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EXPLORING COMPULSORY ADMISSION EXPERIENCES OF ADULTS WITH PSYCHOSIS USING GROUNDED THEORY

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SUMMARY OF THE MRP PORTFOLIO

Section A: reviews literature related to compulsory admissions under the Mental Health Act (1983/2007) of adults presenting with psychosis. It outlines the legal framework and examines empirical data relating to admissions under the Mental Health Act (1983/2007). A brief overview of psychosis, its aetiology and key psychosocial models are provided. Consideration of mental health within the legislative framework is offered and the experience of being compulsorily admitted is explored. Finally, further qualitative research is recommended.

Section B: presents a qualitative Grounded Theory study investigating compulsory admission experiences for adults with psychosis and how it impacts upon their psychological functioning. Individual semi-structured interviews were conducted with 17 service-users and psychiatrists. Study objectives were achieved. Five higher-order categories and 47 categories were identified which contributed to the development of a preliminary model of compulsory admissions. Study limitations, clinical implications, and suggestions for future research are discussed.

Section C: addresses four key questions about the study. The first relates to skills the researcher learnt through conducting the study. The second relates to improvements that could be made if conducting the study again. The third relates to clinical implications, and the forth to further research.

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MAJOR RESEARCH PROJECT

Section A: Literature review

Compulsory Admissions under the Mental Health Act 1983/2007 of adults presenting with psychosis: A literature review

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Abstract

The largest annual increase in formal admissions to psychiatric inpatient wards for four years was reported in 2009-10 (The Health and Social Care Information Centre; October, 2010). Whilst the importance of the patient experience is now recognised in healthcare provision (Department of Health, 2003a) the psychological impact of such experiences is rarely addressed.

This literature review outlines the legal framework for mental health in the UK and examines empirical data regarding who is admitted under the Mental Health Act (MHA) 1983/2007. An overview of psychosis, aetiology and key psychosocial models are provided.

Consideration of mental health and compulsory admissions within the legislative framework is explored. However, research into these compulsory admission experiences is sparse with studies employing diagnostically heterogeneous rather than homogeneous samples. This makes it difficult to make accurate inferences about the effect of compulsory admissions on service-users with particular diagnoses. Consequently, further qualitative research is suggested i) to explore the impact of compulsory admissions (under the MHA 1983/2007) on the psychological functioning of adults with psychosis using a UK-sample, ii) to triangulate the experience by recruiting service-users and involved professionals, and iii) to develop a theory/model for understanding the psychological impact of compulsory admissions on service-users with psychosis.

1 Overview

The importance of the patient experience is increasingly being recognised in healthcare provision with the ‘Improving the patient initiative’ collaborative NHS project being a mark of this (Department of Health, 2003a). This literature review provides a brief history of mental health law in the UK. It offers an overview of relevant aspects of modern day mental health law before examining the empirical data regarding who is admitted under the Mental Health Act (MHA) 1983/2007. An overview of psychosis is then provided before exploring in more detail the aetiology and prominent psychosocial models. Consideration of mental health within the context of the aforementioned legislative framework is made with reference to relevant literature. Research into compulsory admission (CA) experiences is then discussed and a summary with justification for further research is provided.

2 Mental Health and Law in the United Kingdom

2.1 History of the Mental Health Law

The first MHA in the UK was the 1774 Madhouses Act (Porter, 2003). It gave the Royal College of Physicians powers to grant licences to premises housing "lunatics" in London. This Act was later considered ineffectual and was repealed by the Madhouses Act 1828 (Porter, 2003), itself repealed shortly afterwards by the Madhouses Act 1832 (Porter, 2003). In 1845, the Lunacy Act and the County Asylums Act (Porter, 2003) gave "asylums" the authority to detain "lunatics, idiots and persons of unsound mind". These acts were later repealed by the Lunacy Act 1890 (Porter, 2003). This introduced "reception orders", authorising detention in asylums. In 1913, the Mental Deficiency Act (Porter, 2003) renamed the Lunacy

Commission the "Board of Control" and increased the scope of its powers. The functions of the Board of Control were subsequently altered by the Mental Treatment Act 1930 (Porter, 2003) and the National Health Service Act 1946 (Porter, 2003). This 1946 Act aimed to provide informal treatment for the majority of people suffering from mental disorders, whilst providing a legal framework that such people could, if necessary, be detained in hospital against their will. It also aimed to make local councils responsible for the care provision of people with mental health problems who did not require hospital admission. The MHA 1959 (Porter, 2003) abolished the Board of Control. It aimed to provide informal treatment for the majority of people suffering from mental disorders, whilst also offering a legal framework which enabled individuals to be detained in hospital against their will. It also aimed to assign responsibility for the care of individuals with mental health issues who did not necessitate hospital admission to local councils. However, as with the previous Acts, the 1959 Act did not provide clarity as to whether or not hospitals were empowered to impose medical treatment against a detained individual’s will. By the 1970s, treatments such as electroconvulsive therapy, psychiatric medications, and psychosurgery were being used. It became clear that a specific legal framework for such medical treatments was needed in order to balance the rights of detained persons with those of society as a whole. This led to a review of the Act which and the subsequent introduction of the MHA 1983.

2.2 The Mental Health Acts today

The 1983 MHA (Care Quality Commission; CQC, 2011) was divided into ten "parts". Each of these parts was divided into "sections", which are numbered continuously throughout the Act. Whilst there are a total of 149 sections in the Act, Part II of the Act applies to any mentally disordered person who is not subject to the Criminal Justice System. The vast majority of people detained in psychiatric hospitals in England and Wales are detained under one of these civil sections of the Act (The Health and Social Care Information Centre; October, 2010).

Whilst it is not possible to describe all the sections in this paper, some key sections are relevant to this research. Section 12(2) of the MHA 1983 requires two medical recommendations for the CA of a "mentally disordered" person to hospital, and that one of the two must be approved for the purposes of that section by the Secretary of State as having special experience in the diagnosis or treatment of mental disorder (a "Section 12 approved doctor"). The other detaining professional must either have had previous acquaintance with the person under assessment, or also be a Section 12 approved doctor. The two doctors must not be employed in the same service, to ensure independence. Commonly, in order to satisfy this requirement, a psychiatrist will perform a joint assessment with a general practitioner. A third individual, referred to as an Approved Mental Health Professional (AMHP), is also normally involved in sanctioning the admission. However, there are some exceptions to the aforementioned criteria. For example, in an emergency situation where the person is not known to any available doctors and two Section 12 approved doctors cannot be found, a single doctor and an AMHP can detain an individual.

A MHA assessment can take place in a variety of settings such as in a hospital, at a police station, or in a person's home. If the two doctors agree that the person is suffering from a mental disorder, and that this is of a nature or to a degree that, despite their refusal to go to hospital, they ought to be detained in hospital in the interest of their own health, his safety, or for the protection of others, a medical recommendation form is completed and given to the AMHP. If the AMHP agrees that there is no viable alternative to detaining the person in hospital, they will complete an application form requesting that the hospital managers detain the person. The individual will then be transported to hospital and the period of assessment begins. Treatment, such as medication, can be given against the person’s wishes under Section 2 assessment orders (up to 28 day admission), as observation of response to treatment constitutes part of the assessment process.

Section 3 is a treatment order and can initially last up to six months; if renewed, the next order lasts up to six months and each subsequent order lasts up to one year. It is instituted in the same manner as Section 2, following an assessment by two doctors and an AMHP. One major difference, however, is that for Section 3 treatment orders, the doctors must be clear about the diagnosis and proposed treatment plan, and be confident that “appropriate medical treatment” is available for the patient. The definition of “appropriate medical treatment” is wide and may constitute basic nursing care alone.

Most treatments for mental disorder can be given under Section 3 treatment orders, including injections of psychotropic (anti-psychotic) medication. However, after three months of detention, either the person has to consent to their treatment or an independent doctor has to give a second opinion to confirm that the treatment being given remains in the person’s best interests.

Section 4 is an emergency order that lasts up to 72 hours. It is undertaken by just one doctor and an AMHP, in an emergency in which there is not time to summon a second suitable doctor in order to implement a Section 2 assessment order or Section 3 treatment order. Once in hospital, a further medical recommendation from a second doctor would convert the order from a Section 4 emergency order to a Section 2 assessment order. However, Section 4 emergency orders are not commonly used.

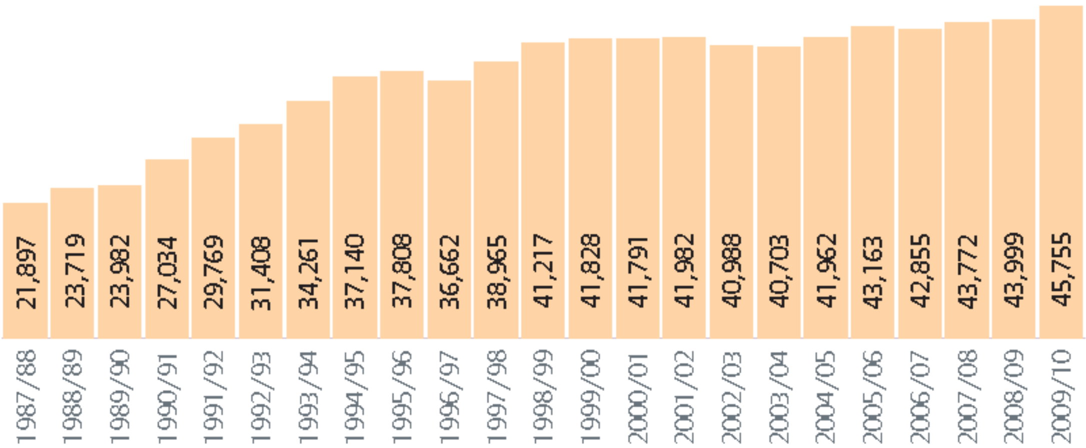
Section 136 allows a police officer to take a person whom they consider to be mentally disordered to a “place of safety”. This only applies to a person found in a public place. Once a person subject to a Section 136 police officer’s order is at a place of safety, they are further assessed and, in some cases, a Section 2 assessment order or Section 3 treatment order is implemented.

The MHA 2007 (The National Archives, 2007) amended the MHA 1983 (and the Mental Capacity Act 2005). It introduced changes such as a new definition of ‘mental disorder’ throughout the Act, and a requirement that someone cannot be detained for treatment unless ‘appropriate treatment is available’. The Act improved patient safeguards by taking an order-making power which enabled the current time limit to be varied, and for automatic referral by hospital managers or Approved Clinicians to a Mental Health Review Tribunal (MHRT). The Act also replaced the role of Responsible Medical Officer (RMO) with that of a Responsible Clinician (RC). The RC has overall responsibility for a service-user’s case. Undertaking the majority of the functions previously performed by the RMO, RCs can be a range of mental health professionals including psychologists.

2.3 Who is detained under the MHA 1983/2007?

In 2010, the Care Quality Commission (CQC: October, 2010) reported that psychiatric patients admitted under the MHA occupied a larger proportion of inpatient services than at any other time since 1983. This is clearly illustrated in Figure 1.

Figure 1. Detentions of individuals under the MHA (voluntary and CAs, 1987/88 to 2009/2010)[1]



Whilst the combined number of voluntary and CAs is increasing, 2009-10 saw the largest annual increase in formal admissions for four years (The Health and Social Care Information Centre; October, 2010). There were 30,774 formal admissions which represented an increase of 7.3 per cent from 2008/09. This is compared to previous years since 2006/07 where increases were all less than 2.1 per cent.

Although the CQC (October, 2010) acknowledged that the number of mental health hospital beds were continuing to decline, they reported that admissions for schizophrenic and manic disorders had not changed significantly. However, the patient mix on inpatient wards has reportedly shifted further towards people with psychotic (and dual diagnosis substance misuse) disorders. The CQC reported that whilst the number of patients who were already in hospital voluntarily at the time of their detention (‘changes from informal admission’) had been decreasing for the past 10 years, the number of people admitted directly from the community had risen.

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[1] Data source: Care Quality Commission (October, 2010)

The CQC (October, 2010) reported that the rise in admissions was a consequence of fewer hospital beds and more community-based care. They suggested that patients were being supported or having to manage for longer in the community before a hospital admission is deemed necessary. Consequently, the CQC reported that when such individuals are eventually admitted, they are more severely ill and less likely to enter hospital voluntarily. Some of these reasons had already been suggested some years previously. For example, Wall, Hotopf, Wessely, and Churchill (1999) suggested changes in the availability of beds had increased the threshold for admission and decreased the threshold for discharge. Davidge, Elias, Jayes, Wood, and Yates (1994) reported that between 1982 and 1992, approximately 43 000 fewer psychiatric hospital beds were available. In inner city areas, Johnson, Ramsay, Thornicroft, Brooks, Lelliot, Peck, et al. (1998) reported that bed occupancy remained above 100% much of the time. Wall et al. (1999) also suggested there was some evidence (e.g. Cuffel, 1992) that an increasing proportion of psychiatric patients misuse drugs and alcohol, and this may lead to more florid presentations of psychosis. Wall et al. (1999) went on to suggest the public's fear of violence by psychiatric service-users coupled with pressures to keep patients in hospital until it was “safe” to discharge them put further strain on bed availability. Yet, as Hiday (1995) pointed out, a diagnosis of major mental illness is far less predictive of violence than being “young, male, single, lower class, and substance abusing or substance dependent”. Such findings are also supported by Blumental and Lavender (2001) in their literature review of violence and mental health.

The NHS has not published CA data which breaks down admissions by diagnosis. However, Law-min, Oyebode and Haque (2003) have explored what happened during a five-year period to 189 service-users with no previous psychiatric admissions, who were detained for the first time in a psychiatric hospital under Part II of the MHA 1983. They reported a mean age of 40 (range 21-65) and found nearly half of the cohort had a diagnosis of psychoses. Nearly a third of the cohort had a further compulsory detention with fifty per cent having a further CA within a year of the index admission. Whilst the retrospective methodology employed was relatively inexpensive compared to prospective designs, retrospective studies rely on the accuracy of written records, and make it difficult to control bias and confounders. However, the findings did support findings by Reicher, Rossler, Loffler, & Fatkenheuer, 1991) who indicated that people with psychosis form a large proportion of those admitted compulsorily. Similarly, Thornicroft, Wykes, Holloway, Johnson, and Szmukler (1998) found that among 500 patients with psychoses, over 50% had been admitted under the MHA at least once in the course of their illness. Given that a large proportion of admissions reportedly result from psychosis it seemed appropriate to explore this diagnosis in more detail.

3 Understanding Psychosis

3.1 Defining psychosis

The Diagnostic and Statistical Manual of Mental Disorders (4th ed.) (American Psychiatric Association, 2000) describes a narrow definition of ‘psychotic’ as “restricted to delusions or prominent hallucinations, with the hallucinations occurring in the absence of insight into their pathological nature”. The International Statistical Classification of Diseases and Related Health Problems (10th Revision) (ICD-10; World Health Organisation, 1992) adopted a slightly broader definition. It suggests ‘psychotic’ ‘simply indicates the presence of hallucinations, delusions, or a limited number of severe abnormalities of behaviour, such as gross excitement and over-activity, marked psychomotor retardation, and catatonic behaviour.' A number of often disputed and controversial diagnoses fall under the wider term of psychosis (e.g. Schizophrenia, Bipolar disorder, Delusional disorder, Schizo-affective disorder).

Harper (2001) described hallucinations as sensory perception in the absence of external stimuli. Unlike illusions, or perceptual distortions, which are the misperception of external stimuli, hallucinations can occur in any of the five senses. They can take on various forms, from simple sensations such as colours, lights, tastes, and smells, to more meaningful experiences such as seeing and interacting with fully formed animals and people, hearing voices, and having complex haptic sensations. Auditory hallucinations such as hearing voices are a prominent feature of psychosis. Individuals with psychosis who hear hallucinated voices may experience the voices talking about, or to them, and may involve several speakers with distinctive personas. Auditory hallucinations may be distressing when they are derogatory, commanding or preoccupying. However, the experience of hearing voices is not always reported to be a negative one. For example, research by Honig, Romme, Ensink, Escher, Pennings, and deVries (1998) suggested that the majority of people who hear voices are not in need of psychiatric help.

Delusions are another positive symptom of psychosis (ICD-10, 1992). Reasoning biases and memory distortions are thought to contribute to the development and maintenance of delusional thinking in individuals with psychosis. Garety and Hemsley (1994) identified a tendency for people with delusions to use limited evidence, the 'jumping to conclusions' reasoning bias. Other reasoning processes identified by Garety and Freeman (1999) included data gathering bias, an externalising attributional style, and poor social understanding or theory of mind. Garety, Kuipers, Fowler, Freeman and Bebbington (2001) suggested a lack of belief flexibility (willingness to consider alternatives to the delusional belief) is associated with poorer outcome (independent of delusion severity). Garety et al. (2001) also suggests that normal belief confirmation biases are likely to maintain psychotic beliefs.

In addition to the positive symptoms of psychosis, individuals may experience negative symptoms. These may include low mood, a restricted range and intensity of emotional expression, restrictions in the fluency and productivity of thought and speech, and restrictions in the initiation of goal-directed behaviour (DSM-IV-TR; APA, 2000). Individuals may also exhibit personality changes, sometimes accompanied by unusual behaviour, as well as difficulties with social interaction and with carrying out daily living activities.

3.2 What is the aetiology of psychosis?

Numerous aetiologies have been purported over the years, ranging from the Kaepelinian disease model (Kraepelin, 1920) to psychoanalytic models (e.g. Jung, 1907) and the genetic-brain disease model (e.g. Gournay, 1995). Whilst psychiatry has attempted to categorise psychosis, others see psychosis as a spectrum (or dimension) which we all find ourselves on. Others find the combination of diagnosis and dimensions useful (e.g. Demjaha, Morgan, Morgan, Landau, Dean, Reichenberg et al., 2009). Certainly, there appear to be multiple causative factors in the development of psychosis but more recently greater emphasis has been placed upon cognitive and social factors, with the stress-vulnerability model (Zubin & Spring, 1977) of psychosis catalysing further research and theoretical development in this area.

Essentially the stress-vulnerability model (Zubin & Spring, 1977) proposed that a vulnerability to psychosis is acquired through a genetic predisposition or as a result of an environmental insult to the brain (e.g. head injury). However, this vulnerability is not considered to be sufficient to manifest the disorder itself and must be 'triggered' by environmental events or processes. The environmental component could be biological (i.e. an infection, or even drugs and alcohol) or psychological (job loss, bereavement, relationship breakdown etc.). The amount of environmental stress needed to 'trigger' psychosis is thought to differ from person to person, as does the amount of vulnerability that at risk people have for developing psychosis. However, whilst the essence of this simple model seems relatively robust, it offers no explanation of the cognitive aspects of psychosis and its positive symptoms.

Garety et al.’s cognitive model (2001) also presumes there is a pre-existing bio-psycho-social vulnerability followed by a trigger. However, it goes further, suggesting that basic automatic cognitive disturbance occurs in one of two ways. The first way is via reduced influences of stored memories of regularities of previous input on current perception which leads to ambiguous, unstructured sensory input and the intrusion into consciousness of unintended material from memory. The second way is via recently developed difficulties with the self- monitoring of intentions and actions, which leads to the individuals' own intentions to act not being recognized and therefore being experienced as alien. At onset both pathways emphasise that the cognitive disturbance leads to anomalous conscious experiences (e.g. thoughts experienced as voices). Emotional changes also occur in direct response both to the triggering event and to the anomalous experiences. Such emotional changes feed back into the processing of anomalous experiences and influence their content.

Garety et al. (2001) argue that the appraisal of experience is therefore influenced by three core elements which include 1) reasoning processes 2) dysfunctional schemas and adverse social environments, 3) emotion (e.g. anxiety, depression, anger, mania) and the associated cognitive processes. Their model also identifies maintaining factors which includes the appraisal of psychosis itself. Garety et al. (2001) argues that this ‘illness perception’ or insight influences engagement with treatment and adaptive behaviour.

Whilst Garety et al.’s (2001) model is speculative it draws on and integrates a range of research findings. Indeed, with seemingly dysfunctional cognitions potentially impacting on their appraisal of experiences, it seems plausible that the experience of CA may exacerbate service-users’ positive symptoms and reinforce maintaining factors such as attributional and reasoning biases, schemas, and their appraisal of psychosis itself.

4 The Mental Health Act and Psychosis

Myin-Germeys, Krabbendam, Delespaul, and Van Os (2003) studied 42 clinically-remitted individuals with psychosis. They found that the cumulative effect of life events on emotional reactivity to daily activities and events rendered individuals more vulnerable to the onset or persistence of psychotic symptoms.

The psychotic experiences that result appear to augment the risks of serious harm coming to individuals with psychosis, or indeed them harming others. For example, figures suggest that ten percent of people with schizophrenia commit suicide (Caldwell & Gottesman, 1990; Heila & Lonnqvist, 2003) and 30% will attempt it (Radomsky, Haas, Mann, & Sweeney, 1999; World Health Organization, 2001). Such deteriorations in mental health and associated increases in risk may necessitate a

MHA assessment and subsequent admission. However, being compulsorily admitted under the MHA 1983/2007 may in itself be another stressful event for many individuals with psychosis and will result in some form of appraisal which may or may not reinforce pre-established cognitions or schemas. Research suggests that removing the liberty of an individual with psychosis to an environment with other distressed individuals may not be conducive to improving mental health. For example, a review by Morrison, Bowe, Larkin and Nothard (1999) suggested that all psychiatric admissions are likely to be associated with pervasive distress and that a number of patients show clinically significant symptoms of post-traumatic stress associated with admission. Frame and Morrison (2001) studied 60 inpatients and found 50% of the sample reported clinically significant PTSD symptoms at time one and follow-up with psychotic symptoms accounting for 52% of the variance in PTSD scores. It therefore seems plausible that being compulsorily admitted under the MHA (1983/2007) can be a traumatic experience that may contribute to the maintenance of a ‘faulty’ self, and reinforce the positive symptom maintaining factors (e.g. reasoning and attribution biases, dysfunctional schemas) outlined by Garety et al. (2001). Indeed, Ehlers and Clark’s (2000) cognitive model of persistent PTSD suggests a key feature of individuals who do not recover naturally is idiosyncratic negative appraisals of the traumatic event that have the common effect of creating a sense of serious current threat. This threat can be external (e.g. the world is a dangerous place, people are dangerous) or internal (e.g. a threat to one’s view of oneself as a capable/acceptable person).

With such vulnerability, stress and potential triggers coupled with limited support networks (Creswell, Kuipers, and Power, 1992), effective coping strategies are paramount. In terms of support, Creswell, Kuipers, and Power (1992) reported that individuals with psychosis are more likely to have small primary social networks, comprising on average only seven people. Whilst a relatively small sample of 40 service-users diagnosed with schizophrenia was recruited, service-users reported on average only seeing three people regularly.

A review by Phillips, Francey, Edwards and McMurray (2009) concluded that most individuals experiencing psychosis implement at least one way to cope with symptoms and life events, and most implement more than one. The most frequently used treatment given to individuals to help reduce or eliminate psychotic symptoms is anti-psychotic medication (Kuipers, Peters, & Bebbington, 2007). This reportedly has a positive effect on some service-users (Kuipers et al., 2007) and may raise an individual's threshold of vulnerability to relapse (Ventura, Neuchtlein, Hardesty, and Gitlin, 1992). However, a review by Nosé, Barbui and Tansella (2003) found that at least one in four individuals with psychosis failed to adhere with treatment programmes. Falloon and Talbot (1981) suggested that individuals with psychosis do have other coping responses but suggested that these are often sub-optimal. For example, people cope with distressing ideas or voices by becoming socially withdrawn, avoiding stressful situations and sometimes by using illicit drugs and/or alcohol. Unfortunately, many of the beneficial aspects of such coping strategies are often short-lived, and ultimately exacerbate symptoms further (e.g. Arsenault, Canon, Whitten, & Murray, 2004), particularly negative symptoms.

Given the stigma associated with psychosis, Rooke and Birchwood (1998) found that many people experience considerable loss as well as trauma (Mueser, Goodman, Trumbetta, Rosenberg, Osher, Vidaver, Auciello et al., 1998). The diagnosis is also associated with poverty and reduced work and social opportunities (Thornicroft, Tansella, Becker, Knapp, Leese, Schene, et al., 2004). Given this, it is unsurprising that individuals suffer with negative symptoms such as apathy, lack of emotion, poor social functioning, as well as poor self-esteem (Freeman, Garety, Fowler, Kuiper, Dunn, Bebbington, & Hadley, 1998).

The Government (DoH, 2007) also acknowledged the ever growing phenomenon of ‘revolving door patients’, whereby patients improve in hospital, are discharged back into the community where they are reintroduced to the environmental stressors that triggered the psychosis and stop taking the anti-psychotic medication which leads to a relapse requiring re- admission. This has led to some people questioning anti-psychotic medication efficacy. For example, Moncrieff (2006) questioned their usefulness in light of the withdrawal symptoms that can include insomnia, agitation, motor disorders and even psychosis. In 2009, a systematic review and meta-analysis of trials in people diagnosed with schizophrenia (Leucht, Arbter Engel Kissling, & Davis, 2009) found that less than half (41%) showed any therapeutic response to an antipsychotic, compared to 24% on placebo, and that there was a decline in treatment response over time. The review also suggested that there was often a bias in which trial results were published. Breggin (1993) argued that anti-psychotic medications have the underlying brain-disabling principle that all major psychiatric treatments exert. Essentially, their primary or intended effect is disabling normal brain function. Breggin argued that none of the major psychiatric interventions correct or improve existing brain dysfunction, such as any presumed chemical imbalance. More worryingly, a systematic review by Weinmann, Read, and Aderhold (2009) found some evidence that long-term exposure to anti-psychotic medication increases mortality in individuals with schizophrenia. However, the review suggests that more rigorous, prospective studies are urgently needed.

As Garety et al.’s (2001) model suggests, individuals with psychosis may have a bio-psychosocial vulnerability to stress and when faced with triggers the individual may experience basic cognitive dysfunction leading to anomalous experience, coupled with emotional changes and impacting upon the individual’s appraisal of experience. With potentially limited coping strategies, and sometimes social isolation, it is unsurprising that deteriorations in mental health (often indicated by reduced insight; Drake, Mueser, Clark, & Wallach, 1996) may occur. It is even less surprising that individuals with psychosis may at some point find themselves subject to increasing Mental Health services involvement and being assessed under the MHA 1983/2007. Given the associated stress and the pre-existing vulnerability, it would therefore be better understand the CA experience and its psychological impact on service-users so that the prevalence of repeat admissions and ‘revolving door’ service-users is reduced. This certainly warrants further investigation so the limited but existing literature base will now be explored.

5 Compulsory Admission Experiences

Only one UK-based published study was found to explore CA experiences (and that was using a heterogeneous sample of service-users) so for the purposes of this review, the literature search parameters were widened to include studies of particular relevance where a non-UK sample or homogenous adult sample was recruited.

Montemagni, Badà, Castagna, Frieri, Rocca, Scalese, et al. (2010) explored clinical predictors associated with CAs for individuals with psychosis. Three variables predicted CA in their sample: excitement (including uncooperativeness, tension, poor impulse control, and hostility), impaired emotion perception, and lesser insight. However, whilst the findings are useful, this study employed an Italian sample so there is an issue of ecological validity and applicability of the findings to a UK population.

