“Why do Working -Age People with Mental Health Needs Enter Long -Term Care”

A study into the decision-making process which leads assessing professionals to reach the conclusion that there is no alternative to admission to long-term care for working-age people with mental health needs.

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Abstract

This study analyses the process by which health and social care professionals decide to recommend working-age people with mental health needs enter long-term residential or nursing care. This type of intervention means that the person is removed from their community and the life they have known because of the need to offer them, and wider society, support and protection. There is little or no existing research into this topic area so this study, its findings and recommendations will contribute to new knowledge about the inevitability of such admissions and potential for alternatives to them.

The thesis employs a mixed method grounded theory methodology to analyse the case records of 72 people recommended for admission (and currently living in long-term care) underpinned by a constructivist ontology and interpretivist epistemology. The data was analysed to yield a model of the decision-making process.

The study finds that four main themes contribute to the decision making: people are admitted because of the risk they pose, the protection they require, the resources they consume and the need to maintain their strengths. The admission arises from behaviours which constitute risk to the person or others for which there is no recourse to criminal law. Although the study is primarily concerned with the social constructs of this behaviour, it is noted that the primary diagnosis of the study population is psychotic-type illness. The admission arose from a lack of contract, assurance or trust between the assessing professional and the assessed person that they would or could desist from these high-risk behaviours.

Theoretically the data analysis and findings were found to be congruent with satisficing, which is an extant theory which best explains the data. As the assessing professional cannot contract with the assessed person, they find a solution which is satisfactory and sufficient which is

ultimately admission to long-term care. The professionals need to steward resources for the wider health system ensure that care arrangements are sustainable for individuals and vulnerable groups. Professionals achieve this balance via of bounded reality which incorporates their professional identity, training and culture and the situations and organisations within which they work.

The study makes recommendations for education, practice policy and further research.

- Education - That social and market forces impacting on front-line professionals are understood and clearly stated so they are overtly aware of how satisficing may impact on practice, so they act as conscious agents of this.
- Practice – That professional curiosity is maintained and the willingness to optimise as opposed to satisfice by strength-building interventions is maintained and further developed.
- Policy – That reliance upon short-term immediate solutions is replaced with an appetite to explore more variety of efficient, effective solutions which bring about long-term recovery by providing intensive support which can be “stepped down”.
- Research – That the way professionals develop “trust” and contract with people they work with is better understood to promote person-centred practice and co-production.

Acknowledgement and Dedication

The study would like to acknowledge in the strongest terms possible Pauline Bonner for her ongoing support and encouragement and her belief in me when mine was failing. She is a truly inspirational leader and mentor and an unwavering support.

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This study is dedicated to my father Tecwyn Williams who sadly passed away during its completion. He was the dearest person, and I regret he did not see this enterprise finished.

Contents

Contents

Index of Tables

Index of Figures

CHAPTER ONE- INTRODUCTION CHAPTER

1.1 Introduction

This study sets out to determine why assessment frameworks applied to working-age-people with mental health needs result in them being admitted to long-term care, which causes them to be removed from their homes, social networks, and communities to greater or lesser extents. It will explore the concept of admission to long-term care and the assessment frameworks applied at the point people enter such settings with the objective of fully understanding the necessity for such admissions and potential alternatives to them. Part of the conduct of the study included a systematic literature review which identified that similar work with this research cohort had not previously been conducted and that this study would generate new knowledge.

The study utilised a retrospective case series design to review the electronic case record of a group of 72 people who were identified as being in long-term care and who had mental health needs to determine why this was in relation to their characteristics and circumstances. The knowledge and theory generation strategy was grounded theory as this has an established reputation for the study of human behaviour and generating knowledge as to how individuals interpret reality (Suddaby 2006). Because there was a significant body of data this facilitated a methodological process of understanding recorded subjective experiences (Fendt and Sachs, 2008). Due to the nature of the data, with the electronic record containing some mandatory fields, and other more free-text subjective elements the data was both qualitative and quantitative and thus a mixed method strategy was employed so that all the data could be systemically evaluated.

Data analysis revealed the following themes: people who exhibited high levels of risk, who required protection and who absorbed large levels of resource were admitted to long-term

care, but as part of application of the assessment framework, the assessing professional had considered the person's strengths and taken positive steps to maintain these. Hence, theory generation was very much around the process of decision-making and the elements and nuances of this, and the extant theory of satisficing formed the theoretical framework of the study.

1.2 Emergence of the thesis as a topic of interest

The researcher is employed in a role concerned with the systemic admission of people with mental health needs to long-term care. This led to a development of professional curiosity as to what theoretical, professional, educational and research knowledge could be generated.

An initial literature review indicated that where admission to long-term care was analysed this was not concerned with working-age people with mental health needs Gilburt and Peck (2014), Priebe and Turner (2003) and Ryan et al (2004) explored the situation of people who had been convicted of a criminal offence who are not included in this study cohort. Bowie et al (2006) concerned themselves with older adults who had a diagnosis of dementia. Briesacher et al (2005) explored the effectiveness of treatment within nursing homes as opposed to why people were admitted. Ryan et al (2004) revealed poor standards of care within nursing homes but again did not interrogate why people were admitted. Naylor et al (2012) and Placentino (2009) found that there was a correlation between co-existing physical and mental ill health among the working-age nursing home population rather than this being the reason for admission.

