Patients’ Experiences of Assessment & Detention Under Mental Health Legislation
Aim

- To synthesise qualitative evidence of patients’ experiences of being formally assessed for admission and/or the subsequent experience of being detained under mental health legislation
  - Including any legal processes (e.g., Mental Health Tribunals)
Methods

Inclusion
- Assessed patients’ (or carers’) experiences of being formally assessed for involuntary admission and/or being detained in hospital
- Over the age of 18
- Individual interviews and/or focus groups

Exclusion
- Mixed sample with no separate analysis for involuntary patients
- Community setting and not a hospital setting
- Under the age of 18 with no separate analysis for those 18+
- Data collected using surveys, questionnaires or case reports

Analysis
- Thematic synthesis
- Discussions with the LEWG
Results
Fig. 1 PRISMA flow diagram.
Results

- 31 studies from the UK
  - Including England & Scotland
- 9 from Sweden
- 5 from Australia
- 5 from Ireland
- 2 from Norway
- Study each from:
  - Austria
  - Finland
  - Greece
  - Israel
  - USA
Results

• 41 included both males & females (6 did not report gender)
• 17 papers reported ethnicity

• Focus of papers:
  • 26 papers reported on experiences of detention in hospital
  • 16 papers reported on experiences of both admission and detention
  • 7 papers reported experiences of admission only – predominantly police involvement
  • 7 focused specifically on coercive interventions (e.g., seclusion)
  • 15 studies reported the experiences of patients in a forensic setting
Results

1. Information and involvement in care
2. Quality of the environment
3. Quality of relationships
4. Impact on self-worth
5. Emotional impact
1. Information and involvement in care

- Why am I being detained?
- How long will I be detained?
- How do I access legal information about my rights and entitlements?
- What are the side effects of this medication?
- Why am I being restrained?

- Reduced fear & impact of coercion
- Improved relationships with staff
- Feeling less disempowered
“[The patients] expressed feelings of failure and powerlessness, that they were not listened to, and whatever they did there would be some sort of coercion anyway. As one patient put it: ‘If I were to say I agree it would be coercion anyway, it would be coercion in some way, even if I accepted it is coercion’.”

(Olofsson & Norberg, 2001)
2. Quality of the environment

“The physical aspects of the hospital were also described as affecting social relationships, with consumers discussing the influence of shared spaces between men and women on their feelings of safety (with women in particular feeling unsafe in communal spaces that are shared with men).”

(Muir-Cochrane et al, 2013)
3. Quality of relationships

“The majority of patients rated trustworthiness as the basis for a good therapeutic relationship. Trustworthy staff were described as those patients could confide in and with whom there was mutual respect. This involved “acknowledgment of power differences and a sensitive approach”. The latter involved “being treated [and treating staff] how I would like to be treated”; “open mindedness (on both sides)” and being given enough individual time. Good communication was viewed as highly important, particularly with regard to being listened to; “being believed”; and being understood.”

(Long et al 2012)
“Patients sometimes felt that healthcare staff were not on their side, and perceived certain members of staff as unkind and disrespectful. They thought that healthcare staff sometimes took advantage and exploited their power to humiliate them.”

(Andreasson & Skarsater, 2012)
4. Impact on self-worth

“[Patients] need to feel that they still have some control and that the healthcare staff will make no more decisions about them than necessary, but instead focus on what is essential to their health and recovery.”

(Andreasson & Skarsater 2002)
“Participants described feeling not capable or worthy and being changed into another kind of person, for example by medication. They spoke of not being allowed to have and express feelings and variations in mood/temper as other people normally do, and of being treated as a ‘gangster’, a ‘criminal’, and wondered if they were dangerous to society, themselves or others because of their involuntary status.”

(Olofsson & Jacobsson, 2001)
5. Emotional impact

“The experience of seclusion evoked many unpleasant thoughts and emotions including fear, shame, anger and loneliness, for example “I get really scared by it” ... “It’s a horrible experience being stripped naked in front of people and made to put on rip proof clothing” ...... “It brings on intense feelings of shame, embarrassment and humiliation. It’s dehumanising. It left me feeling out of control”.”

(Haw et al, 2011)
Involuntary admission was believed to be necessary but negative experiences were common.

Key influences on the experience of admission and detention included:
- Extent of information provision (about care and legal rights)
- Involvement in decision-making
- Feeling supported and cared for by staff
- Physical interventions (e.g., restraint & seclusion) were experienced particularly negatively
- Lasting impact of detention including feelings of shame and marginalisation
Implications

- Information provision – individualised, repeatedly delivered, and provided in accessible language

- Trauma-informed care should be considered to reduce the negative impact of coercive interventions

- A more nuanced understanding is needed of when coercive interventions are considered acceptable

- Improved patient-staff relationships have considerable potential to reduce negative impact of detention
  - E.g., Safewards Model
Future research

- Research focusing on the experiences of BAME individuals
- Experiences of assessment

Potential foci for interventions:
- Improved strategies for providing patients with information
- Engaging patients in decision-making
- Developing trusting staff-patient relationships
This review indicates patients’ experiences of detention under MH legislation are very poor.