McKenna, Simpson, and Laidlaw (1999) compared patient perception of coercion on admission to acute psychiatric services using a New Zealand sample of 69 patients who were admitted involuntarily and 69 patients who were admitted voluntarily. Service-users with psychosis showed a trend toward a stronger perception of coercion in comparison to those who had not presented with psychosis. In terms of situational variables, service-users brought to the hospital by the police had a significantly higher perception of coercion in comparison to those whose admission did not involve police. The findings suggested that service-users compulsorily admitted to hospital felt a loss of autonomy and were more likely than voluntary admissions to perceive hospitalization as coercive. Again this study did not employ a UK sample and only examined the patient perception of coercion within the self-reporting MacArthur Admission Experience Survey (Gardner, Hoge, Bennett, Roth, Lidz, Monahan et al., 1993).

A further study employing a non-UK sample was that of Olofson (1995). Olofson explored nurses’ experiences of using force in institutional care in a Nordic sample of psychiatric service-users. Narrative interviews were conducted with 14 nurses. Whilst this qualitative study lacked generalisability due to its small sample size, it did identify some interesting themes. Participants most commonly described being coercive in their attempts to compulsorily inject patients (n = 11). None of the interviewees wanted to use force against service-users, and when situations requiring its use occurred, they wished they did not have to participate. Although the interviewees had many clear reasons why the use of force was necessary in psychiatric care, its use nevertheless incurred many feelings of discomfort. The study concluded that there was a need to find alternatives to the use of force, and the need for improved communication between physicians and nursing staff.

The above findings concur with findings from a UK study by Gilburt, Rose, and Slade (2008) who explored service-user experiences of psychiatric hospital admission for 19 participants who had had inpatient admissions. Whilst themes such as coercion, trust, safety, communication and cultural competency were identified, the authors suggested that these were contributors to the service-user - service relationship. The authors argued that it was this service-user perception of the relationship that was shaped by the treatment, freedom and environment experienced by service-users. Gilburt et al.'s (2008) study was both qualitative and user-led. Bias may therefore have been an issue as no sample triangulation was conducted. Furthermore the study employed a heterogeneous sample since it did not focus on any particular clinical presentation. Despite such limitations it did support earlier research by Rose (2001) who highlighted the role of both service-user – service relationships and the service environment in psychiatric admissions.

McNally, Beail, and Kellett (2007) explored the experiences of CA under the MHA (1983) for seven people with learning disabilities using interpretative phenomenological analysis. Whilst this small qualitative study included adults with learning disabilities rather than a general adult population, it did identify similar and interesting themes to those of Gilburt et al.'s (2008) study. Key themes that emerged included the impact of perceived lack of control over self, experiences of vulnerability, powerlessness and victimisation both before and after detention. Participant's sense of care versus punishment, the development of 'role' within the mental health system, and attribution of blame were also key themes that emerged. Whilst valuable, the study did not triangulate with the recruitment of other people involved in the detention process (e.g. psychiatrists). It also employed a diagnostically heterogeneous sample, making accurate inferences about particular diagnostically grouped service-users difficult. For example, individuals with psychosis may have distinguishing presentation features (e.g. hallucinations) compared to other mental health diagnoses commonly associated with CAs (e.g. Personality Disorders; DoH, 2003b). However, no studies have yet employed a diagnostically homogeneous sample to explore experiences of CA.

6 Conclusions and Future Research

The largest annual increase in formal admissions to psychiatric inpatient wards for four years was reported in 2009/10 (The Health and Social Care Information Centre; October, 2010). Whilst the importance of the patient experience is now recognised in healthcare provision (DoH, 2003a) the psychological impact of such experiences is rarely addressed.

Garety et al.’s (2001) cognitive model suggests that individuals with psychosis have a bio-psychosocial vulnerability to stressors. Following a ‘trigger’, the individual may experience cognitive dysfunction resulting in anomalous experience coupled with emotional changes which lead to positive symptoms of psychosis. For these individuals, Garety et al. (2001) suggest that the appraisal of experience is influenced by reasoning and attributional biases, dysfunctional schemas of the self and the external world, as well as isolation and adverse environments. Once present, Garety et al. (2001) purports that the positive symptoms are maintained by these biases, schemas and environmental factors with the continuing presence of vulnerability to further stressors.

Given research (e.g. Frame and Morrison, 2001) suggests CA experiences may be traumatic it seems plausible that they could act as such stressors for service-users with psychosis. Furthermore, research suggests these service-users may have poor coping strategies, a lack of support and social isolation coupled with ineffective and or non-compliance with medication. In light of these factors it seems likely that they may come into contact with mental health services and even be subject to CA to an inpatient psychiatric ward under the MHA 1983/2007. Research into these CA experiences is sparse and the paucity of literature that is available uses diagnostically heterogeneous samples rather than homogeneous samples that focus on the experiences of individuals with particular needs. This makes it difficult to deduce the overall effect of CAs on service-users with particular diagnoses.

As well as being generic (in terms of examining a broad range of service-users) existing research investigating the impact of CAs using a UK sample is extremely sparse. With a diagnostically homogeneous UK sample such research can explore the experiences of service-users with particular needs. In turn, this may enable us to better understand the psychological impact such service pathways have on individuals with such complex mental health problems. It may also serve to highlight ways to improve services and the “patient experience”. Hence, further research is needed, initially perhaps using a qualitative methodology (due to the paucity of existing literature) and i) using a UK sample to explore the experience and impact of CAs on the psychological functioning of adults with psychosis ii) Triangulating the experience (e.g. by recruiting service-users and involved professionals) iii) Developing a theoretical model of how the CA process may impact upon the experience and psychological functioning of adults with psychosis.

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8 Appendices

8.1 Appendix 1 – Literature search strategy

Due to the broad nature of the topic area, multiple literature strategies and pathways were pursued. An initial targeted search was conducted to obtain data regarding the history of the Mental Health Act, the Mental Health Act 1983/2007 and associated empirical data. Most of this information was obtained from government websites. Another similar search was conducted to obtain a definition psychosis and aetiology of psychosis. This was conducted both via the internet using key databases and via the university library, by conducting a book search for ‘psychosis’ as a key term. Appropriate literature was reviewed and included where relevant.

In searching for literature regarding CAs under the Mental Health Act, the following databases were searched for articles in the English language: Web of knowledge, Cochrane, Medline, PsychInfo, and PubMed. Combinations of the following terms were used to search by subject, from the year 1983 (introduction of Mental Health Act 1983) to March 2011: ‘Compulsory’, ‘compulsorily’ ‘admission’, ‘committed’, ‘admitted’, ‘detained’, ‘detention’, ‘involuntary’, ‘involuntarily’, ‘formal’, ‘psychiatric’, ‘section(ed)’ and ‘Mental Health Act’. This produced a total of 114,472 potential results which were subsequently refined by date (1983 to February 2011) and topic to produce 5877 potential articles. The all field search term ‘mental’ was used to conduct further screening of the results to produce 1507 potentially relevant articles. Of these results, articles were selected according to relevance (adult population) and applicability to this study. The ‘medicine’ and ‘social sciences’ subjects of Google scholar were also searched using the words ‘compulsory’ and ‘admission’ for articles from 1983 to present day. The search produced 62 hits, of which a further three hits were potentially relevant for inclusion.

Key authors of particularly relevant studies were also contacted to monitor for additional emerging research studies. Abstracts of selected studies were reviewed, as were references of relevant book texts. Of all the articles, only one was deemed directly and wholly relevant to this study so additional articles were obtained by widening the final selection criteria to include key studies which employed a non-UK, non-generic adult sample.

MAJOR RESEARCH PROJECT

SECTION B: Empirical Paper

Exploring Compulsory Admission experiences of adults with Psychosis using Grounded Theory

Word count: 7944 (plus 592 additional words)

(estimated with tables and figures, excluding title page, abstract and references)

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SALOMONS

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Abstract

Objectives: The study's primary objective was to explore the experience and impact of compulsory admissions (under the MHA 1983/2007) on the psychological functioning of adults with psychosis. The study also aimed to develop a preliminary theoretical model.

Design: The qualitative method 'Grounded Theory' (Glaser & Strauss, 1967) was chosen methodology since it worked inductively from the data and enabled the development of a model.

Method: Seventeen participants (eight service-users with psychosis, nine psychiatrists) involved in compulsory admissions were interviewed. Analysis and interviews were undertaken concurrently so initial findings could influence subsequent data collection.

Results: Five higher-order categories and 47 categories were identified. These contributed to the development of the 'A disturbing journey: To and from detention' model of compulsory admissions.

Conclusion: This small-scale qualitative study achieved its objectives, providing a preliminary model and understanding of the compulsory admission experience for adults with psychosis. Key service and clinical implications are discussed. Despite its limitations, the findings indicated scope for further investigation.

The importance of the patient experience is increasingly being recognised in healthcare provision with the ‘Improving the patient initiative’ collaborative NHS project being a mark of this (Department of Health, 2003). This study explores the compulsory admission (CA) experiences of adults with psychosis and the psychological impact of such admissions. To do this, an overview of the legislative context, psychosis, key psychological theory and research into CAs will be given.

Mental Health Law and Compulsory Admissions

The 1983 Mental Health Act (MHA) is divided into ten "parts". Part II of the Act applies to any mentally disordered person who is not subject to the Criminal Justice System. Most people detained in psychiatric hospitals in England and Wales are detained under one of these Part II civil sections of the Act (The Health and Social Care Information Centre; 2010). Since amendments of the MHA in 2007, psychiatrists, psychologists and other mental health professionals have the potential power to compulsory admit individuals under the MHA.

The largest annual increase in CAs for four years was recorded in 2009-10 (The Health and Social Care Information Centre; 2010). There were 30,774 CAs which represented an increase of 7.3 per cent from 2008/09. In the previous three years increases were less than 2.1 per cent. Although the Care Quality Commission (CQC; 2010) acknowledged that the number of mental health hospital beds is continuing to decline, they reported that the proportion of service-users with psychotic disorders on inpatient wards has increased.

Law-min, Oyebode and Haque (2003) explored what happened during a five-year period to 189 service-users with no previous psychiatric admissions, who were detained for the first time. Nearly half of the sample had a diagnosis of psychosis, of whom nearly a third were admitted again within one year. Other studies (e.g. Reicher, Rossler, Loffler, &

Fatkenheuer, 1991) have also indicated that people with psychosis form a large proportion of CAs.

Psychosis: A Cognitive Model

The International Statistical Classification of Diseases and Related Health Problems (10th Revision) (ICD-10; 1992) defined ‘psychotic’ as ‘the presence of hallucinations, delusions, or a limited number of severe abnormalities of behaviour, such as gross excitement and over-activity, marked psychomotor retardation, and catatonic behaviour.’ This encompasses a number of diagnoses (e.g. Schizophrenia, Bipolar disorder, Schizo-affective disorder) and various possible aetiologies have been proposed. However, for some time significant emphasis has been placed upon cognitive and social factors.

Zubin and Spring (1977) proposed the stress-vulnerability model of psychosis. It suggested that a vulnerability to psychosis is acquired via a genetic predisposition or an environmental insult to the brain (e.g. head injury). This vulnerability is not considered to be sufficient to manifest the disorder itself and must be 'triggered' by environmental/psychosocial stressors (e.g. relationship breakdown). The amount of stress needed to 'trigger' psychosis is thought to differ from person to person, as does the level of vulnerability that ‘at risk’ people have for developing psychosis.

Garety, Kuipers, Fowler, Freeman, and Bebbington’s (2001) cognitive model of positive symptoms is based on this understanding. They propose that a ‘trigger’ (e.g. traumatic life event) causes emotional changes and basic cognitive dysfunction which leads to anomalous experience and subsequent appraisal of experience. Garety et al. (2001) suggest this appraisal is influenced by reasoning and attributional biases, dysfunctional schemas of the self and external world, as well as isolation and adverse environments (e.g. a living environment with high levels of expressed emotion). They argue that this leads to positive symptoms of psychosis which are subsequently maintained by reasoning and attribution biases, schemas, emotional processes and appraisals of psychosis.

Coping with Psychosis

As suggested by Garety et al.'s (2001) model suggests that people with psychosis appear to experience a high frequency and intensity of life events. Neria, Bromet, Sievers, Lavelle, and Fochtmanm (2002) reported that the lifetime prevalence of traumatic exposure in people with psychotic disorders was 68.5%. In another study with 42 clinically-remitted individuals with psychosis, Myin-Germeys, Krabbendam, Delespaul, and Van Os (2003) found that there was a cumulative effect of life events on emotional reactivity to daily activities and events which rendered individuals more vulnerable to the onset or persistence of psychotic symptoms.

With such vulnerability, stress and potential triggers coupled with limited support networks (Creswell, Kuipers, and Power, 1992), effective coping strategies are paramount. A review by Phillips, Francey, Edwards and McMurray (2009) concluded that most individuals experiencing psychosis implement at least one strategy to cope with symptoms and life events. Medication is one such way of coping with research by Ventura, Neuchtlein, Hardesty, and Gitlin (1992) suggesting that anti-psychotic medications can reduce the risk of relapse. However, a review by Nosé, Barbui and Tansella (2003) found that at least one in four individuals with psychosis failed to adhere to treatment programmes. Many individuals with psychosis may employ other coping strategies but as Falloon and Talbot (1981) reported these coping strategies are often sub-optimal. For example, individuals may cope with distressing ideas or voices by physically avoiding social contact or stressful situations or by using illicit drugs (e.g. cannabis) and alcohol. With often short-lived benefits, such strategies may ultimately prove counter-productive, exacerbating psychotic symptoms (e.g. Arsenault, Canon, Whitten, & Murray, 2004) and reducing illness perception. Consequently, professionals may perceive such behaviours as augmenting risk of harm to the service-user or other people which can lead to a CA.

UK Research into Psychiatric Admissions

Although there is a paucity of research into the experience, there is some evidence that if the process of admitting a service-user to a psychiatric ward is not well-managed, it may be traumatic for the service-user. For example, a review by Morrison, Bowe, Larkin and Nothard (1999) suggested that all psychiatric admissions are likely to be associated with pervasive distress with some patients showing clinically significant symptoms of post-traumatic stress which was supported by further research (e.g. Frame and Morrison, 2001). However, only one UK study has sought a qualitative understanding of the actual experiences of psychiatric admissions. Gilburt, Rose, and Slade (2008) identified themes such as coercion, trust, safety, communication and cultural competency. They argued that the service-user - service relationship was paramount to the perceived experience of service-users and that the service perception was shaped by the treatment, freedom and environment experienced by service-users. However, because this study employed a diagnostically-heterogeneous sample, it does not necessarily explain the psychological ramifications of such an experience for any particular diagnosis.

Research Rationale

Research suggests that experiences of MHA admissions have not been well explored. Psychosis is reported to be the clinical diagnosis most frequently associated with CAs (Law-min, Oyebode, & Haque, 2003). However, there is a paucity of UK-based research into CA experiences, and no study to date used a homogeneous sample of people with psychosis.

Therefore it seems pertinent to explore the CA experiences of people with psychosis, both from a professional and service-user perspective.

Study Objectives

The following primary and secondary objectives were developed.

Primary Research Objective

To explore the experience and impact of CAs (under the MHA 1983/2007) on the psychological functioning of adults with psychosis from the perspective of both service-users with psychosis and psychiatrists involved in such admissions.

Secondary Research Objectives

1. To examine and compare responses of adult service-users presenting with psychosis and psychiatrists involved in compulsorily admitting such individuals.
2. To develop a theory/model for understanding the psychological impact of CAs on service-users with psychosis from the perspective of psychiatrists and service-users.

Methodology

Grounded Theory (GT: Glaser & Strauss, 1967) was identified as a valuable methodology for this research because:

1. It provides a framework for assessing and understanding individual meanings (Corbin & Strauss, 2008).
2. It ensures rigour and control of subjectivity when analysing data (Mays & Pope, 1995).
3. It provides a systematic and emergent understanding of psychological processes involved and a preliminary theoretical model (Henwood & Pidgeon, 2003).

The GT was positioned within a critical realist framework because as Corbin and Strauss (2008, p.10) explain, it assumes real events occur but each individual attributes meaning as a result of his or her own experiences.

Participants

Seventeen participants were recruited (9 psychiatrists, 8 adult service-users). All psychiatrists (four female, five male) were formally qualified, worked in a range of clinical and service settings, and had considerable experience of compulsorily admitting service-users with psychosis under the MHA. Table 1 provides an overview of psychiatrist participant information.

Table 1. Psychiatrist participant information[1]

Participant	Clinician	Gender	MHA assessment experience (estimated)	Service context
C1	Consultant Psychiatrist	Male	120	Crisis team
C2	Consultant Psychiatrist	Male	200+	CMHT
C3	Consultant Psychiatrist	Male	100-150	Inpatient
C4	Consultant Psychiatrist	Female	Not reported	CMHT
C5	Consultant Psychiatrist	Female	300+	CMHT
C6	Specialist Registrar	Female	20	Crisis team
C7	Consultant Psychiatrist	Male	200+	EIS[2]
C8	Consultant Psychiatrist	Female	Not reported	CMHT
C9	Consultant Psychiatrist	Male	40	Inpatient

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[1] All identifying information has been removed throughout this report.

[2] EIS – Early Intervention Service

All service-users (six male, two female) were 18-65 years old, of varied ethnicity, and all had formal diagnoses of psychosis. All had experienced two or more CAs due to psychotic symptoms (not resulting from neurological disorders), the most recent of which was 3-12 months pre-interview. Table 2 provides an overview of service-user participant information.

Table 2. Service-user participant information[3]

Participant	Gender	Diagnosis	No. CAs
SU1	Female	Schizophrenia	2
SU2	Male	Paranoid Schizophrenia	5
SU3	Male	Bipolar/Schizo-affective	11
SU4	Male	Schizophrenia	2
SU5	Female	Delusional Disorder/Schizophrenia	4
SU6	Male	Bipolar Disorder	3/4
SU7	Male	Schizophrenia	6
SU8	Male	Schizophrenia	4/5

Procedure

Ethics approval

Ethical approval was obtained from the South East and Coastal Research Ethics Committee and relevant Research and Development department (appendix 1 & 2). The British Psychological Society Code of Conduct (BPS, 2006) was also followed.

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[3] All identifying information has been removed throughout this report.

Recruitment

The researcher recruited service-users by contacting care co-ordinators in NHS adult mental health services who were informed about the study and its inclusion/exclusion criteria. Potential service-users were identified by care co-ordinators and team managers who also assessed capacity to consent and provided them with information sheets (appendix 3). At least 24 hours later care co-ordinators contacted the service-users again to ascertain their interest in participating in the study. If service-users wanted to take part, the researcher made contact and arranged interviews.

Psychiatrists were recruited via NHS adult mental health services. They were informed of inclusion/exclusion criteria and given information sheets (appendix 4). At least 24 hours later, potential participants were contacted to ascertain whether they were willing to participate. Interviews were then arranged.

Interview schedule

Interview schedules (appendix 6 & 7) were developed with two research supervisors; a clinical psychologist with extensive research experience in psychosis, and a senior psychotherapist and service lead for a psychosis service.

Initial interview schedule topics were influenced by research literature, the stages of CA and relevant psychological theory. A draft schedule was discussed with a group of trainee clinical psychologists, a researcher, and an independent author with experience of the research topic area.

The schedule was piloted with both research supervisors who were familiar with the MHA and the experiences of adults with psychosis. Interviews were semi-structured and guided by the interview schedule. However, other relevant information offered by the participants was also explored as it arose. As more participants were recruited and interviewed, the interviews became increasingly influenced by “concepts derived from analysis” (Corbin & Strauss, 2008, p.152).

Interviews

All participant interviews were conducted in NHS clinical settings (e.g. community mental health centres) where standard service protocol were followed after written consent was obtained (appendix 5). Interviews lasted 22-100 minutes and were audio-recorded before being transcribed for analysis.

Data Analysis

Data analysis was based on methods described by Corbin and Strauss (2008), and Charmaz (2006). Corbin and Strauss describe the iterative process of GT whereby one moves back-and-forth between data and higher-level concepts so although the coding progressed through the following stages it was not linear in its progression.

1. The first four interviews (two psychiatrists, two service-users) were open-coded line-by-line and placed into descriptive codes. Concepts were used to present codes derived from the raw data.
2. Focused coding helped generate codes to describe larger sections of data using constant comparisons (Willig, 2001). Once initial categories were established, a further four interviews (two psychiatrists, two service-users) were analysed using focused coding whilst continuing to remain open to the possibility of new categories.
3. Axial coding helped explore relationships between categories and sub-categories. Data was continually compared within and between categories.
4. Selective coding was used to generate a main overall theme from the data and to link the categories generated.

5. Memos recorded reflections on the data and provided a data trail of category development (Corbin & Strauss, 2008). Memos were written concurrently which initiated conceptual development of categories.
6. The model was repeatedly checked against the raw data in the transcripts to ensure accuracy and ‘grounding’.

In accordance with GT data synthesis, analysis would normally be performed concurrently with data collection using concepts generated from earlier data to guide subsequent data collection (‘theoretical sampling’: Corbin & Strauss, 2008). However, this was not wholly possible due to the time constraints between some interviews.

Quality Assurance Methods

Elliott, Fisher and Rennie’s (1999) guidelines were considered throughout to assure quality control (e.g. owning one’s perspective, grounding in examples). To ensure reflexivity, a reflective diary (Lincoln & Guba, 1985) was also kept (appendix 8) and discussions were held with supervisors throughout the research process. Respondent validation was addressed (Henwood & Pidgeon, 2003) via communication with two service-users and two psychiatrists who judged the validity and accuracy of the main categories. Participants generally agreed that the findings were valid and representative of their experiences.

Results

Overview of the Model

The model presented below (Figure 1) illustrates the compulsory admission (CA) experience (‘A disturbing journey: To and from admission’) from the perspective of psychiatrists and service-users with psychosis.

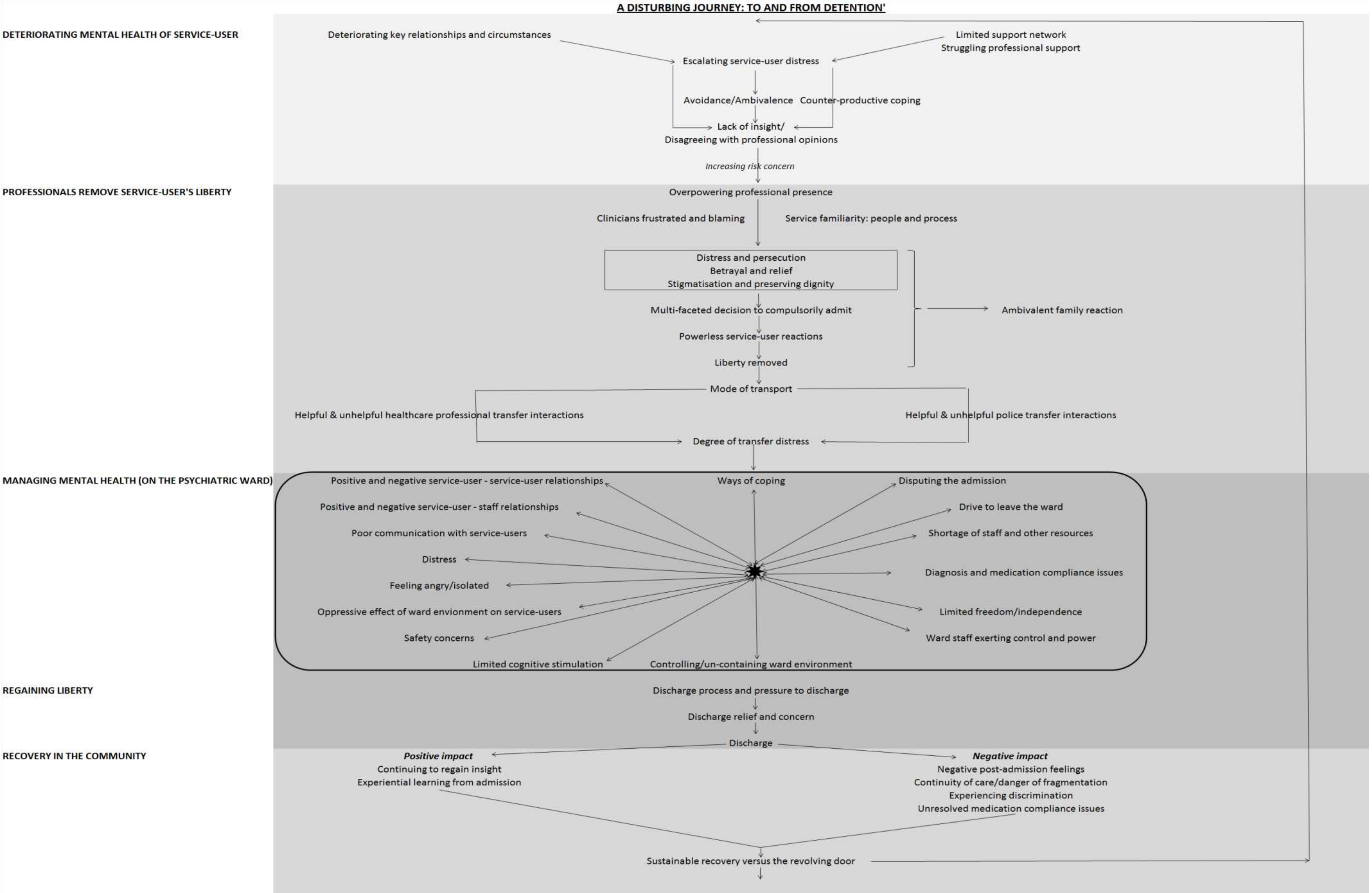

Figure 1. Compulsory admission experiences for adults with psychosis. See main text for further explanation.

Five higher-order categories are presented as the main phases of the CA experience; ‘deteriorating mental health of service user’, ‘professionals remove service-user’s liberty’, ‘managing mental health (on the psychiatric ward)’, ‘regaining liberty’, and ‘recovery in the community’. Within these higher-order categories were 47 categories (8 in ‘deteriorating mental health of service-user’, 14 in ‘professionals remove service-user’s liberty’, 16 in ‘managing mental health (on the psychiatric ward)’, 2 in ‘regaining liberty’, and 7 in ‘recovery in the community’). Within these categories, there were a total of 216 sub-categories. Of the 216 sub-categories, 71 (32%) were exclusively psychiatrist-derived (C) codes, 67 (31%) were exclusively service-user-derived (SU) codes, and 81 (37%) were both psychiatrist and service-user-derived codes.

Further details of each higher-order category (and its associated categories) will be provided in the ensuing text, in the order displayed in the model. Quotes from the interviews are given to illustrate aspects of the model. However, given the word limitations it was not possible to present quotes supporting all the sub-categories (see appendix 13 for additional quotes).

Higher-Order Category A: Deteriorating Mental Health of Service-User

This encompasses ‘deteriorating mental health of service-user’ in the lead-up to their CA. Table 3 shows the categories contained in this higher-order category.

Table 3. Categories (including number of codes per category) relating to 'Deteriorating mental health of service-user'.

HIGHER-ORDER CATEGORY	**CATEGORIES**	**NO. CODES PER CATEGORY**
A.DETERIORATING MENTAL HEALTH OF SERVICE-USER	1. Deteriorating key relationships and circumstances	68
	2. Limited support network	15
	3. Insufficient professional support	52
	4. Escalating service-user distress	44
	5. Avoidance and ambivalence	31
	6. Counter-productive coping	46
	7. Lack of insight/disagreeing with professional opinions	38
	8. Increasing risk concerns	54

A1. Deteriorating key relationships and circumstances

Psychiatrists and service-users reported key relationships breaking down which appeared to increase distress (e.g. *"I was going through a divorce with my wife..."* (SU8)). Psychiatrists and service-users acknowledged service-user's distrust of mental health services. C3 explained that the service-user was "distrusting psychiatric services that they are ruining his life and interfering in his life". Feeling angry (e.g. with family and/or professionals) was another concept which C3 described as *"verbal aggression to the family"*. Other factors cited by psychiatrists included the family's feeling anxious, worried, confused, as well as the family colluding with clinicians.

