

‘Waiting for the verdict’: the experience of being assessed under the Mental Health Act

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Abstract

Background

Following the Independent Mental Health Act review, there is increasing focus on this coercive part of mental health services and a call for service user views to be central to proposed changes. Although there are numerous studies into being detained in hospital, there is a lack of data exploring the service user experiences of the assessment process.

Aim

To explore the subjective experience of being assessed under the Mental Health Act (MHA).

Method

10 participants were interviewed about their recent assessment experience and the transcribed interviews were analysed using framework approach.

Results

The overarching theme of person centred care emerged from these interviews with interconnecting sub themes: 1) information and options; 2) “the barrage of three”; 3) “sit down and listen”; and 4) service user voice.

Conclusion

As one of the first studies into service user experiences of MHA assessments, this exploratory study indicates that there is lack of person centeredness. The Independent Mental Health Act review has set a challenge for treating person as individual and increasing rights and involvement of service users. This study suggests service user’s experiences do not yet meet this aspiration and they want to discuss these experiences and have their voices heard.

Introduction

Rising detentions and inequalities following the English and Welsh government's stated intention to reform the Mental Health Act (1983) (MHA) has raised concerns. To advise this reform, the Independent MHA Review was established to consult stakeholders widely and has produced a report recommending changes. (Department of Health and Social Care (DoHSC), 2018) Alongside this a discourse has arisen about the need for the service user's perspective and prioritising improving their experiences of being under the MHA (Haynes, 2018; Trewin, 2018; Wessely et al., 2019).

One important element of the MHA is the process of assessment undertaken by an Approved Mental Health Professional (AMHP) and two doctors, one of whom must be Section 12 approved and ideally should have previous acquaintance, in order to decide if detention is warranted. This process is referred to overall as a Mental Health Act Assessment (MHAA). The process of being detained has been previously reported as confusing and having the potential for long term negative impact on the service user (Newbigging et al., 2015; Smyth et al., 2017). Due to a paucity of research, there is little understanding of this process (Hall, 2017; Matthews et al., 2014). Where research does exist, it has been dominated by examination of professional roles and experiences (Leah, 2020; Morriss, 2016; Stone, 2019; Vicary et al., 2019) with a lack of focus on service user experience (Akther et al., 2019). In view of NICE guidance (National Institute for Health and Clinical Excellence (NICE), 2011) calling for increased service user involvement in development of services, it is key that we have an understanding of the subjective experience of the MHAA.

Research into the service user experience of the wider MHA has thus far concentrated on being detained in hospital (referred to as involuntary admission) with little or no mention of the assessment process itself (Akther et al., 2019; McGuinness et al., 2018; Wyder et al., 2013). These studies reveal a wide variation of service user experiences with influencing factors, such as levels of involvement, attention to physical and social environments and all highlighted the importance of good relationships with professionals (Akther et al., 2019; Ridley & Hunter, 2013; Wyder et al., 2013). Numerous researchers have called for further understanding of the experience of the assessment process (Akther et al., 2019; Johansson & Lundman, 2002; Ridley & Hunter, 2013).

An additional critique of involuntary admission and coercion studies is the lack of service user involvement within the research process (Campbell, 2010; Gooding & McSherry, 2018; Wyder et al., 2018). As collaborative studies are more likely to be relevant and well-informed (Hughes et al., 2009; Ridley & Hunter, 2013), The authors of this study overcame this criticism by collaboration or consultation throughout.

In the absence of previous studies in this area, we aimed to explore the subjective experience of a MHAA from service users' perspectives adopting qualitative methods.

Methods

Research team

The research team consisted of an AMHP, Assistant Psychologist, Nurse academic and three people with lived experience of MHAA (who chose the title "Service User Researchers"). Service User Researchers were active collaborators and were consulted throughout this project from conception, analysis to publication, in line with Wyder et al. (2018). Service User Researchers were not included as interviewers due to resource limitations.

Sample

Sampling was purposive with the focus being richness of experience (Smith & Osborn, 2004). The study took place in the south of England within two local authority areas and one NHS trust. We selected for inclusion adults under the age of 65 years who had had a MHAA within six months of the research interview and who could recall this assessment. We excluded anyone who lacked capacity to agree to participate in this research or who had any diagnosed organic mental health issues. The study was advertised via local groups and directly to mental health professionals whom acted as introducer to the research team. Information sheets were available and participants had opportunities to ask questions from this point. Interviews were arranged in participants' choice of venue and consent was gained at the time of interview. Ethical approval was granted by the South Central REC (Reference:17/SC/0066). 10 participants were recruited to the study.

