

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

Jonathan Doyle Grace

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and Keele Universities for the jointly awarded degree of
Doctorate in Clinical Psychology
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Declaration

Title of degree programme	Doctorate in Clinical Psychology
Candidate name	Jonathan Grace
Registration number	11027422
Initial date of registration	27th September 2012

Declaration and signature of candidate	
<p>I confirm that the thesis submitted is the outcome of work that I have undertaken during my programme of study, and except where explicitly stated, it is all my own work.</p> <p>I confirm that the decision to submit this thesis is my own.</p> <p>I confirm that except where explicitly stated, the work has not been submitted for another academic award.</p> <p>I confirm that the work has been conducted ethically and that I have maintained the anonymity of research participants at all times within the thesis.</p> <p>Signed: _____ Date: _____</p>	

Acknowledgements

Warning: you are about to be assaulted by metaphors (not literally, of course...). This is because the researcher is Welsh/Irish and so doomed by blood to be mired in imagery...as well as booze, daydreaming, meandering, Gallic shrugs (Norman influence), cod philosophy down the pub etc., but that's another story...

Thank you to my parents, **Ken and Mary Grace**, for keeping the calf fatted and a light on in the window. That calf must have been an old cow and your leccy bill through the roof by the time I eventually returned home, but hopefully it was worth it.

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Contents

A note on thesis format.....	7
Thesis abstract.....	8
Paper 1: Literature Review	9
What is known about the phenomenon of being assessed and detained under the Mental Health Act (1983), from the perspective of service users and mental health workers?	9
Abstract	10
Background.....	11
Aims	13
Method	13
Search Terms.....	14
Limiters.....	14
Inclusion criteria for articles.	15
Exclusion criteria for articles.	15
Search strategy	15
Screening process.....	17
By title.....	17
By abstract	17
By article.....	17
Hand-searching	18
Results.....	18
Critique of key papers	23
Key themes.....	29
The impact of context and relationships.....	29
Agency	30
Risk.....	31
Discussion.....	32
Conclusion	35
References.....	36
Paper 2: Empirical Research.....	42
The experience of being assessed and detained under the Mental Health Act (1983): An interpretative phenomenological analysis.....	42
Abstract	43
Introduction.....	43

Aims and objectives	46
Method	46
Interpretative phenomenological analysis.....	46
Participants and setting	47
Inclusion criteria.....	47
Exclusion criteria	48
Ethical considerations.....	49
Data Collection.....	49
Data analysis	50
Results.....	51
The treatment paradox	52
Fear of the unknown.....	58
Playing the game	60
The common touch.....	62
Limitations.....	65
Implications and conclusion.....	65
References.....	67
Paper 3: Critical commentary	73
Ontology to outcome: Qualitative research processes in a United Kingdom clinical psychology doctoral thesis	73
Abstract	74
Introduction	74
Background	75
The Literature Review.....	77
Theoretical Plurality and Reflexive Analysis	80
Critique of IPA.....	81
The Analysis.....	82
Participants	83
Pre-reflexion	83
Reflexion in action	84
Data Analysis	85
Conclusion	87
Final Reflection	87
References.....	88
Appendix A	
Journal Submission Guidelines – Literature Review paper.....	91
Appendix B	
Journal Submission Guidelines – Empirical paper	92

Appendix C	
Journal Submission Guidelines – Critical commentary paper	94
Appendix D	
Electronic Search Strategy	95
Appendix E	
Other databases searched	100
Appendix F	
University Peer approval.....	101
Appendix G	
Research and Development approval	102
Appendix H	
NHS Research and Ethics Committee Approval.....	103
Appendix I	
Sponser’s insurance	107
Appendix J	
Participant Information Sheet	108
Appendix K	
Consent Form	113
Appendix L	
Interview Schedule	114
Appendix M	
Process of analysis	116
Appendix N	
Participant transcript sample.....	121
Appendix O	
Depth analysis	123

A note on thesis format

This doctoral thesis consists of three papers: Paper 1 - a critical literature review; Paper 2 - an empirical paper using qualitative methodology; and, Paper 3 - a critical commentary of the entire research process. Respectively, the journals that these papers will be submitted to for publication are: The Mental Health Review Journal; The International Journal of Humanities and Social Science; and, The Journal of Theoretical and Philosophical Psychology. The literature review has no upper word limit; the empirical paper has an upper word limit of 25 pages of double-typed text – equivalent to approximately 7500 words; and, the critical commentary paper has an upper word limit of 40 pages of double-typed text – equivalent to approximately 12000 words.

The journals identified have differing style guidance though generally adhere to the American Psychological Association guidance (APA, 6th Edition). There are some exceptions and the Reader is encouraged to refer to Appendices A, B and C for detailed information. For consistency, the main body of the thesis is typed in Arial 12 point font, with 1.5 line spacing. Left hand margins are set at 40mm to allow for binding. Title and sub-title headings are all typed in Arial 12 point font and references are typed according to APA, 6th Edition. Any font and spacing changes, sub-divisions of text, positioning of tables, reference styles etc. will be made following the completion of the doctorate and prior to journal submission. Personal details of participants have been changed to ensure anonymity. Appendices are presented in various styles and fonts due to the inclusion of large tables and scanned documents. The overall word count for the thesis is 19,995 excluding the contents page, references and appendices.

Thesis abstract

This thesis aims to explore some of the key perspectives of service users and mental health workers regarding assessment and detention under the Mental Health Act (1983).

The first paper is a critical review of the research literature on service user and mental health workers' perspectives of the Mental Health Act assessment. The main finding of the review is that context, relationships, agency and risk are issues that influence people's perspectives. A relative paucity of qualitative research may reflect an under-representation of service user perspectives and needs. Qualitative research targeting service user experiences of assessment was recommended.

The second paper employs interpretative phenomenological analysis (IPA) (Smith, Flowers and Larkin, 2009) to conduct an empirical investigation of the assessment and detention process. The main aims of this paper were: to determine how people make sense of their experience of being assessed and detained; and, to identify key interpretative themes that can help inform communication in the assessment setting. The main findings were that participants predominantly perceived their treatment experience as negative. This negative perception might be explained by individual psychological factors associated with negative bias and cognitive perceptual disruption, and relational processes associated with labelling theory.

The third paper is a critically reflexive commentary of the research thesis process. The epistemologies that underpin the development and application of psychological theory are considered. IPA method is critiqued and suggestions for its development provided. Particular attention is paid to the importance of reflexivity in the gathering and interpretation of data. The paper concludes that IPA, not without limitations, is mainly successful in operationalising its theoretical concepts.

Paper 1: Literature Review

What is known about the phenomenon of being assessed and detained under the Mental Health Act (1983), from the perspective of service users and mental health workers?

Abstract

Purpose: Detentions under the United Kingdom Mental Health Act (1983) continue to increase. The Care and Quality Commission (CQC, 2013) consistently identifies shortcomings in the provision of care for detainees. These are chiefly concerned with a lack of empathy, poor therapeutic environments and ineffective communication. The aim of this review was to identify and appraise articles on the Mental Health Act (1983) assessment and detention process from the perspective of service users and mental health workers. This could inform recommendations for future research in order to improve therapeutic engagement.

Method: Peer reviewed articles published after the Mental Health Act (1983) were searched using the following databases: EBSCOhost; Web of Science; and, HDAS. Ten articles were critiqued using the Critical Appraisal Skills Program (CASP) guidelines.

Findings: Three key themes were identified: *The impact of context and relationships* – this encapsulated the primacy of contextual factors; *Agency* – primarily associated with coercion and self-image; and, *Risk* – primarily associated with medico-legal concerns. Issues of coercion and agency in the assessment and detention process may be explained by the incorrect attributions of staff and service users.

Implications: Quantitative articles focusing on the Mental Health Act assessment have a greater focus on risk than qualitative articles. Combined with a relative paucity of qualitative articles producing knowledge from the service user perspective, or about context and relationships, a risk bias is apparent in the evidence-base.

Keywords: psychology, process, assessment, detainee, psychiatric hospitalisation, involuntary treatment, Mental Health Act.

Background

The Mental Health Act (1983, “The Act”) was the first piece of major legislation on mental health to be implemented in the UK since 1959. It provided appropriately qualified clinicians with the legal framework to support the compulsory detention of individuals who were deemed to have a mental disorder; the rationale for detention being that they were a risk to themselves or others. The Act enabled the lawful compulsory administration of medication, electro-convulsive therapy and, under carefully prescribed circumstances, psychosurgery when deemed appropriate. More recent amendments to the Act, the most notable being in 2007, broadened the definition of what constitutes a mental disorder and introduced Community Treatment Orders (CTOs). CTOs allow people released from psychiatric inpatient wards to be treated in the community under specified conditions – if they do not meet these conditions they could be called back to hospital where their CTO may be revoked, if deemed appropriate by the responsible clinician (RC). These amendments preceded an increase in the number of detentions. The most recent available data showed an increase of approximately four per cent for the period April, 2012 - March, 2013, representing in total a rise from 48,631 in the preceding year to 50,408 detentions within a 12 month period (Health and Social Care Information Centre HSCIC}, 2013).

The Care and Quality Commission (CQC) monitors delivery of service to people detained under the Act and compares this with the Department of Health’s national policy standards (DH, 2012). Their most recent report highlighted historical issues concerned with “blanket rules” of institutions impacting on individual care, lack of communication with service users regarding consent to treatment, and care planning that failed to incorporate service user input (CQC, 2013). These findings do not reflect current policy, which highlights the need for empowerment of service users so they have more influence regarding decisions made about their diagnoses and the treatments they receive

When assessing people experiencing mental health crisis the National Institute of Health and Care Excellence (NICE) recommends that assessors:

- address and engage service users in a supportive and respectful way.
- provide clear information about the process and its possible outcomes, addressing the individual needs of the service user,...
- take extra care to understand and emotionally support the service user in crisis, considering their level of distress and associated fear,...

(NICE, 2011)

It is clear that policy and recommendations for best clinical practice prioritise empathy and clarity in communication with service users. Furthermore, service user input on decisions ranging from personal diagnoses and treatment to more systemic and structural components is also prioritised. Therefore, a literature review which takes these points into consideration and explores what is known about the Mental Health Act (1983) assessment is required.

Historically, psychological research has prioritised quantitative methodology with Random Controlled Trials (RCTs) taking precedence. However qualitative research, with a focus on individual meaning making, may better serve the function of ensuring service user perspective is considered (Banister, Burman, Parker, Maye & Tindall, 1994). This would help meet mental health policy and CQC recommendations that interventions should be individualised, empathic and mindful of context (CQC, 2013). A literature review that considers both quantitative and qualitative research can help develop a comparative and critical understanding of how the evidence-base may be impacting on clinical practice, where gaps may exist in current literature and what type of research may best address this.

The decision to focus on the assessment process that precedes detention is partly informed by the inclusion of clinical psychologists as non-medical clinicians able to take on the role of Approved Mental Health Practitioner (AMHP), as decreed in the Mental Health Act amendments of 2007. The AMHP plays a pivotal role in the assessment and detaining process as they case manage the individual involved and are the link

between any other medical professionals and friends/family of the prospective service user (DH, 2008). This role was the first new statutory position to be developed for clinical psychologists following the 2007 amendments and coincided with the aims and values of the New Ways of Working for Applied Psychologists in Health and Social Care (Onyett, 2007). These are chiefly concerned with ensuring clinical leadership is psychologically informed, context aware and evidence-based.

Aims

This aim of this literature review was to determine what is known about the phenomenon of being assessed and detained under the Mental Health Act (1983), from the perspective of service users and mental health workers. The roles and views of both service users and service providers are explored in this literature review. Effective communication between the two is key to ensuring appropriate and fair outcomes (DH, 2008). The findings could help inform recommendations for future research with a view to improving therapeutic engagement.

Method

A search was conducted using the following on-line databases:

- EBSCOhost (Psychology/Sociology Databases Databases included: PsycINFO, PsycARTICLES, PsycBOOKS, CINAHL Plus with Full Text, eBook Collection)
- Web of Science (Core Collection, BIOSIS, Medline, SciELO).
- HDAS (AMED, BNI, EMBASE).

Search terms were identified by employing keywords pertaining to population, intervention, comparison, outcome and setting (PICOS). Only some of these headings were relevant due to the content of the literature search question e.g. when there was no comparison to consider. Search terms were combined using the “OR” Boolean operator to provide a broad

search of the literature. These were then combined using the “AND” function to produce specific and relevant literature for review.

Literature Search Question.

- What is known about the phenomenon of being assessed and detained under the Mental Health Act (1983), from the perspective of service users and mental health workers?

Search Terms

psychol* OR process* OR assess* (1); detain* OR “psychiatric hospital*” (2), “involuntary treatment*” OR “Mental Health Act*” (3); 1 AND 2 AND 3.

These terms best encapsulated articles that addressed the research question. Examples of some key terms searched as part of a fuller and more detailed search, but ultimately discarded as they did not produce relevant articles (this list is not exhaustive. See Appendix D for a detailed account of the final electronic searches employed).

“detention*”, “staff”, “patient” “section*”, “psychiatr*”, “experie*”, “phenomen*”, attribution*, “observe*”, “empathy”, “focus*”, “approved mental health worker*”, “responsible clinician*”, “social worker*”, “crisis”, “assertive outreach”, “coerci*”, “communication*”).

Limiters

- Peer reviewed articles (to ensure quality and provenance).
- Articles published after the Mental Health Act (1983) (as this marked a significant change in mental health legislation).

Inclusion criteria for articles

- Empirical research relating to the Mental Health Act (1983) assessment and detention process.
- Adults (18yrs and above)
- Articles exploring the perspective of service users and/or mental health workers.

Exclusion criteria for articles

- Primary learning disability or dementia presentations.
- Section under a 136 (police section) with a primary forensic issue.

(This study's focus was an adult mental health (AMH) population. Forensic, learning disability and dementia populations were excluded as it was concluded there may be key clinical or medico-legal factors present in these populations that would not be present in an AMH population; these factors may impact on the assessment and detainment process).

Search strategy

Entering the search terms psychol* OR process* OR assess* (1); detain* OR "psychiatric hospital*" (2), "involuntary treatment*" OR "Mental Health Act*" (3); 1 AND 2 AND 3 with limiters into EBSCOHost provided 329 search results. 44 results were provided by the Web of Science database after duplicates were removed, 6 from HDAS after duplicates removed (See Appendices D and E). A three stage screening process was then used to determine eligibility (Figure 1), filtering by title (A), then abstract (B), then whole research paper (C).

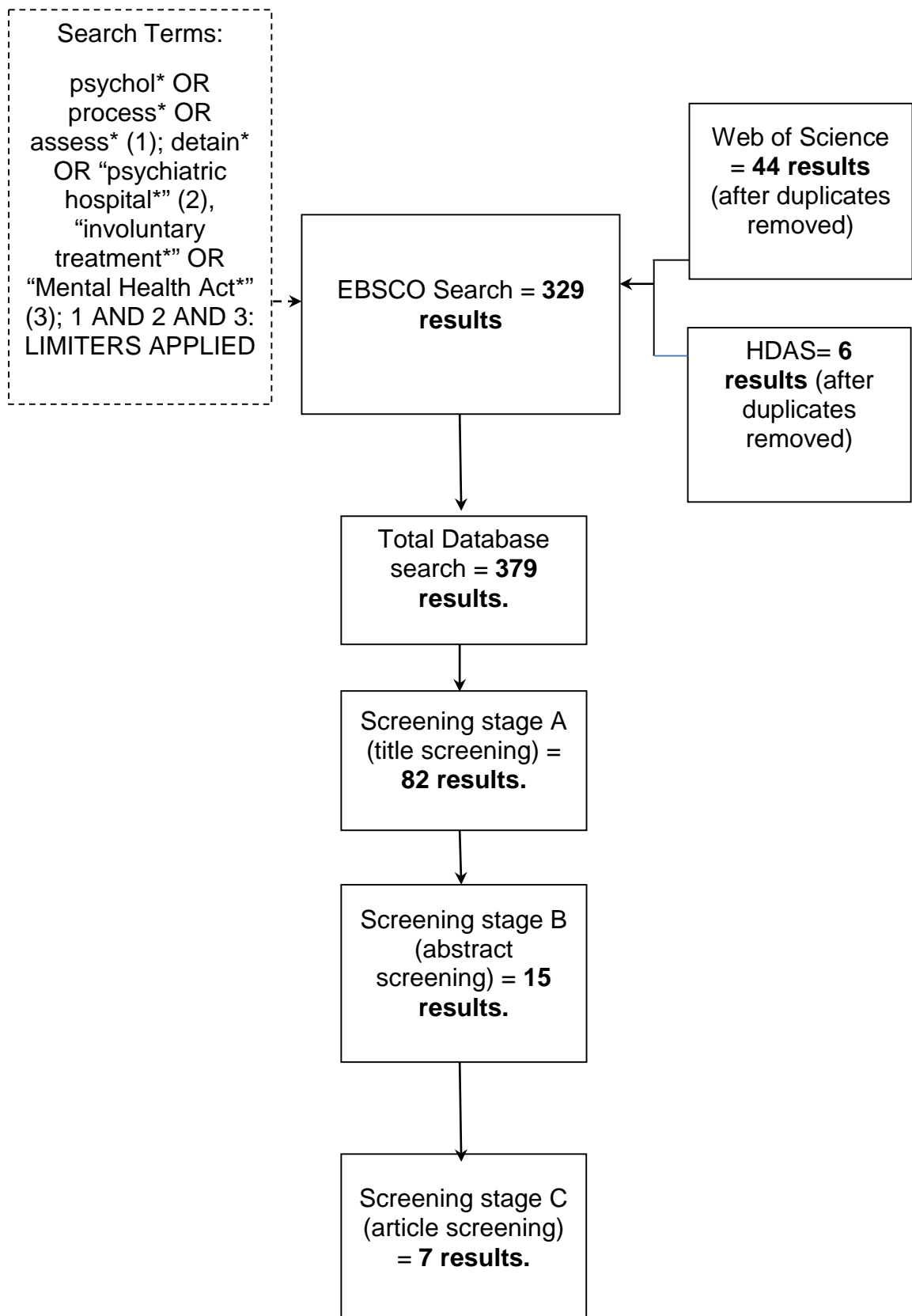


Figure 1. Literature review screening process flow chart

Screening process

By title

From the initial 379 articles 138 were removed because they were not empirical. These were chiefly concerned with medico-legal issues, theory and critique. Another 75 were removed as they did not focus on the Mental Health Act assessment and detainment process. A further 32 articles were removed as they focused on minors. 52 articles were removed as their focus was issues of risk, methodology and psychiatric rating scales efficacy, and overviews of current policy (e.g. Cairns et al., 2005; Benniwith, et al., 2010). Consequently, service users or staff perspective was omitted.