Psychiatrists and service-users reported service-users feeling distressed by employment, financial and other life stressors. Service-users referred to physical environment stressors whilst psychiatrists cited the mental health of service-users' spouses or family members as contributing to escalating distress.

A2. Limited support network

Psychiatrists reported that some service-users received support from family members ("the parents were there supporting him" (C1)), whilst one service-user reported receiving support from neighbours. Both psychiatrists and service-users reported that some service-users had very limited support networks, to the point of being socially isolated (e.g. *"He was quite isolated. He didn't have a big social network outside his family."* (C1)). Despite varying levels of support, it appeared insufficient to contain the service-user.

A3. Struggling professional support

In the lead-up to admission both psychiatrists and service-users reported the need for transparency in often pre-established psychiatrist-service-user relationships (e.g. "I had actually detained him before... so he sort of knew me." (C9)). Psychiatrists empathised with service-users (e.g. ...we all feel sorry about him...*"* (C3)). Nurses tried to build rapport and psychiatrists attempted to intervene early but professionals struggled to engage and support service-users in the community. They cited attempts to coerce them towards voluntary admission; C9 explained *"it will always* be quite a coercive process because when we get to that stage...*we'v*e run out of all other *options."*

A4. Escalating service-user distress

Both service-users and psychiatrists reported service-users becoming tired, lacking sleep, and being distressed by psychotic symptoms:

> *"she felt that*...things were going wrong with her body...*that's quite distressing."* (C7)

Feelings often associated with psychotic symptoms (e.g. feeling out of control of thoughts), and confused/chaotic thinking were reported by service-users and psychiatrists. Paranoia and vulnerability were also reported to increase. SU4 explained *"I was totally out of control…I just* went...*in another world. I was totally out of it."*

A5. Avoidance and ambivalence

Avoidance of or ambivalence about engagement with mental health services was commonly reported (e.g. "He was very reluctant to engage with us" (C1)). Several psychiatrists reported that service-users felt ambivalent about engaging with services (e.g. H*e'd presented earlier and he walked out"* (C9)). Denial of mental health issues (avoidance) was also something service-users experienced in the lead-up to admission.

A6. Counter-productive coping

Illicit drug/alcohol misuse was commonly cited by psychiatrists and service-users as counter-productive ways service-users coped with increasing distress. SU8 said "I had a bad drug addiction...*"* Often, service-users stopped taking their anti-psychotic medication. This was the most commonly cited concept in the whole CA experience with a total of 34 codes (e.g. *"she wasn't concordant with her medication. So there was* a clear precipitant to...*her manic state"* (C4). *"I'd stopped t*aking my medication, so *that's ... when I've been put back i*nto hospital before compulsorily...*"* (SU8)).

A7. Lack of insight/Disagreeing with professional opinion

A very commonly cited factor in the lead-up to admission was service-user insight into their mental health difficulties. C4 said *"her insight was very poor"*; I *don't think [name] ever had that much of insight...I think insight was the key*". Whilst some service-users reportedly had no insight into their mental health, others demonstrated a degree of insight. However, professional/service-user differences of opinion were reported regarding the level of insight (e.g. "*She didn't see things from our* point of view... *she didn't agree that actually she wasn't feeling well.*" C4)).

A8. Increasing risk concerns

Psychiatrists cited drug misuse, child protection issues, adult vulnerability, and forensic history as factors in assessing risk. Both psychiatrists and service-users talked about generic questioning (when assessing risk). The most common concept in assessing risk was considering the risk of harm to self (e.g. "I stoppe*d eating…for about three months..."* (SU2)). Risk of harm to others was also considered, but with lesser prevalence. "I went berserk and went out looking for fights...*"* (SU2). With increasing risk concerns and professional anxiety, psychiatrists strived to act in the "best interest" of service-users and considered a "place of safety", thereby reducing the risk and lowering anxiety. *"It was very clear...*that if she was going to remain in the community *she was going to put her life, and possible others, in danger."* (C2)

Higher-Order Category B: Professionals Remove Service-User's Liberty

This higher-order category occurred after the lead-up to admission when a MHA assessment took place, often in the community and the decision was made to remove the service-users liberty via compulsory admission. This then involved transferring them to a psychiatric ward. Table 4 shows the categories contained in this higher-order category.

Table 4. Categories (including number of codes per category) relating to ‘Professionals remove service-user’s liberty’.

HIGHER-ORDER CATEGORY	CATEGORIES	NO. CODES PER CATEGORY
B. PROFESSIONALS REMOVE SERVICE-USER’S LIBERTY	1. Overpowering professional presence	33
	2. Clinician frustrated and blaming	2
	3. Service familiarity: people and process	13
	4. Distress and persecution	10
	5. Betrayal and relief	4
	6. Stigmatisation and preserving dignity	10
	7. Multi-faceted decision to compulsorily admit	30
	8. Powerless service-user reaction	17
	9. Liberty removal	18
	10. Ambivalent family reaction	5
	11. Helpful and unhelpful healthcare professional transfer interactions	4
	12. Helpful and unhelpful police transfer interactions	13
	13. Degree of transfer distress	8
	14. Transfer mode	7

B1. Overpowering professional presence

> “Sometimes the problem with the detention process is the sheer number of people...I think they can be really intimidating for some people.” (C1)

The presence of police for enforcement of the CA was common (e.g. “I was intimidated by a dozen of them” (SU3). Psychiatrists also cited the importance of the service-user’s care coordinator being present (e.g. “*it’s very helpful to have the care co-ordinator at...assessment because they have an understanding of the person and their needs.”* (C5)).

B2. Clinician frustrated and blaming

At the point of detention, C7 felt frustrated at not intervening sooner and said to the other involved professionals *"*You are doing this quite late...why did it have to go that far?*"* C1 blamed relatives for allowing a service-user's mental health to deteriorate. "I think probably his parents played a big role in it... they had been adamant that he could be treated at home...*"*

B3. Service familiarity: people and process

This category relates to degrees of familiarity with the CA experience gained through previous admission experience. The two aspects included familiarity with people involved in the process and familiarity with the process itself.

> *"I*t can be quite frightening...to be taken by a stranger...to a strange *hospital, to a strange inpatient, nursing staff."* (C9) *"... she's had* previous lengthy admissions, she was already thinking...about how she would cope with this admission...*"* (C5)

B4. Distress and persecution

At the point of detention, some service-users reported feeling as though they were being treated like criminals, and one reported feeling traumatised.

> *"...to be taken away in handcuffs by police... they're casting you as* though you were some sort of criminal and *you're not really a* criminal...*You're not in your right state of mind."* (SU6)

Service-users and psychiatrists reported service-users felt punished and frightened. C9 admitted *"I do think the whole situation is very frightening."*

B5. Betrayal and relief

SU1 reported a sense of disbelief, saying *"I felt disbelief. It was like I can't believe you've gone this far"*. One psychiatrist thought the service-user felt betrayed by their family and the mental health system.

B6. Stigmatisation and preserving dignity

> *"It might be stigmatising if you have been detained under the mental health act so many times."* (C4)

Psychiatrists highlighted how being detained can publicise the service-user's mental health difficulties. Some psychiatrists highlighted the need for discretion when detaining service-users in the community and the need to try and preserve their dignity.

B7. Multi-faceted decision to compulsorily admit

The CA decision was reported by psychiatrists to be taken in the service-user's "best interests", considering risk issues. *"It's actually not just me on my own making such decisions...It's usually a whole team approach."* (C2) Psychiatrists felt the assessment was sometimes disjointed due to problems coordinating all involved professionals. Some highlighted the legal nature of the MHA and how the CA was more often against the will of the service-user. Both psychiatrists and service-users commented on the power professionals had over service-users, coupled with an inherent overarching subjectivity in decision-making. *"We felt as well that she wasn't able even to look after herself in the community..."* (C2)

B8. Powerless service-user reactions

Going to hospital under the MHA was almost invariably against the will of the service-user. However, once the CA decision was made, psychiatrists reported an often passive acceptance, or learned helplessness response to the decision "He kind of just *accepted that, I've been detained now*." (C1).

B9. Liberty removal

Psychiatrists and service-users reported that there was a lack of choice (e.g. *“You don’t have a choice”* (SU1)) and a loss of rights when being compulsorily admitted.

> *“I think taking away somebody’s liberty is always going to be a difficult* thing to do. And I know people feel very strongly about *it.”* (C9)

B10. Ambivalent family reaction

Ambivalence in the service-user’s family about the CA was reported by some psychiatrists. Family members felt a sense of relief (e.g. *“it’s a...*relief that their *relative is detained”* (C9)). However, coupled with this was a sense of sadness and distress (e.g. “the family was quite sad” (C3)).

B11. Helpful and unhelpful healthcare professional transfer interactions

Helpful healthcare professional interactions during transfer to hospital were highlighted. *“... if* the care coordinator can accompany them to hospital and settle *them in it can be very helpful...” (C5)*

SU1 cited the importance of their doctor being present during the transfer and their absence being unhelpful. *“The doctor doesn’t come with you...that’s why it’s unsettling and it’s...unsupportive”*

B12. Helpful and unhelpful police transfer interactions

Some participants reported helpful interactions with police when being detained. SU8 said *“the police weren’t that bad...*there was a young fellow...who was talking to me, and he actually seemed all right... *a decent policeman.”*

Some service-users reported unhelpful police transfer interactions such as being handcuffed. *“I know if I’m unwell...* I would rather have been taken by ambulance rather than by th*e police handcuffing me."* (SU6) In some cases psychiatrists and service-users highlighted the use of force by police.

"I've put my hands behind my back to let the police cuff me and they've... thrown me to the ground..." (SU2)

B13. Degree of transfer distress

Service-users made reference to the transfer being distressing. Both psychiatrists and service-users commented that long transfer distances increased service-user distress. *"...I think the longer the journey is that you have to make, the* more tr*aumatising it is."* (C7)

B14. Transfer mode

"He went with the police...They took him to the ward." (C8)

In addition to transfer mode, psychiatrists and a service-user made reference to the importance of having a familiar person accompanying the service-user.

Higher-Order Category C: Managing Mental Health (on the psychiatric ward)

This higher-order category relates to managing the service-user's mental health from both the service-users and psychiatrist perspectives during the service-user's admission to a psychiatric ward. Table 5 shows the categories contained in each of the higher-order category.

Table 5. Categories (including number of codes per category) relating to ‘Managing mental health (on the psychiatric ward)’.

HIGHER-ORDER CATEGORY	**CATEGORIES**	**NO. CODES PER CATEGORY**
C. MANAGING MENTAL HEALTH (on the psychiatric ward)	1. Positive and negative service-user –service-user relationships	17
	2. Positive and negative staff - service-user relationships	22
	3. Poor communication with service-user	3
	4. Ways of coping	24
	5. Drive to leave the ward	12
	6. Shortage of staff and other resources	2
	7. Distress	21
	8. Feeling angry/isolated	39
	9. Oppressive effect of ward environment on service-users	14
	10. Safety concerns	14
	11. Limited cognitive stimulation	39
	12. Diagnosis and medication compliance	46
	13. Limited freedom/independence	22
	14. Ward staff exerting control and power	13
	15. Controlling and un-containing ward environment	24

C1. Positive and negative service-user - service-user relationships

Some service-users said they made friends whilst admitted whereas others found it difficult to interact with other service-users.

“People were just like walking listlessly, just lifeless.” (SU1)

Both psychiatrists and service-users described the adverse impact of being around other individuals with mental health issues.

> *"I was getting really freaked out by everyone there. I didn't want to talk to anyone."* (SU1)

C2. Positive & negative staff-service-user relationships

Service-users reported finding some ward staff helpful (e.g. caring, empathic) and building good rapport with them whilst admitted. *"On the whole 95, a higher percentage than that, are helpful, they do their job perfectly well."* (SU3) Service-users reported some poor rapport with the ward doctors and psychiatrists. *"... It's all very well the doctors coming in once a week to see you but there's no real bond there."* (SU1). A lack of staff motivation and professionalism was also noted (e.g. "th*ere's just not a professionalism"* (SU1)).

C3. Poor communication with service-user

Service-users reported a lack of information about what was happening upon arrival at the ward, not feeling listened to, and a lack of contact with the ward psychiatrist. *"*...Occasionally you will [see a doctor]*, but it's* always like a breeze through...*"* (SU1)

C4. Ways of coping

Several service-users used religion to cope with the admission. However, psychiatrists and service-users also cited smoking and use of illicit drugs (e.g. cannabis) as coping strategies employed by service-users whilst admitted.

> *"Some people con*tinue to take drugs on the ward...*it's quite easy to get drugs in there..."* (C9)

C5. Disputing the admission

Psychiatrists referred to "evidence gathering" for mental health review tribunals (e.g. "We will go to the tribunal, we will gather evidence*"* (C3)) and service-users' rights to appeal against the admission at tribunal. Both psychiatrists and service-users reported service-user knowledge of the tribunal process and some service-users demonstrated familiarity with it (e.g. “I was sectioned...I should have been on for 28 days. I appealed against the section” (SU6)).

C6. Drive to leave the ward

Several service-users recounted absconding from the ward whilst admitted and home leave was referred to by both service-users and psychiatrists.

> *“I kept trying to escape and leave the place. I thought I’m never going to get out of here.”* (SU8)

C7. Shortage of staff and other resources

SU6 mentioned limited ward facilities (e.g. “the facilities were pretty limited because they were very short staffed...”). A psychiatrist highlighted the added pressure on staff and services which resulted from inadequate service resources.

C8. Distress

Service-users reported a lack of awareness about what was going on in the initial stages of their admission with feelings of paranoia, confusion/disorientation, and anxiety. *“I was upset… you always feel uprooted. I felt horror.”* (SU1). Some felt frightened or unsafe, and both service-users and psychiatrists reported service-users feeling upset and distressed. Some reiterated that their admission was against their will (e.g. *I’d express my views quite clearly that I didn’t want to be there.*” (SU8)).

C9. Feeling angry/isolated

Service-users felt angry at being detained (e.g. *“*... some patients become physically aggressive*”* (C4)). Such feelings were coupled with anxiety, submissiveness, feeling a lack of respect and empathy. However, psychiatrists and service-users most commonly cited feelings of frustration and anger (e.g. “I was absolut*ely livid"* (SU2)). They also reported a sense of feeling isolated or unsupported (e.g. I spent too much time in isolation" (SU3)).

C10. Oppressive effect of ward environment on service-users

Service-users felt the physical environment impacted upon their mental wellbeing, and several comments were made about how the services lacked understanding of this. *"*I didn't like it at [place], that was disorientating, a big space.*"* (SU1)

C11. Safety concerns

Numerous service-users reported being physically attacked by other service-users on the ward. *"He comes into my room…he just grabs my throat...left with two black eyes, busted nose..."* (SU7). SU7 admitted using aggression as a defence against feeling unsafe. A service-user and psychiatrist also highlighted the risk and fear of being physically attacked.

C12. Limited cognitive stimulation

Service-users and psychiatrists reported that activities (e.g. via Occupational Therapy) took place on the ward but some felt there were not enough (e.g. "it got a bit tedious... *there's nothing to do in there*." (SU8)). Some cited food and meals, and having adequate sleep as ways of occupying time (e.g. "eating is just something to do." (SU7)). A lack of psychotherapy was also highlighted (e.g. "*you're never offered any … talking therapy.*" (SU1)).

C13. Diagnosis and medication-compliance

> *"I just thought...there was no way I was ever going to get out if I didn't take medication."* (SU1)

Side-effects of medication (e.g. "waking nightmares" (SU2)) were cited by service-users and psychiatrists as problematic. A medication-focused approach was commonly described and service-users reported being medicated against their will, “binning” medication, and feeling powerless (to medication).

C14. Limited freedom/independence

Numerous service-users and psychiatrists commented on the lack of outside space on wards and the staff power to restrict liberty. *“...for the first two weeks I couldn’t go outside...I couldn’t even walk outside.”* (SU1).

C15. Ward staff exerting control and power

Service-users recounted how ward staff exerted power and control using physical force and restraint (e.g. “They physically dragged me back in” (SU4)). SU6 described a lack of staff flexibility (e.g. “*they didn’t make allowances and cancelled my* weekend leave**”)**. Numerous service-users highlighted the subjective perceptions of staff and their power to influence decision-making.

> *“One person… is judging another person to be in a certain state.”* (SU1)

C16. Controlling and un-containing ward environment

Service-users and psychiatrists described institutionalisation (e.g. “Just follow the regime” (SU4)), and service-users feeling scrutinised, monitored and assessed. Both service-users and psychiatrists commented that the ward environment was not conducive to improving mental health.

> *“This is a place where you’re* supposed to go to become better...in reality, *it’s a place where you’re forced to* take medication and you can go...*”* (SU1)

Higher-Order Category D: Regaining liberty

This higher-order category relates to the process of discharge from the psychiatric ward to the community. Table 6 shows the categories contained within it.

Table 6. Categories (including number of codes per category) relating to 'regaining liberty'.

HIGHER-ORDER CATEGORY	**CATEGORIES**	**NO. CODES PER CATEGORY**
D. REGAINING LIBERTY	1. Discharge process and pressure to discharge	26
	2. Discharge relief and concern	4

D1. Discharge process and pressure to discharge

Discharge planning was the most significant sub-category in this category and involved planning and preparation coupled with pressure to discharge. *"When she was discharged it was done in a planned way..."* (C5)

Several psychiatrists also commented on the pressure ward staff were under to discharge.

D2. Discharge relief and concern

Two service-users and a psychiatrist referred to the relief associated with being discharged. *"I just felt thank god I'm out of there."* (SU1). Another service-user commented on how he felt distrusted by clinicians upon discharge.

Higher-Order Category E: Recovery in the community

This higher-order category refers to experiences when service-users returned to the community. Table 7 shows the categories contained in this higher-order category.

Table 7. Categories (including number of codes per category) relating to 'recovery in the community'.

HIGHER-ORDER CATEGORY	CATEGORIES	NO. CODES PER CATEGORY
E. RECOVERY IN THE COMMUNITY	1. Continuing to regain insight	6
	2. Experiential learning from admission	11
	3. Negative post-admission feelings	19
	4. Continuity of care/danger of fragmentation	32
	5. Experiencing discrimination	11
	6. Unresolved medication-compliance issues	12
	7. Sustainable recovery versus the revolving door	35

E1. Continuing to regain insight

Post-discharge, one service-user and several psychiatrists reported insight continued to improve.

"I think she now recognises that she was extremely unwell because she feels so much better." (C7)

E2. Experiential learning from admission

According to service-users and psychiatrists the CA experience left some service-users feeling fearful of future admission. Others reportedly felt more submissive after discharge whilst some learnt from the experience.

"I do actually need my medication...I've learnt that now" (SU8)

E3. Negative post-admission feelings

Service-user feelings of shame at being compulsorily admitted were reported by psychiatrists and service-users (e.g. "...to be mad is very shameful." (C9)), as was anger towards the family. Some psychiatrists said service-users felt guilt towards their family too and that some service-users experienced low-mood or depression post-discharge.

Two service-users described feeling set-back. *"Nothing has changed, back to where I was, back to who I am now."* (SU3)

E4. Continuity of care/danger of fragmentation

Maintaining support was reported to be important. Both service-users and psychiatrists referred to management in the community (e.g. "he should be managed in the community, out of hospital." (C3)). Psychiatrists highlighted the need to maintain rapport and the form this could take (e.g. individual versus family-focused engagement). However, despite recognising the importance of maintaining support, fragmented and inadequate aftercare was reported with many service-users and psychiatrists commenting on the lack of care continuity throughout the process and the detrimental impact this can have.

E5. Experiencing discrimination

Service-users and psychiatrists reported diagnosis-related stigma.

> *"Being branded as a schizophrenic is very* long-term affecting on your *life…stigmatised, that's it… it affects the way society views you in* general*..."* (SU2)

A service-user and a psychiatrist also made reference to mental health issues transcending through families, and several service-users commented on associated obstacles to having children.

E6. Unresolved medication-compliance issues

Post-discharge issues regarding medication persisted with medication-compliance issues and the undesirable side-effects of medication being cited by psychiatrists and service-users. *"...when I came out of hospital I wouldn't take my medication."* (SU8).

Two psychiatrists mentioned service-users becoming medication-free for a period, before subsequently relapsing.

E7. Promoting recovery and the revolving door

Service-users reportedly risked becoming ‘trapped’ in a long-term cycle of repeat admissions. *“...they* can remain under the mental health services for years and years and sometimes they w*on’t be doing anything at all.”* (C2). C8 stated “It can be like a revolving door.” (C8). Psychiatrists also referred to the importance of service-users reflecting when well and service-user empowerment via psycho-education. Some psychiatrists referred to the use of ‘advanced directives’ whereby discussions and agreements could be sought with service-users regarding their treatment preferences whilst in remission. The idea of promoting recovery was also highlighted.

> *“I’d hope he’d perceived it as helpful and part of his recovery. But some* people find it very distressing*...so I don’t know.”* (C1)

Discussion

This study aimed to explore the experience and impact of compulsory admissions (CAs) on the psychological functioning of adults with psychosis from the perspective of service-users with psychosis and psychiatrists. The findings present the experiences of participants on this journey.

In accordance with Creswell, Kuipers, and Power (1992) findings suggested that service-users had limited support networks and professionals struggled to support them in the community prior to admission. Coupled with deteriorating relationships and circumstances, service-users experienced escalating distress. Service-users attempted to cope but often used counter-productive strategies, which supports the findings of

Falloon and Talbot (1981) who reported that such coping strategies were often sub-optimal. Some of these counter-productive strategies may even have exacerbated psychotic symptoms (Arsenault, Canon, Whitten, & Murray, 2004). Diminishing ‘insight’ or appraisal of service-user’s mental health was reported in accordance with Garety et al.’s (2001) cognitive model and perhaps as a result some service-users disagreed with professional opinions.

With increasing emotional reactivity, a lack of effective coping strategies and commonly non-adherence to anti-psychotic medication, service-users were left vulnerable to the onset or persistence of psychotic symptoms. Indeed, with similar findings to Garety et al.’s (2001) model, Myin-Germeys, Krabbendam, Delespaul, and Van Os (2003) found that a history of life events modified the emotional reaction to daily life stress.

Such factors signified to psychiatrists that the service-user’s mental health was deteriorating and that associated risks were increasing. In some cases attempts were made by professionals to coerce service-users into voluntarily hospital admission, a theme also identified by Gilburt, Rose, and Slade (2008). However, eventually a MHA assessment was made accompanied by the decision to compulsorily admit the service-user. This often involved an overwhelming professional presence and was frequently against the service-user’s will. Service-users were taken to the psychiatric ward using various modes of transport and with varying levels of helpfulness in terms of interactions with police and professionals. For example, the involvement of familiar persons and supportive communications during the transfer was deemed helpful whilst a lack of communication and the use of force were experienced as unhelpful.

The liberty-removal often caused further affective disturbance (Garety et al., 2001) which may have reinforced service-user’s maladaptive schemas, reasoning and attributional biases. The results also support findings by Morrison et al. (1999) who suggested that psychiatric admissions are likely to be associated with pervasive distress. Although the prospect of hospital admission provided relief for some, many service-users felt persecuted, betrayed (e.g. by family members), powerless and stigmatised. Participants indicated that liberty removal also left family members feeling ambivalent about the admission with feelings of relief coupled with sadness.

Once admitted, some service-users felt angry at being detained and isolated in what some described as an oppressive environment on the ward. Some disputed the admission altogether and were driven by the prospect of leaving the ward. Many service-users were surrounded by other distressed individuals. Coupled with limited freedom, safety concerns (Munro, Osborne, Dearden, Pascoe, Gauthier, & Price, 2011), limited cognitive stimulation and a focus on medication-compliance, service-users experienced further distress and anger. Such affective disturbance led some individuals to employ the same counter-productive coping strategies (e.g. illicit drug misuse) that they had used in the lead-up to admission. Some service-users employed adaptive coping strategies (e.g. religion) and developed positive relationships with staff and other service-users. However, some had negative relationships too and no psychological therapy was offered whilst admitted so cognitive issues, dysfunctional schemas as well as attribution and reasoning biases such as those outlined by Garety et al. (2001) could not be addressed through talking therapy. With often limited choice most service-users eventually complied with the medication-focused treatments and their positive symptoms gradually reduced. Their insight or ‘illness perception’ gradually improved and service-user’s distress reduced. Effectively a reverse flow of Garety et al.’s (2001) model, such ameliorations are similar to the findings reported by Ventura, Neuchtlein, Hardesty, and Gitlin (1992).

With ward-based pressure to discharge, regaining liberty through discharge was met with some service-user relief and occasionally with clinician concern. Back in the community, service-users continued to regain ‘insight’ and some reported learning from the experience. However, fragmented and sometimes inadequate care provision meant that negative post-discharge feelings and continuing issues relating to medication (e.g. compliance, side-effects) often remained unresolved. With exposure to further environmental stressors (e.g. discrimination), most service-users appeared to remain vulnerable to positive symptom ’triggers’ (Garety et al., 2001) which could lead to further admissions.

Limitations and Areas for Future Research

Attempts were made to assure quality and limit bias (e.g. using a reflective diary, respondent validity). However, bias may have been exerted in recruitment via care co-ordinators who may have recruited participants who had more positive views about the service. Of course the contrary may also have occurred with care co-ordinators seeking to recruit service-users who had the worst compulsory admission experiences so that such issues could be captured and addressed. With previous experience of working on acute inpatient psychiatric wards, the researcher may also have exerted bias since he conducted the interviews and analysed the data. As a trainee clinical psychologist, the researcher had preconceived ideas and understanding of psychosis, psychological interventions and other personal experiences which may have exerted bias in the data and the analysis of it despite attempts to limit methodological bias. This may have impacted upon the areas explored in the interviews, the data analysis and even its interpretation. For example, in retrospect it became apparent in service-user interview two (appendix 9) that one memo (‘Being treated like a criminal’) was a subjective interpretation of events relating to a service-user being compulsorily detained by police. Such biases may therefore have impacted upon the model and the extent of emphasis placed upon the service-user experience compared to the impact of the clinicians and service-providers on the service-user experience. For example, there was perhaps a lack of exploration of the impact on clinical decision-making resulting from attempts to manage sometimes large caseloads of complex service-users with varying degrees of risk, This was apparent throughout the model (e.g. in 'deteriorating mental health of service-user' and 'recovery in the community').

Another limitation was a lack of triangulation. For example, as well as the obvious omission of Approved Mental Health Professional participants in this study, descriptions of police transfer interactions were only obtained from service-users since psychiatrists were not present during any of the service-user's transfers. It would therefore have been helpful to have interviewed police involved in compulsory admissions (CAs) too. Indeed, such biases and lack of triangulation may also have impacted upon the validity of the results.

Another limitation concerned the absence of a demographics questionnaire which made 'situating the sample' (Elliott, Fisher & Rennie, 1999) more difficult. It would have been useful to collect more detailed demographic data (e.g. age).

Due to the varied levels of involvement through the CA process, psychiatrists' experiences and therefore experiential perspectives were limited at times. Finally, despite providing a detailed account of the experiences and views of those individuals who participated in the interviews the study had a small sample which limits the generalisability. Given that recruitment took place in a single NHS Trust, it would be also useful to expand future studies to other geographical areas, and to employ a larger sample size.