Two studies focussed their findings on diagnosis and correlation with likelihood of admission. Andrews et al (2009) found that people with a diagnosis of schizophrenia were likely to be admitted to a nursing home younger, with a median admission age of 65. Aschbrenner et al (2011) found that 60.3 % of people admitted to nursing care with this diagnosis were under 65. Although these latter studies did consider diagnosis as a factor contributing to admission

this study is far wider-ranging as not everyone with this diagnosis will be admitted to long-term care, and it will determine what additional characteristics lead to admission and which are categorical indicators of the decision to admit working--age people with mental health needs to long-term care. Therefore, there is a gap in the research addressing the specific needs of working-age people which this study aims to address.

The data used in this thesis is recorded by the assessing professional about a persons' interaction with the health and care system in terms of their risk presentation (behaviours, severity, and social tolerance), their experiences of restriction under The Mental Health Act (1983) and their strengths and personhood to determine how these are preserved post admission.

The thesis will include the formulation of several recommendations regarding education; practice; policy and future research.

1.3 Context

How the Research Question Was Arrived At.

The researcher is a senior manager in a large NHS Trust in Central England who has for decades been part of the hierarchy of decision makers that drives the decision-making process which has resulted in working age people with mental health needs being admitted to long-term care. As such, much oversight is held by the researcher over decisions to admit working-age people with mental health needs to long-term care due to the financial cost of the placements and of the impact on the persons' independence and wellbeing which led to curiosity about, and a desire to provide a categorical answer to the question **"Why do working-age people with mental health needs enter long-term care?"**

Negulescu and Doval (2014) formulate an understanding of decision-making processes within social and medical care as a huge responsibility shared by managers, employees, and

stakeholders. However, the decision is taken and encapsulated in the assessment document and appears as a transaction between the assessing professional and the individual to be admitted. Much is made of power relations and how these operate in decision-making transactions and interactions: O'Sullivan (2010) typifies different types of power interactions as collusive, co-operative, protective and oppressive. This study will evaluate the role of the assessing professional as an agent of the state and make recommendations as to what realistic alternatives to admission to long-term care exist.

The ultimate interaction which takes place is the assessment, this is based on the Care Act 2014 and is structured to identify the person's eligible needs. This interaction takes place via conversation with the person, their families, or significant others (where they have these) and professionals providing support. The National Institute on Aging present at Hill et al (2015) defines the following factors which increase the likelihood of admission to long-term care for older people: increased age; gender (females are more likely to be admitted as they live longer); single people (are more likely to be admitted as they are less likely to have voluntary or informal care); lifestyle, with poor dietary and exercise habits being a contributory factor; and health and family history also contributing to characteristics which increase likelihood of admission. It is acknowledged that this is a US (United States) Institute and influencing factors may be different in the UK (United Kingdom) and that there is no corresponding data for people with ongoing mental health needs.

The review which determines that the person will remain in these long-term care settings permanently usually takes place six weeks after admission. The decision-making includes some or all the following dependent on the persons' circumstances: the person, family or carers, representatives of the care facility, and the assessing professional. No written document or policy stipulating that this review should take place at this point exists, although it may be linked to the 6 weeks health funded care available to people should they need it after being discharged from hospital. The content of the assessment framework formally

records the interactions and transactions and places emphasis on the person's care needs and what support will be offered as part of their move to long-term care.

This study is concerned with the examination of the social and personal conditions of the person leading up to and at the time they were admitted to long-term care and subsequently. The essence of the research is to approach data analysis via the coding and memoing processes inherent in grounded theory to scrutinise what staff recorded in the case records about admission to understand the decision-making around this. This was completed to understand the decision-making around admissions as a source of knowledge as to their necessity and the potential to avoid them.

Having provided the context for the thesis, the Introductory Chapter will continue to provide key definitions about the elements of the research question.

Key Concepts

This introduction section will provide information about the key concepts in the research question.

1.4 Mental Health

This study cohort are people who have mental health needs. In this thesis, mental health needs are viewed through the lens of the researcher as a social worker, conducting the study from a socio-cultural viewpoint, which may differ from that provided by a clinician. The socio-cultural influence of mental illness determines whether and when people seek help, what kind of help they seek, their resilience and coping skills and how much stigma they, and society, attach to mental illness (The US (United States)- Office of the Public Surgeon 2001).

This study cohort all have long- term and severe mental illness. Public Health England (2018) describes long-term mental health needs in working-age adults as Severe Mental Illness (SMI) and defines this as follows (p.1): "SMI refers to people with psychological problems that are

often so debilitating that their ability to engage in functional and occupational activities is severely impaired." Schizophrenia and bipolar disorder are often referred to as an SMI; these are separate from illnesses typically associated with ageing in terms of treatment and interventions offered and have specific social and cultural influences.