Recognised need to improve experiences for many years but any improvement since appears to have been insufficient.

Service providers should work towards improving patient experiences and standards set by independent regulators must be significantly increased.

A national framework of local assessment teams could be established to advise MH services on how to improve and monitor subsequent improvement processes.

Such information could be shared with the CQC to inform national regulation of services.

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References (1)

- **UK:**
References (2)

References (3)

- Valenti E, Giacco D, Katasakou C, Priebe S. Which values are important for patients during involuntary treatment? A qualitative study with psychiatric inpatients. *J Med Ethics* 2014; **40**: 832–6.

**Sweden:**

References (4)


• Australia:
References (5)

• Afghanistan:

• Australia:

• Ireland:

• Norway:
References (6)

• Austria:

• Finland:

• Greece:

• Israel:

• USA:
Carers’ experiences of involuntary admission under mental health legislation: systematic review and qualitative meta-synthesis

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Background

- Despite efforts to reduce the number of patients treated as psychiatric inpatients, rates of involuntary admission have increased.
- Greater carer involvement in treatment is associated with reduced risk of relapse and fewer inpatient admissions.
- Detention is likely to have profound impacts on carers.
- No previous reviews of carers’ experiences of detention under mental health legislation.
Methods

Inclusion criteria:
1. qualitative studies
2. individual interviews or focus groups
3. carers any age, patients 18+
4. informal carers/family/friends not professional carers
5. experiences of formal assessment for involuntary admission
6. experiences of detention in hospital

• Searches conducted in MEDLINE, PsycINFO, HMIC, EMBASE, and SSCI
• No restrictions on language
• Meta-synthesis
Characteristics of included studies

• 23 studies
• all published since 2000, 10/23 since 2016
• more than 260 carers
• 3 African Caribbean; 3 African American, 4 Hispanic; 1 East Asian
• 70% female
• all relatives apart from 2 friends
Locations of studies

1 Calgary, 1 New York City
1 Republic of Ireland
2 UK, 6 England, 1 Wales, 1 Scotland, 2 Northern Ireland
3 SE Norway, 2 Leipzig, 1 Greece
1 New South Wales, 1 Queensland
Themes consistent across studies

1. Emotional impact of detention
2. Availability of support for carers
3. Carer involvement in decision-making and the provision of care
4. Carer relationships with patients and staff during detention
5. Quality of care
Emotional impact of detention

Distress  Trauma  Anger  Frustration
Stress  Grief  Guilt  Fear
Sadness  Internal conflict

‘Coping, often with little or no support, with the traumatic and stressful impact of compulsory detention of their relative, had taken significant toll on the carers’ physical and mental health. …Common themes among the carers interviewed were depression and suicidal thoughts as they struggled to prevent health crises in households with multiple and complex needs.’ (Ridley et al 2010, Scotland)
Availability of support for carers

‘Relatives reported not knowing what to do, where to get information and help from, and expressed that this was an extremely stressful and difficult time for them... at this early point, you were ‘on your own’, struggling to persuade others for assistance.’ (Smyth et al 2017, Republic of Ireland)

‘Family members were unable to obtain early intervention [...]; they had difficulty obtaining assistance until the [patient] consumer was acutely unwell or at crisis point. The family felt ignored by the [mental health service] despite their persistence.’ (Hallam et al 2007, Queensland, Australia)
‘Family caregivers...understood that confidentiality was a delicate issue, but sometimes considered that if they were providing care for the patient they needed to know relevant information. This information was important in protecting family caregivers from risks but also in allowing them to optimise the level of care.’ (Jankovic et al 2011, England)

‘Parents wanted to be treated as a resource and described recognizing patterns of emotions and behaviours. They hoped that by sharing these with health professionals, they would make better and more informed treatment decisions.’ (Finlay-Carruthers et al 2018, UK)
Carer relationships with patients and staff

‘...the young person blamed the parent as the cause of their distress [at being detained], and this was difficult for parents to reconcile with their belief that they were ‘doing the best’ for them.’ (Hickman et al 2016, Midlands England)

‘The majority of parents described a strained and invalidating relationship with professionals.’ (Finlay-Carruthers et al 2018, UK)
Quality of care

‘... the fact that Linda’s* mother was offered help too late was a heavy load on the family because they ended up with coercive interventions that they had to take responsibility for.’ (Norvoll et al 2018, SE Norway)

‘When he visited Rob* in hospital, he was shocked by his son’s vacant, heavily medicated condition (there was ‘just nothing there’) and by the environment in which he found him.’ (Wane et al 2009, Warwickshire England)

* pseudonym
Gaps in research

• Assessment under mental health legislation
• Young carers
• Black, Asian and Minority Ethnic Carers
• Implementation of guidance already available
Lived Experience Commentary

• Carers rarely speak about their own needs
• Need to act on what we do know and has been previously reported e.g. in Triangle of Care

first published 2010
Thank you

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