decline in the strength of such disturbance and finally a return to pre-morbid routine behaviour (Jackson & Birchwood 1996).

The general view from the participants was the need to move on. However, participants identified the fact that being labelled as a "psycho" impeded their moving

on and they expressed annoyance at being viewed by others as “unwell”. Most of the participants showed a trend towards change in attitude during the course of hospitalisation. An important component of the success of moving on relates to the style of recovery the person engages in. Mc Glashan (1987), in his studies on psychosis, delineates between two mutually opposing styles of recovery which he calls sealing over and the integrated recovery style. Four of the participants felt that they benefitted from hospitalisation. Katsakou and Priebe (2007) lend support to the notion that those people whose clinical status improved tended to have more positive retrospective judgements about hospitalisation. However, difficulties in moving on were commented on by two participants who talked about labelling and societal perception of mental illness. Those who hold a sealing over recovery style have negative views of the experience and possess the traits of denial and avoidance wanting to put the experience “behind them” (Jackson & Iqbal 2000). This is consistent with this study’s findings as three participants wanted to forget about particular aspects of the detention. On the other hand, a key component of an integrator’s recovery style is that the person takes a sense of responsibility for dealing with difficulties and tries to make sense of their experience. The implications of a sealing recovery style are that there is greater likelihood of involuntary re-admission (O’ Donohue *et al.* 2011). Of 69 people re-interviewed one year after discharge from an involuntary admission, 43% were readmitted and half of these admission were involuntary, promoting the view that individuals with a sealing over recovery style were 4 times the risk of involuntary admission (O’Donohue *et al.* 2011).

### **Study limitations**

The participants interviewed volunteered to be interviewed. Those who did not volunteer may have wanted to forget the experience and may have shared different experiences of their involuntary detention. Given the timing of the interview prior to discharge, it is also conceivable that participants gave a more positive account so as not to sabotage their discharge plans, a limitation mentioned also in O'Donoghue *et al.*'s study (2010). If participants were interviewed post discharge they may have expressed less positive accounts of their admission.

### **Implications and Conclusion**

The study illustrates the difficulties experienced by those who are admitted involuntarily, and suggests that the service to these people needs to be a more caring one that acknowledges their experiences. This can be achieved in some way by the provision of information, providing a sense of being cared for, of being listened to, and remaining cognisant of the need to see the person beyond their illness.

The study findings reveal that there is a need for more dialogue between police and patients and discussion on how admission procedures could be improved. By virtue of section 12 of the MHA (Department of Health and Children 2001), the police (Garda Síochána or Gardaí) have the power to enter the dwelling of the person with force for the purposes of taking the person into custody. The police are under "increasing pressure" to intervene (Jones & Mason 2002, p.74). In Ireland the number of applicants by the Gardaí has risen from 16% to 23% between 2007 and 2010 (MHC 2010). This highlights the need for training of police involved in the admission process

and providing the less restrictive measures in applying the Law (Sibitz *et al.* 2011). Training of police by mental health teams may help reduce possible traumatic effects of involuntary admission (Clarke & Bowers 2000).

‘Learning the way’ appears central to the notion of moving on. It refers to learning the ways of the system: things to do and say to help to move on and “get out” of the approved centre. Moving on is essential to recovery. However, it is conceivable that its roots lie within the principles of theoretical perspectives of conformity, and it is possible that conformity may progress into a sealing over recovery style. Support therefore should be offered after discharge to attempt to deal with experience of involuntary admission.

In conclusion, the findings suggest that the meaning of detention is a varied one that evokes an array of emotional responses for participants and highlights the need for a renewed way of thinking and doing concerning those subject to involuntary admission. Involuntary admission should not be seen as a ‘one stop shop’ but should foster in the individual a sense that help is available and engenders therapeutic optimism in the person going forward following discharge from hospital.

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**Table 1: Participants' Demographics**

<b>Participants (Pseudonyms)</b>	<b>Age</b>	<b>No. of involuntary admissions</b>	<b>Length of involuntary stay</b>	<b>Diagnosis</b>	<b>Urban Rural</b>	<b>Police involvement</b>
Gerry	22	1 <sup>st</sup>	11 days	Acute psychotic episode	urban	Yes
Brid	66	4 <sup>th</sup>	9 days	Relapse of Bipolar affective Disorder	urban	No
Christy	38	1 <sup>st</sup>	75 days	Bipolar affective disorder manic	rural	Yes
George	24	1 <sup>st</sup>	86 days	Bipolar affective disorder manic with psychosis	urban	Yes
Thermo	51	1 <sup>st</sup>	5 days	Brief psychotic episode	rural	Yes
Betty	49	1 <sup>st</sup>	28 days	Brief Psychotic episode	urban	Yes