Interview process

This study was exploratory and there were no previous interview schedules. To ensure relevancy of questions to lived experience, the interview was co-designed with Service User Researchers (Tew, 2008). The questions were developed from their experiences and from research concerning involuntary admissions and coercion. The questions were then worded to ensure they would elicit the subjectivity of the experience and to encourage description and narrative. Lastly, the interview schedule was piloted with the Service User Researchers, then the interviews were conducted by two of the authors. Interviews were recorded and transcribed verbatim.

Analysis

Framework analysis (Ritchie & Spencer, 2002) was adopted as a method, chosen for its systematic coding and use of charting through a framework which is shown to enable involvement of all team members (Gale et al., 2013) (see Table 1).

Table 1. Stages for framework analysis.

Stage	Detail
Familiarisation with the data	The recordings of interviews were listened to (JM,CA, LB) and transcripts were read multiple times to ensure immersion in the data (LB, CA, AE, JM, SW) . A research memo was completed at interview (JM and LB) and initial thoughts and reflections of analysis team members (LB, CA, AE, JM, SW) were added to these documents when reading transcripts.
Group development of a coding index	Members of the team analysed the same 3 transcripts and identified initial coding areas. The coding index with the different coding areas was agreed collectively.
Coding of all transcripts	The main researcher (LB) and one Service User Researcher (AE or CA) coded every transcript. In addition, other members of the team (JM, AE, CA, SW) coded a selection of transcripts so all transcripts coded by three members.
Thematic framework created	A framework was created representing the sub areas on the coding index. This framework was populated from coded transcripts. Through formal meetings of the team, themes were developed by examining the frameworks created.
Further development of themes	Research memos for each participant's interview and transcripts were reviewed and discussed within analysis team to further develop and refine themes. Throughout this process, the themes were checked with Service User Researchers to ensure they reflected the participant's lived experience.

Results

The study recruited 10 participants with a wide variety of MHAA experience and outcomes. MHAA had occurred in different settings and participants had different demographic characteristics although most were female. At the request of the Service User Researchers, diagnostic information was not collected because of the stigma that might be generated (See Table 2).

Table 2. Recruitment figures with demographics and assessment information.

	<i>N</i>	
<i>Recruitment stage</i>		
Numbers approached for the study	31	
Agreed to participate	17	
Eligible for the study	11	
Withdrew from study	1	
Total number of participants	10	
<i>Participant demographics</i>		
Age	Range 22–59 years	
Gender	Male	7
	Female	3
Ethnicity	White	8
	Black Afro-Caribbean	2
No. of previous MH Assessments	First assessment	1
	2–3	6
	5–10	2

		<i>N</i>
	10+	1
<i>Total number of assessments for all participants</i>		35
Location of assessment	General Hospital	3
	Mental Health Hospital	1
	Service User Home	2
	Section 136 Suite	4
Outcome of assessment	Voluntary Admission	1
	Detained – Section 2	6
	Detained – Section 3	0
	Community Support	3

Following the analysis, the participants' experiences revealed a central theme: the person centred approach. This overarching theme has been divided into four interconnecting sub themes of: 1) information and options; 2) "the barrage of three"; 3) "sit down and listen"; and 4) service user voice. Verbatim quotes using pseudonyms have been used to illustrate themes.

Information and options

No participant completely understood the MHAA process, even those who had had multiple experiences of assessment. Participants explained in numerous differing ways how they lacked information and options. Some participants did not recognise the process as a MHAA:

I did not know why they were there (Thomas)

It's like it's deliberately secretive...They don't say "we are a group of 3 people one of us is going to be the main person to ask questions and what we are doing is analysing you to see...if you need to be detained under the mental health act". Why don't they say that? (Stephen)

Even though some participants remembered being introduced to the assessors, the participants frequently cited a lack of knowledge about them, who they were, and their roles:

AMHP and Doctor I know. I don't know I've always had three. I don't know a student or something. (Charlotte)

How information is given was also discussed by participants with Charlotte saying "information's thrown at you, you don't have time to think" and:

You get these letters given to you with so much literature on them and... you start reading the words and the more you read it the worse it becomes. (Bridget)

A key part of the MHAA process for participants to understand is the possible options as well as detention. The participants highlighted numerous gaps in this knowledge with associated feelings of lack of involvement as Natashsa describes:

Explaining to me ...these are the different options from this point...if you were put into the hospital it would be like this. Then if you're not then we'll get you this ... But instead they were like, tell us what's happening. (Natasha)

Participants also reported gaining this knowledge through experience rather than the explanation at the time of assessment:

The importance of this information, what to expect, not a script but what the outcomes could be... all options CRHT [Crisis Resolution Home Treatment], home or hospital. My knowledge of options from a lot of assessments. (Charlotte)

One option that some participants felt was not fully explored was agreeing to admission (informal) with one participant saying more discussion would have changed the outcome from detention:

It was either be detained or not... There wasn't any other options of... I think if they gave you a chance and said 'if you agree to only do this, only go out a couple of hours with family and stay informal' then I probably would've agreed to it. (Katie)

“The barrage of three”

Participants described being interviewed by three or more professionals as “daunting” (Charlotte, Alice), “intimidating” (Katie, Charlotte), “oppressive” (Stephen) and “a terrible pressure” (George). Katie talked about “the panel” expressing the idea of being judged with the number of assessors linked to a feeling of powerlessness:

The barrage of three... looking at you, you know it is oppressive. (Stephen)

A further impact for the participants of this study was a reduced ability to speak for oneself. Natasha explained her quietness as “not feel much to be said as lots of people and being talked at”.

When asked about their involvement in decision making, the majority of participants talked about not feeling involved and the outcome being a fait accompli:

There's no point saying anything when it's not going to have much difference (Natasha)

Decision to be hospitalised was inevitable whether I liked it or not. (Bridget).

I wasn't involved... I got the feeling made mind up before coming through the door. I was going to hospital. They weren't going to listen to me (George)

I was the subject of it but it didn't feel like a two-way process (Stephen)

Only Alice felt involved in the outcome as said what she wanted which she said was unique in her numerous experiences. "She [doctor] probably would have just discharged me and not really listened to me ... at that point I was saying I need a crisis admission."

Another factor of that reduced participation was the negative effect of assessor leaving the room to make their decision. This time was described as:

Waiting for the verdict ... So you're sat there for like half an hour worried, knowing that they're making this choice. That's a bit annoying. (Katie).

"Someone to sit and listen"

Another prevalent theme was the importance of relationships in this process and participants wanting or having someone sit down to either listen or talk with them. Some participants described how it could have helped or improved the process to have time with a professional:

...Even just someone to sit and listen to me rant for 5mins about that I'm angry about this and then it's out there. (Charlotte)

Participants remembered and valued any positive interactions with professionals during the process:

He (AMHP) had quite a calming demeanour...and he just listened to me ...he wasn't like 'oh I've got to go in 10 min' kind of thing and I didn't feel rushed. (Alice)

Participants talked about the relationships with staff in a wider context than just the professionals (assessors) assessing them. For example, Stephen valued a student nurse's time and linked it with a more positive experience in a previous assessment:

I told him that I was worried about it [MHAA]...he was a brilliant ... think because he said to just tell them the truth...I thought was better assessment (Stephen)

Relationships are viewed as key, with numerous comments on good relationships and the difference it makes. Katie talked about having a nurse with her, stating it was a “bit of comfort... really nice having her there”.

Professional approach was highlighted as inconsistent in the participants' accounts. Some were positive:

Professionals [assessors] friendlier than usual. Not as abrupt they usually speak very stern and ask question. As they were friendly I felt safe... (Sharon)

Others were negative. Especially in the interview, with two participants feeling “patronised” by the assessors (Thomas and Stephen) which made the experience “Kafkaesque” (Stephen).

Service user voice

The lack of opportunities for participants having their voice and wishes heard was raised by some participants:

I just rather they listen to me. Rather than be there and they making their own opinion before they even start talking. (George)

For Stephen, it was recognising the lack of power he had in this process and wanted more of a voice:

I want to change the process by being more assertive... Why didn't I just say to them “I don't know what you don't mean, can you repeat the question? Can you rephrase it?” ...have more input. (Stephen)

Alice's experience differs as she “felt kind of supported by the social worker (AMHP) as he helped me to...use interpersonal effectiveness skills to say I'm not happy because you said this”. Thus, through this support, she was able to find a voice:

It's the first time I've said 'this is what I need' (Alice)

There was a call for more support within this process from family or others and Katie feeling the process would then feel fairer and help to give a voice:

If my mum was in the room, I know that I've got somebody who knows me and who's not going to let anything happen that shouldn't happen. So you don't get... doctors ...talk over you or anything.