Clinical and Theoretical Implications

The seemingly cyclical nature of admission and re-admission suggests that for some service-users the process of compulsory admission (CA) and medication-focused treatment does little more than maintain the service-user for periods of time in the community. In accordance with Garety et al.'s (2001) model service-users may tend increasingly towards idiosyncratic negative appraisals of stressful events, thereby creating and reinforcing potentially dysfunctional schemas and core beliefs (e.g. 'the world is a dangerous place'). Indeed the model (Figure 1) highlights aspects of Garety et al.'s (2001) cognitive model of positive symptoms within the context of CAs. However, it seems somewhat of a paradox that the system designed to support service-users with psychosis may contribute to adversely affecting their mental health and inadequately addressing underlying psychological issues. Consequently it is unsurprising that the 'revolving door' (DoH, 2007) phenomenon exists and persists.

CAs are resource intensive and financially burdensome (Munro et al., 2011). Services need to focus more of their resources on preventing relapse and creating sustainable recovery by placing greater emphasis on providing access to treatments and community services with genuine efficacy (Shean, 2009). This is advocated in the new mental health strategy (Cate, 2007)). Transfers to psychiatric wards may help to reduce service-user distress if they are conducted more discretely with the presence of familiar persons (e.g. care co-ordinator), supportive engagement and minimising the use of force. Within the psychiatric wards, a lack of activities and an environment perceived as non-conducive to improving mental health (The Sainsburys Centre, 2002) suggests improvements need to be made. Addressing the reported ward-based violence and ensuring a calmer ambience may reduce environment-derived distress (Beezhold, Williams, Taylor, Harris, & Kandasamy, 2010) as well as the level of expressed emotion may be linked with relapsein psychosis (e.g. Butzlaff & Hooley, 1998). Equally, staff training may be useful in helping to promote more positive and helpful relationships during admissions.

Given that participants reported a lack of ward-based access to psychological interventions, services also need to ensure that service-users have access to appropriate evidence-based therapies (e.g. Cognitive-Behavioural Therapy; Morrison, French, Walford, Lewis, Kilcommons, Green, Parker et al., 2004). Similarly, group psycho-educational programmes (Budd & Hughes, 1997) could be offered both on wards and in the community to help empower service-users with knowledge about their diagnosis, and teach them helpful coping strategies. This may also help to offset less helpful counter-productive coping strategies (e.g. illicit drug-taking).

There may however also be an issue regarding implementation of such therapeutic interventions. For example, a recent qualitative analysis involving community mental health team staff (Prytys, Garety, Jolley, Onwumere, & Craig, 2011) reported issues regarding implementation. They found implementation of National Institute of Clinical Excellence guidelines (NICE; 2009) for schizophrenia may be tempered by issues such as the need for specialist staff and severe workloads. Despite potential resource constraints, clinical psychologists need to cascade and deliver psychological knowledge if they are to maximise the potential positive impact they can have on the mental health of service-users. Hence, a key challenge for clinical psychologists is how to do this within the specified context. For example, in the context of adults with psychosis being compulsorily admitted to inpatient wards, psychologists could providing more targeted training and consultation support to ward and community staff who have direct contact with this group of service-users. Rather than being offered to select groups of staff, such training should be offered to all staff who have contact with these service-users (e.g. nurses, health care assistants, police officers) since they may spend considerably more time with service-users than psychologists and therefore have the potential to contribute to positive change. Training could involve teaching staff how to work with and engage service-users more effectively, to minimise distress and reinforcement of unhelpful beliefs and cognitions, and promoting positive relationships that challenge negatively skewed perceptions (e.g. 'the world is a dangerous place'). Given previous research into expressed emotion and relapse in psychosis (e.g. Butzlaff & Hooley, 1998) it may also be useful for training to be offered regarding expressed emotion and how to reduce home and ward environmental stressors related to this.

Another issue based upon the experiences of the interviewed participants was that the current CA process appears fragmented in its care provision, with different psychiatrists and staff members responsible for service-user's care at different stages of the process. There needs to be greater continuity so that better staff – service-user relationships can be fostered and better clinical outcomes are attained (Adair, McDougall, Mitton, Joyce, Wild, Gordon et al., 2005).

Once service-users have improved insight and emotional stability, it may be useful to establish an 'advanced treatment directive' (Rethink, 2010). This could provide service-users with the opportunity to make choices about their preferred treatment and healthcare provision. It may also help to dispel the perceptions of coercion, persecution, lack of choice and disempowerment seemingly associated with admissions.

Finally, it is worth noting that all the service-level improvements, training and consultation and indeed issues that have been highlighted suggest clinical psychologists could play an increasing role and contribution to management level service provision in the NHS. This is particularly important if we are to maximise the efficacy with which we disseminate our knowledge and skills for the benefit, be it directly or indirectly, to improving the mental health of service-users.

Conclusion

The vulnerabilities evident in service-users with psychosis coupled with the lack of good coping strategies and poor support mean that they may be less able to cope with stressful life events, which in turn may lead to psychotic symptoms. This sometimes leaves mental health services with little choice but to compulsorily admit them to hospital. However, this process appears to be distressing and may cause further disturbed affect and potential exacerbation of positive symptoms as outlined by Garety et al.'s (2001) cognitive model. Returning to the community with often unresolved issues, some service-users may find themselves in a cycle of 'revolving door' admissions. Whilst more research is needed, the findings of this study suggest significant clinical and service provision improvements are needed to minimise repeat admissions, improve psychological functioning and promote genuinely sustainable recovery for service-users with psychosis.

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MAJOR RESEARCH PROJECT

SECTION C: Critical Appraisal

Exploring Compulsory Admission experiences of adults with Psychosis using Grounded Theory

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A thesis submitted in partial fulfilment of the requirements of Canterbury Christ Church University for the degree of Doctor of Clinical Psychology

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SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

Skills Learnt

What research skills have you learned and what research abilities have you developed from undertaking this project and what do you think you need to learn further?

One challenge was ascertaining precise research objectives and an appropriate methodology in light of the existing literature. This was time-consuming as it involved exploring various qualitative and quantitative methodologies. It also required me to consider quantitative measures, sample sizes, forms of analysis, interview questions and numerous other factors. However, this process augmented my research knowledge, particularly for the chosen methodology, grounded theory (GT; Glaser and Strauss, 1967) and the useful accompanying guidance offered by Elliott, Fischer and Rennie (1999).

A key consideration with GT is researcher bias. Having worked clinically with service-users with psychosis, I was aware of associated issues (e.g. stigma) and some of the issues they faced in the community. I have also worked on inpatient wards so I was aware of how traumatic and difficult compulsory admissions (CAs) could be. Whilst the use of a reflective diary helped me consider my biases relating to this research, I nevertheless felt that some of my experiences still resonated with what people described during interviewing. This sometimes made it a challenge to remain objective. However, Thomas and James (2006) suggested it is impossible to totally free oneself of pre-conceptions in the data collection and analysis of data in the way purported by Glaser and Strauss (1967). Despite this, taking a critical realist stance I acknowledged biases and my role in the analysis process. In future research I will try to be more aware of biases and make take further steps to limit their impact on the research.

Another aspect of GT was the ‘iterative process’ (Corbin & Strauss, 2008), moving back and forth between the emerging categories and the raw data. I learnt how to manage the raw data so that a model could emerge and reflect, in a meaningful way, the experiences described by participants.

Applying for and obtaining NHS ethics/research and development approval was a time-consuming experience. However, it proved a valuable learning experience, the familiarity with which will undoubtedly facilitate my future NHS-based research. Another significant learning experience concerned recruitment. Whilst I had wide potential participant pool and appropriate contingency plans, I was nevertheless frustrated at being reliant on care co-ordinators to identify service-user participants due to NHS ethics constraints. Emails were often ineffective and I learnt that often the best way to successfully recruit was via attendance at multi-disciplinary team meetings and via initial discussion with team managers.

Writing a concise report that adequately reflected the rich data obtained from the participants’ experiences was also a challenge. This is a particularly relevant skill for writing publications and I hope to continue honing this skill with increasing efficacy in the future.

Study Improvements

If you were able to do this project again, what would you do differently and why?

The study had a small sample which limits generalisability significantly. However, it did provide a detailed account of the experiences and views of those individuals who participated in the interviews. Nevertheless, if a larger sample with greater triangulation (e.g. including police) had been recruited, generalisability may have been more feasible. Indeed, with less restrictive time constraints, it would have been useful to collect data from multiple NHS Trusts in a variety of geographical areas.

As comprehensive demographic data was not obtained for each service-user (e.g. via a questionnaire), the extent to which 'situating the sample' (Elliott, Fisher & Rennie, 1999) could be achieved was limited. In repeating this study, its inclusion would be advisable. In fact, it may also be interesting to collect data regarding service-user's medication, living arrangements, and support networks (e.g. Perceived Support Network Inventory; Oritt, Paul, & Behrman, 1985) since these factors seemed important for those service-users who were interviewed and are highlighted by Creswell, Kuipers, and Power (1992).

Attempts were made to assure quality and limit bias (e.g. using a reflective diary), and ensure validity (e.g. via respondent validity). However, some bias may have been exerted in recruitment which could be minimised in future via overt discussion with care co-ordinators to raise their awareness of it and the importance of gaining a representative sample. It is also possible that since the researcher had previous clinical knowledge and experience more bias was exerted than was controlled for. Since the researcher collected and analysed the data, validity was affected. For example, there was some evidence that bias or subjective interpretation by the researcher may have been present (e.g. service-user interview two, appendix 9).

Whilst it was envisaged that in line with GT data synthesis, analysis would be performed concurrently with data collection using concepts generated from earlier data to guide subsequent data collection ('theoretical sampling'; Corbin & Strauss, 2008), this was not possible. This was because it was impossible to transcribe and analyse each interview before the next one was conducted, which in terms of time was sometimes only a few minutes because service-users had NHS transport and depot injections arranged for set times.

Whilst not always possible, it would be useful to try and arrange more significant gaps between interviews in future, so that more time was available for transcription and analysis. This would have allowed greater opportunity for theoretical sampling (Corbin & Strauss, 2008).

An issue relating to recruitment was the restrictive nature of one of the service-user inclusion criteria. Only those service-users who had been compulsorily admitted two or more times, with the most recent admission being 3-12 months prior to interview could be recruited. The 3-12 month criteria was imposed to give service-users time to regain their mental health, process the experience and yet still to be able to adequately recall the experience. However, it made recruitment difficult. I found it excluded many service-users who were still on psychiatric wards because they were often detained for less than three months and many of those in the community had been admitted over 12 months ago. I would therefore consider reducing the timeframe to 1-12 months. I would also consider using incentives (e.g. vouchers) to encourage participation.

Due to existing service structures, psychiatrists were often not involved in all stages of the CA process. Hence, their perspective of the experience may be limited. It may have been useful to have recruited psychiatrists involved in a broader range of stages of the process (e.g. ward-based psychiatrists, crisis team-based psychiatrists). This may have enabled a richer variety of clinical experiences to have been obtained but despite attempts to do this I was unsuccessful with the given participant pool.

Finally, improved triangulation (e.g. involving ward staff, police, family members) may also have generated a more comprehensive and representative experience of CAs. For example, descriptions of police transfer interactions were only obtained from service-users since psychiatrists were not present during any of the service-user’s transfers. It would therefore have been helpful to have interviewed police involved in CAs too. It may also have been interesting to interview service-users and professionals linked to their admission (e.g. psychiatrist who detained them, their social worker etc.) so that triangulation of the same experience might have been obtained.

Clinical Implications

Clinically, as a consequence of doing this study, would you do anything differently and why?

For service providers compulsory admissions (CAs) are both resource intensive and financially burdensome (Munro et al., 2011). Yet for the service-users interviewed, the process of CA and medication-focused treatment seems to manage the service-user’s symptoms (and associated risks) for periods of time in the community but appears to fail to address the underlying psychological issues. In accordance with Garety et al.’s (2001) model, service-users with psychosis who are exposed to stressful or traumatic events such as CA may tend increasingly towards idiosyncratic negative appraisals of such events, thereby creating and reinforcing potentially dysfunctional schemas and core beliefs (e.g. ‘the world is a dangerous place’). With underlying psychological issues remaining potentially unresolved, service-users may be discharged into the same environments they were admitted from, which provide continuing sources of stress. With limited support networks (Creswell, Kuipers, and Power, 1992), sub-optimal coping strategies (Falloon and Talbot, 1981) and sometimes little more than anti-psychotic medication to help them manage their mental health, it is perhaps unsurprising that such service-users relapse and become ‘revolving door’ Department of Health, 2007) service-users. Indeed, with questionable efficacy (e.g. Leucht, Arbter, Engel, Kissling, & Davis, 2009) and compliance issues, anti-psychotic medication alone does not currently look able to facilitate recovery from psychotic symptoms. As well as raising questions about the treatment efficacy for these service-users, it also then raises questions concerning the impact such ‘revolving door’ (Department of Health, 2007) service-users have on service-providers. Aside from the most obvious financial burden (Munro et al., 2011), it may be that ‘service users’ caught in the ‘revolving door’ instigate a somewhat routine response from services, in terms of inpatient treatment, often with the goal of regaining medication compliance, reducing psychotic symptoms and discharging back to the community rather than facilitating and promoting sustainable long-term recovery.

More research into this area is needed, but it does appear that if ‘revolving door’ service-users with psychosis are to reach the point of sustainable recovery, service providers and professionals need to place greater emphasis on providing access to treatments and community services with proven efficacy in both decreasing symptoms and assisting individuals to lead more productive, personally meaningful lives and attaining genuinely sustainable long-term recovery. This is purported by Shean (2009) who suggests that as well as drug-based interventions, psychosocial interventions are an important component of comprehensive treatment programs. Hence service-users may benefit from having access to specific evidence-based psychological interventions (e.g. Cognitive-Behavioural Therapy; Morrison, French, Walford, Lewis, Kilcommons, Green, Parker et al., 2004) which address underlying emotional and cognitive issues. This could include brief and/or longer-term interventions on an individual, group or family basis. For example, psycho-educational programmes (e.g. Budd & Hughes, 1997) may empower service-users with knowledge about their diagnosis and teach helpful coping strategies to offset their less helpful counter-productive strategies (e.g. illicit drug-taking). However, there is no shortage in potential psychological interventions or treatment modalities. Instead, recent qualitative research by Prytys, Garety, Jolley, Onwumere, and Craig (2011) found implementation of National Institute of Clinical Excellence guidelines (NICE; 2009) for schizophrenia may be tempered by issues such as the need for specialist staff and severe workloads. Remedying these issues and providing appropriate service funding may facilitate the more effectively implementation of treatment guidelines and the needs of service-users with psychosis being more adequately met. However, given the reported resource constraints it may also be useful to consider ways to more effectively cascade psychological knowledge, practice and support to ward and community staff who have direct contact with service-users with psychosis. For example, clinical psychologists are often well placed to train such staff about complex mental health difficulties such as psychosis. Such training may include how to work with and engage service-users more effectively, and how to minimise distress and promote positive relationships that challenge negatively skewed perceptions (e.g. ‘the world is a dangerous place’). Indeed, such training should be available to all staff who have contact with these service-users and could be extended to other non-healthcare professionals who have contact with them (e.g. police officers).

In addition to psychological interventions, staff training, genuine recovery has also been mentioned. However, for recovery to be promoted service-users need to be given the appropriate environment (i.e. one which reduces stress and hence the manifestation of further psychotic symptoms). Unfortunately, psychiatric inpatient wards contain distressed individuals (Care Quality Commission, 2010) which may detrimentally impact upon the wellbeing of an individual with psychosis. Clearly this needs to be urgently addressed since a calmer ambience may reduce environment-derived distress (Beezhold, Williams, Taylor, Harris, & Kandasamy, 2010). A number of service-users recounted incidents of ward-based violence and this needs to be addressed by service providers. There are many potential reasons for this, such as a lack of mental stimulation, outside space and independence, as well as coercion may contribute to feelings of frustration and disturbance (Gilburt, Rose, Slade, Lloyd-Evans, Johnson & Osborn, 2010). Hence, as well as more effective risk management on the ward, addressing these issues may also contribute to reducing ward violence and distress.

Based upon the experiences of the interviewed participants, the current CA process appeared fragmented, with different psychiatrists and staff members responsible for service-user's care at different stages of the process. Greater continuity and improved communication between community teams, non-healthcare service (e.g. police) and inpatient wards may prove helpful so that stronger staff – service-user relationships can be fostered, more effective interventions implemented, and better clinical outcomes attained (Adair, McDougall, Mitton, Joyce, Wild, Gordon et al., 2005).

Another consideration is that it may be helpful to employ 'advance directives' (Rethink, 2010) for service-users subject to the MHA 1983/2007. Created with service-users when in remission, these could give service-users the opportunity to make choices about their preferred treatment and care provision whilst subject to the MHA. They may also help to dispel perceptions of coercion, persecution, lack of choice and disempowerment seemingly associated with admissions.

Finally, many of the points raised in this section suggest that clinical psychologists have a potentially valuable role to play in shaping mental health services. There is evidence (Department of Health, 2007) that the issues raised by this study (e.g. the 'revolving door') have been observed before and have proved difficult to change. If clinical psychologists are to impact on this experience it is important to become involved in service system redesign which could help to create the contexts where more recovery based approaches and specific psychological interventions could be implemented (Cate, 2007). This means working directly with individuals but also working with the wider systems as well as offering more indirect support, perhaps via service consultation, staff training and supervision.

Future Research

If you were to undertake further research in this area what would that research project seek to answer and how would you go about doing it?

The rich data obtained from this study provides varied scope for further exploration. Firstly, it would be interesting to repeat this study with service-users presenting with Personality Disorders and compare the data sets for common themes since people with this diagnosis may also have multiple hospital admissions (Department of Health, 2003). I would also like to conduct a similar study exploring compulsory and voluntary admission experiences as a result of psychotic symptoms in other NHS services (e.g. child and adolescent, learning disabilities, older adults).

In light of the study’s findings, it may be interesting to investigate police involvement in the process, perhaps exploring Section 136 admission experiences in particular using semi-structured interviews with police and service-users. Similarly, it may be interesting to explore police perceptions of psychosis, particularly given that service-users reported feeling like criminals with the use of handcuffs and physical force. Interpretative Phenomenological Analysis (IPA; Smith, Flowers, & Larkin, 2009) or indeed GT may be suitable methodologies with which to do this.

A common theme throughout this and previous research was service-user distress. Comparing distress in voluntary and compulsorily admitted service-users may help to inform practice guidelines. This could be conducted quantitatively, by employing measures such as the impact of events scale (Horowitz, Wilner, & Alvarez, 1979). Alternatively, a single case design could be used with distress level data being obtained at various stages of the admission process.

Finally, stigma related to diagnosis and admission was reported in this study. Investigating the effects of CA on stigma and other involved persons' perceptions of psychosis (e.g. ward staff, family members) may help to increase awareness of this potential issue and explore ways to combat it. This could be done qualitatively using a methodology such as IPA or GT. Alternatively, it could be investigated quantitatively with a cohort study using measures such as the Internalised Stigma of Mental Illness Inventory (Boyd Ritsher, Otilingam, & Grajales, 2003).

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Invitation letter
& participant info sheet –
Version 2

Canterbury Christ Church University

Salomons Campus at Tunbridge Wells

Research Project: Exploring compulsory admission experiences of adults with psychosis

30th November 2010

Dear participant,

Hi, my name is Niki Loft and I am a third year clinical psychology doctorate trainee. As part fulfilment of my doctorate in clinical psychology I am required to carry out a piece of research for Salomons, Canterbury Christ Church University, Kent. I would be really grateful if you could take part in this study.

The main aim of this study is to generate a better understanding of compulsory admission experiences to hospital for people with mental health issues similar to those you may have experienced. I am interested in your views and experience of this.

This study will be supervised by Professor Tony Lavender, clinical psychologist and Pro-Vice Chancellor/Dean of the faculty of Social & Applied Sciences at Salomons training course and Nigel Bunker, Consultant clinical psychologist for Kent & Medway Partnership NHS Trust. The study has been considered and approved by the NHS South East Research Ethics Committee.

If you would like to participate in this study it will involve being interviewed so that I can understand more about your experience of being compulsorily admitted under the Mental Health Act (1983/2007). The interview will last approximately 45 minutes and will be audio taped. Any information recorded in this study will be kept strictly confidential. All identifiable information (such as names, addresses, dates, and other details) will be disguised from the information so no one other than myself can identify you. It will also be helpful if you can let me know if there are any other details you would like disguised so I can protect your anonymity.

Further information about the study and what you should expect can be found in the enclosed participant information sheet. It is entirely your decision whether or not you take part in this research and your decision to take part in this study will not affect your treatment in any way.

If you feel you would like to participate in this study, then please fill in the participant consent form attached. Alternatively, if you require further information before deciding or would like to talk to me about this study then please contact me on 01892 507666 or via email at nol2@canterbury.ac.uk. I will return your call/email as soon as possible.

Thank you so much for your time and I look forward to hearing from you.

Yours sincerely,

Mr Niki Loft
Trainee Clinical Psychologist

Participant information sheet

Will I find the interview distressing?
I will be asking you some to talk about some experiences that may have affected you psychologically. Whilst I hope this interview will not be distressing for you I cannot guarantee that it will not evoke certain feelings in you. Although I am not in a position to offer any significant help with distressing issues I can help you think about whom you might contact. I will also have an information sheet with me, listing services you may find helpful if required. If you do become upset I will be sensitive to your needs and will make sure you are comfortable about continuing the interview. You may choose to take a break during the interview and we can continue at your request. However, you may decide to end the interview if you feel upset and I will not include your data unless you say otherwise.

Can I end the interview early?
Yes. You can end the interview at any time, for any reason, either by telling me or by simply raising your hand.

Are there any circumstances where you would pass on information about me?
If during the interview you revealed information that suggested you or someone else might be at risk of serious harm then I would be obliged to pass this information on to an appropriate person.

What happens with the results of the research?
In Summer 2011 you will receive a lay summary of the main findings of the study, unless you say you do not want this. The study will then be submitted for examination in July 2011. At a later stage it is likely that these findings will to be published in a professional psychological journal.

Will my taking part be kept confidential?
Yes, personal information collected in this study will be kept confidential. All identifiable material (e.g. your name and address) will be disguised so no one other than myself can identify you. Your consent for the use of quotations in the research report will be sought prior to being included.

Who will have access to my personal data during the study?
Only the researcher will have access to your personally identifiable data. He will be the person interviewing you.

How will you ensure the confidentiality of personal data?
The personal information for each participant will be kept in an electronic code book by the researcher in accordance with the NHS Code of Confidentiality and Data Protection Act. Other persons involved in the study will ONLY have access to the anonymised data and any information provided in the study report and or subsequent publications will be anonymous.

How and where will you store my personal information?
Your personal information will be kept in an electronic code book by the researcher who will be interviewing you. This code book will be held securely on a computer for 10 years. All coded data will also be kept on a secure disk in the clinical psychology programme office at Canterbury Christ Church University in Tunbridge Wells for 10 years.

Why does the interview have to be audio recorded? Will this be confidential?
The type of analysis used in this study requires accurate recordings of what is said in the interviews. The best way of achieving this is by audio taping. The interviews will be typed up to written form within two weeks of interviewing you and you will be offered a copy of the transcript to check. Any information in the transcripts that could identify you will be changed to protect anonymity and stored on my password-protected computer.

Who will listen to the audio recorded interview?
Only the researcher who will be interviewing you will listen to the audio tapes.

How long will the audio recorded interviews be kept?
The audio recorded interviews will be deleted when the project is completed. This will normally occur within nine months of the interview.

Who do I contact for more information?
For any further information please contact me on 01892 507666. If I am unable to answer your call, please leave a message stating that you are calling about the research project.

I have decided to take part in the study. What do I need to do now?
Please contact me on 01892 507666 or let your care manager know so they can contact me. If I do not hear from you within a month I will assume you do not want to take part in this study.

I have decided not to take part in the study. What do I need to do now?
You do not need to do anything.

If applicable, will I be reimbursed for travel expenses I (and/or my carer) incur by attending the interview?
Yes. You (and where applicable your carer) will be reimbursed accordingly.

Invitation letter
& participant info sheet –
Version 2

Canterbury Christ Church University

Salomons Campus at Tunbridge Wells

Research Project: Exploring compulsory admission experiences of adults with psychosis

30th November 2010

Dear participant,

Hi, my name is Niki Loft and I am a third year clinical psychology doctorate trainee. As part fulfilment of my doctorate in clinical psychology I am required to carry out a piece of research for Salomons, Canterbury Christ Church University, Kent. I would be really grateful if you could take part in this study.

The main aim of this study is to generate a better understanding of compulsory admission experiences for people with psychosis. I am interested in your views and experience of this.

This study will be supervised by Professor Tony Lavender, clinical psychologist and Pro-Vice Chancellor/Dean of the faculty of Social & Applied Sciences at Salomons training course and Nigel Bunker, Consultant clinical psychologist for Kent & Medway Partnership NHS Trust. The study has been considered and approved by the NHS South East Research Ethics Committee.

If you would like to participate in this study it will involve being interviewed so that I can understand more about the psychological impact of being compulsorily detained under the Mental Health Act (1983/2007). The interview will last approximately 45 minutes and will be audio taped. Any information recorded in this study will be kept strictly confidential. All identifiable information (such as names, addresses, dates, and other details) will be disguised from the information so no one other than myself can identify you. It will also be helpful if you can let me know if there are any other details you would like disguised so I can protect your anonymity.

Further information about the study and what you should expect can be found in the enclosed participant information sheet. It is entirely your decision whether or not you take part in this research and your decision to take part in this study will not affect your treatment in any way.

If you feel you would like to participate in this study, then please fill in the participant consent form attached. Alternatively, if you require further information before deciding or would like to talk to me about this study then please contact me on 01892 507666 or via email at nol2@canterbury.ac.uk. I will return your call/email as soon as possible.

Thank you so much for your time and I look forward to hearing from you.

Yours sincerely,

Mr Niki Loft
Trainee Clinical Psychologist

Participant information sheet

Will I find the interview distressing?

The interview will be focussing on your professional experience and views relating to the detention of individuals with psychosis under them Mental Health Act. Whilst I hope this interview will not be distressing I cannot guarantee that it will not evoke certain feelings in you. However, if you do become upset I will be sensitive to your needs and will make sure you are comfortable about continuing with the interview. If necessary I shall end the interview at your request. Although I am not in a position to offer any significant help with upsetting issues, I can help you consider accessing appropriate services.

Can I end the interview early?

Yes. You can end the interview at any time, for any reason, either by telling me or by simply raising your hand.

Are there any circumstances where you would pass on information about me to someone else?

If during the interview you revealed information that suggested you or someone else might be at risk of serious harm then I would be obliged to pass this information on to an appropriate person.

What happens with the results of the research?

In Summer 2011 you will receive a summary of the main findings of the study, unless you say otherwise. You may wish to comment on this so that I can get an idea of how well my conclusions fit your experiences. The study will then be submitted for examination in July 2011. At a later stage it is likely that these findings will to be published in a professional journal for the wider psychology community.

Will my taking part be kept confidential?

Yes, personal information collected in this study will be kept confidential. All identifiable material (e.g. your name and address) will be disguised so no one other than myself can identify you. Your consent for the use of quotations in the research report will be sought prior to being included.

Who will have access to my personal data during the study?

Only the researcher will have access to your personally identifiable data. He will be the person interviewing you.

How will you ensure the confidentiality of personal data?

The personal information for each participant will be kept in an electronic code book by the researcher in accordance with the NHS Code of Confidentiality and Data Protection Act. Other persons involved in the study will ONLY have access to the anonymised data and any information provided in the study report and or subsequent publications will be anonymous.

How and where will you store my personal information?

Your personal information will be kept in an electronic code book by the researcher who will be interviewing you. This code book will be held securely on a computer for 10 years. All coded data will also be kept on a secure disk in the clinical psychology programme office at Canterbury Christ Church University in Tunbridge Wells for 10 years.