McCann et al (2004) studied the sense of self or meaning for people with long-term mental health needs. The study reported on the lived experience of working-age adults with long-term mental health needs. It determined that there were three main themes which highlighted how these individuals found meaning within long-term mental health needs socially and culturally. The first one is that of temporality. These people find their perception of time and of the passing of time differ from most of society, which affects their ability to interact and engage with others who have a more conventional sense of time. The second theme was that of relationships and the way people's delusions, intrusive thoughts and hearing voices limited their ability to interact with others effectively. The third theme illustrates how the side effects of antipsychotic medication cause physical ill health and weight gain. This can distort the individual's perceptions of their body and compromise friendships, family, and sexual relationships. They argue these aspects apply especially to working-age adults.

Walsh et al (2016) also carried out a meta-analysis of working-age people with long-term mental health needs; after applying search criteria to databases, 27 studies were included in the analysis. The resultant themes in people's lived experience of this illness are similar to that of McCann et al (2004), with the following five themes identified: negative experience of symptoms; the process of accepting the diagnosis, the difficulty in forming and maintaining personal relationships, negative experiences of treatment and difficulty in maintaining spiritual practices or adhering to their chosen faith (again these are specific to working-age adults as the inability to secure paid employment impacts) . These studies were valuable in that they constitute two of the few studies which present the views of service users and encapsulate the catastrophic effect long-term mental health needs have on the societal aspects of people's

lives and wellbeing. Therefore, the impact of this study continues to emerge as we see that the very interventions which are put in place to help these people are causing them harm; it is therefore vital to understand why they are admitted to begin to formulate rational strategies to avoid this.

Having established that difficulties with establishing and maintaining roles, sense of self and relationships have a cyclical impact on long-term mental health needs, it is next necessary to look at the person's close relationships and how the other person in this relationship often becomes a carer.

Society places the burden of care on those living with the person with mental health needs. Von Kardorffe et al (2016) carried out a study on the burdens for carers of people with long-term mental health needs. They found eleven encumbering themes following interviewing the carers; these are as follows: uncertainty and instability; lack of awareness of the situation; emotional burden; stigma and blame; financial burden; physical burden; restriction in routine; disruption in routine; dissatisfaction with family, relatives and acquaintances, and problems with health and financial support. The study concludes that caring for a person with mental illness affects caregivers emotionally, financially (as they do not work and are reliant on benefits or financial carers), and physically, and it restricts their routines quite significantly. This impact of caring for a person with long-term mental health needs is weighty, and when this impact becomes severe carer breakdown occurs – this may be a substantial contributory factor to working-age people with mental health needs entering long-term care. The calamitous impact on relationships of admission to long-term care needs to be considered thoroughly also. People with mental health needs have trouble in forming and sustaining relationships, and the very powerful and real human emotions caused by the loss of living with or near their loved ones should be considered. There may also be feelings of guilt in the decision to admit the person for carers or for the person leaving their families to enter care.

The next part of the research question, of which the introductory chapter will provide a definition and initial evaluation, is long-term care.

1.5 Long-term Care

All of the study cohort are living in either nursing or residential care; none of them have domiciliary care, which involves carers visiting the person's home once or more a day to provide support. Carmarthenshire County Council (2022) provide a clear account of the distinction between residential and nursing care as follows (paragraph two): "Residential Care Homes offer services such as laundry and meals and help with personal care. You may need to move to a nursing home if your illness or disability means you need regular nursing care, and this cannot be given in your own home. Nursing staff will be available 24 hours a day in a nursing home." so all the study cohort will be residing in establishments which are staffed either by non-professionally qualified staff in the case of residential long-term care or by registered nurses in the case of nursing homes (or a mixture of both in some establishments). They will live in groups of people with similar diagnoses who are not usually family members or individuals they have chosen to live with. Typically, they may have their own bedroom, but most of the accommodation in which they reside is communal. Their freedom to leave these establishments varies, as does access to employment and support needed to facilitate their access to the community.

Having provided a working definition of long-term care, the chapter will continue to provide a definition of what it constitutes to be "working-age" within the study.

1.6 Working-age

All the study cohort are working age. The concept of "working-age" people will be those aged 18-65, the thesis will provide a full explanation of the underpinning legislation and guidance in

the inclusion and exclusion section of the Methodology Chapter. The age of 18 has been determined as the lower limit as it is the age of majority in the UK. The upper limit of 65 is set because in England reported numbers of dementia diagnoses are reported as under 65 and over 65. This is deemed to be the critical age for inflation rates of the illness and forms the reference for NHS reporting (NHS Digital 2020). This is relevant as the research involves ongoing mental illness throughout the lifetime, not illness which has onset later in life. Dementia type organic illnesses differ significantly from functional illnesses, which impact throughout a person's lifetime, not solely in their older years. This exclusion also arises from the way the NHS organised services at the time the study was completed. People were supported and assessed according to age which had the effect of excluding them from adult services at the age of 65 and moving them on to older people's services. Overall, the working-age element of the research question relates to the age at which people would be expected to work according to the previous pension rules of the National Assistance Act (1948). This has a significant threefold impact on the person and on society. They are stripped of the opportunity to contribute to society and their communities and families via work; they are excluded from the benefits of self-esteem and opportunities to socialise work can bring, which has psychological impact on people already experiencing mental health issues. They become a burden upon society through their entire life span, both as individuals and as part of the care economy, as they will typically reside in long-term care for many years or decades.