By abstract

From the remaining 82 articles 35 were removed as the focus was secure wards or community supervision, so the assessment and detention process from the perspective of service users or mental health workers was not addressed. A further 32 articles were removed as the main themes were concerned with psychiatric treatment efficacy, symptom reduction, diagnosis, outcomes following discharge from inpatient psychiatric care, and risk management.

There were a number of articles that focussed on processes that were attributed to impacting on service users' mental health immediately prior to assessment. There were also a number of articles that focussed on the attitudes of those recently detained - from both service provider and service user perspectives. In addition, there were articles that looked at factors impacting on clinical judgments to detain. These articles were included for further screening because they appeared to meet the inclusion criteria.

By article

In total 15 articles were identified that best met the inclusion criteria for critical appraisal. One article examined service user perceptions of admission but was excluded for including minors (Cascardi & Poythress, 1997). One article was highly relevant, but was excluded due to its focus on

people with a learning disability (McNally, 2007). Ridley and Hunter (2013) considered the views of service users regarding compulsory treatment but no account was given of the assessment process. Another article was excluded as its focus was self-harming in psychiatric inpatient populations (Parkes & Freshwater, 2012). Rooney et al's article (1996) was excluded as the Mental Health Act criteria in Ireland at this time were very different from the UK. Articles from different countries that were included for critique all had very similar or exact key Mental Health Act criteria (Zhang, Mellsop, Brink & Wang, 2015). Begum, Helliwell and Mackay's article (2004) was excluded as the focus was specifically the impact of rural locations on GP's decisions to detain. Seed, Fox and Berry's article (2015) focused on the impact of anorexia on perceptions of assessment and so was excluded. The final article was relevant regarding its exploration of detention, but was excluded as there was no account given of the assessment procedure that precedes detainment. (Floyd, 2013). Therefore, following final screening seven articles were identified for critical appraisal.

Hand-searching

Hand-searching (Armstrong, Jackson Doyle, Waters & Howes, 2005) the seven articles' reference lists identified one further article for critique (Marriot, Audini, Lelliot, Webb & Duffit, 2001). In addition, following the database searches the Journal of Mental Health was identified as containing the highest frequency of relevant articles for this literature review. Consequently, titles and abstracts for this journal from July, 2005 – July, 2015 were searched and two new articles identified: (Agar-Jacomb & Read, 2009; O'Donoghue et al., 2011).

Results

Ten articles were critically appraised using the Critical Appraisal Skills Programme (CASP, 2014) guidelines. Quantitative articles were primarily critiqued by checking for validity and reliability. Sample size and origin, statistical tests used, power, and subsequent claims made from the data were all scrutinised. Qualitative articles were primarily critiqued by checking major themes and how these either informed or created other psychological

theories. Credibility, transferability, confirmability and dependability were key concepts used to aid critique (Lincoln & Guba, 1985). Rigour, systematic processes, reflexive issues and subsequent claims made from the data were all scrutinised. A summary of the final articles is provided in Table 1. Each article was critically appraised and coded. The codes were used to develop themes that were employed to compare papers and identify new codes. This reiterative process continued and themes were augmented until the researcher was confident that a high level of rigour was achieved.

Table 1
Critical Review Metasummary

Authors	Title	Participants and Setting	Methodology/Measures	Findings
Lovell (1995)	User satisfaction with inpatient mental health services.	27 service users. Psychiatric secure unit. UK.	Mixed methods: Content analysis; Likert scales. Frequency distribution.	Service users reported fears for their safety on psychiatric wards and a lack of information.
Marriot, Audini, Lelliot, Webb and Duffit (2001)	Research into the Mental Health Act: A qualitative study of the views of those affected by it.	82 participants: service users and mental health workers. Nationwide selection. UK.	Focus group and telephone interviews. Range of qualitative research methods.	There is a need for improved professional knowledge of the Act. Procedural check and balances are not operating effectively.
Engleman, Jobes, Berman and Langbein (1998)	Clinicians' decision making about involuntary commitment.	18 psychologists and social workers. Community Mental Health Teams. UK.	Risk assessment questionnaire. Logistic and multiple regression, and factor analysis.	Underlying psychological constructs: danger to self, danger to others, poor self-care.
Wu, Tang, Lin and Chang (2013)	Professional values and attitude of psychiatric social workers toward involuntary hospitalization of psychiatric patients.	253 psychiatric social workers. Clinicians' placement. Taiwan.	Staff Attitude toward Coercion Scale and the Human Rights of Patients with Severe Mental Illness Scale	Majority supported involuntary hospitalisation. Gender, work experience and level of education associated with attitudes towards coercion and human rights.
Agar-Jacomb and Read (2009)	Mental health crisis services: What do service users need when in crisis?	78 service users Psychiatric outpatients. New Zealand.	Mixed methods: Thematic analysis; Likert Scales. Wilcoxon-Mann-Whitney and Kruskal-Wallis One-way ANOVA tests.	Themes focused on place, relationships, systems and power. Support for an alternative to psychiatric hospitalisation was high.

O'Donoghue et al., (2011)	Perceptions of involuntary admission and risk of subsequent readmission at one-year follow-up: the influence of insight and recovery style.	68 service users. Psychiatric outpatients. UK.	Mac Arthur Admission Experience Interview, Birchwood Insight Scale, Recovery style Questionnaire. Multiple Logistic Regression.	Insight was associated with a more positive perception of admission. Sealing-over recovery style was positively associated with readmission rates.
Quirk, Lelliot, Bernard and Buston (2003)	Non clinical and extra-legal influences on decisions about compulsory admissions to psychiatric hospital.	20 service users. 100 assessors. Community and institutional settings. UK.	Observational. Grounded theory.	A lack of resources, the context of a blame culture and the strength of the team dynamic were all identified as key extra-influences.
Bonsack and Borgeat (2005)	Perceived coercion and need for hospitalisation related to psychiatric admission.	57 service users. Psychiatric secure unit. UK.	Cross-sectional study. Researcher designed questionnaire. Chi-square.	74% reported they had felt pressurised to accept hospitalisation. There was a positive association between involuntary admissions and pressure from family and friends
Larkin, Clifton and Visser (2009)	Making sense of "consent" in a constrained environment.	5 responsible clinicians. 7 service users. Medium-secure psychiatric hospital. UK.	Semi-structured interviews. Interpretative phenomenological analysis.	3 superordinate themes: experiences in relation to consent; communicative features that frame experience; the relationships between doctors and patients.

Wynne, Myklebust and Bratlid (2005)	Psychologists and coercion: Decisions regarding involuntary psychiatric admission and treatment in a group of Norwegian psychologists.	340 psychologists. Clinicians' placement. Norway.	Researcher designed questionnaire. Chi-square and logistic regression.	Age, gender and experience with coercion were predictors of willingness to coerce.
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Critique of key papers

Lovell (1995) conducted a mixed methods study with the aim of investigating service users' views of inpatient services – including admission – and the apparent differences reported in studies using quantitative or qualitative analysis of the same phenomenon. A strength of this study was the use of mixed methodologies, as this provided triangulation of results and so supported theoretical relationships. Simultaneously, this addressed the issue of the differences in the types of knowledge produced by quantitative and qualitative designs. Limitations in this study were concerned with sample size, which was small for both methods (quantitative = 22; qualitative = 5). Also, there was limited credibility in the qualitative study as results were not discussed with service users; transferability was restricted as a homogenous group was not identified; and, confirmability was not addressed as no other researchers were involved in a quality check. The researcher concluded that the study supported previous work that suggested quantitative analysis produces more positive service user views of services than qualitative analysis. Also, that the service user is a disempowered and passive recipient of psychiatric services.

Marriot, Audini, Lelliot, Webb and Duffit (2001) conducted a qualitative study to explore the strengths and weakness of the Mental Health Act (1983), parts two and ten. 82 participants from a variety of backgrounds including mental health professionals, and service users and carers were consulted in one of three groups: a focus group, telephone interviews or an invitation to provide a written response. Following qualitative analysis the results were fed back to a consensus group consisting of key representatives of mental health workers, and service users and carers. The consensus group was asked to summarise findings and identify possible omissions. Ethical issues were addressed in the study by the researchers' focus on the rights and opinions of service user and carer groups. The process of data analysis was clearly presented with a focus on systematic process and a level of dependability. However, there was no theoretical position provided to underpin the process of analysis and so the specific epistemological tenets that informed process were absent. There was a good level of triangulation of methods and a good degree of credibility and confirmability: numerous methods of gathering data were used;

participants' representatives reviewed the results; and, emerging themes from separate analyses were compared and contrasted by different researchers. Findings highlighted a general lack of knowledge amongst mental health workers regarding the nuances of the Act and a need for the role of the "Nearest Relative" to be strengthened in order to empower potential detainees. The decision making process of the responsible clinician was viewed as contributing to a greater amount of detentions due to the perceived "blame culture" that clinicians had to practice in. It was recommended that responsibility for admission and discharge be shared by the Multi-disciplinary Team (MDT). Clinical recommendations were for a greater amount of training for mental health workers and greater dissemination of essential knowledge for service users.

Engleman, Jobes, Berman and Langbein (1998) conducted a quantitative study with 18 clinicians to determine the effects of patient and clinician characteristics, bed availability, and setting on perception of risk and the decision making process in the Mental Health Act assessment. Psychologists and social workers in a Community Mental Health Team (CMHT) completed a Risk Assessment Questionnaire (RAQ) based on 169 cases of detainment from a decade earlier. They used factor analysis to identify three underlying psychological constructs that accounted for 74.3% of the variance in the data set: danger to self, danger to others, poor self-care. The strength of association between these constructs and the decision to detain was determined by a multiple regression analysis and were found to be highly significant. The effects of patient, clinician and bed variables on the overall risk rating and decision to detain were then determined: ($F = 10.91$, $df = 17.136$, $p < 0.001$); ($\chi^2 = 147.69$, $df = 15$, $p < 0.001$). A strength of the research was that controls were explicitly employed to minimise bias. Furthermore, controlling factors to isolate and determine the influence of one specific factor allowed the researchers to get as much as possible from their data. However, the use of data from case notes a decade old also meant that the study lacked ecological validity. Also, the evaluation setting and detention ratios of the clinician being labelled as clinician characteristics was misleading. It was concluded that patient risk was a significant predictor to detain; evaluation setting was a significant predictor of

risk rating and the decision to detain; and, the knowledge of bed availability predicted the decision to detain.

Wu, Tang, Lin and Chang (2012) conducted a quantitative study in Taiwan of 235 psychiatric social workers to determine their attitudes toward involuntary hospitalisation under the Mental Health Act. Ethical issues created by the tensions of perceived coercion, human rights and cultural impact were all explored. The researchers placed the attitudes of psychiatric social workers within a cultural context concerned with the social position of collectivism rather than the individualism of the Western world. The strength of this study was its ability to take broad cultural factors and consider their influence on the attitudes of practitioners based on statistical means. A relatively large sample of 235 plus the use of well-established measures e.g. Staff attitude towards coercion scale (Wilk, 1994; Taylor & Bentley, 2005) supported the validity of the study. Also, the comparison of results with other studies helped explicate possible cultural differences. However, 87.3% of the sample were women so the results were not generalizable to places where more men held psychiatric social worker posts. They concluded that gender, level of education and work experience all impacted on attitudes towards involuntary admission and detainment. Regard for human rights was associated with the opposing views that involuntary hospitalisation was either coercive or therapeutic

Agar-Jacomb and Read (2009) conducted a mixed methods study in New Zealand of 78 psychiatric service users. There were two stages to the study. The main findings of a thematic analysis (Stage one) were that environment and relationships were of high importance to service users in crisis. More specifically, this was concerned with the type of language used to communicate and the impact of cultural values on the interpretation of discourse. Stage two findings were that there was no statistically significant difference between staff and service users' views regarding the need for alternatives to hospitalisation ($p > 0.05$). A strength of this research was that it managed to ensure service user inclusion in proposed clinical development, and to then further determine service user views of the amended proposals; this represented a high level of service user involvement for one article. Low numbers of participants meant that generalisability was limited in this study. Also, although the researchers highlighted the impact of their interpretations on

qualitative data gathering and analysis they did not address ways to mediate this through reflexive practice. They concluded that service users should be given a voice in determining services and should help inform the development of a broader range of crisis services.

O'Donoghue et al. (2011) conducted a quantitative study with 68 service users to explore their perceptions of involuntary admission, and risk of re-admission one year later. They used various assessment tools e.g. Birchwood Insight Scale (1994), to produce data for their exploration of service users' perception of admission. The findings stated that there was a moderate association between patient insight and their perception that admission was necessary ($r_s = -0.30$, $p = 0.02$, $n = 65$). Also, patients' recovery style – either integrated (acknowledgment of their illness) or sealing over (avoidance) – was associated with subsequent readmissions: those with a sealing over recovery style were four times more likely to be readmitted involuntarily ($RR = 4.38$, $CI\ 1.14 - 16.80$, $p = 0.01$). A strength of this study was the use of standardised and validated assessment tools, which supported an argument for reliability. Recognition by the researchers that bias may have been introduced by their involvement in the interview process demonstrated a reflexive awareness absent in many quantitative articles. A limitation of this study was the relatively small sample size of 68 participants. Also, the sample was taken from one site so external validity may have been compromised. They concluded that service user perception of the need for involuntary admissions is not stable over time and that the likelihood of involuntary readmission is associated with recovery style.

Quirk, Lelliot, Audini and Buston (2003) conducted an observational study of the Mental Health Act assessment and admission process to determine the influence of non-clinical and extra-legal influences on decisions of compulsory admission. The perspectives of assessors and potential detainees were used to construct theories about extra-influences. The key strength of this article was its explicit focus on the assessment and admission process – something absent in most of the other articles screened. The perspective of mental health professionals and service users was considered although a lack of engagement from the latter meant that just four of 20 potential interviews occurred so credibility of the study was limited. However, confirmability was

addressed with regular communication between the researchers in order to ratify and modify emergent hypotheses. They concluded that team decisions and high bed occupancy rates raised the compulsory admission threshold; that a blame culture partly explains the ever increasing level of admissions; and, negative service user experiences of psychiatric wards increases the likelihood of a need for compulsory admission as they are more likely to refuse to return.

Bonsack and Borgeat's (2003) cross-sectional study of 87 psychiatric inpatients' subjective experience of the detention process focused on the relationships between legal issues, perceived coercion by clinicians or family and whether detainment was voluntary or involuntary; a number of these factors clearly impacted on service users' perceived agency. 74% reported they had felt pressurised to accept hospitalisation irrespective of whether their admission was voluntary or involuntary though simultaneously 70% agreed with the need for hospitalisation. There was however a positive association between involuntary admissions and pressure from family and friends ($\chi^2 = 4.2$, $df = 1$, $p < 0.5$). External validity was questionable as the sample size was relatively small and drawn from one hospital. The questionnaire used was designed by the researchers and so there were no research or standardisation procedures to support the argument for internal validity of the measure. The questionnaire was conducted with service users who had been admitted the same day. 34% of these admissions were involuntary; this raised ethical issues regarding capacity to consent that were not addressed in the article. They concluded that clinicians could reduce service users reported feelings of coercion by discussing legal and emotional issues separately.