Why does the interview have to be audio recorded? Will this be confidential?
The type of analysis used in this study requires accurate recordings of what is said in the interviews. The best way of achieving this is by audio taping. The interviews will be typed up to written form within two weeks of interviewing you and you will be offered a copy of the transcript to check. Any information in the transcripts that could identify you will be changed to protect anonymity and stored on my password-protected computer.

Who will listen to the audio recorded interview?
Only the researcher who will be interviewing you will listen to the audio tapes.

How long will the audio recorded interviews be kept?
The audio recorded interviews will be deleted when the project is completed. This will normally occur within nine months of the interview.

Who do I contact for more information?
For any further information please contact me on 01892 507666. If I am unable to answer your call, please leave a message stating that you are calling about the research project. Please leave a contact number and I will get back to you as soon as possible.

I have decided to take part in the study. What do I need to do now?
Please call me on 01892 507666 so we can arrange a convenient time to meet for the interview. If I have not heard from you within a month of receiving this letter I will assume you do not want to take part in this study.

I have decided not to take part in the study. What do I need to do now?
You do not need to do anything. Your decision to not take part will in no way be detrimental to your employment.

If applicable, will I be reimbursed for travel expenses I incur by attending the interview?
Yes. You will be reimbursed accordingly.

Canterbury Christ Church University

Salomons Campus at Tunbridge Wells

CONSENT FORM

Title of project:
Exploring admission experiences of adults with psychosis using grounded theory

Name of researcher:
Niki Loft

Please read each statement below and tick the appropriate boxes if you are willing to give your consent:

☐ I understand that my participation in this research study is voluntary and I am able to withdraw from the study at any time without giving my reason and without my healthcare or legal rights being affected.

☐ I am happy to be contacted on the telephone number given to arrange a time to be interviewed.

☐ I understand that I will be asked to consider a potentially traumatic experience (admission to a mental health unit) and am willing to do this.

☐ I agree to have my interview audio taped.

☐ I consent for my GP to be contacted.

☐ I agree that quotations taken from my interview may be used in this study and in subsequent publications. I understand that all quotations will be anonymous and I will not be identifiable from them. I also understand that verbal permission will be sought prior to any of my quotations being used in this study.

☐ I agree that data taken for the purposes of this study may be used in this study and in subsequent publications.

☐ I agree to participate in the above study.

Name: ....

Signature.. Date:......../........../..........

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Semi-structured interview: service-users

Hello, my name's [name], and I am a trainee clinical psychologist. I will be interviewing you today if you decide you would still like to take part [general conversation to relax the interviewee].

Firstly, thank you for showing an interest in taking part in this study today.

I just need to run through a few details with you first of all to check you are still happy to participate in this study and then I will need to ask you to sign a consent form to confirm this. Is that OK?

As you may recall, this study is exploring the compulsory detention process (under the Mental Health Act, 1983/2007) and how it impacts psychologically on service users with mental health issues similar to those you have experienced. You have been asked if you would like to participate in this study because you have direct experience of being detained under the Mental Health Act (1983/2007) and reported personal experience of mental health issues. As mentioned, I am particularly interested in hearing from you how you feel the compulsory detention process impacted upon you psychologically. I will ask you some questions relating to this in addition to some questions about your experience. This could last for up to 45 minutes but it might finish earlier.

This interview is entirely voluntary so if at any stage you feel you want to end the interview, please either let me know or just raise your hand and I will terminate the interview. Subsequently, your data will not be included in the research.

As you may remember from the information sheet I gave you, no personally identifiable information will be kept once the interview is transcribed. I will code this interview so only I will know which interview was yours. All transcribed data will be kept on a password protected PC that only I know the password for. All audio recordings will be deleted upon completion of the research.

Do you have any questions before we begin?
Great, so would you still like to participate in this study? [Ask to fill in consent form if agrees to participate]

*******************START TAPE RECORDING*******************

The following broad questions will be used but further, more specific, questions will be asked as guided by the interview responses.

1) **History of being a service user**: First of all, can you tell me a bit about your history of being a service user?
   Diagnosis/Presenting difficulties/Experience
   When was onset/how long have you been experiencing mental health issues?[associated with psychosis]?

How many times have you been detained, compulsorily or voluntarily?

I would now like you to think about the last time you were compulsorily detained under the Mental Health Act (1983/2007). From your perspective as a service user, I am now going to ask some questions about this experience and how you think the process impacted upon you psychologically?

2) **Leading up to your last compulsory detention:** Can you describe what was going on in the lead up to your last compulsory detention? (e.g. what was going on in your life at the time? What do you think might have triggered it?)

   How did this make you feel?
   What impacted upon how you felt during this time?

3) **The process of being compulsorily detained: Can you describe how you were last compulsorily detained?** (e.g. where were you detained, who detained you?)

   How did this make you feel?
   What impacted upon how you felt during this time?

4) **The admission process: Can you describe what happened when you were admitted?** (e.g. where did you go, what treatment did you receive, how long where you in hospital for?)

   How did this make you feel?
   What impacted upon how you felt during this time?

5) **The discharge process: Can you describe how you were discharged?** (e.g. did you know you were going to be discharged, what did you have to do, how long did it take, where did you go?)

   How did this make you feel?
   What impacted upon how you felt during this time?

6) The overall process: What do you think about the overall process of being compulsorily detained now? (E.g. helpful/unhelpful, short/long-term effects of detention)

   How do you think the whole process impact upon you?

7) **Improvements** – Can you think of any ways in which the detention process could be improved, particularly for individuals with who have mental health issues similar to yours?

8) **Final thoughts** – Finally, do you have any final thoughts or comments that you would like to make about what we have discussed today?

*******************STOP TAPE RECORDING*******************

De-brief
Do you have any further comments or questions you would like to ask me?
(Check the participant is not feeling distressed or worried by the interview)

Thank you for participating in this study today.

[End the interview]

Semi-structured interview: clinicians

Hello, my name's [name], and I am a trainee clinical psychologist. I will be interviewing you today if you decide you would still like to take part [general conversation to relax the interviewee].

Firstly, thank you for showing an interest in taking part in this study today.

I just need to run through a few details with you first of all to check you are still happy to participate in this study and then I will need to ask you to sign a consent form to confirm this. Is that OK?

As you may recall, this study is exploring the compulsory detention process (under the Mental Health Act, 1983/2007) and how it impacts psychologically on service users with with psychosis. You have been asked if you would like to participate in this study because you have experience of working directly in the process of detaining individuals who present with psychosis. As mentioned, I am particularly interested in hearing from you how you feel the compulsory detention process impacted upon you psychologically. I will ask you some questions relating to this in addition to some questions about your role. This could last for up to 45 minutes but it might finish earlier.

This interview is entirely voluntary so if at any stage you feel you want to end the interview, please let me know or just raise your hand and I will terminate the interview. Subsequently, your data will not be included in the research.

As you may remember from the information sheet I gave you, all personal details will be anonymised when the interview is transcribed. I will code this interview so only I will know which interview was yours. All transcribed data will be kept on a password protected PC that only I know the password for.

Do you have any questions before we begin?
Great, so would you still like to participate in this study? [Ask to fill in consent form if agrees to participate]

*******************START TAPE RECORDING*******************

The following broad questions will be used but further, more specific, questions will be asked as guided by the interview responses.

1) **Job role**: First of all, can you tell me a bit about your job?
   Job title
   Place of work (Trust, service etc.)
   Team (who is in it, how big, purpose)
   How long have you been doing this job?

2) **Detention experience** - Can you tell me a bit about your experience of detaining individuals presenting with psychosis?
   a. How many times have you detained individuals/been directly involved in detaining individuals (compulsorily and voluntarily)?

b. How many of these detentions involved detaining individuals presenting with psychosis?

I would now like you to think about the last time you compulsorily detained a service user presenting with psychosis under the Mental Health Act (1983/2007). From your perspective as a psychiatrist, I am now going to ask some questions about this experience and how you think the process impacted psychologically upon the service user?

3) **Leading up to the compulsory detention:** Can you describe what you think was going on in the lead up to the service user's compulsory detention? (e.g. what was going on in his/her life at the time? What do you think might have triggered it?)

How do you think this made them feel?
What do you think impacted upon how they felt during this time?

4) **The process of being compulsorily detained: Can you describe how you compulsorily detained that service user?** (e.g. where were they detained, who detained them with you?)

How do you think this made them feel?
What do you think impacted upon how they felt during this time?

5) **The admission process: Can you describe what happened when the service user was admitted?** (e.g. where did you go, what treatment did you receive, how long where you in hospital for?)

How do you think this made them feel?
What do you think impacted upon how they felt during this time?

6) **The discharge process: Can you describe how the service user was discharged?** (e.g. did you know you were going to be discharged, what did you have to do, how long did it take, where did you go?)

How do you think this made them feel?
What do you think impacted upon how they felt during this time?

7) The overall process: What do you think the service user thinks now about the overall process of being compulsorily detained? (E.g. helpful/unhelpful, short/long-term effects of detention)

How do you think the whole process impacted upon them?

8) **Improvements** – Can you think of any ways in which the detention process could be improved, particularly for individuals with psychosis?

9) **Final thoughts** – Finally, do you have any final thoughts or comments that you would like to make about what we have discussed today?

*******************STOP TAPE RECORDING*******************

De-brief
Do you have any further comments or questions you would like to ask me?
(Check the participant is not feeling distressed or worried by the interview)

Thank you for participating in this study today.

[End the interview]

Date	Diary entry
February 2009	I emailed [external EIS clinician] about some of my research ideas. She replied, warning me that it can be difficult to recruit people to talk about early trauma, saying that ethics committees will be concerned about the effects on people. She also said it can be hard to get consent from people who have just been admitted under section. She said I need to think carefully about the ethics of this and how it could be done.
March 2009	I am concerned that I will not be able to find supervisors interested in this area of research. I have contacted a few clinicians [external EIS clinicians]) but I have not heard back from them yet. I really want a good supervisor as I really want to get this study published (if the findings are interesting!!). I met with [Internal staff member] and we talked about my project ideas and some of the potential methodologies. I really hope he will be able to be my internal supervisor as he has had many psychosis-related publications and knows the subject area well. I got an email from him that said he would be willing to supervise but had been approached by several other trainees too. Fingers-crossed! I am so pleased [Internal supervisor] has agreed to supervise me. I have also met with [external clinician] who works as the Service Lead in an Early Intervention Service for Psychosis, and he also has agreed to act as my external supervisor. I am so relieved!
April 2009	I have completed my IRP supervisor form and both [Internal supervisor] and [external supervisor] have signed it. I received an email from [external supervisor] saying that I may need to take his retirement plans into account as he is thinking of retiring at the end of March 2011. If that does go ahead, then I guess I'll just have to make good plans in advance.
May 2009	What with the deadline we had with other academic submissions I haven't found time to do some literature searches I wanted to. I must begin collating literature. It appears there is quite a bit of literature about trauma in psychosis (e.g. stemming from early childhood) and possible links with PTSD
July 2009	I am working on my draft IRP proposal. I got an email from [Internal research staff] reminding the cohort that it is due to be submitted to our internal supervisors by 1st October. He suggested the main thing to get right first is the research question(s), then go on to think about the appropriate literature and then the design and methodology. But how can I decide on my research question if I don't know about all the literature?!? [Peer] emailed me a useful link with statistics about the Mental Health Act today. It looks like the number of admissions under the MHA is on the rise. I emailed [external researcher/consultant] today. He taught us in the psychosis teaching block a few months ago. I remember him saying he was interested in sectioning and psychosis. He emailed me back and said we could correspond via email.
August 2009	I'm thinking of using a quantitative design to look at the extent of trauma experienced by individuals experiencing hallucinations/delusions who are detained under the Mental Health Act. I am hoping to recruit across [geographical area].

	I am starting to think of questions to ask service users about the context of their sectioning experience. I imagine things like having a family member (or other familiar supportive person) present, where it was (home or in public), who was sectioning (police, psychiatrist etc). I would like to draw up enough questions to cover all the key contextual issues. I've emailed [external researcher/consultant] about this. [External researcher/consultant] emailed me back. He has highlighted all sorts of potential variables that may impact on the trauma level experienced in relation to the compulsory admission (e.g. presence of familiar person, police, state at time of assessment etc). How am I going to control for all these variables!!?
September 2009	I have arranged to meet with [Internal supervisor] to discuss my proposal. The meeting with [Internal supervisor] went well. We talked about my concerns about controlling variables and he suggested mapping out the research idea using a) a quantitative method 2) a qualitative method, and seeing which one seems to address the aims of the research best. I mapped out my research idea with both methods I sent [Internal supervisor] my revised proposal. I decided to stick with the quantitative method. I should say that the proposal is not at all complete but should serve to give [Internal supervisor] a good idea of where I am going with it. Now that my other academic submissions have been handed in, I plan to work on it over the coming weeks and will send [Internal supervisor] a more complete and polished version before the October 1st deadline.
October 2009	Met with [Internal supervisor] to discuss proposal. Received an email from [internal researcher] regarding internal ethics reviews. I need to send them my revised proposal by the first week of November. I got an email from [external supervisor]. He is concerned about being able to recruit a sample size big enough for the quantitative proposed method (60+). I have tried to arrange to meet with him but he's really busy and it's proving difficult. This is quite frustrating. Finally I've got a meeting with [external supervisor]. We discussed the proposal and he was happy to sign it off. We talked about ethics and R&D procedures particular for the Trust.
November 2009	I had my internal ethics review. They were interested in the proposal and thought the subject area was a good one to explore. However, they did have some reservations about the proposed methodology, largely due to the time/cost restraints. I received feedback from them. They suggested that an alternative approach would be to revise the proposal, approaching the question of what makes the detention process traumatic for psychotic individuals from a grounded theory approach. This might involve interviewing a mixture of service-users and professionals (perhaps 12-20, or until theoretical saturation is obtained). It could be conducted face-to-face and/or via telephone. I have tried contacting [external supervisor] to discuss the revised proposal but he is

	out of the office for several weeks.
December 2009	I got an email from [external supervisor]. He thought the grounded theory approach looked very appropriate for a study in this area, and the proposal as a whole looked 'convincing and realistic'. He said he also liked the semi-structured interviews. I met with [external supervisor] a few weeks later to go through the proposal. We were both happier with it. I have also met with [internal supervisor] and again, it feels much more appropriate to be using grounded theory than trying to tackle it quantitatively. Having made all the proposed changes to my proposal now I am ready to send it back to the internal ethics panel for consideration. I have also been asked to propose a journal that I would like the research to be considered by. [Internal supervisor] suggested the Journal of Mental Health.
January 2010	Having submitted my revised proposal internally, I received a fairly swift response agreeing to the revised proposal. Phew! I can now get on with my ethics form. I have registered with the Integrated Research Application System (IRAS) application so that I can start familiarising myself with the NHS ethics/R&D forms. I have been working on my ethics form and am due to meet [external supervisor] in a few weeks time to discuss it.
February 2010	Met with [external supervisor] to discuss the ethics form. He suggested I make contact with [Trust R&D staff member] to check what I need to submit as it has recently changed. [External supervisor] forwarded me an email from the Trust R&D which explained that I cannot get trust approval until ethics approval has been obtained. They ask for so much detail on these ethics forms. I have just had to email [internal/external supervisors] requesting details of their qualifications and their CVs.
March 2010	I have sent [internal supervisor] a draft copy of my NHS ethics form and arranged to meet with him to discuss it. I met with [internal supervisor]. He has suggested various changes to the form. I emailed the Trust R&D and they responded with the details of someone I should put on my NHS ethics form as the Trust R&D contact.
May 2010	Because of other academic submissions I still haven't finalised my ethics form. I'm getting all the necessary paperwork together though (e.g. insurance certificates, CVs etc). I've also been working on draft interview schedules, information sheets and consent forms. I've sent drafts to both supervisors. Had another meeting with [internal supervisor] to discuss the ethics form, interview schedules, information sheets and consent forms.
June 2010	I've submitted my IRAS/ethics form and I have contacted the REC co-ordinator to book an ethics panel review. It's quite a relief that I've got the form submitted but it was a bit disappointing that I've got to wait nearly a month for the ethics panel

	review.
July 2010	I attended the ethics panel review and I have to say I have never been subjected to such a hostile review! Despite clarifying and addressing their concerns they have rejected my application. I can't believe it. It has been reviewed internally and yet they were highly critical of certain aspects of it. I tried to explain but none of them had any professional experience of mental health and my responses seemed to fall on deaf ears. Very disappointing! I've arranged to see [internal supervisor] to talk about the changes the ethics panel have suggested I make. I've also made contact with the Trust R&D co-ordinator who seems very helpful. I've contacted the REC office and requested there be at least one mental health professional on the next ethics panel review I attend. They found me one and booked me in for September (it was the earliest one they could do!). This is so frustrating. My project timeframe plan is getting pushed back further and further. I wanted to start collecting data over the summer. Now I will have to wait until the autumn.
September 2010	I was a bit more anxious attending this ethics panel review. There are a lot of people at them and it can be difficult to address everyone's concerns on the spot. However, the meeting seemed to go better than last time. Mind you, even though I made the suggested changes proposed by the last ethics panel, this one has raised other issues! This is so frustrating and suggests a lack of internal consistency! I got a response from the ethics panel. They said they will give the project 'favourable opinion' subject to me making some small changes.
October 2010	I have made the necessary changes and sent the amendments to them. In the meantime I have emailed the Trust R&D co-ordinator as she advised me to get on with completing all the R&D forms before I get a final response back from ethics (to speed up the process a bit).
November 2010	It's 22nd November and I have finally received ethics approval! It seemed to take them a long time to get back to me and I'm feeling quite frustrated by how long this process has taken. I also feel a great sense of relief! I'm trying to arrange to meet with [internal supervisor] but it's proving really difficult to get a date in the diary.
December 2010	I finally received Trust approval for the project to go ahead today (21st December). I feel so behind. I now need to get on with recruitment quickly! [External supervisor] sent me three possible psychiatrist participants and I have emailed them. I have arranged my first interview for January, right after the Christmas break.
January 2011	I conducted my first interview with a psychiatrist participant. It made me question whether or not service-users were getting enough support in the community. It went well but was shorter than I thought it would be. It was also apparent from the interview that as a community-based psychiatrist he did not have much knowledge or information about the experience of service-users once they were admitted which was a little surprising. I think I need to interview some ward-based psychiatrists too. The psychiatrist said he knows of a few psychiatrist colleagues who may be willing to

participate. He said he will contact them and email me.
[External supervisor] has sent an email round to his colleagues in other teams informing them of the research and the inclusion criteria for service-user participants. I have also arranged to meet with the service lead for one CMHT team. I’ve made more interview appointments with psychiatrists. I’ve also contacted a few clinicians I know in the Trust to see if they can help with service-user recruitment.

{External supervisor] got back to me and said he hasn’t had any response from some of the people he contacted. He has suggested I now contact them directly. I have been contacting people by email to little avail. I have been calling people and leaving messages when I cannot reach them but it is proving difficult to get hold of some people. It’s also frustrating that many of them don’t seem to return my calls or respond to emails. [External supervisor] said that everyone feels swamped by overwork, and that suggesting potential research participants isn't an everyday thing for any of the staff concerned. He said it is likely to take some persistence to produce results.

I’ve got another two psychiatrist participant interview arranged which is encouraging. I’ve also had contact from a care co-ordinator who has a client who meets the inclusion criteria. She is going to contact him with the details and ask if he will consider participating.

I am getting worried about the time constraints and the lack of participants, particularly service-users. I have contacted the Trust R&D co-ordinator for advice about what to do if I want an extension for the project. In terms of ethics/R&D, she said an extension to the time of your project is only classed as a minor amendment and it is only a courtesy to inform the REC and the R&D Office. She also said that I even if I haven't recruited any service-users, I should maintain my current protocol and simply analyse the data I accrue from the psychiatrists. She said I can then discuss in my thesis why I think service-user recruitment was so low/non-existent.

I’ve conducted my second psychiatrist interview. Service-user insight, and engagement came up as an interesting themes but support networks seemed to be overlooked. I wonder if some sort of ‘advance directive’ may be useful for service-users given their reported lack of insight at the point of admission. Next week I have more psychiatrist interviews lined up, all on my study day. Transcription takes quite some time so I’d better try and get it done soon! Not to mention the line-by-line coding!! . I’m going to do 2 line by line coding for clinicians interviews before moving on with the coding process.

I’ve conducted three more interviews. The first was a ward psychiatrist. It was interesting to have a ward-based perspective and to see the focus much more on Mental Health Review Tribunals (as well as medication). The second interview was also very interesting as was the third. Whilst some new themes emerged (e.g. educating service-users whilst in remission) I am also noticing common concepts arising (e.g. insight, support, medication, continuity of care) which is reassuring. Whilst it is a relief to have a few more interviews completed, transcribing/analysing one before the next one is proving impossible when I have one study day a week and have to travel quite long distances between interviews.

February 2011	I've arranged to meet with [internal supervisor] to update him on progress and discuss recruitment issues. Meanwhile I have spoken to [external supervisor] and we have sent emails to team managers in various services asking care co-ordinators to identify suitable service-users. These managers also gave me a list of direct email contacts for some care co-ordinators so I have emailed and phoned them directly too to discuss the project and recruitment. I have also contacted numerous other team managers (e.g. EIS). I've interviewed another psychiatrist which was interesting as they were from a crisis team. I did also have my first potential service-user participant but I got an email from their care co-ordinator saying their client decided not to participate. That was very disappointing. I met [internal supervisor] and we discussed the emerging concepts, categories etc. in the context of the codes. We also discussed biasing and I found it useful to reflect on this. We also discussed literature for Section A. I have arranged to present my project and explain the inclusion/exclusion criteria at a multi-disciplinary team meeting for a recovery team in the hope that I can recruit some service-users through the care co-ordinators. I have had another psychiatrist interview today. It went really well and but was quite long. The psychiatrist said he knows of a service-user who may be willing to participate (and who meets the inclusion criteria). Fingers-crossed! I had another psychiatrist interview today. There are now a lot of common themes in the interviews, and fewer new themes. However, it was an interesting interview and the psychiatrist also said they would email a few care coordinators who had potentially appropriate service-user participants. In the afternoon I visited an inpatient ward and they identified some potentially suitable participants who were now back in the community. However, they said it was a shame the inclusion criteria were not a bit less restrictive in terms of time since compulsory admission because there were service-users on the ward who would probably be willing to participate, but they had only been admitted around six weeks ago. Today I got an email from a service-user saying they would be willing to participate. I am so pleased (and relieved). I will arrange to meet with them. I was due to meet with another psychiatrist today to see if they could help with recruitment but they cancelled at the last minute. How frustrating! Today I presented my research and the criteria for recruitment to a recovery team. There were a lot of care co-ordinators present and the team manager was very helpful. They said they would email me individually if they had suitable potential participants on their caseload. I had my first service-user interview today. It was very moving and the participant had clearly found aspects of the compulsory admission experience difficult and distressing. They had some strong views about the system and psychiatry too!

	I have discussed the data so far and general progress with [internal supervisor] and am continuing to request articles for my Section A literature review.
March 2011	I have not heard from any of the team members following my presentation at their meeting over a week ago. So I have contacted the team manager to send a reminder. I am also continuing to pursue team managers, care co-ordinators and other clinicians in my quest to recruit service-users. Finally some care co-ordinators have got back to me. I have arranged some more service-user interviews! It's such a relief. I've also had one more psychiatrist interview. Whilst it was interesting no new themes were emerging which is reassuring as I am still a way off reaching data saturation with my service-user interviews!! Today I had two service-user interviews. Whilst it was quite a difficult interview due to his rigid thinking and slightly angry demeanour, they raised some interesting points about violence on the wards and about illicit drug-taking. I also got a clearer sense of what it was like on the ward and how unsupported and vulnerable some service-users seem to be. I have been line-by-line coding the first two service-user interviews. It does take a long time! There are a lot of codes and emerging concepts and I am finding it difficult to group. I had one more service-user interview which went well too. However, similar themes (e.g. Violence, drug-taking, distress) emerged but it was clear that this person was still quite delusional in their thinking, and still resorting (in the community) to the same adverse coping strategies they had used before being admitted (e.g. cannabis). It was also sad that they commented after the interview that they had found it helpful to talk to me and wanted to see a psychologist (as they never had previously!). I got an email from [external supervisor] to say he is retiring. As I have been busy I did not get round to responding immediately. However, when I did I got an auto-response saying they had left the Trust! I have contacted another team member and hope that they will forward my email to [external supervisor]. To be honest, I am a bit disappointed with the support I have received from them with regards to recruitment.
April 2011	I have several more service-user interviews and found the same themes coming up with no new ones. With data saturation reached I can now get on with completing data analysis and generating the model. I have updated [internal supervisor].
May 2011	It has been a busy and disjointed month with several clinical teaching blocks and changing clinical placement. However, I am writing my Section A (literature review) having met with [internal supervisor] and agreed a structure and broadly what will be included. I've also come across an interesting new psychodynamic model which I was hoping to include in Section A. However, having emailed the author I have learnt that it is unpublished so it will not meet the literature inclusion criteria. I got an email saying [external supervisor] is out of the country for a month. That is frustrating as I was hoping to send them a draft of my Section A before then.

	Anyway I have sent a draft to [internal supervisor] for review. I have met with [internal supervisor] and discussed changes to Section A. I have mapped out a timetable for completion of the remaining parts of the MRP and plan to have a draft of Section B to within a few weeks. We went through my coding and I explained what I had done and he thought it was OK. However, there were some queries about my potential axial coding and thought that some of my concepts/-sub-categories and categories needed shifting around. They also thought that some of the category/sub-category labels did not accurately reflect the contained concepts and coding. I agreed to address this. It was helpful to have someone else look over the data.
June 2011	I received an email from [external supervisor] saying they would be willing to read a draft. There is just over a month to go and I have a lot of work still to do. It feels quite overwhelming and I am worried I won't get it finished in time. Section B is proving to be a lot more involved and time-consuming than I thought. Creating the model took a lot of time and just managing the vast amount of data takes ages! I'm worried about the lack of space (word count) to convey the findings of the study because I really want to do it justice. I have contacted several service-user and psychiatrist participants with details of the model etc. requesting respondent validation. Within a few days they had gotten back to me, agreeing on the whole with what I have presented. I have managed to get a draft of my Section B to [internal supervisor]. I met with [internal supervisor] to discuss Section B. They felt that there were some changes that needed to be made. The word count needed reducing and there were changes to both the introduction and discussion, both of which were also too long! They also thought the model needed some minor changes as it was quite complicated. I am truly experiencing the 'iterative process' and the 'grounding' aspects of grounded theory!
July 2011	Having emailed Sections A and B to [external supervisor] I was grateful to receive a swift response. They said strong aspects of the work were the sheer interestingness of the subject, the surprising paucity of existing studies on it, and the vividness of respondents' testimony. They made a few suggestions regarding minor alterations but it was encouraging feedback considering how exhausted I feel! I am making changes to Sections A/B and writing Section C. This section seems easier to write and more manageable. I have also been gathering Section D appendix materials as there is quite a lot to include in that. I've not got long to go now and it is beginning to feel like the end is in sight. I hope to finish it a few days ahead of the deadline on 15th July so I have time to check it through finally and get it bound. I have finished my thesis! I have sent a summary letter to the NHS ethics panel, R&D, and to participants. All that remains to be done is printing and binding. I can't believe I have done it! I hope that the examiners enjoy reading it.

Appendix 10: Category development table illustrating original sub-categories, how some were amalgamated, then ordered into categories and higher-order categories.