The MHAA experience seems to be not spoken about from these participants' experiences as most of them reported having little or no discussion with mental health professionals afterwards:

You don't really talk about it to be honest ...think mum and I talk about it.... but I haven't really talked about it with like professionals or anyone. (Katie)

Thomas did discuss with a mental health professional, although he did not feel that the professional responded well:

I was telling him I'm not happy with the way I was treated and he couldn't do much that's what he said... I was still angry because of the way I was brought into the hospital (Thomas)

Apart from Thomas, the participants did not recall any discussion after the MHAA. In contrast, they offered numerous suggestions to improve the process. Charlotte's advice to assessors was "how do you feel?, that would be like the first question... cos it is important". George wanted to know about possible MHAA in advance so he can have his own belongings rather than use the wards:

You can get to pack and you can be organised ...I don't have any sort of my clothes all, or anything ... I have to use all their stuff.I don't like it...I feel that I'm being inadequate

Within this cohort, participants expressed having no opportunity to talk about the assessment process, even after difficult experiences:

Made me feel sick. I felt degraded. I felt completely humiliated, ashamed, embarrassed. It was awful. It was like the worst thing that could happen to anyone anywhere. But that was the worst thing that could happen to me. (Natasha)

Discussion

Haydon et al. (2018) describes person-centeredness as "really listening and valuing what the person experiences and making their wishes central to decisions about care" (p. 125). This study has indicated that, for the participants of this study, the process of being assessed under the MHA is not experienced by the research participants as person centred. The findings show that from a

participant perspective this process is not only a legal one, but also an episode in their mental health care in which being heard, being involved and having an understanding of what is going on, are all important.

The present English MHA Code of Practice, which gives clear standards for MHAA, does not explicitly discuss person centeredness. It does however, have an overarching principle of empowerment and involvement and discusses increasing the personalised care whilst detained (Department of Health [DoH], 2015). The Independent MHA review has suggested “treating the person as an individual” as a new principle of the amended MHA and reflects the findings of this study (DoHSC, 2018). Similar themes are shown within involuntary admission experience research where the service users want improvements in the way mental health professionals relate to, and treat them whilst being detained involuntarily (Gault, 2009; Gilbert et al., 2008; Hughes et al., 2009; Ridley & Hunter, 2013). They also wish to receive care from more humanising health services (McCormack et al., 2015), which give service users a voice.

Even among participants who have experienced numerous MHAA, there appears to be a lack of gaining knowledge about the process and legal safeguards. Like the participants of this study, service users in other studies have expressed dissatisfaction with a perceived lack of information whilst being involuntarily detained in hospital (Jankovic et al., 2011; McGuinness et al., 2013; Smyth et al., 2017). It seems to be difficult for the participants to understand what is happening within this assessment and one reason could be the proven effect of distress on memory (Kessels, 2003). For some participants, these assessments appear to be experienced in isolation with little information or discussion before and after the assessment so knowledge share is limited. Lawn et al. (2016) links the level of understanding to service user participation in the community involuntary care process, thus showing how vital understanding and inclusion in the process is. This study supports the call for more effective and creative ways of providing information with a broader focus than just at the assessment, to before, during and after an assessment (Smyth et al., 2017).

Other studies have found that significant numbers of service users do not understand why they are detained, as in this study (Barnes et al., 2000; Katsakou & Priebe, 2007). Presently, there is no statutory requirement for the assessors to give service users the reason for detention in writing whereas the assessors are required to give their justification through the application forms and the MHAA reports (DoH, 2015).

Although understanding all the possible options was important to them, some participants described being told outcome rather than options. When there are discussions about going into hospital voluntarily, one study found that service users subsequently express that they have felt listened to (Harrison et al., 2015). There is concern about whether voluntary admission is truly

voluntary as evidence shows that service users can perceive coercion within these admission although significantly less than detention under the MHA (O'Donoghue et al., 2014; Perry et al., 2019). The participants in this study are asking for more information about options, in a format they understand and time to consider which bears similarities to evidence on best practice for informed consent. When good levels of informed consent happen with voluntary admission there are reductions in subsequent need for detentions under the Act (Perry et al., 2019). Being more explicit and engaging in repeated discussions with service users about possible options including voluntary admission may increase feelings of involvement.

A significant finding of this study is the disempowering effect of having three assessors interviewing. It highlights the difficulties that service users have advocating for themselves at this crucial point when their liberty is being decided. It is a good practice standard for MHAA to have all three assessors interviewing together so policy and legal reform could be considered to reduce this number of assessors or to explore different ways to improve advocacy and representation for service users at this time.

As part of a person-centred approach, relationship is widely recognised as key to high quality care (Hummelvoll et al., 2015). Relationships with professionals are raised by the participants as impacting on their involvement through the importance of being given time to sit and be listened to. Other studies have shown positive relationships and being treated with respect, reduces the negative impact of coercion (Olofsson & Norberg, 2001; Sheehan & Burns, 2011) and positively influences service users' views of involuntary hospital admission (Wyder et al., 2015). Having positive time with a professional could reduce the negative aspects of the experience and possibly increase involvement during a time that can be bewildering and distressing for service users.