Larkin et al (2009) conducted qualitative research to explore the elements of the Mental Health Act (1983) associated with capacity/competency and informed consent to treatment. They used semi-structured interviews with seven service users and five responsible medical officers to study the experience of consent from different perspectives. The meaning derived from the process of consent and the consequences of legislative and clinical processes were considered. A key focus of this article was the ethical issues involved in this process. The researchers postulated that current practice may interpret "bad" decisions by service users with capacity as evidence of a lack of capacity. Additionally, they highlighted concerns from the British Psychological

Society that risk management may be prioritised over the protection of vulnerable people. A strength of this article was its exploration of the perspectives of staff and service users. A purposive sample ensured a wide variation of experience was captured. There was no account of results being checked by participants so credibility was lacking. Also, a quality check by multiple researchers was not accounted for and this suggested a lack of confirmability. The researchers noted that service users' insights and claims are devalued by current legislation; that just two participants highlighted the need for consent for psychological interventions as well as medication; and, that "double-binds" exist in current practice that impact on effective and ethical practice e.g. risk management versus providing care. Increased training and input from service user groups was recommended to develop more robust legislative mechanisms.

Wynn, Myklebust and Bratlid (2005) conducted quantitative research in Norway to determine the attitudes of psychologists towards coercing service users who may need involuntary admission or treatment. Since changes to the Norwegian Mental Health Act in 2001 some psychologists with specialist qualifications had the power to make legal decisions to detain. A questionnaire pertaining to three clinical vignettes was posted on the websites of major Norwegian hospitals. 340 psychologists responded - 61.2% were currently employed in psychiatric services. A strength of this research was the sample size which represented 10% of all active psychologists in Norway; this supported claims for external validity. However, the questionnaire used to elicit data was devised by the researchers and no information was provided on its structure or content; therefore internal validity may have been compromised. Ecological validity was compromised by the use of vignettes, as psychologists may have behaved differently in real cases. Results showed that 39.4% would admit involuntarily when the service user had a historical schizophrenia diagnosis and current problems managing life. In the case of a violent service user with delusions 80.2% would admit involuntarily, and in the case of a service user with alcohol issues and poor self-care 43.6% would admit involuntarily. An interesting issue raised in the discussion was the positive association between previous experience of using coercion and decision to coerce in two of the vignettes. The researchers suggested that medico-legal

changes may have resulted in an attitudinal shift by psychologists working in psychiatric services towards the acceptance of coercion. The researchers concluded that fewer psychologists would coerce when people are in the early stages of psychosis. Although over a third of psychologists would involuntarily admit a person with no current symptoms of major mental disorder, whose main risk was concerned with poor self-care, the researchers did not find this worthy of critique. The decision of so many psychologist to involuntarily admit a person who did not meet any of the key criteria for detainment was worthy of investigation. Not exploring this issue was a limitation of the study.

Following critique of the key articles they were coded and then grouped under three key thematic headings, namely: the impact of context and relationships; agency; and, risk.

Key themes

The impact of context and relationships

This theme was determined by the frequency and relevance in the articles critiqued of accounts, predominantly from service users, of the importance of the context of psychiatric environments and their relationships with family and staff.

In Engleman et al's (1998) article the evaluation setting predicted the decision to detain and so was an explicit example of context impacting on clinical decision making. The article's conclusion suggested that the legal context impacts heavily on the decision to detain. The main theories generated in Quirk et al's (2003) article clearly contributed to the theme of context and relationships impacting on process. A lack of resources, the context of a blame culture and the strength of the team dynamic were all identified as key extra-influences. Larkin et al (2009) identified the existence of power relationships as a superordinate theme in their study; specifically, the relationship between doctors and service users. They placed this relationship within an historical narrative that positions the doctor as a person with knowledge and power who is automatically trusted. They then positioned this perspective within the context of the bureaucratic culture of the hospital. The two elements combined were

shown to create issues regarding the process of consent to treatment – power remaining firmly with the practitioner.

Marriot et al's study placed the attitudes and decisions of mental health workers and service users within the context of specific parts of the Mental Health Act (1983). The study was commissioned by the Department of Health to inform its review of some of the key problems with working clinically, or being the recipient of clinical decisions, within a specific medico-legal context. The context of a "blame culture" and the risk averse practices that may occur as a result were provided as examples of some of the possible key factors contributing to problems implementing mental health act legislation in a clinical setting.

Agency

The theme "agency" was determined through the combining of the underlying codes of control and self-image.

Agar-Jacomb and Read's (2009) study highlighted agency as an important factor for service users. They linked a sense of service user agency with appropriate communication from staff and an element of choice in treatment. Service user involvement, their influence regarding the things that matter in crisis – their agency - and the type of service that would best address their needs all informed understanding of some of the processes involved in detainment. More specifically, the processes that precipitate and perpetuate distress - and those that address and alleviate it – were identified as being chiefly concerned with staff and service user attribution of each other's motivations. There was evidence of negative qualities attributed to service users by staff that were associated with the stigma of mental health and labelling. Service users also interpreted some staff behavior as being associated with the negative attributes of a desire to control and coerce.

Although Wu et al's (2012) study addressed issues of context it was primarily concerned with human rights, paternalism and coercion. Therefore the attitudes of social workers, primarily based on gender, work experience and level of education, were associated with the level of agency they deemed service users should have. Lovell's study (1995) highlighted the relatively negative outcomes generated by qualitative methods. This provided evidence of

a lack of agency that was primarily associated with the continuation of a lack of the service user voice despite clinical policies implemented to address this.

Bonsack and Borgeat (2003) recommended the use of positive pressure instead of coercion as a means of initiating a collaborative and therapeutic relationship. This represented a focus on issues of agency as the researchers attempted to directly address the clinical problems identified in their study associated with promoting the power of the service user. Agency was also a key issue for Larkin et al's (2009) study. Agentic constructions (first-person, present tense, future facing) were highlighted as frequently used by psychiatrists in order to justify their decision making processes regarding assessments of capacity and consent. Also, the use of bureaucracy as both an obstacle and mechanism for process by psychiatrists was identified as a major agentic force that was simply an obstacle for service users.

A salient issue in many of the articles that identified agency as a key process was the influence of situational factors such as unemployment, the absence of support systems, medico-legal systems, bed availability etc. Frequently, both service users and staff would understand these processes in terms of the negative disposition of others.

Risk

The final theme was the concept of risk. This theme was situated within a predominantly medico-legal framework.

In O'Donoghue et al's quantitative study the negative implications of insecure attachment on the likelihood of readmission provided some insight into the types of psychological processes that may be impacting on service users' presentations at the time of admission/readmission. Attribution was a salient concept, as insecure attachment style is predominantly defined by incorrect negative attributions assigned to meaningful others (Pearce and Halford, 2008). Therefore the relational style of those with an insecure attachment was linked with their inability to act positively on their situation in order to break the cycle of relapse. This article did not consider the risk of service users to self or others but was concerned with the risk of readmission following discharge into the community.

Engleman et al's study (1998) had a clear focus on clinicians' perception of risk. Clinician characteristics that may impact on their interpretation of, and preference for, key criteria of the Mental Health Act (1983) were explored using a quantitative design. The focus of Wynn et al's article (2005) was attitudinal change in psychologists regarding decisions to coerce. This could be associated with the theme of agency, but perceived risk was a key element of the decision making process for the psychologists who responded to the researchers' questionnaire. The most salient issue was associated with the impact of legislative change on the clinical decision making process. Psychologists involved in admitting psychiatric service users were viewed as more risk aware, and consequently more likely to admit. However, the issue of risk was not simply associated with protecting the public but was equally concerned with the perceived risk of self-harm. Therefore, the researchers interpreted their results as possibly being due to a reduction of idealism in psychologists who worked in psychiatric services, coupled with the knowledge of the risk that people in crisis can pose to themselves.

Marriot et al's study placed the attitudes and decisions of mental health workers and service users within the context of specific parts of the Mental Health Act (1983). The study was commissioned by the Department of Health to inform its review of some of the key problems with working clinically, or being the recipient of clinical decisions, within a specific medico-legal context. The context of a "blame culture" - with negative attributions being ascribed to individuals - and the risk averse practices that may occur as a result were provided as examples of some of the possible key factors contributing to problems implementing Mental Health Act (1983) legislation in a clinical setting.

Discussion

The aim of this review was to determine the amount and type of research available that addresses the phenomenon of assessment and subsequent detention under the Mental Health Act, from the perspective of service users and mental health workers. One of the key issues identified was concerned with attribution. This was not explicitly addressed in the literature, but was evident in the accounts of staff and service users regarding their interpretation of each other's behavior. Negative attributions of other people's behavior were most

frequent and were chiefly explained by dispositional factors and not situational ones; this was indicative of fundamental attribution error. This concept is a key cognitive bias identified in social psychology (Ross & Nisbett, 1991; Sanderson, 2010). It is well evidenced in the research literature and can be applied as a hypothesis to explain the negative attributes of staff often reported by service users. Similarly, the attribution of dispositional factors to the negative aspects of service users' behavior by staff may also be explained by attribution error. Often the reality may be that situational factors such as medico-legal constraints for staff and life stressors for service users are key to explaining individual's behavior. Situational factors have been clearly identified in many of the articles critiqued in this literature review regarding the impact of context and medico-legal issues. Although the life stressors precipitating service users' crises are not comprehensively explored in the articles reviewed, the impact of situational factors on individual distress and behavior are extensively covered in the psychological literature (Midlands Psychology Group, 2012).

The strengths of this literature review were concerned with the authors' appreciation of the epistemologies that underpin the various methodologies utilised in the research literature. This augmented a reflective approach to the process by adding another level of critical appraisal. However, the exclusion criterion concerned with police detainment (Section 136) prevented the appraisal of a number of relevant articles. The prevalence of police involvement in the detainment process in 2012/13 was approximately 36% (HSCIC, 2013). Although this by no means constituted primary forensic issues – which may weaken this review's focus on primarily Adult Mental Health presentations – police involvement is often concerned with providing a place of safety until mental health professionals can attend. Following assessment people are either released or taken to an inpatient unit, usually on a Section 2 (on which an individual can be held for up to 28 days for assessment). Those instances where offending is not a key concern would be relevant to this review – excluding these articles was therefore a limitation.

The choice to include articles from outside the United Kingdom (UK) was based on the lead researcher ensuring the key criteria for a Mental Health Act assessment in the UK was reflected in the mental health legislation of other countries. It was hoped that inclusion of a broader range of articles may

illuminate some of the key cultural factors impacting on the views of service users and staff. Although this did occur, the issues are complex enough to warrant further research; it was not possible to explore cultural issues in sufficient depth whilst simultaneously maintaining the focus of this article.

A broad review of the literature evidenced a strong tendency for research aims to be determined by services and clinicians. The saliency of clinical issues was driven by the policies, concerns, aims and narratives of service providers. Although this produced a wealth of information that provided insight and progression, the evidence base appeared to be biased: the dominance of medico-legal issues; the lack of service user involvement at a research level; the profusion of clinical rating scales as opposed to semi-structured interviewing; and, the targeting of staff input or statistical evidence rather than service user perspective and qualitative evidence, suggests that the research literature provides a limited understanding of the key issues.

NICE guidelines (2011) stress the need for a person centred approach to assessment, but the focus on risk management that is evident in the research literature regarding inpatient practices and issues of assessment may be cancelling out therapeutic practice in favour of effective management. Risk assessment is historically problematic (Barker & Moore, 2006) and the debate continues regarding the relative value of validated risk tools and clinical judgement. Based on this literature search it is clear that risk management continues to be of prime importance; three of the ten articles critiqued had a primary focus on risk and one had a secondary focus. Few would argue against the need to protect vulnerable individuals and the public, but if these priorities are weighted too heavily then they could impact on effective and ethical decision making.

Since 1992 the National Health Service (NHS) has utilised evidence based medicine/practice to inform its recommendations for clinical intervention (Sackett, Rosenberg, Grey, Haynes & Richardson, 1996). Currently, most hierarchies of evidence identify meta-analysis and Randomised Controlled Trials (RCTs) as the gold standards in research. However, the relevance of a methodology in the hierarchy is determined by the extent to which that methodology answers the research question (Aveyard, 2007). The findings of this literature review were that qualitative methodologies explored key

phenomena as effectively as quantitative approaches and so were equally placed in the hierarchy.

Conclusion

The qualitative articles appraised were shown to explore service user and staff perspectives primarily within the themes of context, relationships and agency; quantitative articles focused on agency and risk management. The key themes identified in the ten critically appraised articles could be viewed as a result of the methodologies employed. Thus, a tentative association can be made between the lack of qualitative research designs in the evidence base focusing on issues of context and relationships, and the findings of the CQC (2013) that service users experience a lack of therapeutic environments and poor levels of communication. Also, the possible prevalence of fundamental attribution error in the process of assessment and detention may be a key factor impacting on negative outcomes; it is worthy of further investigation.

Research that adopts a qualitative methodology, to explore how service users interpret the experience of being assessed for detention, could provide a valuable addition to the evidence-base. The recommendation of this review is for such research to be undertaken using the methodology of interpretative phenomenological analysis (IPA) (Smith, Flowers & Larkin, 2009). As this approach focuses on phenomenology and hermeneutics it is best placed to explore how service users both describe and make sense of the experience of being assessed for detention under the Mental Health Act.

Word Count - 7465

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Paper 2: Empirical Research

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

Abstract

The aim of this qualitative study was to explore the experience of being assessed and detained under the Mental Health Act (1983). Semi-structured interviews with a sample of seven adult service-users, who had been assessed and detained, were analysed. The methodology employed was interpretative phenomenological analysis (Smith, Flowers & Larkin, 2009). Four super-ordinate themes were identified: *The treatment paradox*; *Fear of the unknown*; *Playing the game*; and, *The common touch*. The findings suggest that perceived negative initial contact with mental health services, often at the assessment stage of the detainment process, may be linked with cognitive disruption and negative cultural perceptions of mental health issues. Recommendations include specialist interpersonal skills training for assessors informed by attachment theory, dynamic theory and communication skills developed in working with learning disability populations.

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

Introduction

The Mental Health Act (MHA, 1983) is medico-legal legislation that allows medical practitioners to detain and treat people, sometimes against their wishes, the majority of whom are considered to have a mental disorder. Individuals are assessed to determine whether they should be detained, and if so, what specific legislation should apply; this is informally known as sectioning. Different types of MHA section exist ranging from being held in a place of safety by the police - Section 136 - to a six month detainment in a psychiatric inpatient unit with indefinite extension if necessary - Section 3. On specific sections compulsory treatments can include injections of anti-psychotic medication and electro-convulsive therapy. The rationale behind sectioning is that it protects both the service user and the public.

In 2007, amendments to the Mental Health Act (1983) broadened the definition of what constitutes a mental disorder. Community Treatment Orders (CTOs, MHA, 2007) were introduced to allow people to be discharged from psychiatric inpatient settings with the option of compulsory recall if deemed

necessary. The purpose of CTOs was to reduce the problem of “revolving door” service users (repeatedly entering and leaving treatment) and to manage problems of non-compliance with treatment; the latter issue being linked to raised levels of risk to self or others. The Department of Health predicted that 400-600 CTOs would be used in the first 12 months – in reality the number was 6,327 in the first 17 months of implementation (Mental Health Alliance, 2012). Also, nearly a third of people on CTOs were identified as having no history of being non-compliant with treatment and over a third had no history of being a risk to themselves or others (CQC, 2010). The number of people being detained has steadily increased for the past twenty years. The only exception was a decrease of 0.3% in 2012/13, which was attributed to a lack of NHS beds. However, overall for the period 2010/13 there was a 4% rise from 48,631 to 50,408 detentions (Health and Social Care Information Centre {HSCIC}, 2013).

Deprivation of liberty and the compulsory use of psychiatric treatments on those deemed mentally ill has been heavily critiqued (Foucault, 2006/1961; Newnes, Holmes & Dunn, 1999; Bentall, 2009; Rogers & Pilgrim, 2010; Coales, Kennan & Diamond, 2013). There is a historical and contemporary position that views the Mental Health Act and associated treatments as at best paternalistic, and at worst as unethical. However, this is counterbalanced by research literature that provides a more positive view. There are many reports in the research literature of service users who attribute their wellbeing to the containment and structure that admission provided in a time of crisis (e.g. Hall & Dornan 1988; Kuosmanen et al., 2006).

Although some service users report that being detained is beneficial, as it provides them with a place of safety and appropriate treatment, long-term problems with sectioning and treatment persist. Reports by the Care Quality Commission (CQC, 2012; 2013) indicate that control and containment of service users was often prioritised over care and support. The report highlighted that the reality of good care provision for those detained did not match the goals and values set out in the Department of Health’s policy – “No health without mental health” (DOH, 2012), specifically around informed consent, patient involvement and effective care planning.