Occupation is a key aspect of bringing meaning to the person with long-term mental health needs. This is linked to the "working-age" and "ongoing mental health" elements of the research question but is explored here as the point is around its impact on mental health. Eklund et al (2003) carried out a study in Sweden which involved interviewing people with long-term mental health needs about how occupation impacted on them. For these purposes, occupation included a range of activities ranging from paid employment to voluntary work to activities in which people were supported to engage. The study concludes that engagement in occupation reinforced positive feelings. The findings also suggested that further research is

needed to develop a greater understanding of the connections between occupation and improved mental health. Mee and Sumsion (2001) corroborated this, confirming the motivating power of occupation for people with long-term mental health needs.

Having established the purpose, context, and key definitions of the thesis, the Introductory Chapter will continue to specify the objectives of the thesis which will be concluded in the Conclusion and Recommendations Chapter.

1.7 Research Question, Aims and Objectives

This section of the Introduction will outline the aims of the research in terms of the research's long-term overall goals, and the objectives will provide an oversight of what it is about and how these will be achieved. To detail the intent of the study, the research question will be restated.

Research Question

"Why do Working-Age People with Mental Health Needs Enter Long -Term Care"

A study into the decision-making process which leads assessing professionals to reach the conclusion that there is no alternative to admission to long-term care for working-age people with mental health needs.

The overarching aim of this thesis is to better understand decision-making around long-term care to improve choices and outcomes for working-age people with mental health needs. This decision-making is carried out by assessing professionals and the social and market influences of this are overtly stated and considered at the point decisions are made.

It can also enable the exploration of alternatives to admissions (e.g. intensive crisis support) continue to be pursued in order that the rates of admission of working-age people with mental health needs to long-term care can be reduced.

Aim

The aim can be formulated as follows:

To address the lack of existing research into the decision-making around the admission of working-age people with mental health needs to long-term care by critically evaluating the reasons for admission and to identify the unique theoretical and methodological social construction of such decision making.

Objectives

The principal intention of this research is underpinned by the following objectives:

- To devise a grounded theory methodological approach to understanding the professional justification of the decision to remove the person from their community
- To consider the personal circumstances of people at the point of admission to form a theory informed perspective of the reasons for admission.
- To evaluate interpersonal transactions between the assessing professional and the admitted person by an examination of the theoretical balance between the assessor working as an agent of the state and / or of the person.
- To explore systemic social care and health organisational influence upon decisions to admit people to long-term care and to make recommendations about policy, research and education based upon the results of this.

Outline of Chapters Within the Study

Having stated the research question and the objectives of the thesis, the Introductory Chapter will continue to outline the content of this and subsequent chapters:

- Thus, the purpose of the Introductory Chapter is to provide clarification of the research question including the key concepts and the purpose, to determine how the study will seek to meet this.
- The Background Chapter provides context to the study and evaluates the use of the assessment framework, which is in essence, the decision-making tool by which people are admitted to long-term care. Evaluation of responses to mental health needs and how we have arrived at current models of service provision will take place within this chapter.
- The Literature Review Chapter develops the context supplied within the Background Chapter and critically reviews previous research into this and connected topics to identify the nature and quality of knowledge which this thesis will generate.
- The Methodology Chapter justifies the sampling methods juxtaposing the method and methodology utilised in the study. It considers the symbiotic relationship between the two and how this is drawn out by grounded theory analysis of the mixed qualitative and quantitative data whilst incorporating the interpretivist epistemology and constructivist ontology.
- The Findings Chapter identifies themes, which arise from the data analysis. The themes that emerge in this chapter will determine why people who exhibit risk require protection via sustainable services which seek to maintain their strengths and aspire to have greater choices in outcomes for this study cohort in the future.
- The Discussion Chapter takes the themes, which are the content or matter which combine to plan necessary interventions and reviews existing literature concerning them and applies the theoretical framework of satisficing to the decision-making

mechanism. It justifies the use of an extant theory (that it is the “best fit” for the themes which are the matters which dictate a decision needs to be made).

- The Conclusion and Recommendations Chapter provides recommendations for change in education, practice, policy, and future research concerning the care for working-age people with mental health needs. This will recommend that people be given intensive treatment in their own homes so that they need not be admitted, and where they are admitted, considering this being on a temporary basis. This will include considering the possibility of making family settings or group homes available to them as opposed to large care settings The study will conclude positively that there is evidence that the assessing professional aspires to maintain strengths and is committed to diversification of the mental health care market, and that there is cause for optimism for the future.

1.8 Conclusion to Introduction

This Introductory Chapter has outlined that this thesis is a study of how working-age people with mental health needs come to end up in long-term care. The thesis is born from the professional curiosity of the author about the way these people never emerge from these settings. Admission is an ending for them removing them from everything they have, know and have been able to exert control over.

