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**Title**

The psychiatric paradox: An interpretative phenomenological analysis of the experience of being assessed and detained under the English Mental Health Act (1983).

**Summary**

People’s interpretation of being assessed and detained under the Mental Health Act suggests the process does more harm than good.

**Abstract**

The aim of this qualitative study was to explore the experience of being assessed and detained under the English Mental Health Act (1983). Semi-structured interviews with a sample of seven adult service-users were analysed. The methodology employed was interpretative phenomenological analysis. Three super-ordinate themes were identified: The psychiatric paradox – chiefly concerned with the finding that treatment actually increased distress in many cases; fear of the unknown – considering the role that a lack of information plays in perpetuating distress; and, playing the game – exploring the finding that some people presented falsely in order to be discharged. Recommendations include a cultural shift from the dominant model of biomedical conceptualisation and treatment of “mental illness”, to a more psychosocial conceptualisation utilising the Open Dialogue approach.

Keywords: assessment, detained, Mental Health Act, phenomenological.

**Introduction**

In the absence of an alternative taxonomy, the current functional psychiatric diagnosis approach to categorising human distress is used in this paper. However, the authors fully recognise this is an area that is hotly contested (Division of Clinical Psychologists, 2014) and that psychiatric diagnoses are likely to be lacking in validity and reliability (Bentall, 2009).

The English Mental Health Act (MHA, 1983) is medico-legal legislation that allows medical practitioners to detain and treat people, usually against their wishes, who are deemed to be suffering from a mental disorder, and to be either a risk to themselves or to others (Department of Health [DOH], 2015). Individuals are assessed to determine whether they should be detained, and if so, what specific section of the legislation should apply; this is informally known as ‘sectioning’. On specific sections, compulsory treatments can include injections of anti-psychotic medication and electro-convulsive therapy. The rationale behind sectioning is that it protects both the service user and the public.  Although criteria differ marginally across nation states, the key criteria are the same across the majority of European countries, the USA and Canada, and Australia and New Zealand (Zhang et al, 2015).

Deprivation of liberty, irrespective of whether it has occurred within the law - currently detailed in the Deprivation of Liberty Safeguards (DOLS) (Mental Capacity Act, 2005) - and the compulsory use of psychiatric treatments on those deemed mentally ill has been heavily critiqued (Foucault, 2006/1961; Newnes, Holmes & Dunn, 2001; Bentall, 2009; Coales, Kennan & Diamond, 2013). However, this is counterbalanced by research that provides a more positive view. There is evidence of service users who attribute their well-being to the containment and structure that compulsory admission provides in a time of crisis (Kuosmanen et al., 2006). If service users have felt well-informed and safe, then their experiences can be positive (Gilbert, Rose and Slade, 2008). Much of the quantitative research focus has been on the socio-demographic and clinical factors that impact on inpatients’ perception of care (Rosenhack, Wilson and Meterko, 1997). When the focus has been on service delivery factors, then greater inpatient satisfaction had been associated with positive staff attention and communication (Hackman et al., 2007)

Although some service users report that being detained is beneficial, as it provides them with a place of safety and appropriate treatment, long-term problems with sectioning and treatment persist. This is clearly evidenced by reports from the UK Care Quality Commission (CQC, 2014; 2014/15), which indicate that control and containment of service users is often prioritised over care and support. Long-term key issues are concerned with lack of involvement in decision making, restrictive practices, and lack of consent to treatment.

Wood and Alsawy (2016) conducted a systematic review and identified just 11 qualitative papers that focused on service users’ experiences of involuntary admission and treatment. Key findings tended to highlight issues of relationships and identity (Welches & Pica, 2005). A study conducted by Lilja and Hellzen (2008) used content analysis of semi-structured interviews with psychiatric inpatients and found that the emergent themes were overwhelmingly negative, with people struggling for dignity in an environment of discrimination and rejection. The dominant themes across all articles reviewed were that service users valued autonomy, collaboration with staff, and a sense of being cared for over all other concerns. A picture emerged of clinical understanding on detainment issues as being chiefly guided by service provider concerns and a dominant risk management narrative. The issue of risk is highly relevant and an essential factor to be considered. However, the possible bias of management over therapy – or control over therapeutic treatment – was identified in the literature review as a factor that may be influencing some of the problematic outcomes highlighted by the CQC (2014; 2015).