Quantitative research designs with global outcomes produce more favourable accounts of service users’ experiences than qualitative designs and

dominate the evidence-base (Greenwood et al., 1999; Wagstaff & Salts, 2003). Similarly, much of the clinical research targeting psychological factors and processes involved in the assessment and detention of people under the Mental Health Act uses quantitative designs. These articles are more likely to focus on issues of risk and service user management: Bhugra and Dazzan's study (2000) identified that the criterion of dangerousness to self and others was the primary factor influencing the decision to detain; Brimblecombe et al. (2003) also identified risk to self as the primary factor influencing the decision to admit people who were being treated in the community. In a literature review by the researchers there was a relative paucity of qualitative research identified. Those articles that adopted qualitative designs focused on the service user's experience of being detained. Key findings tended to highlight issues of relationships and identity (Welches & Pica, 2005) and communication and context (McGuinness, Dowling & Trimble, 2012). The prevalence of qualitative articles on assessment and detention under the Mental Health Act identified in the review was approximately 6-7%. Consequently, a picture emerged of clinical understanding on detainment issues as being chiefly guided by service provider concerns and a dominant risk management narrative. Obviously, the issue of risk is highly relevant and an essential factor to be considered. However, the possible bias of management over therapy – or control over therapeutic treatment – was identified in the literature review as a factor that may be influencing some of the problematic outcomes highlighted by the CQC (2012; 2013).

Previous qualitative studies have been conducted on service user experiences as psychiatric inpatients (Welches & Pica, 2005; Agar-Jacomb & Read, 2009). However, there are no qualitative research articles that primarily focus on the Mental Health Act assessment that informs the decision to detain. A key factor that health staff attribute to people who are detained is their perceived lack of co-operation during the assessment process (Cotton et al., 2007). For many, the Mental Health Act assessment is the first structured contact they have with services; it is often conducted when people are in crisis and so highly vulnerable. All the research identified in the literature on the Mental Health Act assessment process with an Adult Mental Health population has been quantitative. Therefore, qualitative research that focuses on the

experience of being assessed and detained under the Mental Health Act would be a valuable addition to the research literature: it can build on previous qualitative articles that target the inpatient experience; it can address a process that to date has only been operationalised through statistical methodology; and, it can explore some of the ethical issues raised by the Mental Health Alliance (2012) regarding the inappropriate detention of a large proportion of people since the 2007 amendments to the Mental Health Act.

Aims and objectives

The primary objective of this study was to develop a better understanding of the subjective experience of being assessed for detention under the Mental Health Act. The secondary objective was to use this understanding to inform psychotherapeutic interventions during the assessment process.

The key aims of this study were to determine: how people who have been assessed for detention under the Mental Health Act make sense of their experience; and, the key themes and how these might inform communication during the assessment. These aims were informed by the Mental Health Service User Movement key values which are based on combating stigma whilst helping people to stay out of services and function in their communities (Wallcraft, 2003).

Method

Interpretative phenomenological analysis

This study used the qualitative methodology of interpretative phenomenological analysis (IPA) (Smith, Flowers & Osborn, 1997; Smith, Flowers and Larkin, 2009). This is primarily concerned with how people make sense of the experiences that they have. The phenomenological element of IPA is focused on the detailed description of experience, whilst the interpretative element incorporates the philosophical position that experience is subjective, and so idiographic. IPA is informed by Critical Realist epistemology (Bhaskar, 2008). It posits that reality has qualities that are structured through shared concepts that transcend subjectivity whilst simultaneously being reliant on individual interpretation. IPA attempts to address the naïve realism of positivism and replace it with an understanding of the fluid nature of human experience,

hence the name *Critical* Realism. Experience is viewed as ideographic, yet when taken collectively creates a common pool that represents a shared experience of the world as *it appears*. Reflexivity is an essential process when conducting an IPA study. The researcher must constantly analyse their own pre-suppositions in order to understand how they may impact on the process of gathering and analysing data.

IPA was chosen in order to explore both the ideographic nature of experience (divergence) and the commonalities that provide empirical grounding for themes that exist across accounts (convergence). Although there are similarities between IPA and grounded theory, the latter takes a broader view that seeks to identify larger theories that do not fully consider the individualistic nature of interpretation. IPA explicitly targets the processes that underpin interpretation via its conceptualisation of the double-hermeneutic circle (Smith et al., 2009). Experience is viewed as occurring through the interpretative lens of the participant, which in turn is relayed to the researcher who interprets it through the lens of their own pre-suppositions. Phenomenological psychology was not used as it too does not have the idiographic focus of IPA and is primarily concerned with the essence of phenomena as determined through the identification of convergence across data sets.

Participants and setting

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

Inclusion criteria

- Adult (>18yrs).
- Psychiatric diagnosis of “mental disorder”.
- Experience of being detained under the Mental Health Act in the last five years.

Exclusion criteria

- Primary learning disability or dementia presentations.
- Section under a 136 (police section) with a primary forensic issue.

Participants were currently residing in a rural community and had their treatment managed by a care co-ordinator, usually a Registered Mental Health Nurse (RMHN). Initially the researcher attended CMHT caseload meetings to outline the research proposal. Care co-ordinators discussed the research with potential participants who then had the option to contact the researcher by telephone or email for more information. This reduced the possibility of people feeling obliged to take part. Seven people were recruited for this study - their demographics are provided in Table 2; names have been changed to ensure anonymity. All participants were White/British and male.

Table 2

Participant demographics and detainment details

Name	Age	Number of Sections	Last Sectioned	Police Involved	In/voluntary
Mark	32	4	12 months:	No	voluntary
Callum	40	3	46 months:	Yes	involuntary
Craig	28	>10	13 months:	Yes	involuntary
James	53	2	8 months:	No	involuntary
Bob	24	>10	10 months:	Yes	involuntary
George	53	5	34 months:	Yes	involuntary
Mike	32	1	14 months:	Yes	involuntary

Ethical considerations

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

It was recognised that recalling an episode of detention may be emotive. A prerequisite of taking part was that care co-ordinators would be kept informed of the interview process to ensure clinical support.

Data Collection

Interviews took place at participants' CMHT sites. Participant Information Sheets were provided at least 24 hours prior to interview and informed consent obtained (Appendices J and K). Participants were given the option to withdraw at any time during the interview. The interview was semi-structured and used open questions to encourage the exploration of key experiences (Smith et al.,

2009) (See Appendix L). Interviews were digitally recorded and then transcribed verbatim. The mean duration of the seven interviews was 48 minutes and 20 seconds with a range of 18 minutes and one second to sixty-nine minutes and seventeen seconds.

Data analysis

The analytical process was heavily influenced by the advice provided in Smith et al.'s key IPA text (2009). The transcript was initially analysed for descriptive and linguistic comments. This was achieved manually by highlighting hardcopies of the interviews. Initially a transcript was highlighted for descriptive comments. Linguistic comments were identified by highlighting them in the text and then providing some commentary in the exploratory comments right hand column. This commentary was more interpretative and often presented as a question rather than a statement as to what it might mean. Laughter, repetition and pauses in the text were interpreted based on context. A clear move towards the researcher's interpretation occurred during the process of conceptualising the participants' accounts. However, this process involved returning to the descriptive and linguistic comments highlighted – the essence of each transcript. In doing so it represented the place where the interpretations of the participant and researcher overlap the most: the double-hermeneutic circle. Groups of concepts informed the development of emerging themes in the left-hand column (see Appendices M, N and O for a Master Table of Themes, a theme table for one participant, and an example of an analysed extract).

Themes were compared and contrasted across transcripts and given sub- theme titles. Relevance and saliency was determined following deeper analysis: contextualisation (narrative elements); polarisation (oppositional relationships between themes); and, hermeneutics of suspicion (move towards a more questioning analysis). The choice of which deeper analytic process to use was determined by issues deemed meaningful by the researcher e.g. contextualisation was used if sub- themes appeared to have a particular flow or position within the data. This reiterative process of returning to the data once sub-themes had been provisionally identified, augmenting themes and again returning to the data, continued until the researcher was confident a high level

of rigour had been achieved. Reflexivity was paramount throughout the process of data collection and analysis. A reflective journal was maintained to provide an account of possible researcher pre-suppositions that may be influencing interpretation of the data. This ensured partial bracketing occurred (priority is given to the phenomena of analysis rather than the researcher's interpretation whilst simultaneously recognising that this can only be partially achieved). Following analysis by the researcher, analyst triangulation was achieved via a quality check by the two co-researchers and an IPA group consisting of three trainee clinical psychologists. Finally, super-ordinate themes were determined by applying the same analytical process to the sub-themes.

Results

The data evidenced a high degree of convergence and divergence across transcripts. Similar sub- themes arose for at least four participants on four occasions and are included in Table 3.

Table 3

Super-ordinate themes and sub-themes

<u>Super-ordinate theme</u>	<u>Sub-theme</u>	<u>Theme present in cases</u>
The treatment paradox	1) The threat of treatment.	Mark, Callum, James
	2) The negative impact of treatment	George, Bob, Craig
	3) Interventions increasing problems	All cases
Fear of the unknown	1) What's going on?	Callum, Craig, Mark
	2) Lack of communication	Craig, James
Playing the game	1) Detention as a game	Mark, Callum,
	2) Being somebody else	Callum, Craig, George
The common touch	1) Familiarity promotes security	Callum, Mark, James
	2) Relating reduces stress	Callum, Craig, Bob

The treatment paradox

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

This super-ordinate theme was not provisionally identified, but was developed as a direct result of contextualising individual transcripts. Callum's transcript was interpreted as an account of how the experience of treatment resulted in avoidance of mental health services for a number of years and deterioration in his well-being. Contextualisation of his transcript developed greater clarity and a subsequent reinterpretation of other transcripts. Therefore, sub-themes that were not initially linked became so following deeper analysis. Consequently, the theme title for Callum – *Negative first impressions last* (which

was the best fit for his individual transcript) - was incorporated into the final analysis as the sub-theme –*The negative impact of treatment*.

The Treatment paradox was primarily associated with the psychological theories of: the self-fulfilling prophecy in a clinical setting (Harris, 1994); and, the labelling theory of mental health (Hinshaw & Cicchetti, 2001; Kroska & Harkness, 2008). Some aspects of this theme were further interpreted by reference to Ventegodt et al. (2010) who linked the prolonged use of anti-psychotics with negative outcomes.

The threat of treatment

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

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

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

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

Callum's first experience of treatment was perhaps the most telling account provided. Placed in the context of his overall contact with mental health services, his Mental Health Act assessment stands out as a particularly

negative experience that resulted in him avoiding services for a number of years:

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

Negative impact of treatment

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

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

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

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

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

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

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

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

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

Interventions increasing problems

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

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

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

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

For Craig and George the problem was also part of the assessment process though the issues were different. Craig's issue was concerned with the lack of familiar staff. Having a familiar face or process was an issue that arose regularly for a number of participants and is more fully explored in the super-ordinate theme – *The Common Touch*. In this instance it was specific to familiar staff members rather than practices; for Craig this constituted a problem:

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

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

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

These interpretations provided evidence to suggest that some of the experiences people are subjected to, when assessed and detained under the Mental Health Act, increase levels of psychological distress. The assessment process was generally described as a negative experience. Some participants' interpretations likened the process to a form of interrogation; the most salient issue associated with this being the lack of information provided. Having little or no idea of what was happening to them generated higher levels of anxiety whilst service provider led assessment processes reduced levels of perceived agency. This study complements the findings from McGuiness, Dowling and Trimble (2013). They identified - *The early days* – as a super-ordinate theme in their study of people detained on a psychiatric unit. This theme was “a critical period in setting the scene for the formation of the overall experience” (p. 730) and segued into the super-ordinate theme in this study – *The treatment paradox*. This theme was primarily informed by the sub-theme –*Negative impact of treatment* - and was maintained by all participants whose initial contact with

services, which involved assessment, heightened levels of anxiety and may have created a perceptual bias for negative aspects of the experiences that followed (Cabeleira et al, 2014).

This concept is supported by the psychological theory of the self-fulfilling prophecy in a clinical setting (Harris, 1994). In this theory both the clinicians' and the service users' expectancies impact on how their relationships develop. If a service user's initial contact is perceived as negative it may affect how they experience the entire treatment process. The labelling theory of mental health (Kroska & Harkness, 2008) suggests that the process of becoming a psychiatric patient results in individuals developing negative self-feelings based on cultural stereotypes of mental illness represented by diagnostic labels. The combination of a negative bias regarding treatment and a negative sense of self based on the stigma of diagnosis may partially explain participants' interpretations of their experience. Also, those with an affective disorder are more likely to develop negative self-feelings (stigma-sentiment hypothesis); in this IPA study four of the seven participants were diagnosed with bi-polar disorder. In addition, participants' negative experiences were compounded by assessors not introducing themselves, assessments being rushed, not being informed regarding what was happening to them, and of assessments being delivered with a high focus on meeting the needs of the service provider and not the service user. Labelling theory may also go some way to explaining this. Hinshaw & Cicchetti (2001) contend that stigma is pervasive and affects, amongst other things, the standards of care and professional attitudes towards those with mental illness. These issues reflect concerns highlighted by the Care and Quality Commission (CQC, 2012; 2013) regarding control and containment of service users taking priority over care and support.

Fear of the unknown

This super-ordinate theme was primarily concerned with a lack of effective communication exacerbating anxiety and distress. It was the result of combining two sub-themes that were evidenced in most transcripts, though their frequency or relevance in some was not considered high enough to warrant them being identified as key themes for some of the participants. The two sub-themes combined were – *What's going on?* and - *Lack of Communication*. The super-ordinate theme title was chosen because it was more indicative of the anxiety and fear generated by being kept uninformed and may be explained by the evidence-base for complex trauma (Cook et al., 2005); anxiety discharge (Siegal, 2001; Neborsky, 2006; Frederickson, 2013) and affective neuroscience (Panksepp & Biven, 2013).

What's going on?

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

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

The key interpretation for participants was concerned with the lack of information provided by staff. Not knowing what was being done to them or what was going to happen in the future was a significant source of psychological distress primarily associated with heightened levels of anxiety. Also, this theme can be viewed as serving the function within participants' accounts of conveying the intense emotions experienced during the detainment process:

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

At the time of their assessment and detention the people in this study were clinically conceptualised as experiencing either hyper-mania or psychosis. Both these labels have a psychiatric etymology rooted in a medical model of understanding that chiefly regards “mental illness” as the result of neurochemical imbalances (Bentall, 2011). In order to provide a more psychologically informed understanding the theory of cognitive perceptual disruption was employed (Siegal, 2001; Neborsky, 2006; Frederickson, 2013). This contends that long-term high levels of anxiety are mediated through the nervous system’s parasympathetic pathway and result in the manifestation of psychotic-like symptoms: dissociation, altered thought process, hallucinations and disturbed orientation in time and space. This anxiety is often attributed to complex trauma across development (Cook et al., 2005). As 94% of people with a diagnosis of “schizophrenia” report an average of 3.6 incidents of trauma over their lives (Kilcommons & Morrison, 2005) the theory of a link between trauma, anxiety and psychotic-like symptoms is a compelling one. The theory receives further support from the discipline of affective neuroscience (Panksepp and Biven (2013) and so presents a coherent biopsychosocial model that reconceptualises “mental illness” as primarily influenced by highly problematic interpersonal relationships.

No participant account recalled attempts by service providers to regulate anxiety. Assessors were generally perceived as strangers or detached professionals who were focused on garnering the specific information required to complete a Mental Health Act assessment. If people are conceptualised as “ill” and in need of medication then it follows that there may be very little attempt at meaningful communication at the stage of assessment and early detention.

Lack of communication

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

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

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

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

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

Playing the game

This super-ordinate theme was primarily concerned with participants' accounts of having to become something that they were not in order to be discharged or to prevent readmission. The most notable data in this theme was the use of figurative language to aid participants' interpretation. Therefore, even if its frequency was less, it is probable it would still have been included due to its role in helping bridge the gap between description of experience and conception (Smith et al, 2009). Furthermore, the idea that service users may have to keep their true nature from the very people who are there to help them reconcile it was a particularly powerful one. This theme was interpreted as being associated with social constructions of normality and the subjection of individuals through the internalisation of social norms (Foucault, 1977/1995; Henderson, 1994).

Playing the game

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

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

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

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

Being somebody else

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

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

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

Foucault (1977) was concerned with how hierarchical observation – in this instance experienced on a psychiatric ward – combined with normalising judgement (the assumption that thought and behavior that is not normative is abnormal or deviant) results in service users internalising social judgement to the extent that its presence is no longer necessary. In effect, the subjection of the individual is maintained by the individual upon themselves. This is one way of interpreting Craig's experience and may also explain Mark and Callum's need for pretence. Psychiatric nurses, immersed in the processes of observation, may unwittingly objectify the people they care for and in doing so damage therapeutic relationships as there is little time left for empathy (Henderson, 1994).