The aim of the thesis is to generate new and vital knowledge to enable understanding of decision-making processes leading to the identification of alternatives to long-term care or to the justification of its use where it is warranted. The thesis will seek to generate understanding and theory about the reasons for admission and to make recommendations about policy, education and practice to improve the situation of people admitted to such settings. The

Introductory Chapter also signposts to the subsequent chapters, and the first of these, The Background Chapter will now be embarked upon.

2.0 BACKGROUND / KEY CONCEPTS CHAPTER

2.1 Introduction to Background

The purpose of this background section is to provide context to the practical, situational, and interactional elements of the research question. It is provided to ground the reader with contextual knowledge about the study and to inform with prerequisite knowledge prior to being presented with information about the conduct of the research. This study has a strong element of socio-economic content, and thus the following elements will be included:

- The policy framework and its impact on admission of working-age people with mental health needs to long-term care.
- The legislative framework and its restrictive impact on working-age people with mental health needs.
- The economic context for admission of working-age people with mental health needs to long-term care.
- The paradigm shifts between institutional and community care and how far this shift is still in flux.

However, in addition to these practical elements, the study is also grounded in theory. Consequently, a subsequent section of the Background Chapter will augment the useful context and will provide a view of the following theoretical elements from the perspective of the thesis:

- Medical, social and psycho-social theories and if there are any grounds for assuming interaction between these.
- Resource allocation and its justification based on the substantive theoretical notions of satisficing. These arise from professional duties to satisfice, steward resources to

maintain sustainability and ensure services are satisfactory and sufficient (the combination which results in satisficing) whilst aspiring to optimal services by being proactive in providing them.

2.2 The Policy Framework and its Impact on Admission of Working-age People with Mental Health Needs to Long-Term Care

This section of the background chapter will evaluate the impact contemporary government policy has upon the assessment framework. The Coalition Government's mental health strategy, No Health without Mental Health (2011) was a cross - governmental mental health outcomes strategy for people of all ages which made explicit its objective to give equal priority to mental and physical health. The initiative also set out the strategic plan to improve people's mental health and wellbeing and improve services for those with mental health problems.

The NHS Five Year Forward View (2014) committed to working towards a more equal response and achieving genuine parity of esteem by 2020. It also set ambitions to expand access and waiting time standards, which included children's mental health services. It highlights the higher incidence of mental health problems among people living in poverty, those who are unemployed and people who already face discrimination. Mental health features in the NHS Long-term Plan (2019) which provides several commitments to improve mental health services. For example, it committed NHS England to providing an additional 380,000 people per year with access to adult psychological therapies by 2023/24. It also stated by 2023/24, the NHS 111 service would act as a single point of contact for NHS services for people experiencing mental health crises, and new services intended to support patients going through a mental health crisis would be introduced.

A key feature of the legislation is a seeming reluctance to admit the existence of people who do not have the potential to recover to an extent they can remain in their communities or will require intensive support or respite care to enable them to do so. All the aspirations of the

policies are admirable but do not address the needs of the cohort of people this study is concerned with. The legislation does not provide strategies for people with needs such as this study cohort, so unsurprisingly, assessing professionals find their only alternative is to respond by placing people in long-term care.

There is no evidence within the policy framework that the situation of working-age people with mental health needs who are in long-term care or liable to be admitted to long-term care is a high priority in terms of policy. This is understandable, in that the reasons for admission are poorly understood and, therefore, cannot be legislated against. There are some potentially positive developments; the new Liberty Protection Safeguards[1] in the Mental Capacity Act (Amended) (2019) will apply to people's homes, so it may be possible to use them to avoid admission in future, although the date this will be enacted is not currently known. Having determined that making service improvements for this study cohort is neither prioritised nor well understood, it is necessary to evaluate how the underpinning legislation may impact on this.

2.3 The Legislative Framework and its Restrictive Impact on Working-age People with Mental Health Needs.

The terms Mental Health Act Assessment and Mental Health Assessment can be used interchangeably which causes confusion and unfulfilled expectation in practice, so the clear distinction will be made here in order that the impacts of these pieces of legislation can be fully appreciated as they will be alluded to in the Findings Chapter. No apology is made for the attention paid to this legislation as it has a significant impact on the assessment framework,

[1] [1] On 5 April 2023 the Department of Health and Social Care announced the implementation of the Liberty Protection Safeguards (LPS), the Mental Capacity (Amendment) Act 2019, will be delayed "beyond the life of this Parliament" (therefore likely beyond Autumn 2024). Liberty Protection Safeguards: delayed or doomed? 6 Apr 2023

places significant restrictions on people in the study cohort and, as we will see in the Findings Chapter there is substantial correlation between being placed under these restrictions and being admitted to long-term care for working-age adults with mental health needs.

The “spirit” of the Mental Health Act (1983) requires that the least restrictive alternative should be used in all assessments of people with mental health needs and this ethos will be adapted to structure this part of the Chapter. Mental Health Assessments (which are more interactional and do not offer the opportunity of detaining the person against their will) will be considered first, followed by Mental Health Act Assessments and then by Mental Capacity Assessments, which are also legislative and allow more “open-ended” restrictions than the Mental Health Act.