**Aims**

The key aim of this study was to determine how people who have been assessed and detained under the Mental Health Act make sense of their experience.

**Method**

This study used the qualitative methodology of interpretative phenomenological analysis (IPA) (Smith, Flowers and Larkin, 2009). This is primarily concerned with how people make sense of the experiences that they have. The phenomenological element of IPA is focused on the detailed description of experience, whilst the interpretative element incorporates the philosophical position that experience is subjective, and so idiographic.

**Participants and setting**

The study was conducted at four Community Mental Health Team (CMHT) sites in England. CMHTs provide secondary care to adults with enduring and complex mental health needs. In order to target a specific experience, participants were purposively selected and homogenous (Smith & Osborn, 2003).

**Ethical considerations**

The research proposal was initially ratified by Staffordshire University Peer Review Board. It was then given approval by the local health trust Research and Development Board and NHS Research Ethics Committee (REC).

**Data Collection**

Interviews took place at participants’ CMHT sites. Participants were given the option to withdraw at any time during the interview. Interviews were digitally recorded and then transcribed verbatim. The mean duration of the seven interviews was 48 minutes and 20 seconds with a range of 18 minutes and one second to sixty-nine minutes and seventeen seconds.

**Findings**.

*Superordinate theme 1: The psychiatric paradox*

The main interpretation of this theme was that the process of being assessed and detained actually increased symptoms of psychological distress.

*Sub-theme 1: The threat of treatment*

All participants experienced parts of their assessment and detention as impacting on their well-being, but the focus of each was different. Mark’s interpretation was interesting as it suggested that the threat of treatment may be a way of controlling service users and that a fear of further treatment prevented the expression of intense emotions:

*I know that if you kick off then it’s just going to be worse for you. They end up deciding that you need to go to a higher secure unit or start talking about forced meds and stuff.* (Mark, 132-134)

James shared Marks’s concern about what was possible regarding various treatments. Where these two accounts diverged was in the source of their pre-suppositions. Mark’s interpretation was primarily based on his previous experiences of being detained; James, on his first detention, based his interpretation on stories that he had heard:

*…horror stories about being sectioned […], it sort of becomes a lifelong thing you know, and I saw all these people taking these drugs and lots of medication and I heard about ECT and I thought that I don’t want this to happen to me and I thought, I was frustrated…* (James, 449-453)

Callum’s first experience of treatment was perhaps the most telling account provided. Placed in the context of his overall contact with mental health services, his Mental Health Act assessment stands out as a particularly negative experience that resulted in him avoiding services for a number of years:

*…I’m not going back to them because I’m not exposing myself to all that again, so I just went missing in services for years till I have a suicide attempt years later.* (Callum, 337-339)

*Sub-theme 2: Negative impact of treatment*

 Bob, George and Craig’s accounts had the greatest amount of convergence, with all three highlighting how treatment increased their distress. Simultaneously there were idiographic elements to their accounts. For Bob, it was being around other ill people for long durations:

*…got me really low […] with all these people around you that aren’t very well you know and you think you’re doing alright. I don’t know what made it drag on so long but it made me get really low...* (Bob, 210-212)

The focus for George was the effect of the medications he was forced to take. He uses the particularly powerful metaphor of being flayed to describe the experience:

*… I went through a really sensitive phase where again to use a metaphor I felt I had been flayed and I had no skin […] it felt like a physical thing which I think is partly to do with the awful drugs I was taking at the time which I had been forced to take […] the experience was awful, I was taking risperidone which has awful side effects that was making me depressed* (George, 99-107)

Mike’s account converged with George’s, though his focus was the physical effect rather than the psychological:

*They decide it’s not working and they took me off and put me on something else and then something else […] there were times I had a rash all over my body and I had to be rushed to the emergency room at the hospital to get that dealt with quickly.* (Mike, 96-100)

Craig was more concerned with his view that the process itself was wrong and that the consequence of this was the deterioration of people’s wellbeing:

*We keep people in the hospital too long because we create more frustration, we actually make someone worse and it’s costing this country dearly.* (Craig, 331-332)

*Sub-theme 3: Interventions increasing problems*

Although this sub-theme was more general it served the purpose of encapsulating convergence across the data set pertaining to an overall sense of negativity. For Mark and James the issue was primarily one of trust:

*…they pay attention to what you say but then section you because you can’t be trusted to make sense*. (Mark, 162-163)

In Mark’s case he believed that the lack of trust came from the assessors and was a result of their belief that his psychosis deemed him incapable of making any sense.  For James, the issue was his lack of trust of the assessors as he thought they had been dishonest:

*They lied to me basically and then I ended up at the hospital*. (James, 90)

For Craig and George the problem was also part of the assessment process though the issues were different.