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

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

His use of the metaphor "mask" suggests that he may have adopted a new identity whilst in hospital – the one that he thought staff wanted to see. Callum outlines that he changed his behavior, followed treatment protocol and even consumed whatever was required, all with the purpose of getting out as soon as possible. Unfortunately for Callum this meant he also had to pretend he was ok.

The common touch

The common touch (which began as a sub-theme) - was specifically representative of instances where participants had experienced a connection or alleviation of their distress due to an experience with a service provider that was identified as a shared interest (football) or shared past-time (a cup of tea).

This theme was interpreted as being associated with the psychological theories of empathy and rapport in the therapeutic alliance generated by a process of common-basing (Hays, 2008).

Familiarity promotes security

The key experience communicated was interpreted as being concerned with the need to make a connection. In contextualising this interpretation it is sensible to conclude that when in a strange place, with little control and often in crisis, the familiar and the common may be straws to be grasped in earnest. Callum referred to the common touch the most. In this extract, he mentioned sharing a cup of tea – a common and comforting practice for many – and discussing football – a common shared interest:

And then at the end when he must have thought I was ok, I was sane, then it was all doors open and he took me out and had a cup of tea with me and I think we ended up talking about football or something. Because you know I was quite relaxed and he was a good psychiatrist" (Callum, 687-689)

The importance of empathy in the therapeutic alliance is well accounted for in psychological theory (Rogers, 1959; Snyder, 1992). Part of the empathic process can be generated through the identification of cultural values and knowledge that are shared by the therapist and service user. Hayes (2008) labels this process as common basing. By identifying common cultural practices it may be possible to connect with a service user and simultaneously address the inevitable power dynamic present during the assessment and detainment process. This is achieved by identifying something the service user has considerable knowledge of, such as football or music, and then making this the topic of the conversation. This helps build rapport and may increase the service user's confidence, which in turn may help regulate anxiety.

For Craig and Bob it was the familiarity of the person that took precedence:

...they should move hell for leather to make sure somebody who knows me attends those assessments. They should move heaven and earth for that because I've been assessed by complete strangers... (Craig, 146-149)

One possible reason for Craig and Bob's convergence on this issue is that they had both been assessed and detained numerous times over a fairly short time period. For Craig, there was a degree of frustration associated with having to repeatedly give his life history and also a concern that historical factors from many years ago may be misinterpreted by someone who does not know him. Bob's interpretation was similar, though primarily linked with his belief that familiar psychiatrists and nurses would result in a better outcome for him because they would know his usual presentation and so manage his distress more effectively:

... especially people who know about your illness and things like that cuz they can be a bit more understanding and they ask the right sort of questions. (Bob, 179-181)

There were a number of similarities to the experiences that Craig and Bob had regarding assessment and detainment: frequency; at home and in public;

regular police involvement. The idiographic elements of their interpretations came to the fore when they were asked to elaborate on the meaning of the experience.

The common touch highlighted a subjective decrease in the levels of stress experienced when assessors or inpatient staff were known or engaged service users on topics of common interest. The issue of specialised communication skills amongst staff is not part of Approved Mental Health Practitioner (AMHP) training. AMHPs are predominantly social workers and mental health nurses and play a key role in the early stages of assessment and detention. Although AMHP training is rigorous and includes considerable service user and carer input, the focus is primarily medico-legal issues (General Social Care Council, 2012). There is no training provided regarding specialist communication skills and although psychologists are now able to train as AMHPs the uptake in 2010/11 was nil. The skill of mediating anxiety and building rapport with highly distressed individuals requires an understanding of nuanced and complex interpersonal processes primarily informed by: attachment theory (Golding, 2007); transference issues (Lemma, 2003); and, once on an inpatient ward, an understanding of group dynamics (Haslam, 2004). Although there are often ward psychologists available this does not extend to the assessment process. Furthermore, relevant communication skills used with a learning disability population could be applied in order to address the cognitive perceptual disruption and reduced cognitive functioning prevalent in the acute and chronic stages of “mental illness” respectively. These are primarily concerned with identifying cognitive and emotional cohesion, adapting pace, content and tone of speech to the perceived ability of the recipient, and providing visual aids as an adjunct to verbal communication (Kyle, Melville & Jones, 2010).

Relating reduces stress

This sub-theme was chiefly concerned with the sense of well-being that is generated when staff demonstrate a good level of empathy and communicate that they really care about service users

They took their time. They were patient with me. I remember that much. They really seemed like they cared about me and what was going to happen. (Mark, 225-227)

In contrast to Mark's positive account, James was more concerned that the staff, although very pleasant, did not spend time engaging with service users.

...the nursing staff. Some of them were lovely [...] but they didn't spend much time with the patients, you know talking to them, there was the odd one. I also found it very confusing to work out who was who. (160-163)

Limitations

Recall of being assessed and detained was limited for some and may be explained by the high levels of cognitive disruption associated with episodes of crisis. Consequently, elements of participants' interpretations were recalled with a limited amount of clarity and reports were usually of the combined experience of numerous assessments or mixed with accounts of experiences whilst detained. Although still relevant, this meant that the essential experience of the assessment process was diluted.

Probably due to the emotive nature of the subject matter, recruitment was difficult. The initial criterion of having been detained in the last 18 months was extended to five years to increase the probability of extra recruitment. Although this was effective it also increased the probability of poor recall. Although the results of this study can help illuminate some aspects of being assessed and detained, no claim for external validity can be made. The participants recruited all had predominantly negative experiences and this may have been a motivating factor in them coming forward for interview.

Implications and conclusion

Although there have been positive developments in the care systems applied to manage people in severe psychological distress, problems still remain. This is evidenced by the findings of the CQC (2012; 2013), which have consistently highlighted issues around the imbalance between managing people

and providing effective therapeutic interventions. The importance of service user and carer input has increased in the past decade and its relevance is evident in the current training packages for AMHPs. Although this is a positive development regarding the Mental Health Act assessment and early detainment stages of the sectioning process, the influence of the service user perspective is still limited and requires further change (National Service Users Network, 2014). The absence of psychologists taking up AMHP roles means that psychological concepts that could complement the current predominantly medical model of treatment are not being used. Consequently, the lack of effective communication during the assessment and detainment process, which is consistently related by service users in qualitative studies, may be a major issue perpetuating psychological distress. Undesirable first impressions of treatment may then be developing a cognitive bias that results in service users perceiving their experience through a negative lens. Effectively, they expect a negative experience and this expectancy increases the likelihood that this will be the case. An addition to the AMHP training package of a module that addresses anxiety regulation, specialist interpersonal issues and communication techniques could help rectify the situation and so improve clinical care.

The implications for clinical psychologists, particularly those working in a psychiatric ward setting, are primarily concerned with the need to promote a psychological alternative to the functional psychiatric disease model of mental health. As outlined in this paper, formulating psychosis as predominantly concerned with complex trauma and chronic anxiety issues can provide an evidence-based psychological alternative that could prove fruitful in determining effective interventions.

Further research could use quantitative designs to target the assessment process with a focus on communication and anxiety rather than risk. By including service user researchers in the process of developing global questionnaires some of the methodological problems associated with service provider bias may be effectively addressed.

Word Count – 7099

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Paper 3: Critical commentary

Ontology to outcome: qualitative research processes in a United Kingdom clinical psychology doctoral thesis

Abstract

The purpose of this paper is to provide a critically reflexive commentary of the research process for a United Kingdom (UK) professional doctorate in clinical psychology (DClinPsy). The paper opens with a reflective commentary on the literature review that preceded the empirical research process. The application of multiple psychological theories to address the problem of reflexivity in Interpretative phenomenological analysis (IPA) (Smith, Flowers & Larkin, 2009) is then considered. A critique of IPA is explored and some processes of analysis are offered as means to address criticisms. The paper concludes that although there are ongoing methodological issues with IPA analysis it nonetheless provides the framework for a rigorous process that reflects its critical realist epistemology.

Introduction

This paper's account of the research process in a clinical psychology doctorate is organised in a linear fashion (from inception to completion) and the content reflects some of the researcher's particular theoretical interests in clinical psychology; namely critical psychology and epistemology. The research thesis was comprised of three papers: a literature review; an empirical paper utilising interpretative phenomenological analysis (IPA) (Smith et al., 2009); and, a reflective paper. The thesis was produced as part of a professional doctorate and so represented about a third of the doctorate's requirements.

Although clinical psychologists are chiefly concerned with the application of psychological research in the workplace, they also learn doctoral level research skills. They are therefore in a rare position, as many non-clinical psychologists are involved purely in research. Clinical psychologists witness the gap between theory and application on a daily basis. Theoretical models occupy every place on a spectrum ranging from the beauty of simplicity to the deeply complex.

The types of knowledge that are constructed in psychological research are all reliant on some type of ontology and episteme. The validity claimed for that knowledge is restricted by the axioms of its constitution. This paper addresses these issues by paying particular attention to critical reflexion in the qualitative research process. Initially, personal perspectives and interests, essential factors in qualitative research, are considered. This is followed by a critique of the types of

knowledge that are produced by different methodologies, and how these inform understanding of clinical and ethical issues

Background

Studying undergraduate psychology as a mature student provided solid grounding in the fundamentals of the discipline. Child development, Cognitive psychology, Neuropsychology and statistical analysis constituted the bulk of the course. There were module sections that considered attribution, perception and even consciousness, but these were relatively limited in depth and scope. This was understandable given the sheer volume of information that could be studied. These topics were engaging and challenging, but it was not until the final year of study and an introduction to Critical Social Psychology that the course became revelatory. Such texts as *Madness and Civilisation* (Foucault, 1961/2006), *Time and Being* (Heidegger, 1927/1962), and, *Discourse and Social Psychology* (Potter & Wetherell, 1987) addressed psychology in dynamic and illuminating ways that incorporated epistemological issues as fundamental to understanding. These texts did more to answer philosophical and psychological questions for the researcher than any others e.g. a belief in both individual agency and the influence of society had been difficult to reconcile, but critical social psychology explained the issue by transcending the individual-social dichotomy with concepts of intersubjectivity and social constructionism. The idea of knowledge as situated and intricately related with issues of power has continued to inform study, clinical practice and research choices.

Reflexively speaking, a longstanding interest in society's marginalised groups, and a libertarian attitude, made it more likely that these texts would be enthusiastically engaged with. Although the outcomes from research with quantitative designs could be applied ethically to alleviate psychological distress, the qualitative designs that were chiefly employed by critical and social psychology approaches were more explicit in their links with socio-political issues such as discrimination, social identity and the manipulation of narrative to justify social action (Parker, 2002). It was also made clear that mainstream science and psychology were not immune to these influences, though generally were naïve or rejecting of them. Also, qualitative methods more directly represented service user views. Many designs were concerned with applying rigorous, ethical

approaches to determine the essence of service users' experience and how it informs, or is explained by, psychological understanding. Perhaps of more interest was the hypothesis that mainstream positivist approaches to psychological research may be producing an understanding of the human condition that was complex in the processes of deduction, but ultimately simplistic in its conclusions. An example that immediately came to mind was Cognitive Behavior Therapy (CBT) and its focus on the individual self, reliance on "objective" knowledge, and its assumption that statistical numbers represent nuanced and context based interpretations that people make in multi-directional social situations (Maloney, 2013).

The issues outlined above were central in determining the choices made regarding research aims and methodology for the research thesis. This also influenced decisions in the first year of the doctorate regarding the population to be studied and the types of questions to ask. Armed with the limited knowledge of a psychology graduate, training began with the belief that clinical psychology was complicit in upholding a view of "mental illness" that was rooted in a medical model. This was perhaps understandable as the reality for most National Health Service (NHS) clinical psychologists in the U.K. was as a minority working in teams that were generally trained in understanding mental "illness", dementia and learning disability chiefly from a biochemical viewpoint. Just as psychiatry was influenced in its conceptualisation of mental illness by a motivation to be accepted by the medical fraternity, so clinical psychology focused its attentions on positivist research processes that resulted in clinical application dominated by Behaviourist and Cognitive psychology (Bentall, 2010). Consequently, the early development of the identity of clinical psychologists can be conceptualised as situated within a context of positivist scientific understanding. The credence afforded to Randomised Controlled Trials (RCT's) was strongly associated with positivism and for many years had relegated the value of qualitative research.

The purpose of outlining the above is to provide some context for the decisions taken regarding research choices. Reflecting on this it is clear that personal preferences/interests had a strong influence on how clinical psychology was perceived and what its key aims should be. Although the researcher entered into the research process with a reasonable capacity for reflection it is clear that perception of the profession was influenced by self-perception and the personal

values identified with. This could be viewed in two ways: it could be argued that this approach was decidedly non-scientific as personal issues only cloud judgement and impact on outcomes. Conversely, it can be argued that an appreciation of the impact of personal values on the research process is not only essential, but to omit this consideration is to be decidedly non-scientific. The veracity of each view is, of course, determined by the epistemology that informs it.

The Literature Review

The review began with a broadening of the empirical research question in order to encapsulate the research that may be available regarding the detaining process, and more specifically the Mental Health Act assessment that precedes it: As the potential research literature available was considerable, the key search terms and inclusion/exclusion criteria needed to be appropriate and precise. Based on the advice of two research health librarians, the initial search process involved using countless search terms and thesaurus functions on search engines to help develop appropriate terms. Although the review was not systematic in its true sense there was a systematic element to the process. However, at this stage it was minimal as the process appeared to be much more flexible with luck and tenacity playing equal parts in identifying terms and subsequent articles for review. This was an example of the gap between method and execution. Although this initially seemed unscientific, the process was rigorous - and tenacity is a quality of good science that perhaps receives little attention. The actual process was better described as reiterative with new search terms from thesaurus use and subsequent database searches informing the next search, and so on until a combination of search terms are identified that produce the most relevant set of articles – in this manner at least, it could be termed systematic. Furthermore, the relevance of the articles searched, although based on clear inclusion and exclusion criteria, were determined by a more subjective process. This is where the importance of reflexivity gained importance. For example, the exclusion of articles that focussed on people of less than 18 years of age was an objective criterion. Similarly the exclusion of people with a primary forensic presentation or learning disability was also a decision based on objectivity – though it can be argued that the label “learning disability” is much more subjective than a person’s

age, irrespective of whether their Full Scale Intelligence Quotient (FSIQ) is less than 70.

It became clear that what constitutes objectivity is open to definition, and is really determined by research aims and the episteme that informs its methodology. For example, on one side of a psychological research/episteme continuum neuropsychological research could be placed, as it is generally concerned with cognitive explanations of psychological processes and possible neural correlates (Valencia and Delgado, 2013). Critical social psychological research could be placed opposite as it adopts the view of individuals primarily determined through interaction with their environment and context (Hepburn, 2003). Somewhere in the middle of the continuum would lie social cognitive psychology – a quantitative approach that targets the impact of social factors on individual psychology. Neuropsychology develops its knowledge through primarily statistical methodology and a neo-positivist paradigm; critical social psychology utilises primarily qualitative methodologies and interpretative models of understanding.

The hierarchy of evidence is primarily informed by the perceived validity of research articles. Historically, qualitative research has not been given the same weight as quantitative research as it is thought to lack objectivity – which it does within a dominant positivist narrative. Most qualitative approaches do not lay claim to objectivity (Grounded theory may be an exception), but are specifically designed to explore subjectivity. In fact it could be argued that qualitative approaches are more valid than quantitative as they address subjectivity through a research lens defined by its reflexivity. The validity of a paper is itself judged through a specific episteme and so the extent of its validity is determined by the process of its construction and the value attributed to specific qualities. Perhaps most telling is that qualitative approaches openly recognise and address this, but very often quantitative approaches do not. Quantitative approaches in psychology, rather ironically, lose claims to validity through their adherence to a positivist paradigm, albeit neo-positivist. Consequently, non-material “objects” inadvertently become reified, and psychological constructs (i.e. social constructs) become concrete. Furthermore, the observation of behavior from which mental processes are inferred is deemed objective and the theory of knowledge that states “percepts without concepts are blind” is conveniently overlooked (Harre, 2005 p.15).

The context in which psychological research grew was dominated by a positivist episteme and this domination is still clear. Psychology was concerned with patterns of behaviour, causal relationships, objectivity and prediction. The fact that objectivity in psychology was usually based on inference and not on direct observation did not seem to be an issue for many. Furthermore, unlike psychology, units of analysis in the natural sciences are often not affected by context – a brick is a brick in Japan or Brazil. Therefore *empirical* claims in mainstream psychology were made about “objects” that have no discernible material substance, are context dependent, and are not directly observed. The value placed on objectivity can be directly linked to the historical dominance of the natural sciences and psychology’s attempt to be accepted in to that fraternity (Bentall, 2010). However, there is a school of thought that believes the hierarchy should be determined by methodologies that best answer the research question (Avyard, 2007).