Mental Health Act Assessments are more of an intervention “done to” the person; their potential outcomes and impacts will be detailed also. The restrictions liable to be placed upon this study cohort because of the Mental Capacity Act (Amended 2019) will also be detailed. However, this is slightly more conjectural as the Liberty Protection Safeguards being enacted at the time of writing and may change this. The final set of restrictions that are placed on the study population are financial, taking the form of Deputyship and Appointeeship, and they are outlined as they are applicable to working-age people with mental health needs who are admitted to long-term care.

The Care Act (2014) is the first line of assessment, and it is under this legislation that mental health assessments are carried out. These may also include health assessments by professional health or medical colleagues. The Care Act (2014) is the least intrusive dimension of assessment for working-age people with mental health needs, and it focuses on reducing dependence and maintaining independence and well-being by assessing several domains in which the person may need support (these include maintaining a habitable home and

accessing and engaging in work, training, or volunteering) and application of this may lead to admission to long-term care.

The previous paragraph has determined how the assessment framework is applied under the Care Act (2014); the study will continue to outline how the Mental Health Act (1983) is used. A Mental Health Act Assessment will usually take place when the person is in crisis, and there is concern that the person presents a risk to themselves and / or others. It is thus presented as a protective factor for all, but the experience of a Mental Health Act Assessment may not feel supportive for the person undergoing it. Howe (1999 p.11) expresses this as follows: “At this point, often terrified and paranoid, they are no longer able to understand what is going on around them and often have no awareness that they are ill and need help. If they do not comply with the assessment the outcome may be that they are forced onto an ambulance by the police, with their neighbours witnessing the scene play out as the assessing team and emergency vehicles arrive and leave.” Whilst not disputing that emergency measures are required when a person is severely mentally unwell and subject to significant risk, emphasis should be placed on the impact assessment under the Mental Health Act framework has on people who are already critically mentally ill and in crisis. Having considered the effect of the actual assessment it is necessary to consider the outcome of the assessment and the impact of this.

There are 2 broad outcomes to a Mental Health Act Assessment: the person will either be deemed to need treatment in a psychiatric hospital or not. If not, the person will remain in the community, and dependent on need, will be offered support and medical review. When a person is deemed to need to go to hospital, there is the option (if they have mental capacity to make the decision and have no history of absconding from hospital) to be admitted informally. If this option is taken, the person may be detained in hospital at any time if they deteriorate or do not comply with the treatment plan considered necessary. If the person is

not eligible for or will not agree to informal admission, they will be admitted to hospital under Section 2 or Section 3 of the Mental Health Act (MHA) (1983).

Barcham (2016) provides a helpful distinction between the two stating that, Section 2 is only to be used where the person is not known to the team and does not have a precise diagnosis or treatment plan, they are a well-known patient presenting differently, have not had recent admissions and / or will agree to comply with treatment when admitted; Section 3 is utilised where a person is well known to the service (this may be written recorded information as opposed to personal acquaintance), is presenting as they have done previously, and they have a clear and established pattern of illness and relapse history. Consequently, the person may be admitted initially on Section 2 for assessment, followed by a Section 3 for treatment if they do not agree to accept this voluntarily. So, they will have two Mental Health Act Assessments in relatively short succession. Section 3 has a crucial impact on the assessment framework as it is followed by Section 117 aftercare.

Section 117 services are provided under the remit of Section 46 of the NHS and Community Care Act (1990) and require that the Local Authority (or delegated partner where Section 75 arrangements are in place) carry out a two-stage assessment of needs for Section 117 services. Once S117 is applied, the order can only be discharged by a doctor and AMHP (Approved Mental Health Professional) because the person is no longer suffering from the mental illness the Section 3 was utilised originally for. This places a duty on ICBs (ICS's) (Integrated Care Boards, Integrated Care Systems as they are termed in different areas) and Local Authorities to provide funded aftercare for patients detained for treatment; the duty commences when a person is discharged from the hospital from Section 3. Consequently, the findings of this study will analyse how (if at all) Section 117 entitlement impacts on the way the assessment framework is applied. A period of psychiatric admission remains permanently on a person's record and forms a "risk marker" of mental instability and potential for further crisis.

Another potential consequence of being placed on Section 3 of the MHA is that this makes people subject to be liable to be placed on a Community Treatment Order (CTO). This order arises from S17 of the Mental Health Act (1983). Appropriate treatment must be available in the community, which must be necessary for the patient's health or safety or the protection of others. The conditions of a CTO may stipulate that the person lives at an agreed address, be available for treatment and receive it. This has a considerable impact on the way the assessment framework is applied, as any assessment must incorporate the conditions of the CTO. Golightly (2014) points out a key aspect of the CTO: it requires that a person receives the identified treatment and, therefore, is stronger in compelling the person to comply than S117. Hence, as the powers of the Mental Health Act unfold, we see the levels of restriction that the application of the assessment framework places upon people; as in effect, this legislation compels people to comply with conditions (including residing in long-term care and taking medication) lest they be returned to a psychiatric hospital under a Section 3.