Key:
🟦 Psychiatrist(s) only
⬛ Service-user(s) only
🟥 Psychiatrists and service-users

These were the original sub-categories (see column below).	Some of the original sub-categories were clarified and merged due to overlap/repetition. Sub-categories were colour-coded to identify origin of quotes (i.e. Service-user, psychiatrist, or both)(see column below).	These sub-categories were organised into the following categories (see column below).	The categories were ordered into the following higher-order categories according to the timeline of the experience (see column below).
Lack of/disturbed sleep Distressed by psychotic symptoms Feeling out of control of thoughts Feeling detached from reality Confused/chaotic thinking	Tired/lack of sleep Distressed by psychotic symptoms Feeling distressed Higher levels of expressed emotions Feeling anxious/worried Feeling vulnerable/unsafe Feeling paranoid Feeling out of control of thoughts Feeling detached from reality	Escalating service user distress	DETERIORATING MENTAL HEALTH OF SERVICE-USER

Feeling distressed Employment/financial stressors Higher levels of expressed emotions Avoidance of engagement Denial of mental health problem Perception of experience Generic questioning Family colluding with clinicians Family anxious/worried Discord/breakdown of key relationships Feeling betrayed by family Distrusting of mental health service Parental support Neighbours call emergency services Discord with neighbours Support from neighbours Poor service user-psychiatrist rapport	Confused/chaotic thinking		DETERIORATING MENTAL HEALTH OF SERVICE-USER (continued)
	Avoidance of engagement with mental health services Denial of mental health problem Ambivalent about engagement with mental health services	Avoidance and ambivalence	
	Partial insight Degrees of insight and subjective interpretation	Lack of insight/Disagreeing with professional opinion	
	Feeling betrayed by family Family colluding with clinicians Family anxious/worried Discord/breakdown of key relationships Distrusting of mental health service Feeling angry (e.g. with professionals,family) Poor service user-psychiatrist rapport Discord with neighbours Family members feeling confused Employment/financial stressors Precipitating life stressors	Deteriorating key relationships	

Social isolation/Lack of support Feeling confused Stopping medication/non-compliance Drug/alcohol misuse and smoking Reduced insight Delusional attribution (or lack of insight) Feeling angry (e.g. with professionals, family) Feeling anxious/worried Feeling vulnerable/unsafe Feeling paranoid Precipitating life stressors Feeling ambivalent about engagement Mental health of service user's spouse/family member Clinical/forensic history Use of street drugs & perceived increase risk Insight and lack of	Mental health of service user's spouse/family member Living environment stressors		DETERIORATING MENTAL HEALTH OF SERVICE-USER (continued)
	Parental support Support from neighbours Social isolation/Lack of support Neighbours call emergency services	Failing support	
	Drug/alcohol misuse Stopping medication/non-compliance	Counter-productive coping	
	Use of illicit drugs & perceived increase risk Risk of harm to self Risk of harm to others Child protection issues Vulnerable adult	Increasing risk concerns	

Stopping medication/non-compliance Risk of harm to self Risk of harm to others Child protection issues Vulnerable adult Risk averse practice "Place of safety" Family/carer perception of service user behaviour Acting in best interest of service user "Evidence" gathering for detention Clinician anxiety Clinician empathising with service user Early intervention/Crisis team involvement Established psychiatrist/doctor-service user relationship Nurses rapport-building with service user Increasingly intense involvement/visits Family members	Forensic history Professional's anxiety Risk averse practice "Place of safety" Acting in best interest of service user Generic questioning Clinician empathising with service user		DETERIORATING MENTAL HEALTH OF SERVICE-USER (continued)
	Established psychiatrist/doctor-service user relationship Early intervention/Crisis team involvement Nurses rapport-building with service user Need for transparency Coercing service users towards admission Increasingly intense involvement/visits	Insufficient professional support	

feeling confused Tired/lack of sleep Importance of transparency Coercing service users towards voluntary admission			
58	52	8	
Feeling frightened Family sad/distressed Feeling disbelief Feeling punished Feeling surprised Feeling betrayed by family/system Feeling grateful for help Feeling relieved Presence of supportive person(s) Disjointed MHA assessment Multi-professional decision Risk-focused	Disjointed MHA assessment Multi-professional decision Risk-focused assessment Police-initiated detention Act in "best interests" of service user Government/legal enforcement Subjective opinions and power in decision to detain Inter and intra-professional /team working	Multi-faceted decision to compulsorily admit	PROFESSIONALS REMOVE SERVICE-USER'S LIBERTY
	Importance of care coordinator presence	Overpowering	

assessment Police-initiated detention Lots of professionals Family/spousal relief	Police presence for enforcement Lots of professionals Professional presence dependent on time of assessment Presence of supportive person(s)	professional presence	
	Clinicians frustrated at not intervening sooner Clinicians blame parents	Clinician frustrated and blaming	
The worst of it has passed Understanding of how environment impacts on individual Lack of choice Liberty removed Act in "best interests" of service user Government/legal enforcement Against will Passive acceptance	Feeling punished Being treated as a criminal Feeling frightened Feeling traumatised	Distress and persecution	
	Feeling disbelief Feeling surprised Feeling betrayed by family/system Feeling grateful for help	Betrayal & relief	POINT OF MHA ASSESSMENT & DETENTION

			(continued)
Learned helplessness Mental health difficulties made public (e.g. to neighbours)	Familiarity with process Familiarity with staff	Service Familiarity: Process & people	
Need for discretion Distressed family members	Family feel sad Family/spousal relief Distressed family members	Ambivalent family reaction	
Feeling traumatised Service user not taken seriously Clinicians frustrated at not intervening sooner Trying to preserve dignity Service users blame clinicians	Mental health difficulties made public (e.g. to neighbours) Need for discretion Trying to preserve dignity Stigma attached to admission	Stigmatisation & preserving dignity	
Loss of human rights Family empathy for service user Importance of care coordinator presence Police presence for enforcement	Lack of choice Loss of freedom Loss of human rights Separation from children	Liberty removal	POINT OF MHA ASSESSMENT & DETENTION (continued)

Feeling persecuted Stigma attached to admission Being treated as a criminal Familiarity with process/staff Clinicians blame parents Subjective opinions and power in decision to detain Inter and intra-professional /team working Disjointed MHA assessment	Against will Passive acceptance Learned helplessness Service user not taken seriously	Powerless service user reaction

44 40 10

Use of handcuffs Use of force by police Transfer to 136 suite Long transfer distance traumatising/distressing Mode of transfer (e.g. Police, ambulance,	Use of handcuffs Use of force by police Transfer to 136 suite	Degrading treatment by police	
	Long transfer distance traumatising/distressing Transfer distressing Reduced distress if choice of ward	Transfer distress	TRANSFER

private car) Familiar person accompanying Separation from children Police communication with service user Transfer distressing Reduced distress if choice of ward			
	Police communication with service user Familiar person accompanying Mode of transfer	Mode of transfer & In-transit interactions	
10	9	3	

Lack of information about what is happening Nobody listening to me Lack of awareness Feeling paranoid Institutionalisation Not conducive to improving mental health Perception of ward influenced by comparison to home environment Use of street drugs	Lack of information about what is happening Nobody listening Lack of contact with psychiatrist on ward	Poor communication with service user	WARD ENVRIONMENT
	Lack of awareness Feeling paranoid Against will Frightening/unsafe Feeling distressed/upset Feeling confused/disorientated Feeling anxious Feeling persecuted	Distress	WARD ENVRIONMENT (continued)

Impact of physical environment Lack of outside space Lack of therapy Having adequate sleep/rest Food and meals Activity Lack of activity Protective Feeling scrutinised, monitored and assessed/lack of privacy Against will Frightening, unsafe Feeling distressed/upset Physical attack Shortage of staff and other service resources Whistle-blowing Home leave Religious coping Staff coercion Good rapport with staff Rebelling Conformity and focus on medication "Binning medication" Medicated against will		
	Physical attack Aggressive as defence against feeling unsafe Risk/fearful of being physically attacked	Safety concerns
	Lack of outside space Power to restrict liberty Rebelling	Limited freedom/independence
	Conformity and focus on medication "Binning medication" Medicated against will Paranoid about medication Side effects of medication Powerless (to medication) Medication-focused approach v getting to the root cause Medication as a "magic wand" Service user knowledge of diagnoses	Diagnosis & medication compliance

WARD

Paranoid about medication Lack of staff flexibility Side effects of medication Frustration, anger and anxiety at lack of control over external events Feeling frustrated/angry Unfriendly Superficiality of professionals Difficult to relate/interact with other service users "Lifeless" service users Making friends whilst admitted No respect for ward doctors/psychiatrists Lack of contact with psychiatrist on ward Subjective staff perceptions influencing decision-making "Evidence" gathering			ENVRIONMENT (continued)
	Anger/frustration and anxiety at missing external events Feeling frustrated/angry Feeling isolated/unsupported Angry at being detained Lack of respect Lack of empathy Anxious Feeling punished Submissive Feeling surprised (at what they had done)	Feeling angry/isolated	
	Absconding from ward Home leave Family anxious (when home leave)	Drive to leave the ward	WARD ENVRIONMENT (continued)
	Helpful staff Good rapport with staff	Positive staff-service user relationships	

for tribunal v MH assessment Right to appeal to tribunal Home leave Family anxious (when home leave) Feeling isolated/unsupported Angry at being detained Aggressive as defence against feeling unsafe Fearful of being attacked Risk of physical attack Adverse impact of being around other service users with mental health issues Lack of engagement Engagement Lack of professionalism Lack of respect Lack of empathy Trying to prove sanity Helpful staff Staff use of physical force/restraint			WARD ENVRIONMENT (continued)
	Superficiality of professionals Poor rapport with ward doctors/psychiatrists Lack of staff motivation/professionalism Short admissions feel disruptive/Chaotic	Negative staff-service user relationships	
	Lack of staff flexibility Staff use of physical force/restraint Whistle-blowing to combat mistreatment of service users Subjective staff perceptions influencing decision-making	Ward staff exerting control & power	
	Impact of staffing levels on care Shortage of service resources	Shortage of staff & other resources	
	Making friends whilst admitted Difficult to relate/interact with other service users "Lifeless" service users Adverse impact of being around other service users with mental health issues Dynamics dependent on number/mental health of other service users	Positive & negative service user-service user relationships	

Dynamics dependent on number of other service users Dynamics dependent on how unwell other service users were Impact of staffing levels on care Anxious Absconding from ward Reflecting when insight regained Service user knowledge of tribunal process Service user knowledge of diagnoses Anger/frustration at missing life events Feeling surprised (at what they had done) Increased transparency gives hope to service users Support providing relief Powerless (to medication) Power to restrict			WARD ENVRIONMENT (continued)
	"Evidence" gathering for tribunal Right to appeal at tribunal Service user knowledge of tribunal process	Disputing the admission	
	Use of illicit drugs Smoking Religious coping Support providing relief Visits from friends/family	Ways of coping	
	Food and meals Activity Lack of activity Lack of psychotherapy Getting adequate sleep/rest	Limited cognitive stimulation	
	Perception of ward influenced by comparison to home environment Impact of physical environment	Oppressive effect of ward environment on service users	

liberty Familiarity with staff Medication-focused approach v getting to the root cause Medication as a "magic wand" Distressing being controlled Short admissions feel disruptive/Chaotic Lack of service resources affects quality of care	Lack of understanding of how environment impacts on individual		
	Unfriendly Institutionalisation Not conducive to improving mental health Feeling scrutinised, monitored and assessed/lack of privacy Trying to prove sanity Slow paced Distressing environment	Controlling & un-containing ward ambience	WARD ENVRIONMENT (continued)
82	79	17	
Discharge planning Involving family and	Involving family and service users in discharge planning Organising & preparing for discharge	Discharge process & pressure to discharge	

service users in discharge process Continuity of care Pressure on services (e.g. PbR) Relief at being discharged Distrusted by clinicians Excessive discharge paperwork Staff providing emotional support Staff under pressure to discharge	Excessive discharge paperwork Staff under pressure to discharge		DISCHARGE
	Relief at being discharged Distrusted by clinicians	Discharge relief & concern	

9 6 2

Advanced directives/choice Recovery (Medication-free, away from ward/hospital) Promoting recovery Revolving door/perpetuating mental health difficulties	Increasingly submissive Fear of future admission Learning from admission experience	Experiential learning from admission	COMMUNITY
	Stigma attached to diagnosis Stigmatised Familial transcending of mental health issues Socially perceived doctor-MH service user power differential	Experiencing discrimination	

Stigma Familial transcending of mental health issues Anger towards spouse/family Feeling guilt towards family Lack of social services support Income support Stress related to child protection/removal Undesirable side effects of medication Regaining insight Recovery in home environment Feeling setback after admission Empowerment via psycho-education Learning from admission experience Reflecting when well Confusion about persona/MH changes Increasingly submissive Fear of future admission Relief at having accommodation	Separation from children and obstacles to having them		COMMUNITY (continued)
	Post-admission depression/low mood Feeling guilt towards family Anger towards spouse/family Feeling setback after admission Shame about being compulsorily admitted Feeling loss due to absence of psychotic part of individual	Negative post-admission feelings	
	Income support Maintaining rapport despite admission Management in community Individual versus family-focused engagement Lack of continuity of care Lack of social services support	Continuity of care/danger of fragmentation	
	Confusion about persona/MH changes Regaining insight Clinicians hope for increased insight	Continuing to regain insight	

Socially perceived doctor-MH service user power differential Always medicated /medication compliance Stigma attached to diagnosis Getting to the root cause Post-admission depression/low mood Lack of continuity of care Maintaining rapport despite admission Management in community Clinicians hope for increased insight Individual v family-focused engagement	Always medicated /medication compliance Undesirable side effects of medication Medication-free	Unresolved medication-compliance issues	COMMUNITY (continued)
	Advanced directives/choice Revolving door clients Promoting recovery Reflecting when well Recovery in home environment Trying to establish causality Empowerment via psycho-education	Promoting recovery & the revolving door	
32	29	7	
Total = 235	Total = 219	Total = 47	Total = 6

Memo 1: Lots of professionals

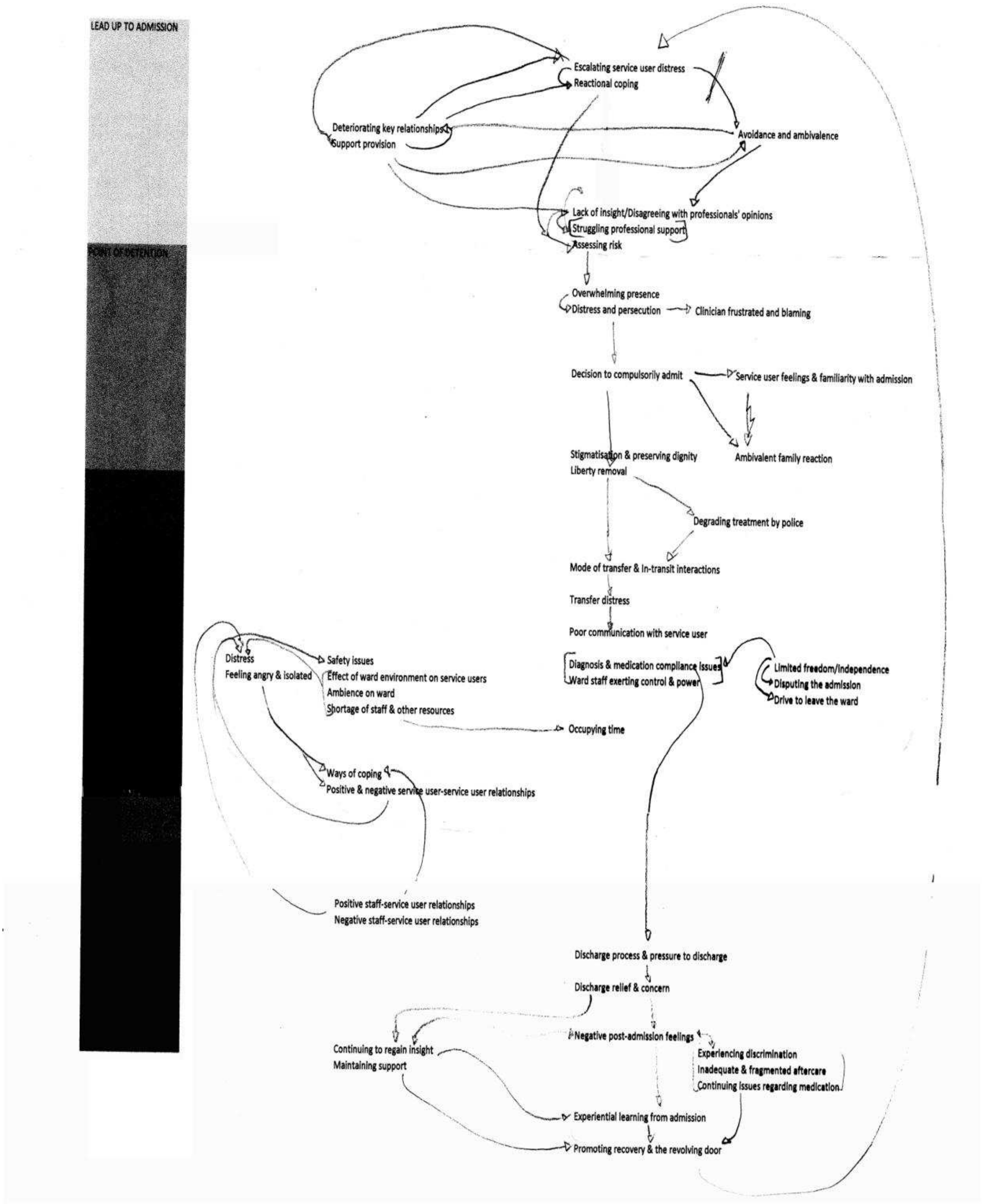
March 2011 – I have completed two service-user and two psychiatrist interviews now. There seem to be a lot of professionals involved in the process of detaining a service-user. It appears to be at the point of detention that service-users reported there being lots of professionals present (police, psychiatrists, doctors and social worker/AMHPs). I was particularly surprised in the second service-user interview to hear about there being ten policemen arriving to detain the individual. On top of this was the use of seemingly unnecessary force which left the service–user feeling angry. Indeed, I'm wondering what effect the presence of so many professionals must have on the service-user particularly when the service-user is feeling distressed must feel quite overwhelming. From the psychiatrist's perspective, it is a legal requirement to have certain people present for the MHA assessment (e.g. psychiatrist, Section 1 approved doctor, AMHP) so that might be quite reassuring in the sense that it is a multi-professional decision. Nevertheless, psychiatrists are acknowledging how daunting it might be for the service-user to have so many professionals there at the point of detention. I wonder if it is also quite obvious to neighbours and other member of the public when someone is being assessed under the MHA in their home, and what that might feel like for the service-user.

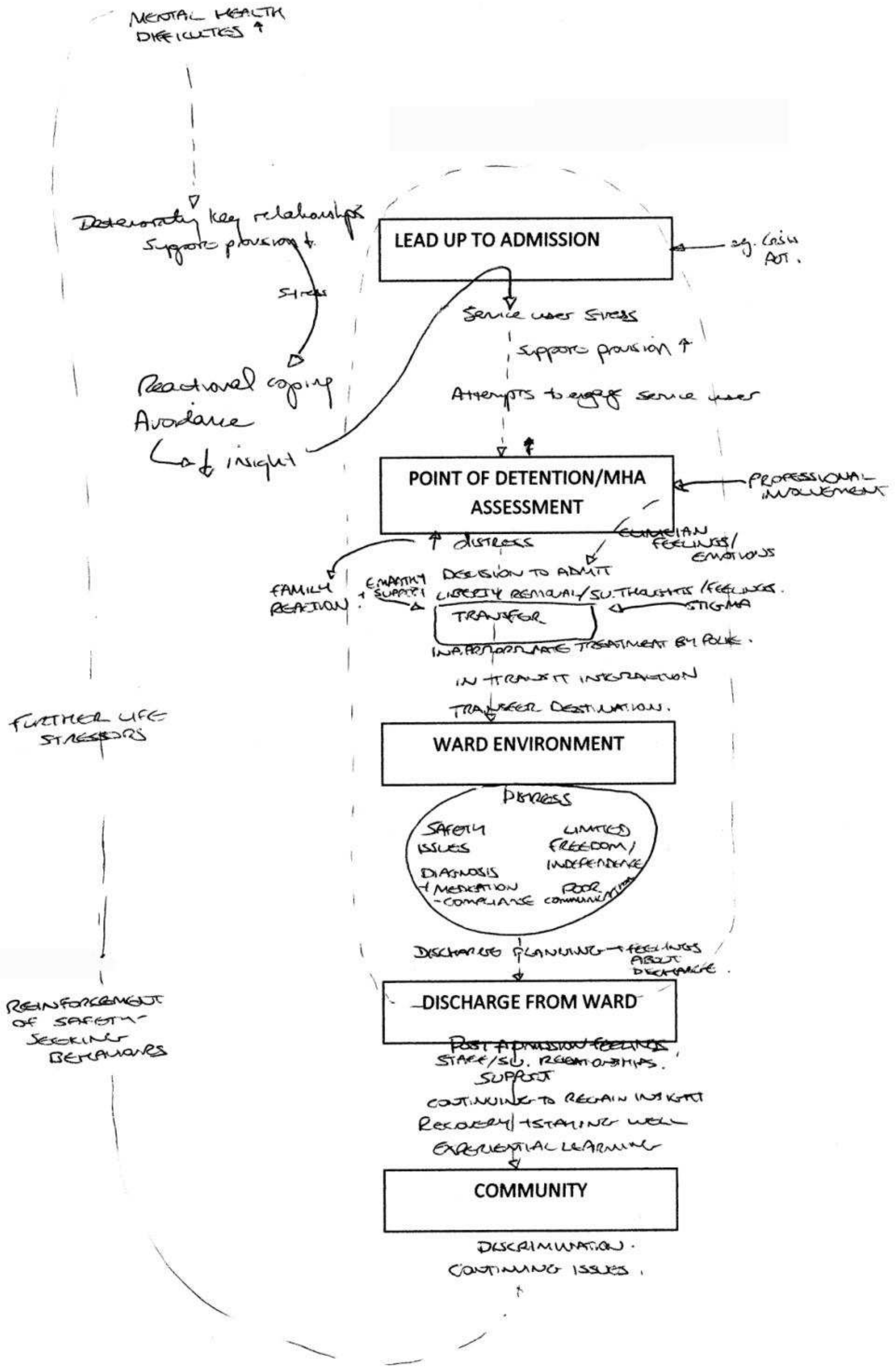
June 2011 - There have been lots of service-users and psychiatrists making reference to the presence of lots of professionals at the point of MHA assessment and detention. It seems that service-users feel overwhelmed with the presence of so many professionals but find that it is helpful to have certain people there (e.g. supportive person). Service-users have often reported the police being present for enforcement of the compulsory admission. Psychiatrists have reported the presence of the care co-ordinator being useful, as they usually know the service-user and are able to provide support. Nevertheless, the sheer number of professionals seems overwhelming for service-users. It is a significant sub-category but I think it does link with others so I think I might group this sub-category with the following; police presence, care-co-ordinator presence, supportive person presence and professional presence being dependent on the time of day. Collectively these sub-categories will come under the category 'overwhelming presence' at the 'point of MHA assessment and detention' (higher-order category). This fits well with in the timeline of experience and still reflects the sentiment.

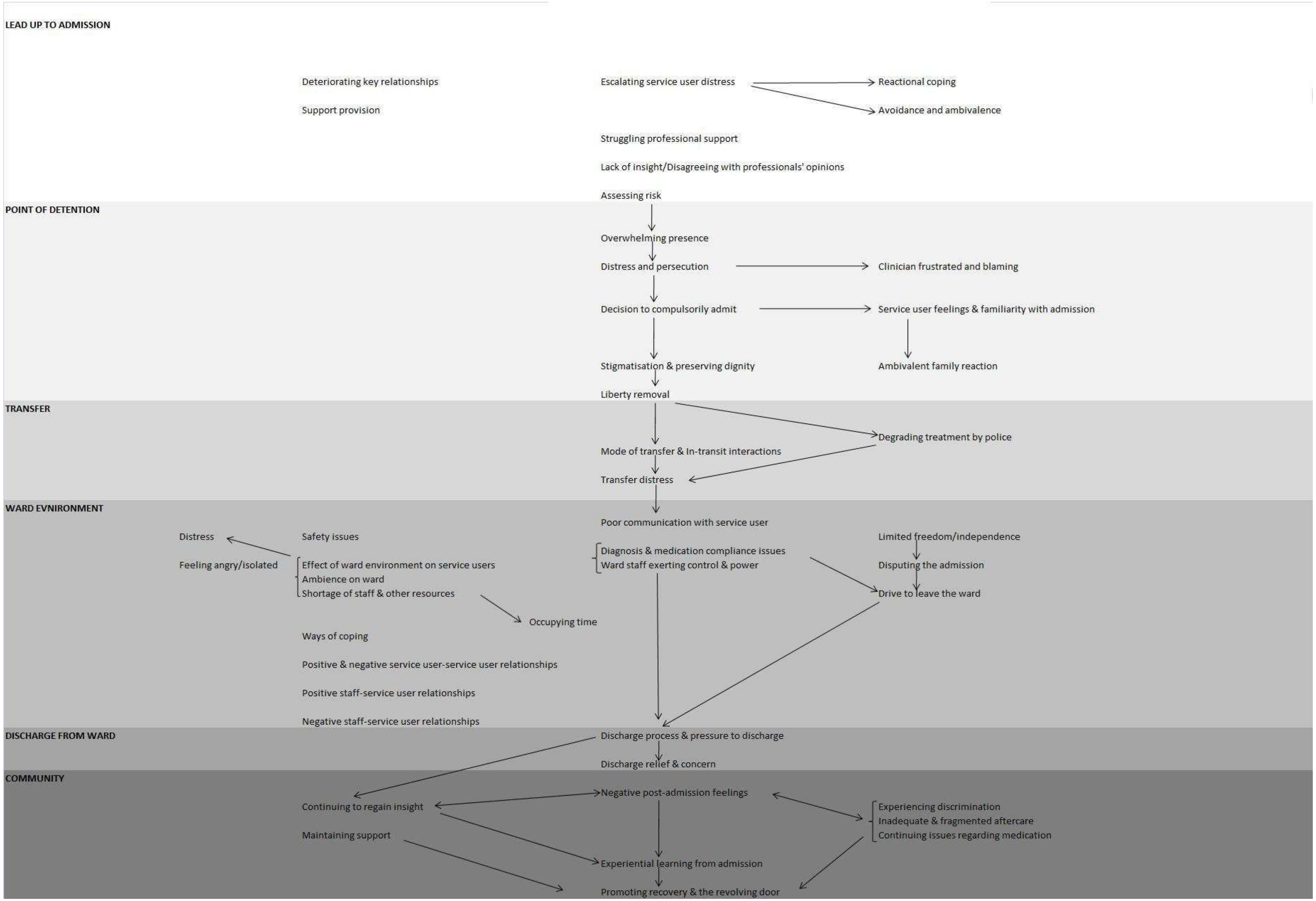
Memo 2: Conformity and focus on medication

March 2011 – From the outset of the first service-user interview medication was cited as the primary reason for admission. This seems to tie in with the available literature in this field (e.g. regarding medication, compliance, efficacy etc.). Refusing to take medication or simply stopping whilst living in the community was also cited in the second service-user interview. Furthermore, once on the wards, service-users reported a noticeable focus on medication and conforming. The second service-user reported "binning" medication to try and avoid taking it, and whilst the first service-user did not agree with taking the medication, they eventually conformed because they said they didn't think they would ever get out if they didn't. Yet with people reportedly walking around the ward looking “lifeless” as a result of medication it is unsurprising that there was some resistance to taking it. The side-effects were described particularly poignantly by service-user two who mentioned ‘waking nightmares’. In the first psychiatrist interview there was reference to medication as a ‘protective element’ and by stopping the medication in community that ‘protective element’ was lost. Whilst details about medication on the ward were limited due to the lack of apparent continuity in care (there was a different psychiatrist responsible for the service-user’s care on the ward), there was still an overarching focus on medication from the psychiatrist. Indeed, no reference was made to any other treatments (e.g. psychological therapies). In the second psychiatrist interview, such an emphasis was replicated, with stopping medication being seen as the pre-requisite to admission. However, the psychiatrist did acknowledge that some service-users find it difficult to adhere to medication even on the ward and may take time to “settle down”.