Following critical appraisal the articles were synthesised to identify common themes. Each was coded for descriptors that best encapsulated their focus and findings. Once again, a reiterative process took place whereby the codes were used to identify themes in the literature, which in turn were used to review the articles for further codes, and so on until rigour was achieved. This resulted in three central themes: The Impact of context and relationships, Agency, and Risk. The first two themes were constructed from the focus and outcomes of qualitative articles, whilst the theme of Risk was primarily the outcome from the quantitative articles appraised.

No claim can be made for the entire “population” of research literature from this small sample, but the themes illustrated a pattern in the shortlisted literature that may be applicable to the entire corpus. This raised the issue of whether quantitative research designs used to explore the detention process tended to produce findings that focused on risk management, and qualitative designs produced findings that focused on contextual and relational issues. The ramifications for an NHS that uses an evidence-based practice model could be considerable; the issue is worthy of further investigation.

A claim of many qualitative researchers in psychology is that qualitative designs better address the position and concerns of service users (Banister, Burman, Parker, Maye & Tindall, 1994). It could be argued from this that the

choice of methodology is an ethical issue as the British Psychological Society (BPS, 2009) states that respect for the knowledge and opinion of Service users is a central tenet of clinical practice. Also, the Department of Health (DH, 2007) highlights the importance of service user (and carer) inclusion in service development. The quantitative research critiqued in the literature review represented a relatively “top down” approach, the interests of the service provider manifesting in research outcomes where risk management was given primacy at the expense of other concerns. The humanistic element of psychological research was reduced as systems of control, management and ultimately risk aversion developed that reflected a social context of increasing health and safety controls, which in turn were influenced by the prospect of accountability and litigation. Of course, the need for risk management is self-evident and that is not being contested here. Rather it is the extent of that control and the factors associated with it. As identified in the literature review – a tentative association can be posited between the dominance of quantitative research in detainment processes and the risk management practices that prioritise service provider concerns.

Theoretical Plurality and Reflexive Analysis

Doctoral training in clinical psychology exposes the trainee to multiple experiences with multiple clinical populations, whilst simultaneously providing teaching on multiple theoretical perspectives. The outcome of this in the research process was a position taken by the researcher during the gathering of data that incorporated theory from Phenomenology, Attachment therapy, Mindfulness and Psychoanalysis. The phenomenological attitude (Finlay, 2008) adopted during the interview process was also informed by the concept of the Mindful Self (Kabat-Zinn, 1994), and countertransference from psychoanalysis (Lemma, 2003). What these approaches all have in common is a development of awareness - either of emotions, unconscious processes, thoughts, or presuppositions or the Self; the focus of the approach being dependent on the philosophy that informs it. For instance, the Buddhist teaching that informs Mindfulness posits a universal self that can be conceptualised as the attention that manifests when the researcher tries to identify who/what it is that is thinking about thinking about thinking: consciousness. This takes the researcher one step beyond meta-cognition and is a useful position to consider when attempting the phenomenological attitude.

Therefore, multiple psychotherapeutic techniques as outlined by Wallin (2007) - utilised in order to be more present for the client - can also be adopted in the research interviews as tools that enable greater reflexivity. Reflexivity, a difficult concept to apply in the interview setting, becomes through practice a process that is more automatic in function – analogous to driving a car where the higher functions of the conscious mind and attention are initially employed to achieve a novel task. Through practice the conscious focus is replaced by more automatic processes that enable the researcher to practice reflexion in action.

Fortuitously, Mindfulness had been practised by the researcher for three years prior to the research taking place. The practice of focusing attention, and exploring thoughts and feelings that interrupt focus in a non-judgemental way, promotes the ability to take an outsider view of the self. In effect consciousness interrogates consciousness. This enables an extra level of reflexivity that moves beyond thinking about thinking (reflection), or even beyond the awareness of meta-cognition as contextual and reciprocal (reflexion).

Critique of IPA

IPA has been heavily critiqued by some leading phenomenologists. Giorgi (2010) challenged the scientific credentials of IPA. This was chiefly concerned with IPA's claims to be phenomenological. Giorgi outlines in detail how IPA fails to address key concepts in phenomenological philosophy. He also contends that IPA fails to provide a coherent and systematic method of enquiry, and so fails to provide a methodology that is replicable. Smith (2010) defends IPA by highlighting that it is a qualitative approach and so replicability is not a key criterion. A lengthy response from Giorgi (2011) follows in which he painstakingly lays out the philosophical phenomenological method, particularly the phenomenological reduction. In doing so he somewhat misses the point of what Smith et al. are trying to do. There is no claim for phenomenological reduction by IPA researchers. In operationalising an interpretative phenomenological approach the philosophical elements of phenomenology cannot be fully adhered to. Furthermore, the reduction as described by Edmund Husserl, the “father” of phenomenology, requires an intense meditative process akin to religious conversion (Husserl, 1936/1970). Quite how an exponent of the reduction would be able to scientifically prove they have bracketed presuppositions is never elucidated by Giorgi.

Ultimately, any claim could be no more than intersubjective, and so the type of objectivity validated would be more relativist than realist i.e. based on a shared belief that is historically situated. The problem is that even if the philosopher has, in their mind, achieved a true reduction, the recipients of their enlightenment would not have, and so would tarnish the reduction through the lens of their own perception.

Giorgi (2010; 2011) does make some valid points that address some of the difficulties in operationalising the philosophical foundations of IPA. Most pertinent is the issue of data gathering and analysis. To what extent researchers should try to adopt some version of a phenomenological reduction is still not clear. Smith et al (2009) provide theoretical background and procedures for IPA method, but the finer details of reflexive analytical process are not considered. Also, the word count for many journals does not allow for a detailed consideration of the processes involved in research method. Consequently many IPA papers contain only a brief paragraph outlining reflexive processes.

The Analysis

IPA research demands a reflexive approach but does not provide a clear account of how to be reflexive. Research outcomes are presented as participant interpretations of specific experiences, which in turn are interpreted by the researcher: the double hermeneutic circle (Smith & Osborn, 2003). Therefore, a degree of latitude is afforded to the IPA researcher regarding their approach to adopting a reflexive attitude. The analysis presented below primarily adopted a phenomenological psychological attitude (Finlay, 2008) mediated by the practice of Mindfulness. The purpose of this was to ensure a sincere attempt was made to address reflexive issues and so increase the depth of analyses. This paper contends that IPA cannot make claims for uncovering elements of phenomena - the subtle difference from phenomenological psychology being that the elements are recognised as a shared interpretation within a social cognition framework rather than the essence of the phenomenon itself – without providing clearer guidance on how the uncovering is to be achieved.

The examples given below are not presented as an account of how to ensure reflexivity. Rather, they are illustrative of the *processes* involved in an

attempt to attain an element of reflexivity. By providing this account the researcher aimed to address some of Giorgi's (2010; 2011) critique of IPA regarding a lack of method exposition.

Participants

Seven participants were interviewed. The account below provides a sample of some of the more salient issues regarding reflexivity for two participants: Callum and Mark.

Pre-reflexion

Prior to the interview external pressures, expectations, hopes, belief systems and possible biases were all considered in order to pre-empt reflexive issues. The demands of the doctorate were experienced as exerting pressure on the need to recruit participants for research. The expectation was that the participant – Callum - would attend though there was considerable anxiety that he may cancel. It was hoped that he would provide rich data for analysis. The researcher believed that there were some existing problems with detaining people. These were chiefly concerned with balancing issues of managing risk and ensuring appropriate liberty. Reflecting on this it was realised, perhaps for the first time, that the ethical issues associated with detaining people under the Mental Health Act could never be fully resolved. This informed a more balanced approach to understanding what might be conveyed during the interview. The issue that had existed was concerned with the use of detention as a tool - one that exerted power through seemingly benevolent systems, which were ultimately structured through the dominant narrative of reason and normality (Foucault, 1961/2006).

Next, a ten minute Mindfulness exercise was used prior to the interview in order to focus attention on anything that appeared to be vying for prominence e.g. an image of a blank canvas was brought into attention with a blank face representing the participant at its centre. Thoughts were then attended to as they entered consciousness, not judged or valued, but observed, explored and then allowed to dissipate. The main content of these were concerned with mental health treatment and violent offending. It is likely that the latter was associated with the researcher's involvement in a Mindfulness group on a forensic placement.

However, Callum's care coordinator had provided some background on him, and this had included a violent past. An underlying tension was identified. By reflecting on the likelihood of any real risk, any processes to consider managing it, and the likelihood of challenging behavior at the interview, it was possible to reduce tension. This increased the probability of being able to conduct the interview in a calm, bounded manner that would in turn reduce the probability of the participant picking up on unconscious cues, which in turn may make them more defensive. This was an example of addressing a reflexive issue associated with transference and countertransference.

Reflexion in action

Callum's description of his psychological distress was very similar to aspects of the researcher's personal experience of distress a decade earlier: the idea of having no knowledge or insight into what was happening and how terrifying the experience could be. By recognising this during the interview it was possible to partially bracket some of the emotions and assumptions associated with this experience in order to better enter Callum's life-world. This affected the types of questions asked, the weight given to the responses, and the amount of time spent on the issue. Therefore, reflexive awareness of presuppositions developed through the researcher's previous experience of psychological distress affected the interview process. This in turn affected Callum's responses; whose own presuppositions were influenced by the experience of the interview and the type of questions asked. The reflexive processes of the double-hermeneutic circle involved in the discussion were made evident, altered and ultimately employed to attempt a more "objective" rendering of Callum's experience.

Two recurring metaphors in Callum's interview were concerned with him feeling "like a little kid" during the Mental Health Act assessment, and the belief that he had to "wear a mask" in front of mental health professionals in order to ensure being discharged from care. Similar metaphors had been used in a previous interview with Mark, albeit in a slightly different way - in Mark's interview he had referred to feeling "like a child" and also the importance of knowing the "best way to play it" in order to expedite his discharge. Knowing that these differences may be important allowed the researcher to explore the metaphors to

determine what their specific meaning was for Callum and Mark. This helped address the idiographic focus of IPA (Smith et al., 2009) that aims to uncover specific detail about individual experience – in turn this added depth to the analysis that followed. For Callum, the little kid metaphor was associated with thoughts of being guilty of doing something wrong. Mark had used the metaphor primarily to communicate a sense of lost agency in his adult life. These different interpretations informed different sub-themes in the analysis. Callum's was concerned with how the emotion of guilt impacted on his interpretation of the assessment, which he viewed as a type of interrogation; Mark's was concerned with the need for a secure base. Without reflecting on this in action, the questions asked may have been based on presuppositions generated by the previous interview i.e. explored feelings of guilt. Conversely, the metaphors concerned with wearing "masks" and knowing how to "play it" were interpreted as different ways of expressing the same thing: the need for pretence in order to ensure discharge from a psychiatric unit.

Data Analysis

This account is a reflection on the analysis of the entire data set: seven participants.

Smith et al.'s process of analysis involves the identification of themes for each individual transcript. These are pooled together once all transcripts have been analysed. Common themes across the data set are grouped as sub-themes; groups of sub-themes are given super-ordinate theme titles. The problem with this process is that the mere mention of an issue that could technically be related to a sub-theme is enough for it to be included in a master table of themes as evidence of coherence of descriptions across the data set. This is misleading because tiny elements of individuals' accounts could end up grouped together to give some impression of importance or value. Across the data set it then looks like this is indeed evidence of a super-ordinate theme, but may have held little importance for the individuals within the context of their own accounts.

The analytical process of an IPA could be altered slightly in order to address some of these issues. The initial process of coding and identification of themes could follow Smith et al.'s (2009) methods though a different direction

taken once all transcripts have themes identified. Each individual transcript's themes could be grouped under sub-theme headings *for that transcript*. Therefore, provisional sub-theme headings would be the result of *the pooling of individual themes within individual transcripts* as opposed to Smith et al.'s (2009) process of pooling themes across the data set. Provisional sub-theme headings could then be compared across the data set – where there was sufficient evidence of sub-theme coherence a provisional super-ordinate title would be identified. By analysing the themes in this way it may be possible to ensure that the idiographic elements of participants' transcripts are highlighted and maintained whilst simultaneously identifying their relevance to the entire data set. The idiographic element would primarily highlight the interpretative aspects of the analysis whilst the relevance to the entire data set would primarily highlight the phenomenological aspects. Also, the problem of individuals making meagre reference to an issue and that reference being used as evidence of a sub-theme could be resolved.

As the data analyses progressed it became evident that in some instances participant responses were being interpreted by the researcher in light of possible themes, metaphors and linguistic tools identified in previous analyses. For example, some participants in the earlier interviews discussed the negative impact of psychiatric interventions. In future interviews the mention of a slightly negative experience was met with questions that although not explicitly leading did give the participant the time and space to explore it. This in turn increased the chance that they may elaborate in a similar fashion to previous participants and so increase the likelihood of a theme being identified. It became clear that the weight given to participant statements was clearly influenced by previous interviews. Noting this early in the interview process allowed adjustments to be made, not just about how things were interpreted, but also about the amount of time and focus given to particular topics. This level of awareness ensured that the data being analysed was not inherently biased based on the researcher's previous experience of interviewing. This issue is addressed by Smith et al. (2009, p.100) and they advise that awareness is enough. However, it may be more effective to code all transcripts first and then return to identify and group themes. If transcripts are fully analysed after all interviews have taken place and themes identified as the final process, then the influence of experience on subsequent interpretations is limited.

Conclusion

The approach adopted in this paper was critically reflexive. In effect, this mirrored what the researcher had identified as the necessary approach to apply in order to conduct an effective interpretative phenomenological analysis.

The critical elements of IPA were defined by idiographic evidence and divergence of participant accounts. The realist elements were more descriptive parts of the analysis and defined by convergence of participant accounts. IPA was therefore able to simultaneously demonstrate the subjective nature of experience and the commonalities within that experience that provide a tantalising idea of what reality may be like. It can be concluded from this that IPA provides a true reflection of the epistemology it claims to utilise. Also, the relativist ontological position adopted by IPA is upheld, as although it is recognised that a reality exists, the idiographic focus of IPA ensures that the subjective quality of perception is never omitted and that objects are only qualified as they *appear to us* and not as *they are*.

Final Reflection

Interpretative phenomenological analysis is a time consuming affair. There can be a sense during transcription and analysis that similar conclusions may be reached by simply reading the interviews two or three times. This does not do justice to IPA and is more likely the effect of too many hours spent immersed in the data. On reflection, there is a need to go beyond the text, back to the preverbal, in order to best uncover the experience that has manifested in the language of the participant. Only then can there be a full engagement with the text, a rediscovering of words and context, and the multiple possible meanings they convey. The experience of being assessed and detained under the Mental Health Act was, for the participants in this study, a visceral and often life changing experience. The language that conveys this experience must be deconstructed, stripped down to its fundamentals, and then reformed in a psychological interpretation that is always mindful of the transformative nature of interpretation. IPA, not without its limitations, provides a suitable vehicle to achieve this though the reflexive processes of analysis are not adequately addressed in its key theoretical texts.

Word Count - 5166

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Appendix A

Journal Submission Guidelines – Literature Review paper

The Mental Health Review Journal

This journal focuses on the delivery and evaluation of mental health services in the UK, with particular attention to innovation, implementation and service user experience.

Word Limit - should be between 4000 and 7000 words in length, except for literature reviews or review articles which have no word limit. This includes all text including references and appendices. -

Abstract - authors must supply a structured abstract in their submission, set out under 4-7 sub-headings. Purpose (mandatory) Design/methodology/approach (mandatory) Findings (mandatory) Research limitations/implications (if applicable) Practical implications (if applicable) Social implications (if applicable) Originality/value (mandatory) Maximum is 250 words in total (including keywords and article classification, see below). Authors should avoid the use of personal pronouns within the structured abstract and body of the paper (e.g. "this paper investigates..." is correct, "I investigate..." is incorrect).

Literature review - it is expected that all types of paper cite any relevant literature so this category should only be used if the main purpose of the paper is to annotate and/or critique the literature in a particular subject area.

Headings - must be concise, with a clear indication of the distinction between the hierarchy of headings. The preferred format is for first level headings to be presented in bold format and subsequent sub-headings to be presented in medium italics. - See more at:

http://www.emeraldgrouppublishing.com/products/journals/author_guidelines.htm?id=mhrj#sthash.7hxT4S1U.dpuf

References - to other publications must be in Harvard style and carefully checked for completeness, accuracy and consistency.

Appendix B

Journal Submission Guidelines – Empirical paper International Journal of Humanities and Social Science (IJHSS)

Aims and Scope

IJHSS aims to promote interdisciplinary studies in humanities and social science and become the leading journal in humanities and social science in the world. The journal publishes research papers in the fields of humanities and social science such as anthropology, business studies, communication studies, history, industrial relations, information science and psychology.