Similarly, to the Mental Health Act (1983) the Mental Capacity (Amendment Act 2019) allows for people to be deprived of their liberty and to be required to live in an NHS or care home setting. This provision has been in flux as Deprivation of Liberty Safeguards (DoLs) are replaced with Liberty Protection Safeguards (LPS). Although the rhetoric around this aspires to better outcomes for people and the title advocates maintaining as opposed to depriving people of liberty, the outcome for people is that they are required to live in a care home or to be closely monitored in their own homes. Brown (2016) defines the key contrasts between the use of the Mental Capacity Act (2005) and the Mental Health Act (1983) are that the Mental Capacity Act cannot be applied where Mental Health Act restrictions apply; the person must be subject to and require continuous supervision but not have capacity to consent to arrangements for their care and are not free to leave their care setting. This cannot be used to remove a person from their home to a care setting as the Mental Health Act (1983) can.

Some of the cohort in this study are subject to Appointeeship or Deputyship orders. This has arisen as the working-age person's mental health needs have prevented them from being able to manage their financial affairs or they have been vulnerable to financial abuse from others. Graham and Cowley (2015) distinguish between Appointeeship and Deputyship thus: an Appointee is responsible for managing a person's finances via the Department of Work and Pensions (usually benefits with most of this study population), but where a person's financial situation is more complicated (i.e. they have investments, inheritances, or other sources of income), then deputyship is the better option. Again, this restriction is viewed as protective, and this study does not dispute that it serves this function. However, it is relevant to consider the personal impact of facing constraints due to making unwise financial choices due to vulnerability, addiction, coercion, or loneliness.

As the legislative framework leans towards protection and restriction, it is next necessary to look at the economic landscape and how this influences the admission of working-age people with mental health needs to long-term care.

2.4 The Economic Context to Admission of Working-age People with Mental Health Needs to Long-Term Care

The cost of long-term care has been alluded to previously, but this needs to be considered in the background section to contextualise working-age people's admission to long-term care. The individual's mental health problems make them unable to work, so they cannot contribute to their own upkeep and are not meaningfully employed. This is why this study specifically refers to people of working-age as they experience the cumulative effects of mental ill health and the inability to sustain paid employment uniquely. As well as the impact this has on the self-esteem of people already experiencing psychological distress, it means they do not have the social and intellectual benefits that work brings, further disadvantaging them.

Government financed and legislated for care companies providing long-term care for working-age people with mental health needs by the advent of The Community Care Act (1990). This divided health and social care providers into “units” that purchased and provided services respectively, with purchasers typically being NHS and Local Authority organisations and providers private “for profit” organisations. Although the financial benefits of closing the asylums were not overtly stated as motives for doing so, authors such as Barham (1992) and Murphy (1991) began to discuss the spending cuts, which were seen as part of the drive to close mental hospitals and treat patients by means of community care. These authors also speculated on the inadequacy of community care and support. This is the beginning of the evolution of what is characterised by Grabowski et al (2010) as the “best value” or “cost-effective” mental health care, it is designed to ensure that needs, not wants are met and only the needs of individuals who are deemed to be eligible can be considered for funding. (Grabowski et al 2010) also state that this dictates that the assessment framework is “risk” led as need is closely linked to the protection of people with mental health needs and the public.

Consequently, the assessment framework is dominated and primarily directed by the professional leading it as Peay (2004 p.14) states: “Whilst clinicians may think they know best, they do not always know best, nor do patients necessarily share their views in practice…this will leave such patients with few options to successfully challenge those views.” This thesis would ask the reader to consider whether the crux of the issue is not a lack of knowledge on the part of the professional applying the assessment framework but a lack of options as to what viable alternative they can offer that person except admission to long-term care.

Forder (2000) identifies that most of the long-term care takes place in nursing homes and that this is a significant burden on government finance; whilst the cost is mainly due to the aging population, this study would urge that the requirements of working-age people with mental health needs should be considered as they are likely to remain in long-term care for decades,

at huge expense. It should also be considered that in the area in which this study took place, 85% of people with mental health social workers are on Section 117 of the Mental Health Act and thus, the state will fund their care, for the few who are not, it is rare that they fall within the financial threshold to contribute to their care.

Market forces also come into play as independent sector providers want permanent residents, so it is not in their interests to encourage respite or short-term stays. This seems to be a symptom of "Baumol's disease" (Baumol 1990), whereby governmental concern about health expenditure prevents the necessary investment to achieve efficiencies in the field as expedient as opposed to long-term measures are taken. This would seem to be somewhat short-sighted as an investment in intensive crisis support for people (even if this occurs by incentivising the care providers) would surely be preferable to assigning the working-age people to long-term care for the remainder of their lives. The Background Chapter will now continue to provide context as to the way current services are provided for working-age people with ongoing mental health needs as it examines the paradigm shift from institutional to community care for this study cohort.