June 2011 - Medication focus and conformity continues to be a strong theme throughout both service-user and psychiatrist interviews. It is perhaps no surprise that some have reported feeling powerless or paranoid regarding the medication. There is also a desire by some to get to the root cause of their mental health issues and they don’t all feel that medication is enabling them to do that. I have considered using ‘conformity and focus on medication’ as a main category but there are other closely linked sub-categories that can be grouped together (e.g. “binning medication”, side-effects of medication, medication focus versus getting to the root cause). I think a more encompassing category for all these sub-categories would be ‘diagnosis and medication-compliance’. Despite there being some medication issues in the community, these seem to be more related to stopping medication and the consequences of that whereas the more overt medication-focus and compliance appears to be most strongly referred to in the context of the ward environment. As a result, I think this category will come under the higher-order category of ‘ward environment’ and I will assign another suitable category to the ‘lead-up to admission’ so that the other medication issues can be reflected at that stage in the process too.


LEAD UP TO ADMISSION
POINT OF DETENTION
Escalating service user distress
Reactional coping
Deteriorating key relationships
Support provision
Avoidance and ambivalence
Lack of insight/Disagreeing with professionals' opinions
Struggling professional support
Assessing risk
Overwhelming presence
Distress and persecution
Clinician frustrated and blaming
Decision to compulsorily admit
Service user feelings & familiarity with admission
Stigmatisation & preserving dignity
Liberty removal
Ambivalent family reaction
Degrading treatment by police
Mode of transfer & In-transit interactions
Transfer distress
Poor communication with service user
Distress
Feeling angry & isolated
Safety issues
Effect of ward environment on service users
Ambience on ward
Shortage of staff & other resources
Diagnosis & medication compliance issues
Ward staff exerting control & power
Limited freedom/independence
Disputing the admission
Drive to leave the ward
Occupying time
Ways of coping
Positive & negative service user-service user relationships
Positive staff-service user relationships
Negative staff-service user relationships
Discharge process & pressure to discharge
Discharge relief & concern
Negative post-admission feelings
Continuing to regain insight
Maintaining support
Experiencing discrimination
Inadequate & fragmented aftercare
Continuing issues regarding medication
Experiential learning from admission
Promoting recovery & the revolving door


MENTAL HEALTH DIFFICULTIES ↑
Deteriorating key relationships
Support provision ↓.
Stress
Reactional coping
Avoidance
Lack of insight
LEAD UP TO ADMISSION
eg. Crisis Act.
Service user stress
Support provision ↑
Attempts to engage service user
POINT OF DETENTION/MHA ASSESSMENT
PROFESSIONAL INVOLVEMENT
↑ DISTRESS
CLINICIAN FEELINGS/ EMOTIONS
FAMILY REACTION.
EMPATHY + SUPPORT
DECISION TO ADMIT
LIBERTY REMOVAL/SU THOUGHTS /FEELINGS.
STIGMA
TRANSFER
INAPPROPRIATE TREATMENT BY POLICE.
IN TRANSIT INTERACTION
TRANSFER DESTINATION.
FURTHER LIFE STRESSORS
WARD ENVIRONMENT
DISTRESS
SAFETY ISSUES
LIMITED FREEDOM/ INDEPENDENCE
DIAGNOSIS + MEDICATION - COMPLIANCE
POOR COMMUNICATION
DISCHARGE PLANNING + FEELINGS ABOUT DISCHARGE.
REINFORCEMENT OF SAFETY-SEEKING BEHAVIOURS
DISCHARGE FROM WARD
~~POST ADMISSION FEELINGS~~
STAFF/SU. RELATIONSHIPS.
SUPPORT
CONTINUING TO REGAIN INSIGHT
RECOVERY/ + STAYING WELL
EXPERIENTIAL LEARNING
COMMUNITY
DISCRIMINATION.
CONTINUING ISSUES.


LEAD UP TO ADMISSION
Deteriorating key relationships
Support provision
Escalating service user distress
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Maintaining support
Experiential learning from admission
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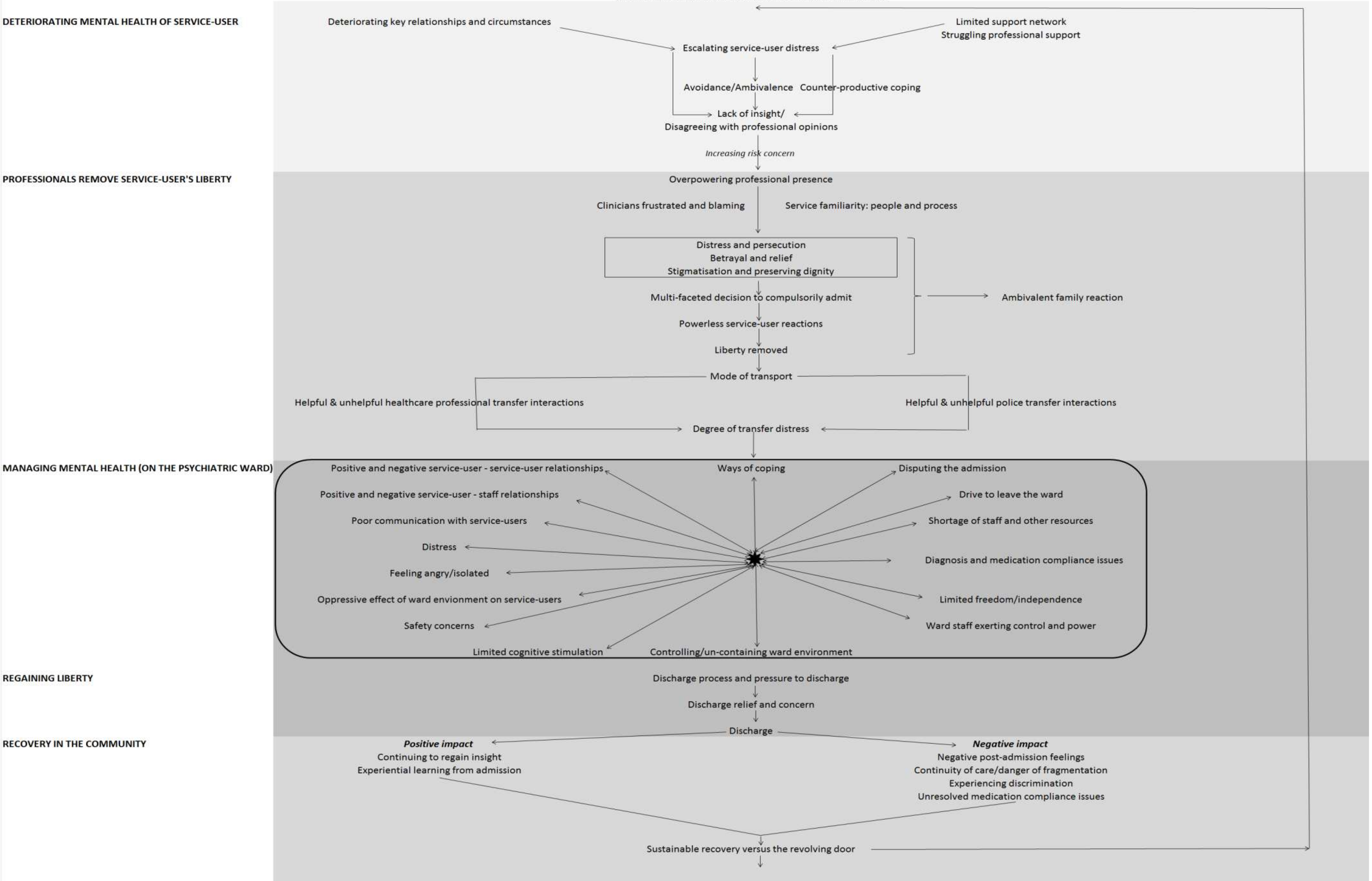
A DISTURBING JOURNEY: TO AND FROM DETENTION'



Appendix 13: Illustrative quotes for categories and sub-categories

Key:

🟦 Psychiatrist(s) only
⬛ Service-user(s) only
🟥 Psychiatrists and service-users

HIGHER-ORDER CATEGORY	CATEGORIES	SUB-CATEGORIES	EXAMPLE CODES
A) LEAD-UP TO ADMISSION	1. Deteriorating key relationships and circumstances	Family colluding with clinicians	“His parents were almost starting to put his medication in food to try and get him to take it” “We are colluding, yeah...And that’s not good.”
		Family anxious/worried	“Family still very concerned” “The mother withdrew, she was worried”
		Discord/breakdown of key relationships	“His girlfriend he had separated from...” “Family dynamics were very difficult.”
		Distrusting of mental health service	“...distrusting psychiatric services that they are ruining his life and interfering in his life.” “*So you didn’t trust the staff??* No.”
		Feeling angry (e.g. with professionals, family)	“She was very irritable” “...just very angry”
		Poor service user-psychiatrist rapport	“me and psychiatrists, our conversations tend to deteriorate rapidly because I have very little respect for them…I don’t think they understand reality at all.”

		Discord with neighbours	“I was frightened of the neighbours...I was causing all kinds of ... I don’t mean physical fight but yelling at them and telling them to leave me alone.”
		Family members feeling confused	“Mother was completely confused.”
	2. Escalating service user distress	Tired/lack of sleep	“I hardly had any sleep” “She hadn’t slept well and part of the issue as well, I think.”
		Distressed by psychotic symptoms	“...I think part of the reason why she was distressed was generally she was experiencing quite, she was quite psychotic at the time.”
		Feeling distressed	“She turned up here in a distressed state. I mean she was shouting, banging on the front door and she was requesting to be seen.”
		Higher levels of expressed emotions	“...the home environment, with its high level of expressed emotions, would have not have been beneficial, and probably it wasn’t.
		Feeling anxious/worried	“She was very anxious”
		Feeling vulnerable/unsafe	“She appeared quite vulnerable “ “Clearly she was not very safe at all.”
		Feeling paranoid	“He was very paranoid about his environment.”
		Feeling out of control of thoughts	“She felt out of control with the intrusive thoughts of setting herself alight.”
		Feeling detached from reality	“I was in another world. I didn’t know what I was doing… I was thinking I was someone else.”
		Confused/chaotic thinking	“It was very clear that she was very, quite chaotic in her behaviour and her way of thinking as well.” “I was a bit confused.”
		Employment/financial stressors	“They did have financial problems, her partner had lost his job.”

			"The first episode was caused by overwork. I was a workaholic, basically."
		Precipitating life stressors	"He had had some stress in his life which precipitated it."
		Mental health of service user's spouse/family member	"Her partner is also a service-user."
		Living environment stressors	"I was homeless...I was staying in a drop in centre in [place]...I was knocking around on the streets and also in hostels."
	3. Counter-productive coping	Drug/alcohol misuse	"I was drinking heavily." "A huge percentage of these patients, they do have psychotic disorders, and some of them may have additional problems, particularly substance misuse."
		Stopping medication/non-compliance	"She wasn't taking her medication, she stopped taking her medication." "I became unwell again because I wasn't taking my medication."
	4. Avoidance and ambivalence	Avoidance of engagement with mental health services	"He was very reluctant to engage with us." "He'd kind of gone to a few outpatient clinics and stopped going."
		Denial of mental health problem	"Denial was a very important mechanism involved in, you know, the process. After the episodes often he wouldn't talk about the experiences and the past."
		Ambivalent about engagement with mental health services	"She still showed ambivalence."
	5. Failing support	Parental support	"They [parents] kinda wanted to support him."
		Support from neighbours	"Next door neighbours come out and said "Are you alright...I had [name] and [name] saying "Come in and have a cup of tea and calm down."

		Social isolation/Lack of support	“He doesn’t have the protective element of a good social network” “I’ve been living on my own for a long time, you know, years…I’m not very good at making friends since quite a while now, since I got divorced…I never wanted to be close to people.
		Neighbours call emergency services	“...neighbours were phoning up police because I was being erratic and odd behaviour.”
	6. Insufficient professional support	Established psychiatrist/doctor-service user relationship	“I’d seen him a few times by then so he was slightly more comfortable about me coming to the house.”
		Early intervention/Crisis team involvement	“...every attempt should be made to contact services, get services involved, right at the start and to engage right at the start, be very active...” “So my view about detention is that some of it can be avoided. I was not made aware that he was on a relapse.”
		Nurses rapport-building with service-user	“...it’s the nursing staff who build up, usually, the rapport and the closer relationship, because we try to, even with the larger team, we try to keep some consistency with the workers.”
		Need for transparency	“It’s completely out of context from what I said...I want all my medical records and I want to have a look at them.”
		Coercing service-users towards admission	“We have to sometimes, try to persuade them to stay informally, and if they don’t accept and they are incapacity to make decisions, then we kind of have to compulsory detain them.”
		Increasingly intense involvement/visits	“So for a period of about a week probably we were seeing him every day at home.”
	7. Lack of insight/Disagreeing with professional	Partial insight	“She didn’t see things from our point of view. And certainly she didn’t agree that actually she wasn’t feeling well.” “Some patients...will have a level of understanding, you know, that things are not

	opinion		well for me, I need to be in hospital, while some of them, they may not have that...they may not have that understanding.”
		Degrees of insight and subjective interpretation	“People were telling me I was one thing I knew that that was an outward appearance…I could reason why they would think those things…basically I really changed character… a lot of my family weren’t aware of why I’d changed, or couldn’t really understand.”
	8. Increasing risk concerns	Use of illicit drugs & perceived increase risk	“He was smoking cannabis.”
		Risk of harm to self	“He was posing a risk, that he could put himself at risk if he went to act on those delusions.”
		Risk of harm to others	“I made a threat to kill one of the nurses.”
		Child protection issues	“... and there were children. I think he’s got a [number]-year-old son or the brother has got a son that lives there. There are young children involved.”
		Vulnerable adult	“In both cases there was a risk of sexual exploitation, because they were quite dis-inhibited in their sexual behaviour.”
		Forensic history	“It was a patient who had had a forensic assessment, had been identified as a very high risk patient, because of past fire-setting behaviours.”
		Professional's anxiety	“We did express to her that we were very worried about her safety, because she appeared to be quite distressed and confused.”
		Risk averse practice	“ I think it’s a risk averse, the way that we work now and sometimes with work, so much concern about risk, that we forget about the psychological impact of detention and removing somebody’s freedom.”
		"Place of safety"	“For instance, someone who’s homeless, who’s suffering from a mental health issue, it [hospital] would probably provide, er, a safe place.”

		Acting in best interest of service-user	"You have to pay the, the benefits and the costs and try to weigh it out and see what's best for the patient."
		Generic questioning	"You're never going to get there by coming up with a set list of questions like how are you feeling in yourself? You need to converse."
		Clinician empathising with service-user	"I think just looking at it from the medical model, a perspective would be to empathise with their situation. How would I want to be treated if I was in their situation?"

HIGHER-ORDER CATEGORY	CATEGORIES	SUB-CATEGORIES	EXAMPLE CODES
B) POINT OF MHA ASSESSMENT & DETENTION	1. Multi-faceted decision to compulsorily admit	Disjointed MHA assessment	"Usually, we always try to do all the recommendations together and have the assessment together. However that's not always possible."
		Multi-professional decision	"It's actually not just me on my own making such decisions. It's usually a whole team approach. Er erm, mental health practitioners, and another section 12 approved doctor as well."
		Risk-focused assessment	"I think, as a psychiatrist we tend to look at patients, especially from the risk point of view, yeah the whole process of compulsory detention is usually to prevent, well always to prevent them or others, or in this case it was always to protect them from themselves."
		Police-initiated detention	"He was brought back by the police."
		Act in "best interests" of service user	"As professionals, you have your best interests at heart for the patients but sometimes they are not aware of them."
		Government/legal enforcement	"... it's the state coming down on you, literally, and we are agents of the state."

		Subjective opinions and power in decision to detain	“We felt as well that she wasn’t able even to look after herself in the community.”
		Inter and intra-professional /team working	“We arranged a mental health act assessment with the social worker and erm, another section 12 approved doctor.”
	2. Overpowering professional presence	Importance of care co-ordinator presence	“I think, if possible that the care coordinator could be present at the time of the assessment ‘cause they are usually the people who know them the best. If they have a good rapport with them it might be easier to go through the whole process.”
		Police presence for enforcement	“The next day the police were called because he was already threatening.”
		Lots of professionals	“Often there will be two doctors, a social worker, somebody assisting the social worker...Sometimes the police will be sat outside, and then there will be the service user and there might be one or two members of the service users’ family. So you’ve got 7 people all focusing on one person.”
		Professional presence dependent on time of assessment	“It’s usually better if you do it within normal working hours because you could have key worker, or the person who knows the client well.”
		Presence of supportive person(s)	“The [x] Minister from the church and charity was with me when they came round.”
	3. Clinician frustrated and blaming	Clinicians frustrated at not intervening sooner	“You are doing this quite late. Why did this have to develop? Why did it have to go that far?”
		Clinicians blame parents	“I think probably his parents played a big role in it. Erm, because they from the start had been adamant that he could be treated at home and he should be treated at home.”
	4. Distress and persecution	Feeling punished	“She was not having any of it and er, she felt that we were just trying to punish her.”
		Being treated as a criminal	“ ...to be taken away in handcuffs by police... they’re casting you as though you

			were some sort of criminal and you're not really a criminal. You're just not all there at the time..."
		Feeling frightened	"...where they can Section you is quite daunting, when all of a sudden you're not allowed out of hospital and that, that's quite frightening." "He was very scared."
		Feeling traumatised	"It's very traumatic."
	5. Betrayal & relief	Feeling disbelief	"I felt disbelief. I couldn't believe it. It was like 'I can't believe you've gone this far'."
		Feeling surprised	"I was just lying in bed and my mum was like, the doctor's here and then all of a suddenly they just took me to this far away place..."
		Feeling betrayed by family/system	"He was blaming his family for his, he was blaming services, he was blaming myself, that for some reason I had grudges against him and wanted to detain him."
		Feeling grateful for help	"I was grateful. I was grateful that they'd found me..."
	6. Service Familiarity: Process & people	Familiarity with process	"She would have known it very well as she's had admissions that have lasted for months...she would know even possibly the room she was going to go into, so there would have been a lot of familiarity about the ward... She would know the rules and regulations...I think it's not unusual for patients who have, particularly the revolving door type patients, to know the set up."
		Familiarity with staff	"Every face that they saw was familiar. Would you like a cup of tea, you know, they'd ask, would you like a cup of tea, they'd ask about it, he even showed us his house plant that was dying. So there was a lot of familiarity."
	7. Ambivalent family reaction	Family feel sad	"The family was quite sad."
		Family/spousal relief	"Her partner seemed to be relieved, the service-user herself, there was, I think, a sense of relief that control was being taken of the situation."
		Distressed family	"I think probably the parents were more distressed that he was. Erm, because they

		members	felt that kind of they'd of failed in some way."
	8. Stigmatisation & preserving dignity	Mental health difficulties made public (e.g. to neighbours)	"Their life is sometimes made a little bit public isn't it... some people, neighbours, might come to know about it."
		Need for discretion	"Maybe have the team of dedicated mental health police that don't have flashing lights."
		Trying to preserve dignity	"In the end we had to organise a Mental Health Act assessment after trying to do it to preserve her dignity."
		Stigma attached to admission	"It might be stigmatising if you have been detained under the mental health act so many times."
	9. Liberty removal	Lack of choice	"You don't have a choice."
		Loss of freedom	"She does obviously lose her freedom."
		Loss of human rights	"I was adamant that I wouldn't be forced to do anything against my will, which is why I had such a problem with like, the Mental Health Act, because I thought, in some respects, it goes against human rights."
		Separation from children	"...when she was led away the police escorted her and the kids got taken away…"
	10. Powerless service user reaction	Against will	"I think the very nature of detaining someone is it's like you're going to be held here against your will."
		Passive acceptance	"You tell people that, and they come to passively accept that they have to go to hospital now. And all you've done is sign a piece of paper."

		Learned helplessness	"I guess there's a kind of hopelessness about that isn't there. People kind of go into a learned helplessness mode where they're like that's it now."
		Service user not taken seriously	"Everyone is treating him as mentally ill, that anything he says is not taken seriously."

HIGHER-ORDER CATEGORY	**CATEGORIES**	**SUB-CATEGORIES**	**EXAMPLE CODES**
C) TRANSFER	1. Degrading treatment by police	Use of handcuffs	"I'm never, ever violent with people or myself. And they took me away in handcuffs, which I didn't like."
		Use of force by police	"...I got bundled to the ground…They dragged me to the road and they kicked me a few times, and emptied my pockets, and one of them said they were placing me under some section…"
		Transfer to 136 suite	...on 136 basis by police in the middle of the night, you wouldn't have a person who knows them well apart from the relatives and they would be dragged to a police station or 136 suite."
	2. Transfer distress	Long transfer distance traumatising/distressing	"She was admitted to a bed in [place] because there were no local beds, and from [place] to [place], that's quite a long way...I think the longer the journey is that you have to make, the more traumatising it is."
		Transfer distressing	"I freaked out and I cried all the way to [place], like I do every time, thinking no, my life has just degraded away once again, and I'm going through absolute torture."
		Reduced distress if choice of ward	"Women tend to prefer to go to a female-only ward... That makes a big difference if they can be promised that that particular ward is available to them. They are less distressed."
	3. Transfer mode & In-transit supportive	Police communication with service user	"He [policeman] was just saying, how are you doing, and that, what have you been up to. We realise you've been on the street for a little while and how have you been getting by, and are you all right."

	engagement		
		Familiar person accompanying	" It's helpful if the care coordinator can go with them too... if the care coordinator can accompany them to hospital and settle them in it can be very helpful."
		Mode of transfer	"Transport was arranged for them to be taken to hospital... we called the ambulance and the police as well actually."

HIGHER-ORDER CATEGORY	**CATEGORIES**	**SUB-CATEGORIES**	**EXAMPLE CODES**
D) WARD ENVIRONMENT	1. Poor communication with service user	Lack of information about what is happening	"It would be helpful to have someone explain to them what is being done, who's coming in the room to see you, what they are in the hospital, what they do in the hospital."
		Nobody listening	"Nobody is listening to my side of the story."
		Lack of contact with psychiatrist on ward	"You never see a doctor on a ward...occasionally you will, but it's always like a breeze through...it's always like you go into a room down the hall which is weird."
	2. Distress	Lack of awareness	"I was swearing and totally off my head. I didn't have a clue what was going on."
		Feeling paranoid	"I can remember sitting in front of a window and for some reason I kept thinking I was going to be shot through the back of the head. I kept looking round and was looking for a gun."
		Against will	"I'd express my views quite clearly that I didn't want to be there."
		Frightening/unsafe	"It makes you feel a bit frightened sometimes. There were some dodgy characters when I was in there again this time round."
		Feeling distressed/upset	"Most people, I think probably it is, it might be distressing for patients because, at the end of the day they have been detained compulsorily."

			“I used to cry a lot...I used to cry a lot and say “why”.
		Feeling confused/disorientated	“At one point I asked one of my nurses, is this someone’s home? Ha. Do you know what I mean? I was really confused at one point.”
		Feeling anxious	“I was freaking…really etchy and really nervous.”
		Feeling persecuted	“He thinks again that the system makes a big mistake...consultants and managers are all collaborating to kind of keep him on the ward.”
	3. Safety concerns	Physical attack	“I had a cup of coffee kicked out of my hand by another patient.”
		Aggressive as defence against feeling unsafe	“ I know that every time I go to hospital I’m going to almost get killed again, so I actually have to become really violent.”
		Risk/fearful of being physically attacked	“She was quite worried that she might be attacked by other patients.”
	4. Limited freedom/independence	Lack of outside space	“I’d like to be able to go outside. I think that all of the wards should have an open space…even just to get fresh air because this was a big problem for me in the past.”
		Power to restrict liberty	“I think they [police] do it because they enjoy having power and control over people. I think people are in that job for that reason generally.”
		Rebelling	“I just started to become a bit awkward with people around me. I started to become a bit awkward on purpose.”
	5. Diagnosis and medication-compliance	Conformity and focus on medication	“...it just reminds me that it’s just, it’s 100% based around medication.”
		"Binning medication"	“I was binning medication, which is what I do generally. I don’t take medication…After a couple of weeks, yes, they found out.”
		Medicated against will	“I didn’t want them to come and inject me, it was like they were enjoying it.”

		Paranoid about medication	"He was very paranoid about the medication"
		Side-effects of medication	"She didn't like the sedation and she didn't like the weight gain, and she was non-compliant on [medication]. She had made it very clear I don't want that."
		Powerless (to medication)	"I felt powerless because it is like even if I say something it is up my medication."
		Medication-focused approach v getting to the root cause	"I stayed in because the question was, you're not taking medication, I'm not taking medication. Ok, then you're not leaving. It wasn't like we're assessing your mental health. It was 'you can take medication then you can go'. It's not a place where you're truly assessed…"
		Medication as a "magic wand"	"This pill means that you're ill. This is a currency, like a sort of seal that says that you'll be better and I will look after you."
		Service-user knowledge of diagnoses	"I would question really his, his level of understanding of the nature of his illness."
	6. Feeling angry/isolated	Anger/frustration and anxiety at missing external events	"...missed my court date, so that then meant that my court date was now three months later."
		Feeling frustrated/angry	"I was p!$$ed off still, and I got to [hospital] and I remained p!$$ed off until I was released from hospital, which was [x] weeks later."
		Feeling isolated/unsupported	"Patients can be quite isolated when they're on the ward. There's a ward phone but they don't always work."
		Angry at being detained	"I was charged with aggression and testosterone and suchlike things."
		Lack of respect	"People don't respect the sensitivity of people who are supposedly mentally ill."
		Lack of empathy	"Maybe it's just not being there, not connecting with them."
		Anxious	"Anxious. I wanted to get out of there because it was driving me nuts."
		Feeling punished	"Obviously she wasn't willing to engage initially because she felt that actually

			mental health services, erm, were punishing her by putting her in hospital.”
		Submissive	“I was being controlled, so I just sort of said “Right, fair enough, if I can’t leave here then I’ll just ... I was sort of letting them show me the way to go sort of thing, submissive, if you like.”
		Feeling surprised (at what they had done)	“I was very surprised, because I had no recollection. Normally throughout an episode I can tell you what I’ve done.”
	7. Drive to leave the ward	Absconding from ward	“I just absconded, so no one could find me.”
		Home leave	“I think he was on a [Section] 2 for about a couple of weeks and then he had home leave.”
		Family anxious (when home leave)	“The family were concerned that she was not quite, when she went out with them for periods of leave, they found she still was not behaving in her usual way.”
	8. Positive staff-service user relationships	Helpful staff	“They were all very helpful. They said, [name], come on, what’s up?”
		Good rapport with staff	“They asked you how you’re feeling, and medication and stuff like that. I felt part of the family…I knew the nurses…care workers, yes. I knew them. They were like friends, you know…they seemed to care about you.”
	9. Negative staff-service user relationships	Superficiality of professionals	“You’re not going there to make friends, which is how I felt like. Some of the people…it was completely superficial.”
		Poor rapport with ward doctors/psychiatrists	“Me and psychiatrists, our conversations tend to deteriorate rapidly because I have very little respect for them…I don’t think they understand reality at all.”
		Lack of staff	“You would have like members of staff just sitting there as well.”

		motivation/professionalism	
		Short admissions feel disruptive/Chaotic	"It's a short admission, usually 28 days, and if people are ill it creates some sort of chaos and creates some sort of rush."
	10. Ward staff exerting control & power	Lack of staff flexibility	"They didn't make allowances and cancelled my weekend leave."
		Staff use of physical force/restraint	"I mean obviously there's one guy on my head, there's another guy holding my legs down and then one on each arm...I wasn't even posing a threat when they decided they needed to restrain me."
		Whistle-blowing to combat mistreatment of service users	"I think there's a lot of cliqueness definitely involved and if something happens that is maybe a little bit too much or someone is restrained in a more aggressive way, they should feel about speaking up."
		Subjective staff perceptions influencing decision-making	"...every week you meet with a doctor to discuss like your progress. And they are informed by the nurses…so basically that was a problem…the doctors are informed by people who don't really...understand."
	11. Shortage of staff & other resources	Impact of staffing levels on care	"The facilities were pretty limited because they were very short staffed, owing to the bad weather conditions."
		Shortage of service resources	"I think the pressure is coming from lack of resources and the pressure."
	12. Positive & negative service user-service user relationships	Making friends whilst admitted	"I've made a few good friends as well through being... I've met them because I've been sectioned."
		Difficult to relate/interact with other service users	"Interacting with the other patients…I recognised the people who weren't right… as I came down to normality I wanted to cut myself away from the worst cases, you know, because I couldn't relate to it."