Manuscripts

The length of the paper should not exceed 25 pages. Papers containing more than 25 pages words will be returned to the author(s) to abridge. Articles should be typed in double-space (including footnotes and references) on one side only.

Title

Title should be concise and informative. Try to avoid abbreviations and formulae where possible.

Abstract

A concise and factual abstract is required (maximum length of 150 words). The abstract should state briefly the purpose of the research, the principal results and major conclusions. An abstract is often presented separate from the article, so it must be able to stand alone. References should therefore be avoided, but if essential, they must be cited in full, without reference to the reference list.

Subdivision of the article

Divide your article into clearly defined and numbered sections. Subsections should be numbered 1, 2. (then 1.1, 1.1.1, 1.1.2), 1.2, etc. The abstract is not included in section numbering.

Table and Figures

Present tables and figures at the end of the article. Please note that the article will be published in black and white.

References

Author(s) should follow the latest edition of APA style in referencing.

Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Avoid citation in the abstract. Unpublished results and personal communications should not be in the reference list, but may be mentioned in the text. Citation of a reference as 'in press' implies that the item has been accepted for publication.

Appendix C

Journal Submission Guidelines – Critical commentary paper

The Journal of Theoretical and Philosophical Psychology

Format

- Have you checked the journal's website for instructions to authors regarding specific formatting requirements for submission (8.03)?
- The entire manuscript—including quotations, references, author note, content footnotes, and figure captions must be double-spaced and neatly prepared.
- The margins must be at least 1 in. (2.54 cm; 8.03)?
- Are the title page, abstract, references, appendices, content footnotes, tables, and figures on separate pages (with only one table or figure per page)? Are the figure captions on the same page as the figures? Are manuscript elements ordered in sequence, with the text pages between the abstract and the references.
- Are all pages numbered in sequence, starting with the title page.

Title Page and Abstract

- Does the byline reflect the institution or institutions where the work was conducted?
- Does the title page include the running head, article title, byline, and author note.
- Does the abstract range between 150 and 250 words.

Paragraphs and Headings

- Is each paragraph longer than a single sentence but not longer than one manuscript page?
- Do the levels of headings accurately reflect the organization of the paper.
- Do all headings of the same level appear in the same format?

Abbreviations

- Are unnecessary abbreviations eliminated and necessary ones explained?
- Are abbreviations in tables and figures explained in the table notes and figure captions or legends?

Mathematics and Statistics

- Are Greek letters and all but the most common mathematical symbols identified on the manuscript?

- Are all non-Greek letters that are used as statistical symbols for algebraic variables in italics?

Units of Measurement

- Are metric equivalents for all nonmetric units provided?
- Are all metric and nonmetric units with numeric values?

References

- Are references cited both in text and in the reference list?
- Do the text citations and reference list entries agree both in spelling and in date?
- Are journal titles in the reference list spelled out fully?
- Are inclusive page numbers for all articles or chapters in books provided in the reference list

Appendix D

Electronic Search Strategy

EBSCOhost and Web of Science search engines were accessed via Staffordshire University Library Login. HDAS search engine was accessed via

NICE Open Athens Login. Searches were targeted on title, abstract and keywords (Table D1). The searches were conducted on 22nd July, 2015.

Following searches of multiple variations of relevant search terms with use of Mesh and Thesaurus functions, the final search terms were determined by the frequency of relevant articles identified.

Table D1

Electronic Search

<u>Search Engines</u>	<u>Search Terms</u>	<u>Articles</u>
EBSCOhost: Psychology/Sociology Databases (Databases included: PsycINFO, PsycARTICLES, PsycBOOKS, CINAHL Plus with Full Text, eBook Collection)	psychol* (S1)	3,797,035
	process* (S2)	3,053,107
	assess* (S3)	3, 472,691
	detain* (S4)	4,960
	“psychiatric hospital*” (S5)	42,792
	“involuntary treatment*” (S6)	1,699
	“Mental Health Act*” (S7)	2,225

	S1 OR S2 OR S3	8,612,041
	(S8)	
	S4 OR S5 (S9)	47,461
	S6 OR S7	
	(S10)	3,816
	S8 AND S9 AND	409
	S10	
	(S11)	
	S8 AND S9 AND	
	S10	
	Limiters (Peer reviewed and post 1983)	329
	(S12)	
Web Of Science	psychol* OR	11,817,493
(Core Collection, BIOSIS,	process* OR assess*	
Medline, SciELO)	(*1)	
	detain* OR	
	“psychiatric hospital*”	25,233
	(*2)	

		"involuntary treatment" OR "Mental Health Act" (*3)	1,576
		*1 AND *2 AND *3 (*4)	138
		*4 (Limiters – social sciences; Peer reviewed and post 1983)	
		(*5)	97
			Duplicates removed
			44
HDAS (AMED, BNI and EMBASE)	psychol*	(1)	274,740
	process*	(2)	1,799,689
	assess*	(3)	2,635,110
	detain*	(4)	2,494
	"psychiatric hospital*"	(5)	12,163

“involuntary treatment**”	(6)	340
“Mental Health Act**”	(7)	3,716
1 OR 2 OR 3	(8)	4,387,442
4 OR 5	(9)	14,556
6 OR 7	(10)	1, 482
8 AND 9 AND 10		116
(Peer reviewed and post 1983)		Duplicates removed
	(11)	6

Appendix E

Other databases searched

Web of Science

The 97 articles available for scrutiny on this database were mainly from psychiatric journals although some psychology journals were included. This may be explained by the historical dominance of psychiatry and the medical model in mental health, especially in the field of inpatient admission and treatment. It also demonstrates a relative paucity of psychologically informed research in this area, which in turn strengthens the argument for more.

44 articles remained after duplicates were removed. The themes identified in the EBSCOhost search were also evident in this database with legislation and medico-legal issues constituting the bulk of the articles. There were no new articles that met the inclusion criteria for shortlisting.

HDAS

This database provided 116 articles based on the search terms. There were six articles remaining after duplicates were removed. Four were excluded due to their focus on medico-legal issues; the remaining two focussed on minors and so were also excluded.

Appendix F

University Peer approval



**STAFFORDSHIRE
UNIVERSITY**

Faculty of Health Sciences
The Science Centre
Staffordshire University
Leek Road
Stoke-on-Trent ST4 2DF
United Kingdom
+44 (0) 1782 294000 (enquiries)
+44 (0) 1782 294643 (direct)
www.staffs.ac.uk

Date: 4th March 2014

To whom it may concern

Application for Independent Peer Review Approval

Researcher: Joe Grace
Study Title: Being sectioned: An exploration of the experience of being assessed and detained under the Mental Health Act

I can confirm that Staffordshire University supports this research project proposal being put forward by the above research project applicant, and that the University is willing to act as sponsor of the project if it received LREC approval.

Our support for this project takes account of the outcome of an independent peer review of its scientific merit undertaking within the University.

I can also confirm that the University has generic indemnity/insurance arrangements in place as stated on the attachment to this letter, that arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed, that arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts and that the duties of sponsors set out in the NHS Research Governance Framework for Health and Social Care will be undertaken in relation to this research.



Professor Nachiappan Chockalingam
Chair,
University Academic Ethics Sub-Committee

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INVESTOR IN PEOPLE

Appendix G

Research and Development approval

South Staffordshire and Shropshire Healthcare **NHS**
NHS Foundation Trust

Our Ref: AB/R280
26 June 2014

Mr Joe Grace
10 Longner Street
Shrewsbury
SY3 8QS

A Keele University Teaching Trust
R&D Department
Block 7
St George's Hospital
Corporation Street
STAFFORD ST16 3AG
Telephone: 01785 221168

Dear Mr Grace

Study title: The experience of being assessed and detained

We have considered your application for access to patients and staff from within this Trust in connection with the above study.


On behalf of the Trust and the Responsible Care Professionals within the Psychology Directorate have now satisfied themselves that the requirements for Research Governance, both Nationally and Locally, have been met and are happy to give approval for this study to take place in the Trust, with the following provisos:

- That all researchers coming into the Trust have been issued with either a letter of access or honorary contract by ourselves
- That you conform to the requirements laid out in the letters from the REC dated 13 May 2014, which prohibits any changes to the agreed protocol
- That you keep the Trust informed about the progress of the project at 6 monthly intervals
- If at any time details relating to the research project or researcher change, the R&D department must be informed.

Your research has been entered into the Trust database and will appear on the Trust website.


As part of the Research Governance framework it is important that the Trust are notified as to the outcome of your research and as such we will request feedback once the research has finished along with details of dissemination of your findings. You will be asked to provide a copy of the final report and receive an invitation to present final feedback via our research seminar series. To aid dissemination of findings, copies of final reports are placed on our Trust Website. To this end, please contact me towards the completion of the project to discuss the dissemination of findings across the Trust and a possible implementation plan.

If I can help in any other way please do not hesitate to contact me.

Yours sincerely

Ruth Lambley-Burke
R&D Manager

Appendix H

NHS Research and Ethics Committee Approval

		 Health Research Authority NRES Committee East Midlands - Derby Research Ethics Office The Old Chapel Royal Standard Place Nottingham NG1 6FS Telephone: 0115 883 9525
13 May 2014		
Mr Joe Grace Trainee Clinical Psychologist South Staffordshire and Shropshire Foundation Trust C/o Clinical Psychology Department Faculty of Health Sciences, Science Centre, Stoke-on-Trent ST42DF		
Dear Mr Grace		
Study title:	Being sectioned: A qualitative study of the experience of being assessed and detained under the Mental Health Act.	
REC reference:	14/EM/0146	
IRAS project ID:	137743	
<p>Thank you for your letter of 12 May 2014, responding to the Committee's request for further information on the above research and submitting revised documentation.</p> <p>The further information has been considered on behalf of the Committee by the Chair.</p> <p>We plan to publish your research summary wording for the above study on the HRA website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the REC Manager Ms Tracy Leavesley, NRESCommittee.EastMidlands-Derby@nhs.net</p> <p>Confirmation of ethical opinion</p> <p>On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.</p> <p>Ethical review of research sites</p> <p>NHS sites</p> <p>The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).</p>		

Non-NHS sites

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering Letter		22 March 2014
Evidence of insurance or indemnity	Zurich Municipal - Indemnity	16 July 2013
Evidence of insurance or indemnity	Zurich Municipal - Liability	01 August 2013
Interview Schedules/Topic Guides	1	15 February 2014
Investigator CV	Mr Joe Grace	24 March 2014
Letter from Sponsor	1	04 March 2014
Letter of invitation to participant	2	12 May 2014
Other: CV - Dr Helena Priest	1	29 January 2014
Other: Letter from Leicester Proportionate Review Sub Committee	No Opinion Letter	07 April 2014
Participant Consent Form	2	12 May 2014
Participant Information Sheet	2	12 May 2014
Protocol	1	15 February 2014
REC application	137743/584365/1/995	24 March 2014
Response to Request for Further Information	Letter from Joe Grace	12 May 2014

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

14/EM/0146

Please quote this number on all correspondence

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

With the Committee's best wishes for the success of this project.

Yours sincerely



Mr Peter Korczak (Chair)

Email: NRESCommittee.EastMidlands-Derby@nhs.net


Enclosures: "After ethical review – guidance for researchers"

Copy to: Dr Liz Boath

Ms Audrey Bright, SSSFT

Appendix I

Sponser's insurance


**ZURICH
MUNICIPAL**


Certificate of Employers' Liability Insurance(a)

(Where required by regulation 5 of the Employers' Liability (Compulsory Insurance) Regulations 2008 (the Regulations), a copy of this certificate must be displayed at all places where you employ persons covered by the policy or an electronic copy of the certificate must be retained and be reasonably accessible to each employee to whom it relates).

Policy No.	NHE-02CA03-0013
1. Name of policyholder	Staffordshire University
2. Date of commencement of insurance policy	01 August 2013
3. Date of expiry of insurance policy	31 July 2014

We hereby certify that subject to paragraph 2:

1. The policy to which this certificate relates satisfies the requirements of the relevant law applicable in Great Britain, Northern Ireland, the Isle of Man, the Island of Jersey, the Island of Guernsey and the Island of Alderney **(b)**
2. **(a)** the minimum amount of cover provided by this policy is no less than £5 million **(c)**

Signed on behalf of Zurich Insurance plc (Authorised Insurer).
Signature

Stephen Lewis
Chief Executive Officer, Zurich Insurance plc (UK Branch)

Zurich Municipal is a trading name of Zurich Insurance plc
A public limited company
Incorporated in Ireland
Registration No. 13460
Registered Office Zurich House,
Ballisbridge Park, Dublin 4
Ireland.
UK branch registered in
England and Wales Registration
No.
, BR 7985
UK Branch Head Office
The Zurich Centre, 3000
Parkway,
Whiteley, Fareham, Hampshire
PO15 7JZ

Notes

(a) Where the employer is a company to which regulation 3(2) of the Regulations applies, the certificate shall state in a prominent place, either that the policy covers the holding company and all its subsidiaries, or that the policy covers the holding company and all its subsidiaries except any specifically excluded by name, or that the policy covers the holding company and only the named subsidiaries.

(b) Specify applicable law as provided for in regulation 4(6) of the Regulations.

(c) See regulation 3(1) of the Regulations and delete whichever of paragraphs 2(a) or 2(b) does not apply. Where 2(b) is applicable, specify the amount of cover provided by the relevant policy.

Authorised by the Central Bank of Ireland and subject to limited regulation by the Financial Services Authority. Details about the extent of our regulation by the Financial Services Authority are available

Appendix J

Participant Information Sheet

Participant Information Sheet

Research Title:

Being sectioned: An exploration of the experience of being assessed for detention under the Mental Health Act.

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. **One of our team will go through the information sheet with you and answer any questions you have.** We'd suggest this should take about 15 minutes

Part 1 tells you the purpose of this study and what will happen to you if you take part.

Part 2 gives you more detailed information about the conduct of the study.

Please ask us if there is anything that is not clear.

Part 1

Who is carrying out this study?

This study is being carried out by Joe Grace – the lead researcher and a trainee clinical psychologist; Dr Cai Dunn – a clinical supervisor and clinical psychologist; and, Dr Helena Priest – the Research Director for the Staffordshire and Keele Universities Doctorate program in clinical psychology. Therefore this study represents a professional collaboration between South Staffordshire and Shropshire Foundation Trust (SSSFT) and Staffordshire and Keele Universities.

What is the purpose of this study?

The purpose of this study is to better understand what it means to an individual to be detained under the Mental Health Act. The focus is the assessment process that occurs prior to detention taking place. It is hoped this research will

provide service users with a chance to express their views. This may help improve the communication skills of mental health professionals involved in the assessment process.

Why have I been invited?

You have been invited to take part because you have experienced being sectioned in the past five years.

Do I have to take part?

No. It is up to you to decide to join the study. The researchers will describe the study and go through this information sheet with you. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. This would not affect the standard of care you receive.

What will happen to me if I take part?

If you agree to take part then you will be asked to engage in one 30-45 minute interview in order to discuss your experience of being sectioned. The interview will take place in an NHS building and will be audio-recorded. The research should be completed by June, 2015 and you can choose to request a copy of the completed article by contacting the lead researcher on a number that will be provided.

The interview will be semi-structured. This means that there will be some general questions about the topic of interest but there will be plenty of opportunity for you to express your feelings and thoughts on the assessment process.

What will I have to do?

Simply turn up at the allotted interview time.

What are the possible disadvantages and risks of taking part?

During the interview you will be asked questions about the sectioning process that may prove emotive. If you feel strongly about contributing to this topic but do have concerns then try and bring a supportive family member or health care professional with you. They could not attend the actual interview but could be on hand for support following its completion.

What are the possible benefits of taking part?

Contributing to this research can help ensure that the opinions of service users are heard. This can help the NHS to better understand some of the difficulties people might be experiencing during a section. This may help them respond in

a more caring and effective manner. Also, you will be reimbursed for travel costs and a Tesco gift voucher of £10 will be provided as a small token of appreciation.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2

What will happen if I do not want to carry on with the study?

You are free to withdraw from the interview at any time and any information gathered can be discarded on request. However, once the interview is completed the information will go into a general analysis and cannot be withdrawn.

What if there is a problem?

The researcher is an NHS employee. Any concerns/complaints about the research can be directed to them in the first instance. The number to call is 07791859970. If you do not wish to speak to the researcher about the issue then please contact their supervisor on 07970665487. Alternatively Patient Advice and Liaison Service (PALS) can be contacted for support and advice: 01785 221469 or 221490, 221499, 221544.

Will my taking part in this study be kept confidential?

Yes. The only exception to this would be if any information was disclosed during the interview that suggested the interviewee was a risk to themselves or another. In this scenario the researcher would have to notify their supervisor.