*…there is a problem with the assessment, um, both times that’s happened I was assessed by doctors that hadn’t encountered me before.* (Craig, 57-58)

Although Craig did not explicitly link the lack of familiar staff to a sense of feeling intimidated or vulnerable, this was communicated by George:

*…trying hard to get them to be less intimidating to people who were going through mental health issues...* (George, 239-240)

*Superordinate Theme 2: Fear of the unknown*

This super-ordinate theme was primarily concerned with a lack of effective communication exacerbating anxiety and distress.

*Sub-theme 1: What’s going on?*

This sub-theme was experienced by Craig and Callum as analogous to the process of interrogation and torture. Placed in thematic context it is clearly linked with the super-ordinate theme – The psychiatric paradox:

*How long am I going to be detained, how long will I be here. Am I ever going to be released? Is it gonna be Section 3, if its Section 3 again I’m gonna have massive problems*... (Craig, 338-340)

The key interpretation for participants was concerned with the lack of information provided by staff. Not knowing what was being done to them or what was going to happen in the future was a significant source of psychological distress primarily associated with heightened levels of anxiety:

*…sitting down in a room with questions, being questioned, then I’m thinking what are they gonna do, I was really scared*… (Callum, 268-270)

*Sub-theme 2: Lack of communication*

The torture analogy is even more explicit in this extract from Craig:

*I don’t know how long my freedom is gonna be taken from me, that is the basis of torture, what is the basis of torture is to create in the state of mind of that person, how long is their freedom going to be taken away from them.* (Craig, 500-502)

James’s account converges with Craig’s to the extent that he is affected by the lack of communication. The rather striking difference, and a good example of individual interpretations, was James’s sense of indignation as opposed to Craig’s abject fear:

*I was gobsmacked because the way I was treated at the hospital sort of just carried on, a massive lack of communication…* (James, 103-106)

James did not experience the same levels of distress as Craig and appeared better able to cope with the lack of communication.

*Superordinate theme 3: Playing the game*

*Sub-theme 1: Playing the game*

Mark’s interpretation was interesting because it not only suggests that he had learnt the best way to behave on a section, but also that he thought staff were complicit in this:

*If I were sectioned again then I know how to play the game [pause] because that’s what it is really. They know you’re probably not as bad as they’re making out and you know that you are not.* (Mark, 156-159)

Unfortunately, in his desire to be discharged, Callum focused on presenting himself to psychiatric staff as somebody who had benefited from treatment; he was consequently discharged and, as recorded in the theme – The Treatment Paradox, avoided services for years until he attempted to commit suicide:

*…and it was all going the wrong way, so I just done everything I could to appear like I was ok, so then they let me out. Yeah, and I wasn’t ok.* (Callum, 368-371)

*Sub-theme 2: Being somebody else*

Craig’s interpretation was concerned with what he needed to do to not be detained again rather than what was required to ensure release:

*To not get sectioned I have to be a model citizen, I mean, I have to be like a member of the royal family and be nice to everybody and never lose my temper …* (Craig, 597-599)

Craig’s use of the terms “model citizen” and “royal family” might be indicative of his interpretation being associated with the influence of the state and hierarchy, and the need to conform. It seems clear that he feels pressured to behave normally in order to avoid further detainment.

Callum was explicit in conveying his desire to get out of hospital as quickly as possible:

*The saying about we all wear masks, it was like I was wearing a mask, the one that they wanted to see so I was like - said good morning, I ate me meals, I drank what they wanted me to have, I took what medication they wanted me to take, I answered whatever was asked and my goal was just to get out of that place.* (Callum, 392-396)

Callum’s use of the metaphor “mask” suggests that he may have adopted a new identity whilst in hospital – the one that he thought staff wanted to see.