From the participants' data, it seems there is a lack of discussion after the MHAA with the mental health professionals involved in their care. In contrast, the participants wanted to talk about this experience and offered insights and improvements on the process. Preliminary research indicates that this type of discussion could help mitigate the negative effects of involuntary admission experiences (Murphy et al., 2017) and coercion (Ling et al., 2015) by fostering increased feelings of power, involvement and therapeutic relationship. Care co-coordinators, ward staff and other professionals could be facilitating discussions to understand this experience and have open dialogue about what makes a good MHAA (Lorem et al., 2015). At present, professionals may be missing opportunities to learn from service users' experiences and to increase their own understanding of MHAA process.

Practice and policy implication

With the English and Welsh government's commitment to reforming the MHA, it is an important time to discuss potential legal and policy changes. Although the Independent MHA review has concentrated on strengthening service users' rights (Trewin, 2018), there is little mention of changes to MHAA. This study shows how important the MHAA experience is to service users. Indications for improvements on practice and policy, as suggested by this study are presented in Table 3.

Table 3. Policy and Practice recommendations based on suggestions from participants and the research findings.

Area	Recommendations
Policy and MHA reform	<ol style="list-style-type: none"> 1. Written summary for service user including the names of the assessors, the decision and reasons for the decision completed by assessors (Stephen and Thomas) 2. Reducing the number of assessors (Stephen) 3. To have formal role that represents the service user's views and wishes within the MHA assessment process.
Mental health services (health and social care)	<ol style="list-style-type: none"> 1. To support and train mental health staff to offer opportunities for service users to discuss MHA assessments before and after the experience and these discussion to inform future care 2. To use crisis plans or advance statements that include service user's wishes, potential support or advocacy and preferences for MHA assessments to allow advance decision making and increased involvement (All participants) 3. Information leaflets for before and after assessment to be jointly produced with service users with who have been assessed (Stephen, Natasha and Bridget) 4. Further training for assessors regarding communication with service users during times of crisis. (Stephen) 5. To develop the advocacy/ support available for the service user, whilst being assessed, through advocates, working with family/ friends and enabling professionals that know the service user to be involved. (Katie, Sharon and Thomas)
Professional	<ol style="list-style-type: none"> 1. Professionals at all stages of the assessment process to communicate with service users about information on MHA assessment and the person's experiences, like community and inpatient staff. 2. Other professionals than assessors to be involved and support service user during assessment 3. For assessors, when making decision on MHA assessment outcome, to involve service user if possible rather than do these discussions in another room (Natasha and Katie) 4. Assessors to repeatedly discuss different option and allow time for service user to consider them. (Katie, Bridget and Sharon) 5. Assessors to leave written information for service users about thse MHA assessment (Stephen, Thomas, Tanya and Bridget)
Service users	<ol style="list-style-type: none"> 1. Self-advocacy – training and support for service users (Stephen and Alice)

Future research/limitations

One of the main strengths of this study is investigating a relevant and under-researched perspective of the MHAA: that of the service user. This perspective is further strengthened by having Service User Researchers with their own experience of the assessment process. Ideally, these Service User Researchers would have been involved more and due to resource limitations they were not involved in interviewing. If the power dynamic was removed between researcher and service user, then it may have helped enhance the findings. A further strength of the study is having different mental health professionals as part of the team like an AMHP and nurses. A further limitation was that no assessors or mental health professionals were interviewed and they would have offered a different viewpoint. Frequently it was the first time a participant had ever spoken about their experience.

As a little understood experience, future research needs to develop a fuller understanding through larger samples, comparative perspectives like family and professionals and exploring the factors that could improve experience like communication and involvement. This study found there was a lack of dialogue around MHAA therefore further research is required to explore whether these participants' experiences are widespread and the barriers and facilitators of these discussions. This study has shown that it is possible to research the service users' experiences of this MHA process and highlights the importance of their perspective with the need for further research in this area.

Conclusion

There are numerous obstacles to the participants having a voice and making their wishes known at the time of MHAA. From their accounts, they do not always understand what is happening, can feel intimidated, feel the decision is already made and they report inconsistent experiences of relationships and support. Some participants did report feeling listened to and this shows that a more person centred approach can be achieved. These findings highlight that a MHAA is a difficult point for a service user to express their views and mental health services need to look at different ways to gain their wishes, give information and increase their involvement and in this crucial process. This study has shown that it is possible to research the service users' experiences of this MHA process and highlights the importance of their perspective with the need for further research in this area.

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