All information gathered in this study will be processed and stored in accordance with the Caldicott principles. These ensure that client information is shared on a strictly “need to know” basis; that information is anonymised when possible and there is minimum use of personal details. All use of personal information must be lawful and in accordance with the Data Protection Act, 1998.

Research supervisors from the NHS and Staffordshire University will have access to the information. Interviews are recorded and then transcribed and stored on computers. All information is kept locked and secure at all times including when in transit from site to site. Research data is stored for five years by Staffordshire and Keele Universities and may be audited by the NHS Research and Development Team to ensure standards are being met. After five years the data is destroyed.

Involvement of other professionals

It is possible that you currently have an NHS care co-ordinator. Ideally they should be informed of your involvement as a professional courtesy and also to ensure you are adequately supported.

What will happen to the results of the research study?

The research will be submitted for publication in a health journal. All participants will be offered a summary of the research article, which will be mailed at their request.

Who is organising and funding the research?

The research is a joint venture between Staffordshire and Keele Universities and Shropshire and Staffordshire Foundation Trust.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the NHS Research Ethics Committee.

Further information and contact details

For general information about research please see access the following websites:

<http://www.nres.nhs.uk/>

<https://www.myresearchproject.org.uk/>

For more specific information on the methods used in this research please access the following website:

<http://ipacommunity.tumblr.com/>

If you would like to discuss your suitability for this research and any other concerns you may have then please contact Joe Grace (Lead Researcher) on 07791859970; Cai Dunn (clinical supervisor) at Ptarmigan House on 01743 255 830; or, Helena Priest (Research Director) on 01782295785.

Alternatively if you would like to talk with someone outside the research team then perhaps your care co-ordinator would be appropriate.

Appendix K

Consent Form

Consent Form

Study Number:

Title of Project: The experience of being assessed and detained under the mental health act: a service users' perspective.

Name of Researcher: Joe Grace

Please read the following statements and initial each box if you wish to give consent.

1. I confirm that I have read and understand the information sheet dated..... for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

☐

3. I understand that data collected during the study, may be looked at by individuals from Staffordshire University, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to this data.

☐

4. I understand that anonymised quotes from my interview will be used in this study. I give my

☐

permission for this to occur

☐

5. I wish to "opt in" to receiving a copy of the study results

6. I give my permission for interviews to be recorded and transcribed, and for

☐

anonymous quotes to be used in the final study.

7. I agree to take part in the above study.

☐

Name of Participant Date.....Signature

Name of Person taking
consent.....Date.....Signature.....

Appendix L

Interview Schedule

Interview Schedules

Check information sheet.

Sign consent.

Remind can withdraw at any time.

Description and interpretation for individual.

Demographics

REFLEXIVITY

Preamble

Ok So now we are recording. I am going to ask you some questions about your experience of being assessed under the Mental Health Act – are you ok to start?

I thought it would make sense to put things in the order that they happened. So, could you describe to me some of the reasons you ended up being assessed under the Mental Health Act?

Pre assessment

- What were your relationships like with others in the weeks or days building up to your assessment?

friends, family, partner, work

- How were you feeling prior to the assessment – can you describe it for me.
- How do you make sense of what was going on for you back then?

The assessment

- Could you describe the immediate build up to the assessors coming to see you. What was going on?
- Could you describe what it was like when medical professionals came to assess you?

- Can you describe what you were you thinking when you were being assessed? How did you make sense of what was going on?
- Can you describe the experience of being assessed for detention - what stands out as particularly significant or important about the experience?
- Can you describe what the assessors did??
- Were there any friends or family present when you were being assessed. Describe what it was like to have the assessment with people close to you present?
- How do you think other people see you once they know you have been detained?
- What do you think about the whole process of sectioning people under the mental health act? What does it mean to you?
- If you had to describe your assessors, not so much what they were wearing or how tall they were but more there personalities or characters – what would you say?
- What do you think motivated the assessors?
- What motivated you at the time of the assessment – what meaning does it have for you?
- What do you think could have been done differently by your assessors?
- If this wasn't your first assessment can you tell me about the things from previous assessments that really stand out for you. Describe them in detail.
- How do you think things would have been different if you had not been detained?
- Do you think the right decisions were made about your sectioning?

In addition to these key questions various prompts will be used and new questions asked based on what the participant brings to the interview.

Endings

Check in with emotion; What happens now; Thanks.

Appendix M

Process of analysis

The amount of themes initially identified for each participant varied considerably. The main reasons for this being the length of interviews and the speed at which some participants spoke i.e. the sheer volume of data provided. However, there were other reasons some participants produced more themes. For example, Craig produced the most data, but was subjectively the least stable of the participants interviewed. Consequently, there were numerous digressions and the relevance of his contribution to the topic under discussion was reduced. Callum digressed the least and produced a lot of data; consequently a relatively large number of themes were identified in his transcript (67 – 34 of which were finally incorporated into the sub-themes for the data set).

Master Table

A master table of some of the most pertinent quotes from each participant is provided as evidence of the empirical grounding of super-ordinate themes in the transcripts (Table M1).

Table M1

Master Table of Themes for the Group

1. The treatment paradox

The threat of treatment

Mark -

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

Callum -

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

James –

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

The negative impact of treatment

Mark -

- ...they pay attention to what you say but then section you because you can't be trusted to make sense. (162-163)

Callum -

- Torturing someone...asking them questions and stuff. (52-53)

Craig –

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

James -

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

Bob -

- ...it just seemed to take forever [...] I did run away a few times and the police took me back and they got me really low as well. (207-208)

George -

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

Mike –

- I didn't know where I was going and they didn't say where they were taking me. (55-56)

Interventions increasing problems

Craig –

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

Bob

- ...got me really low as well you know, sort of like with all these people around you that aren't very well you know and you think you're doing alright. I don't know what made it drag on so long but it made me get really low.... (210-212)

George

- Yeah, well it felt like a physical thing which I think is partly to do with the awful drugs I was being forced to take...the experience was awful, I was taking Resperidone which has awful side effects that was making me depressed and then I was given Risperidone an anti-depressant which, one of the symptoms of being depressed is you get extremely constipated and the depression gets worse. (103-109)

2. Fear of the unknown

What's going on?

Callum -

- ...if they sat down with me and said look this is an assessment this is what we are gonna do, and told me about it I would have understood it better and I probably would have been more at ease but I, it's the first time I had been in that situation, I did not know what they were gonna do. (231-235)
- Well, because, because I would've known what was going on. Cuz just sitting down in a room with questions, being questioned, then I'm thinking what are they gonna do, I was really scared...(268-270)

Craig –

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

Mark –

- The first time this happens to you it's a nightmare, there is nothing like it on earth and people who think they understand it without being there don't know what they're going on about. (215-219)

Lack of communication

Craig -

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

James

- I was gobsmacked because the way I was treated at the hospital sort of just carried on, a massive lack of communication... (103-106)
- I didn't know that you see, again no discussion so I looked at that and thought to myself what's happened and so I wasn't really paranoid or anything, it's just there was no communication. (430-432)

3. Playing the game

Detention as a game

Mark

- "Thing is, you start to work out what's going on after a while, how the system is and the best way to play it." (126-127)
- "If I were sectioned again then I know how to play the game [pause] because that's what it is really. They know you're probably not as bad as they're making out and you know that you are not". (156-159)

Callum

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

Being somebody else

Callum

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

Craig

- "I don't think I'll be sectioned again, because now I know exactly how to behave..." (572)
- "To not get sectioned I have to be a model citizen, I mean, I have to be like a member of the royal family and be nice to everybody and never lose my

temper and I have to I have to behave like a model citizen..." (597-599)

4. The common touch

Familiarity promotes security

Bob -

- ... especially people who know about your illness and things like that cuz they can be a bit more understanding and they ask the right sort of questions. (179-181)

Craig -

...they should move hell for leather to make sure somebody who knows me attends those assessments. They should move heaven and earth for that because ive been assessed by complete strangers... (146-149)

Relating reduces stress

Callum -

- And then at the end when he must of thought I was ok, I was sane, then it was all door open and he took me out and had a cup of tea with me and I think we ended up talking about football or something. Because you know I was quite relaxed and he was a good psychiatrist. (687-689)

Relating reduces stress

Callum -

- ... it's not someone saying hiya, do you wanna sugar in your tea, how are you today. It was more personal, it was getting into the nitty gritty of how I was about me past and all this kind of stuff and I just felt really invaded... (226-229)

Mark -

- They really seemed like they cared about me and what was going to happen. (226-227)

James –

- ...the nursing staff. Some of them were lovely...but they didn't spend much time with the patients you know talking to them, there was the odd one. I also found it very confusing to work out who was who. (160-163)
- ...I had met a doctor that I could relate to at the hospital so I was in a much lower mood. The way I was talked to was immediately more honest and so much more sensible that I could immediately see where they were coming from. (323-326)

Appendix N

Participant transcript sample

Emerging Themes	Participant 2 : "Callum" – Transcript	Exploratory Comments
<p>Family promotes security.</p> <p>Being before parents reflects relationship dynamics</p> <p>The influence of maternal illness narratives</p>	<p>223P: Yeah.</p> <p>224I: Can you expand a bit on that.</p> <p>225P: Well essentially I've got 2 strangers in front me asking me questions about 226me history and about the way I am feeling. And, you know, it's not someone 228227 saying hiya, do you wanna sugar in your tea, how are you today. It was more 229personal, it was getting into the nitty gritty of how I was about me past and all 230this kind of stuff and I just felt really invaded and the more I kinda let them know 231that I didn't wanna engage in this the more forceful they were about it and said 232me and said look this is an assessment this is what we are gonna do, and told 233me about it I would have understood it better and I probably would have been 234more at ease but I, it's the first time I had been in that situation, I did not know 235what they were gonna do. For all I know they could have put me in a mental 236hospital for months at a time, or a year because my Grandmother, she had been 237in and out of a mental institution for what, 30 years, and they'd just take her and 238put her in here and she'd have 6 months or a year at a time so I had that in me</p>	<p>Family promotes security. Narratively promotes relaxation.</p> <p>2 strangers asking very personal questions</p> <p>Convey a need for normality</p> <p>Needed to engage - felt invaded</p> <p>Sense of not knowing (being isolated & anxiety)</p> <p>As explanation of the school was happening would have helped</p> <p>Sense of not knowing made worse by perception of how madly ill I've been - Grandmother</p> <p>Communicating past experiences Grandmother informing her he never sense of assessment!</p>

<p>side of communication occurs when it's</p>	<p>239 and I'm thinking I don't like all this but no-one was explaining it to me.</p> <p>240 I: Ok. So, because of the things you knew, because of your Grandmother, and</p> <p>241 her experience. That kind of primed you in a way, that that might happen to you.</p> <p>242 P: Yeah, it may me quite defensive.</p> <p>243 I: It made you quite defensive. And because they didn't explain who they were or</p> <p>244 what they were doing and kind of went straight into it. That made you feel how?</p> <p>245 P: Um (pause), it made me feel like a little, like a little kid in school. Being told,</p> <p>246 ye know, ye gotta answer this, you gotta answer that. And because I'd, (pause) I</p> <p>247 felt like I'd done something wrong.</p> <p>248 I: Yeah.</p> <p>249 P: And I know I had, I'd punched the glass in the hospital and broke it and stuff</p> <p>250 like that so yeah I'd caused criminal damage I suppose. But I felt like I'd done</p> <p>251 something wrong and it was my fault that I'd ended up there...</p> <p>252 I: Yeah.</p> <p>253 P: When really, I'm thinking I feel like I'm getting grilled and pressured to</p> <p>254 answer these questions when I really need help and I remember being really</p>	<p>Taking away choice, not hearing, taking - all leads to sense of powerlessness x unwillingly</p> <p>Felt defensive</p> <p>to metaphor - suggest's powerlessness, guilty,</p> <p>treated like a child.</p> <p>Sense of guilt</p> <p>Repeat sense of wrongdoing</p> <p>Criminal damage as moral fault (see Bolton, 2009).</p> <p>My fault</p> <p>Hearings always done to me - not with me - suggest's manipulation: guilty</p> <p>Being pressured to answer,</p>
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side of communication

the moral element
of treatment

the guilty child

side of communication
occurs when it's

Appendix O

Depth analysis

Analysis of one participant's interview: Callum

All Identified themes for each participant were grouped together based on frequency and similarity – provisional sub-themes were tentatively identified. The transcripts were then reviewed individually, holistically and through the lens of provisional sub-themes. The suggestions for deeper levels of analysis were considered in turn (contextualisation etc.) and the most relevant applied to each transcript.

A full account of the analysis of Callum's interview transcript is provided in Table O2 below. Provisional sub-themes are underlined as labels for all relevant themes within his individual transcript. This helps illustrate how individual themes were eventually grouped and then compared and contrasted across the data set. By scrutinising both tables alongside the scanned example of two pages of Callum's transcript (Appendix N) it is possible to follow the analysis of one participant from initial descriptive coding through to super-ordinate themes for the entire data set. Coding in the transcript has descriptive comments highlighted in purple, linguistic comments in green and conceptual comments are underlined.

Table O2

Themes and sub-themes for one participant: Callum

<u>Themes</u>	<u>Line</u>	<u>Key Words</u>
<u>Assessment as Interrogation</u>		
Assessment as Interrogation	52-53	Torturing someone...asking them questions and stuff
The guilty prisoner	627	I just felt trapped
The guilty child	245-247	Like a little kid...like I'd done something wrong

The perpetuating
influence of
rejection

Abandoned by loved ones	85	Just left with meself
Vicious circle of illness and isolation	94-95	Everything was breaking down around me. All me relationships
Sense of abandonment	104	Just me and the whole world separate

Information as an
Intervention

Knowledge of condition brings relief	123-124	No medication and no knowledge and no support it was just a really black time
Being informed reduces anxiety	232	This is the assessment and this is what we are gonna do.
Fear of the unknown	270	I was really scared

Negative first
impressions last

Negative first impressions last	184	I drifted away from services
Negative first impressions last (2)	355	I just avoided them like the plague
Fear of exposure	338	Not exposing myself to all that again
Lack of collaboration	57-62	I... they

The common touch

Familiarity promotes security	227	Do you wanna a sugar in your tea/
Importance of knowing assessors	206	Essentially there was just 2 strangers sitting there
Normalising	515-516	It was ok to be around them people and talk about that

promotes

wellbeing

The common touch

- | | | |
|-----------------|-----|------------------------|
| 1. Behavior | 686 | Had a cup of tea |
| 2. Conversation | 687 | Talking about football |

Clarity promotes
security

Need for clear communication	451	Talking quite fast...I couldn't always understand everything
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More effective communication required	534-535	Communicate with people...explain to them what's happening...I think it can often help
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Assessment as a
secure base

The need for a secure base	283	Like being a baby
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The need for explicit empathy	310-311	Parents weren't listening...
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Dominance of
service priorities
increases
psychological
distress

Assessors needs are prioritised	437	Hurry up and get on with it so he could go and do what he had to do next.
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self-value reduced by rushed assessment	460-461	Not important...like someone else was more important...
-----------------------------------------	---------	---------------------------------------------------------

Playing the game

Pretence	368	Done everything I could to appear I was ok.
----------	-----	---------------------------------------------

Playing the game	393	I'm gonna have to play ball here.
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Becoming
someone else

590

Like I was wearing a mask.

Contextualisation

Callum's account of his experience clearly describes how the development of his distress was closely linked with family and friends. The end of his relationship and his father's illness were precipitative factors impacting on his ability to cope. The rejection he experienced from loved ones, or lack of understanding, was repeated in the hospital and the MHA assessment. This initial experience of treatment resulted in increasing isolation and the conscious decision to avoid services. This account is neatly encapsulated within the two themes – *First impressions last*, and - *The perpetuating influence of rejection*. Both themes are introduced quite early in the narrative, but occur throughout. The former helps Callum to explain his negative relationship with services over the early years; this is balanced by some reference to developing better knowledge in more recent positive experiences of service delivery, which have enabled him to become an expert on himself. Unfortunately this positivity was not salient enough to warrant a theme of its own and so could not be identified as polarisation of themes. It is however loosely contained within the theme - *Information as an intervention*.

Callum's need for familiarity and security is contained within a number of themes – *Assessment as a secure base*; *Clarity promotes security*. These themes help Callum express the level of need for containment; they neatly complement his account of rejection and negative experience. The flow of themes is concluded as Callum explains the development of pretence in order to escape from his ordeal and manage day-to-day life – *Playing the game*.

The middle position – between the hermeneutics of empathy and suspicion

This brief analysis was tentative and mindful of taking care to remain grounded in the text.

An alternative way to consider some of the themes that emerged is to conceptualise Callum as an actor making sense of his place in the world through the use of rhetorical devices and positioning. It is possible that Callum, now he has more insight into his condition and a more favourable view of services, has positioned himself within the narrative of his detainment experience as an unwitting participant with no agency. This may have served the purpose of assuaging any regrets he may have about avoiding services for so long following his first negative experience.