		"Lifeless" service users	"It was like, this is the place where people have just been put, because people have forgotten about them. They were like dying."
		Adverse impact of being around other service users with mental health issues	"You're surrounded by people who are very ill, some of them, and some of them are not so ill, and that can affect your mental state in itself"
		Dynamics dependent on number/mental health of other service users	"It very much depends on the ward environment and how many other disturbed patients there are present at the time. "
	13. Disputing the admission	"Evidence" gathering for tribunal	"...so we carried, we carried that on for a period of time 'til, almost to get evidence..."
		Right to appeal at tribunal	"... right to appeal to an MHRT... The patient can write appeal against the compulsory detention to a mental health tribunal."
		Service-user knowledge of tribunal process	"She would know her rights to appeal, her partner is very aware of, of his rights as her nearest relative."
	14. Ways of coping	Use of illicit drugs	"Some people continue to take drugs on the ward because a lot of acute psychiatric services it's quite easy to get drugs in there… mostly cannabis..."
		Smoking	"I was having two cigarettes every hour, because that's all there is to do..."
		Religious coping	"I never missed a church Sunday, I used to go to the little service they hold in church on the ward."
		Support providing relief	"As soon as a couple of weeks went by I was relieved to be in their care. I was relieved to see everyone again."
		Visits from friends/family	"I've got my friend who came to see me."

	15. Limited cognitive stimulation	Food and meals	“eat a lot... I was eating more regularly than I would do when I was well.”
		Activity	“You had OT that you could go to but they didn’t advertise that frequently.”
		Lack of activity	“To be honest, it was very, very boring. I talked to patients, talked to staff, had home leave, but not really an awful lot...”
		Lack of psychotherapy	In some cases there is psychological input but in most cases that would be, if we had the capacity to provide for example, family therapy for clients that would be preferable. In my experience that almost never happens.”
		Getting adequate sleep/rest	“The more sleep and rest I have, I’ve got very quick recuperative powers.”
	16. Oppressive effect of ward environment on service users	Perception of ward influenced by comparison to home environment	“You are also being put in a place that’s not home and if home is a problematic environment then there is an advantage to be detained er elsewhere.”
		Impact of physical environment	“the lighting was awful.”
		Lack of understanding of how environment impacts on individual	“...it just shows that people don’t really have like an understanding,..I don’t think they really understand how much the environment affects people.”
	17. Controlling & un-containing ward ambience	Unfriendly	“The ward environment was not very friendly.”
		Institutionalisation	“They’re in this institutional environment....Someone wakes you up and gives you your meals and tells you when to go to bed. It’s a very different environment to being at home.”
		Not conducive to	“They weren’t really putting them in a condition that’s conducive to mental

		improving mental health	health.”
		Feeling scrutinised, monitored and assessed/lack of privacy	“They’re constantly monitoring you all the time without you realising most of the time.”
		Trying to prove sanity	“I just remember having lots of like conversations where I would be arguing for my sanity.”
		Slow paced	“It’s very slow paced, it’s not like a normal hospital where everything’s buzzing.”
		Distressing environment	“You can’t control the environment on the ward sometimes. Sometimes you’re walking onto a very distressing environment.”

HIGHER-ORDER CATEGORY	**CATEGORIES**	**SUB-CATEGORIES**	**EXAMPLE CODES**
E) DISCHARGE FROM WARD	1. Discharge process & pressure to discharge	Involving family and service users in discharge planning	“Normally at such a meeting [discharge planning] family would attend but there was nobody from her family to attend.”
		Organising & preparing for discharge	“I admit people and work with them, and then kind of prepare for discharge and then discharge people and er liaise with other teams.”
		Excessive discharge paperwork	“There’s so much paperwork and forms and things. I think that’s got to change.”
		Staff under pressure to discharge	“When people are under pressure they tend to discharge patients and so on...”
	2. Discharge relief & concern	Relief at being discharged	“I was relieved to be out of the place yes.”
		Distrusted by clinicians	“It made me feel like a little kid again because it was as though they were letting you out but they didn’t really trust to let you out.

HIGHER-ORDER CATEGORY	CATEGORIES	SUB-CATEGORIES	EXAMPLE CODES
F) COMMUNITY	1. Experiential learning from admission	Increasingly submissive	"... and so I suppose I'm submissive now. I'm more submissive than I was then."
		Fear of future admission	"I'm just frightened that I'm going to go again, you know."
		Learning from admission experience	"You cannot learn absolutely nothing, you will always learn something but whether you learn the right thing, that's an entirely different matter... the thing to learn is well that's what happens when you stop your medication."
	2) Experiencing discrimination	Stigma attached to diagnosis	"You end up being labelled in society as a mad woman, so then even if you are provoked you don't have a right to say anything...Labelled."
		Stigmatised	"When you come out of... people do look at you different, weirdo, nutter, I've acquired the nickname nutty [name] without even realising it."
		Familial transcending of mental health issues	"She's [daughter] been part diagnosed with bi-polar as well."
		Socially perceived doctor-MH service user power differential	"Everything is physical, there's no understanding that actually like, erm, it's not just a chemical imbalance."
		Separation from children and obstacles to having them	"You're not allowed to have children, basically, if you're psychotic..."
	3) Negative post-admission feelings	Post-admission depression/low mood	"At first she got a bit depressed when she went home."
		Feeling guilt towards family	"... guilt having brought about that detention."

		Anger towards spouse/family	“I think she may still carry some, erm, feelings of erm, anger probably towards her partner.”
		Feeling set-back after admission	“They put me in hospital for two months and I've gone back five months.”
		Shame about being compulsorily admitted	“ I think in a way I think he will feel shame”
		Feeling loss due to absence of psychotic part of individual	“Do you feel that there was a sense of loss there and you were trying to perhaps hold onto that? Yes, yes, the psychotic part of me was...that sort of gave me power, you know.”
	4) Continuity of care/danger of fragmentation	Income support	“I’m on benefits now so I haven’t got that pressure of trying to find work.”
		Maintaining rapport despite admission	“I didn’t feel it, it destroyed our relationship. I think she feels, she still feels quite positive about seeing me, although I detained her.”
		Management in community	“He should be managed in the community, out of hospital.”
		Individual versus family-focused engagement	“If you say for us, the focus is the family, then automatically the focus is not the patient, I mean you can’t be centred on many things at the same time.”
		Lack of continuity of care	“She went to hospital, erm yes. But unfortunately the way things work these days ...I would look after community patients and if somebody is going to be admitted to hospital they would normally be looked after by a different team all together.”
		Lack of social services support	“...a bit more social services support…I’m not too happy with them. Their support has been a bit blasé.”

	5) Continuing to regain insight	Confusion about persona/MH changes	“It confuses me because I don’t understand the transition from that condition to who I am now.”
		Regaining insight	“I think she now recognises that she was extremely unwell because she feels so much better.”
		Clinicians hope for increased insight	“ I would hope that he has been able to develop some insight.”
	6) Unresolved medication-compliance issues	Always medicated /medication compliance	“A couple of times I did stop taking it but I did tell them I’d stopped taking it...I'm taking it basically just to keep them happy...I'm actually functionally compliant, I'm only compliant to keep them happy.”
		Undesirable side-effects of medication	“I knew the [medication] made me relaxed, sleep for a long time but it was just making me put on weight.”
		Medication-free	“He’s done very well as he did last time. He recovered fully and was medication-free for a year or two erm before he relapsed.”
	7) Promoting recovery & the revolving door	Advanced directives/choice	“If they have a psychotic episode and they are recovered, at that point you sit them and make an informed decision ...but you can’t do that when somebody is intensely psychotic and lacks the capacity to make logical decisions.”
		‘Revolving door’ clients	“I think this pattern of admission and discharge was, in a way, detrimental to his health.” “You feel trapped.”
		Promoting recovery	“Basically the whole idea is to try and promote recovery more than anything else.”
		Reflecting when well	“The new thing for me [psychiatrist] is, you know, er, I do not spend time discussing the experience with the, so maybe that is something that is worth doing...”
		Recovery in home environment	“I felt that she’d improved enough in [month] to have been allowed home…where I thought she’d make a full recovery a lot easier in the peace of

			home.”
		Trying to establish causality	“I don’t feel that drugs are the only solution at all…for some people the core problems are in their beliefs, what they believe…you need to find out what’s causing ... If you get to the root of the cause and you solve the problem at the root of the cause then the rest of it kind of falls into place.”
		Empowerment via psycho-education	“Educating them about the course of the illness, the relapses, the risks associated with the relapses and er how we can prevent a further hospital admission.”

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10th July 2011

Exploring compulsory admission experiences of adults with psychosis using grounded theory

Dear participant,

I would like to take this opportunity to thank you for taking part in the interviews for my study. I greatly appreciated your time and valued hearing about your experiences of compulsory admissions. Indeed, you may remember I was aiming to explore compulsory admission experiences for adults with psychosis using a qualitative method called ‘grounded theory’. I have now finished collecting data for my research and have produced my results based on this. Below I have summarised the main themes which came out of the interviews. I have listed the main themes and given a brief explanation about each of them.

Summary of findings

A. Lead-up to admission

In the lead-up to compulsory admissions there were eight key categories which summarised the experiences described. Both service-users and psychiatrists reported deteriorating key relationships (e.g. partner, family, services etc.), escalating service-user distress and counter-productive coping strategies (e.g. use of illicit drugs, alcohol). There was also often an increasing avoidance (e.g. of mental health services, other people) and often failing support systems. Commonly, insight was reported to diminish as the service-user’s mental health deteriorated yet service-users and psychiatrists sometimes disagreed in terms of the degree to which insight was affected. Invariably, there were increasing risk concerns relating to the service-user (E.g. risk of harm to self) which led to a Mental Health Act (MHA) assessment being arranged.

B. Point of MHA assessment and compulsory admission

Some clinicians felt frustrated and were blaming because they felt earlier intervention should have taken place. At the point of MHA assessment and compulsory admission an overwhelming professional presence was reported in what was essentially a multi-faceted and multi-professional decision to compulsorily admit the service-user under the MHA. The service-user was often reported to be distressed and felt persecuted, with the removal of their liberty. Many service-users reacted powerlessly (e.g. submissive) to the decision whilst psychiatrists also reported that family members felt ambivalent about their relative being detained (e.g. mixture of relief and guilt). There was also an awareness of the potential sigma of being admitted and the potentially adverse impact on the service-user's dignity.

C. Transfer

Worryingly, numerous service-users reported somewhat degrading treatment by the police (e.g. use of physical force, handcuffs) and service-users were often reportedly distressed during the transfer from the community to the psychiatric inpatient ward. However, some service-users did report receiving supportive engagement during the transfer which was via a variety of transport modes (e.g. ambulance, private car, police).

D. Ward environment

With limited freedom/independence, and reportedly poor communication with service-users (reported only by service-users), ward staff were reported by service-users to exert control and power (reported only by service-users). A focus on diagnosis and medication-compliance was reported, with an emphasis on conformity. Some service-users disputed their admission (via Mental Health Review Tribunals) but commonly they felt distress, anger and isolation.

The controlling and un-containing ward ambience coupled with the general ward environment had a seemingly oppressive effect on service-users. This was further exacerbated by safety concerns (e.g. risk of physical attack). With limited cognitive stimulation on the ward (e.g. lack of activities) some service-users also reported shortages of staff and other resources.

Service-users coped in a variety of way (e.g. religion, illicit drug-taking, smoking). Some also formed positive relationships with staff (reported only by service-users) and other service-users. However, others did not, and there was a drive to leave the ward which either resulted in absconding, or eventually in home leave and subsequent discharge.

E. Discharge

There was commonly a discharge process regarding service-users being discharged from the ward, yet some psychiatrists suggested there was pressure on services to discharge. Service-user relief upon discharge was met with some lingering psychiatrist anxiety.

F. Community

Back in the community, as service-users continued to regain insight and improve their mental health, some service-users had negative post-admission feelings. Whilst some experiential learning from the admission was apparent, there were numerous unresolved medication-compliance issues and some experienced discrimination (e.g. stigma-related). Unfortunately, whilst attempts to maintain support were cited, so was inadequate and fragmented aftercare. Despite attempts to promote recovery, the risk of re-admission was highlighted, often in the context of the 'revolving door' phenomenon.

Summary of main categories

Overall the study suggests that the compulsory admission experience appears to be distressing. Containing psychotic symptoms with medication alone appears limited in its ability to meet the needs of service-users with psychosis. Whilst more research is needed, the findings of this study suggest significant clinical and service provision improvements are needed.

If you have any questions or would like to feedback or comment on any of the results please do not hesitate to contact me. In the meantime, thank you once again for contributing to this study.

Yours sincerely,

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INSTRUCTIONS FOR AUTHORS

Contents

Introduction

The British Journal of Psychiatry is published monthly by The Royal College of Psychiatrists. The Journal publishes original work in all fields of psychiatry. Manuscripts for publication should be submitted online via http://submit-bjp.rcpsych.org.

All published articles are peer reviewed. Contributions are accepted for publication on the condition that their substance has not been published or submitted for publication elsewhere, and this includes web-based documents. Authors submitting papers to the Journal (serially or otherwise) with a common theme or using data derived from the same sample (or a subset thereof) must send details of all relevant previous publications and simultaneous submissions.

The Journal is not responsible for statements made by contributors. Material in the Journal does not necessarily reflect the views of the Editor or of The Royal College of Psychiatrists.

Manuscripts accepted for publication are copy-edited to improve readability and to ensure conformity with house style.

Online submission

Manuscripts for publication must be submitted online at http://submit-bjp.rcpsych.org. A unique account will be created for each contributor using his or her email address as identification. (Note for contributors with more than one email account: please ensure you use the same email address whenever logging on to the manuscript submission website.) Contributors may track the progress of their submissions at any time via this website. For assistance with online submission, please email bjp@rcpsych.ac.uk or telephone +44 (0)20 7235 8857. A cover letter should be included with the submission explaining why you consider the submitted article suitable for publication in the Journal.

To submit a letter to the Editor, see below.

Fast-track assessment

Authors have the option of submitting articles for fast-track assessment. Those wishing to take this route should state this in the first or second sentence of their cover letter, together with the reasons for rapid assessment. A decision whether to approve the fast-track route will be made within 10 days of submission; those papers that are not selected for this route will be assessed in the normal way unless the authors state specifically that they want fast-track assessment only. All papers approved for the fast-track route will be assessed within 4 weeks of submission. Review articles will not be considered for fast-track assessment.

Title and authors

The title should be brief and relevant. Subtitles should not be used unless they are essential. Titles should not announce the results of articles and, except in editorials, they should not be phrased as questions.

All authors must sign the copyright transfer and publication agreement, which can be downloaded from http://submit-bjp.rcpsych.org once a manuscript has been accepted. One of the authors should be designated to receive correspondence and proofs, and the appropriate address indicated. This author must take responsibility for keeping all other named authors informed of the paper's progress. The contribution of each author to the paper must be stated at the end of the article; this information may be published online. Authorship credit should be based only on substantial contribution to:

- conception and design, or analysis and interpretation of data
- drafting the article or revising it critically for important intellectual content
- and final approval of the version to be published.

All these conditions must be met. Participation solely in the acquisition of funding or the collection of data does not justify authorship. In addition, the corresponding author must ensure that there is no one else who fulfils the criteria but has not been included as an author. Group authorship is permitted but individuals choosing this option will not be cited personally, as only those listed as authors on the title page of the manuscript and (on acceptance for publication) whose signed copyright agreement has been obtained, qualify for author status. It is the responsibility of the corresponding author to ensure that authorship is agreed among the study's workers, contributors of additional data and other interested parties, before submission of the manuscript.

The names of the authors should appear on the title page in the form that is wished for publication, and the names, degrees, affiliations and full addresses at the time the work described in the paper was carried out should be given at the end of the paper.

Declaration of interest

All submissions to the Journal (including editorials and letters to the Editor) require a declaration of interest. This should list fees and grants from, employment by, consultancy for, shared ownership in, or any close relationship with, at any time over the preceding 36 months, an organisation whose interests may be affected by the publication of the paper. It should also list any non-financial associations or interests (personal, professional, political, institutional, religious, or other) that a reasonable reader would want to know about in relation to the submitted work. This pertains to all the authors of the study, their spouses or partners and their children (aged under 18). We recommend use of the disclosure form developed by the International Committee of Medical Journal Editors for this purpose.

Structure of manuscripts

Papers

A structured abstract not normally exceeding 150 words should be given at the beginning of the article, incorporating the following headings: Background; Aims; Method; Results; Conclusions; Declaration of interest. The abstract is a crucial part of the paper and authors are urged to devote some care to ensuring that all the important findings are within the word limit.

Introductions should normally be no more than one paragraph; longer ones may be allowed for new and unusual subjects. This should be followed by Method, Results and Discussion sections. The Discussion should always include limitations of the paper to ensure balance. Use of subheadings is encouraged, particularly in Discussion sections. A separate Conclusions section is not required.

The article should normally be between 3000 and 5000 words in length (excluding references, tables and figure legends) and normally would not include more than 25 essential references beyond those describing statistical procedures, psychometric instruments and diagnostic guidelines used in the study. All large tables (exceeding half a Journal page) will be published only in the online version of the Journal (see Online data supplements, below). Authors are encouraged to present key data within smaller tables for print publication. This applies also to review articles and short reports.

Review articles

Review articles should be structured in the same way as regular papers, but the length of these may vary considerably, as will the number of references. Systematic reviews are preferred and narrative reviews will be published only under exceptional circumstances. Reviews done for the Cochrane Collaboration, the National Institute for Health and Clinical Excellence and other groups likely to be published, or already published, elsewhere, should have the submitted paper accompanied by the latest version of the parent review and its status so that an informed decision can be made about the added value of the submitted paper.

Short reports

Short reports require an unstructured summary of one paragraph, not exceeding 100 words. The report should not exceed 1200 words (excluding references, tables and figure legends) and contain no more than one figure or table and up to 10 essential references beyond those describing statistical procedures, psychometric instruments and diagnostic guidelines used in the study. Short reports will not exceed two printed pages of the Journal and authors may be required to edit their report at proof stage to conform to this requirement. This may be necessary even if the report does not exceed 1200 words if the figure or table is unduly large.

Editorials

Editorials require an unstructured summary of one paragraph, not exceeding 50 words. Editorials should not exceed 1500 words and may contain no more than one figure or table and up to 10 essential references. Editorials may only exceed two printed pages in length at the Editor's discretion. A good-quality photograph of the lead author for publication alongside the editorial must be submitted with the manuscript, along with brief biographical details (up to 25 words) for all authors.

Reappraisal

This is a section following the structure of Editorials but with up to 15 essential references. These articles are mainly commissioned by the Editor and are concerned with well-known subjects in psychiatry which are going through a period of controversy or re-evaluation. Reappraisals are intended to give a long-term balanced perspective on the subject based on the latest evidence.

Debates

Two debaters have three rounds of debate (1-2-1-2-1-2), responding to each other after each round. Each author may use up to 2000 words and 15 references, divided as they wish between their three rounds. A short introduction will be provided by the Debates Editors post-acceptance.

References

Authors are responsible for checking all references for accuracy and relevance in advance of submission. Reference lists not in the correct style will be returned to the author for correction. From January 2008, all references should be numbered in the order in which they appear in the text and listed at the end of the article using the Vancouver style (see below), in which the names and initials of all authors are given after the appropriate reference number. If there are more than six authors, the first six should be named, followed by 'et al'.

The authors' names are followed by the full title of the article; the journal title abbreviated (in italics) according to the style of Index Medicus; the year of publication; the volume number (in bold type); and the first and last page numbers. References to book or book chapters should give the titles of the book (and the chapter if selected), names of any authors, name of publisher, names of any editors, and year. Examples are shown below.

1 Kapusta ND, Etzersdorfer E, Krall C, Sonneck G. Firearm legislation reform in the European Union: impact on firearm availability, firearm suicide and homicide rates in Austria. *Br J Psychiatry* 2007; **191**: 253-7.

2 Thornicroft GJ. *Shunned: Discrimination Against People with Mental Illness.* Oxford University Press, 2006.

3 Casey P. Alternatives to abortion and hard cases. In *Swimming Against the Tide; Feminist Dissent on the Issue of Abortion* (ed AB Kennedy): 86□95. Open Air Books, 1997.

4 Lancet. Burnished or burnt out: the delights and dangers of working in health (editorial). *Lancet* 1994; **344**: 1583-4.

5 Pharmaceutical Research and Manufacturers of America (PhRMA). *PhRMA Guiding Principles on Direct to Consumer Advertisements About Prescription Medications*. PhRMA, 2005. http://www.phrma.org/publications/policy//2005-08-02.1194.pdf

6 Soni SD, Mallik A, Mbatia J, Shrimankar J. Late paraphrenia (letter). *Br J Psychiatry* 1988; **152**: 719-20.

7 Viding E, Frick P, Plomin R. Aetiology of the relationship between callous-unemotional traits and conduct problems in childhood. *Br J Psychiatry* 2007; **190** (suppl 49): s33□8.

Personal communications need written authorisation (email is acceptable); they should not be included in the reference list. Unpublished doctoral theses may be cited (please state department or faculty, university and degree). No other citation of unpublished work, including unpublished conference presentations, is permissible.

Tables

Tables should be numbered and have an appropriate heading. The tables should be mentioned in the text but must not duplicate information. The heading of the table, together with any footnotes or comments, should be self-explanatory. The desired position of the table in the manuscript should be indicated. Do not tabulate lists, which should be incorporated into the text, where, if necessary, they may be displayed.

Authors must obtain permission from the original publisher if they intend to use tables from other sources, and due acknowledgement should be made in a footnote to the table.

Figures

Figures should be clearly numbered and include an explanatory legend. Avoid cluttering figures with explanatory text, which is better incorporated succinctly in the legend. 3-D effects should generally be avoided. Lettering should be parallel to the axes. Units must be clearly indicated and should be presented in the form quantity (unit) (note: `litre' should be spelled out in full unless modified to ml, dl, etc.). All figures should be mentioned in the text and the desired position of the figure in the manuscript should be indicated.

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Colour figures may be reproduced if authors are able to cover the costs.

Statistics

Methods of statistical analysis should be described in language that is comprehensible to the numerate psychiatrist as well as the medical statistician. Particular attention should be paid to clear description of study designs and objectives, and evidence that the statistical procedures used were both appropriate for the hypotheses tested and correctly interpreted. The statistical analyses should be planned before data are collected and full explanations given for any post hoc analyses carried out. The value of test statistics used (e.g. t, F-ratio) should be given as well as their significance levels so that their derivation can be understood. Standard deviations and errors should not be reported as ± but should be specified and referred to in parentheses.

Trends should not be reported unless they have been supported by appropriate statistical analyses for trends.

The use of percentages to report results from small samples is discouraged, other than where this facilitates comparisons. The number of decimal places to which numbers are given should reflect the accuracy of the determination, and estimates of error should be given for statistics.

A brief and useful introduction to the place of confidence intervals is given by Gardner & Altman (1990, British Journal of Psychiatry, **156**, 472-474). Use of these is encouraged but not mandatory.

Authors are encouraged to include estimates of statistical power where appropriate. To report a difference as being statistically significant is generally insufficient, and comment should be made about the magnitude and direction of change.

Randomised controlled trials

The Journal recommends to authors the CONSORT guidelines (1996, Journal of the American Medical Association, **276**, 637-639) and their basis (2001, Annals of Internal Medicine, **134**, 663-694) in relation to the reporting of randomised controlled clinical trials; also recommended is their extension to cluster randomised controlled trials (2004, BMJ, **328**, 702-708). In particular, a flow chart illustrating the progress of participants through the trial (CONSORT diagram) must be included.

Qualitative research

The Journal welcomes submissions of reports of qualitative research relevant to the scope of the Journal. These manuscripts will be evaluated in terms of design, conduct and reporting of the study, which need to be of sufficient quality and merit to warrant inclusion in the Journal. The Editor recognises that the term ‘ qualitative research’ encompasses diverse methods underpinned by various epistemological or theoretical frameworks. Accordingly, manuscripts will be evaluated on the basis of the appropriateness of the selected framework to the enquiry, the internal coherence of the report and its adherence to quality criteria consistent with the methodology and method as follows:

Epistemological and/or theoretical frameworks

- The epistemological underpinnings and/or theoretical framework is made explicit and applied consistently

Study design and method

- The research goal is clearly articulated, justified with reference to literature, and placed in context
- The approach matches the purpose of research and is justified
- Methods of sampling, data collection, data management and analysis are explicit and consistent with methodology
- Analytical and interpretative processes are described fully

Findings, discussion and implications

- Findings represent the depth and breadth of data
- Findings and interpretations are supported by the data
- Direct quotations, exemplars or other data presentations are used judiciously in a way that illustrates the findings
- Findings are presented in a way that is consistent with methodology, method and study aims
- Authors are appropriately cautious about knowledge claims
- Findings are explored theoretically and applications discussed

Process issues

- The report provides an account of reflexive practice in keeping with the methodology

The review of the manuscript will determine whether the authors present their research in such a way that the reader can evaluate the relevance, credibility and applicability of the generated evidence.

General

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Registration of clinical trials

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Case reports and consent

If an individual is described, his or her consent must be obtained and submitted with the manuscript. Our consent form can be downloaded here. The individual should read the report before submission. Where the individual is not able to give informed consent, it should be obtained from a legal representative or other authorised person. If it is not possible for informed consent to be obtained, the report can be published only if all details that would enable any reader (including the individual or anyone else) to identify the person are omitted. Merely altering some details, such as age and location, is not sufficient to ensure that a person's confidentiality is maintained. Contributors should be aware of the risk of complaint by individuals in respect of defamation and breach of confidentiality, and where concerned should seek advice. In general, case studies are published in the Journal only if the authors can present evidence that the case report is of fundamental significance and it is unlikely that the scientific value of the communication could be achieved using any other methodology.

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