**Discussion**

The introduction of anti-psychotic medication was experienced by the majority of participants as detrimental to both physical and mental well-being. Levels of challenging behaviour reduced in the acute stages, but service users went on to experience increased levels of confusion and distress, which they interpreted as being a consequence of pharmacological intervention.  In a critique of a Cochrane meta-analysis of the therapeutic value of anti-psychotic medication Ventegodt et al. (2010) highlight that the use of anti-psychotics as a means of managing acute distress is effective, with numbers needed to treat (NNT) = 4. However, for a sustained improvement in mental health this increases substantially to NNT=50 alongside numerous adverse side effects – numbers needed to harm (NNH) = 0.67. These findings, combined with the self-reports of service users in the researcher’s study, suggests that the therapeutic value of the continued use of antipsychotics following initial admission to an inpatient unit is in need of review.

The assessment process was generally described as a negative experience. Some participants’ interpretations likened the process to a form of interrogation; the most salient issue associated with this being the lack of information provided. Having little or no idea of what was happening to them generated higher levels of anxiety whilst service provider led assessment processes reduced levels of perceived agency.

The combination of a negative bias regarding psychiatric treatment and a negative sense of self based on the stigma of psychiatric diagnosis may partially explain participants’ interpretations of their experience. Also, those with an affective disorder are more likely to develop negative self-feelings (stigma-sentiment hypothesis); in this IPA study four of the seven participants were diagnosed with bi-polar disorder. In addition, participants’ negative experiences were compounded by assessors not introducing themselves, assessments being rushed, not being informed regarding what was happening to them, and of assessments being delivered with a high focus on meeting the needs of the service provider and not the service user. Labelling theory may also go some way to explaining this. Hinshaw & Cicchetti (2001) contend that stigma is pervasive and affects, amongst other things, the standards of care and professional attitudes towards those with mental illness. These issues reflect concerns highlighted by the Care and Quality Commission (CQC, 2014; 2015) regarding control and containment of service users taking priority over care and support.

The people in this study were clinically conceptualised as experiencing either mania or psychosis/schizophrenia. Both these labels have a psychiatric etymology rooted in a medical model of understanding, which chiefly regards psychosis and schizophrenia as the result of neurochemical imbalances caused by genetic predisposition with biological mechanisms underpinning pathology; there is no conclusive evidence to support this claim (Bentall, 2009) and the Diagnostic and Statistical Manual of Mental Disorders – 5 (DSM-5) makes no claim for biological causation (Division of Clinical Psychology, 2014).

A meta–analysis by Varese et al. (2012) found that people who had experienced childhood trauma were significantly more likely to develop psychosis than those who had not. They also found that nine of the ten studies that tested for a dose-response relationship found one i.e. a strong suggestion of a causal relationship between trauma and psychosis. It has been suggested that people who have endured three kinds of abuse (e.g. sexual, physical, emotional) are 18 times more likely to develop psychosis, while people who have experienced five types are 193 times more likely to become psychotic (Shevlin et al., 2007). Collectively, this presents a coherent multidisciplinary model that reconceptualises “mental illness” as primarily influenced by highly problematic interpersonal relationships: a “psychosocial-bio” model of psychosis.

**Limitations**

Recall of being assessed and detained was limited for some. Consequently, elements of participants’ interpretations were recalled with a limited amount of clarity and reports were usually of the combined experience of numerous assessments or mixed with accounts of experiences whilst detained. Although still relevant, this meant that the essential experience of the assessment process was diluted.

Although the results of this study can help illuminate some aspects of being assessed and detained, no claim for external validity can be made. The participants recruited had predominantly negative experiences and this may have been a motivating factor in them coming forward for interview.

**Clinical recommendations**

First time detainees should be given enhanced care in order to increase the likelihood of their initial experiences being more positive; this could adopt an Open Dialogue (OD) model (Seikkula et al., 2004). OD is a psychosocial approach to managing psychosis that has been developed in Lapland, Finland since 1989 and is currently being piloted in the U.S.A., Germany and England. Essentially, teams of family therapists work closely with families from initial referral to discharge. The purpose is to explore ways for individuals and their families to find meaning for experiences of psychosis. OD has the best outcomes for treating psychosis in the Western world. In research covering two year follow up of two consecutive periods only a third of patients had been placed on neuroleptic medication, and 81% had no residual psychotic symptoms (Seikkula et al., 2011). If successful across cultures, it could mark the beginning of the end of widespread and long-term medication use by psychiatric inpatients, with a view to managing people in their communities with support from families and professionals.

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