2.5 The Paradigm Shift Between Institutional and Community Care – How Did We Get Where We Are Today?

As the decision was taken that Mental Health Support would move away from hospitals it was necessary to devise a means of delivering mental health care in the community, and thus the agency for delivering this – the Community Mental Health Team – came into being, which was an advance in the way psychiatric services were provided. The Joint Commissioning Panel for Mental Health (2016 p.6) identify the characteristics of the Community Mental Health Team thus: "A whole system approach to recovery from mental illness that maximises an individual's quality of life and social inclusion by encouraging skills, promoting independence and

autonomy to give them hope for the future and leads to successful community living through appropriate support". This description is redolent of the way Community Mental Health Services have evolved in the area this study pertains to, although it is worthy of note that the optimistic assertion that people would recover did not come to fruition for any of the 72 people who met the inclusion criteria for this study.

Leff (2002) comments upon the way psychiatric services have moved to an emphasis on Community Services and away from hospital-based mental health institutions. He concludes that this has not been beneficial to patients for two reasons: the increased reliance on private provision means that the care companies depend on the ongoing funding received from local authorities, and the potential reluctance of people receiving care to avoid exhibiting symptoms of recovery which could result in them losing their secure tenure in long-term care. Therefore, as well as the disincentive for providers of long-term care to offer focussed recovery-based time-limited interventions, this may not be attractive to working-age people in long-term care who may feel vulnerable in society, especially after long periods in these care settings which has made them dependent on the support received.

The assessment framework for mental health service locally is delivered against the backdrop of community multi-disciplinary or integrated care. Integrated care is defined by Kodner and Spreeuwenberg (2002 p.3) thus: "integration is a coherent set of methods and models on the funding, administrative, organisational, service delivery and clinical levels designed to create connectivity, alignment and collaboration within and between the cure and care sector … to enhance quality of care and quality of life, consumer satisfaction and system efficiency for patients with complex, long-term problems cutting across multiple services, providers and settings." This is very much the intention of integration; however, as there are several different mental health settings, there are several different models of integration. These involve interfaces between primary and secondary mental health care, community and inpatient mental health care, and the various specialisms within community and inpatient services.

There have been several scandals relating to the care of people in large, long-stay hospitals (these include Ely: Abel Smith (1967); Rampton, Boynton (1975); Normansfield, Spencer (1978); and Ashworth Blom Cooper (1992). Research carried out by Hutchison (2016) concludes that scandal is a socially constructed concept based on the condemnation of poor treatment of people who are vulnerable in society and who have been harmed by the institutions which should protect them. These scandals exposed the poor standards of care in these institutions and provided increasing evidence that such treatment methods were neither humane nor cost effective. These sentiments were compounded by work around "institutionalisation" (Wolfensberger 1983), which detailed the debilitating effect that admission to these institutions had on individuals. The resulting policy shift included much more consideration of the views of people experiencing mental health issues, although the changes needed to be made with few additional resources (Stanton 2014). As part of the response to these scandals, the latter part of the twentieth century saw a movement away from an emphasis on treatment for people with mental health needs to a steady increase in the rhetoric concerning the issues of rights, confinement, treatments, and high numbers of the population residing long-term in psychiatric hospitals (Hess and Majerus 2011).

The dichotomy between medicine and psychiatry and the lack of scientific basis for some of the treatments carried out in psychiatric hospitals led to the "anti–psychiatry" movement. Jansson, (2013 p.720) outlines the underlying principles of this as a recognition of the poor standards of care and lack of civil liberties for people with mental health needs residing in the hospitals. The anti-psychiatry movement gained momentum throughout the twentieth century. This viewed psychiatric treatments as oppressive and counterproductive, but as people receiving them were typically in institutions, it was not surprising that their voices were not heard in society.

The 1980s saw the concept of “service user involvement” taking prominence, with the 1983 Mental Health Act notionally offering more opportunities for voluntary treatment, although, as York (2009) points out, some people undergoing Mental Health Act Assessments have expressed that they felt compelled to agree to go to hospital to avoid being sectioned. Goldberg and Williams (1991 p.185) detail the growth of this movement through the founding of groups such as The Mental Patients Union, The Community Organisation for Psychiatric Patients (COPE), Protection for the Rights of Mental Patients in Treatment (PROMPT). Gordon (2012 Chapter 2) suggests that the UK’s number of service-user groups expanded from around 12 in 1985 to over 500 by 2005. In the area under study, we have several SURF (Service User Representative Forum) Groups notably, none of the residents in long-term care in the area attend these groups.

Movements based on the work of Szasz (1961), which stated that people should not be compelled because of mental ill health but should be intensively supported when challenges occur, were developed. However, these approaches were rejected by service user groups who felt that these developments were led by people who had no lived experience of mental ill health and consequently had little understanding of the impact of this. Authors such as Beresford (2007) also began to challenge this, arguing that the knowledge of service users should be utilised to develop professional theory and expertise.

Having oriented the reader to the practical aspects of the thesis, which are: the policy framework, the legislative framework, the economic context of admission of working-age people with mental health needs to long-term care, and the paradigm shift between institutional and community care, the thesis will continue to explore the theoretical aspects of the research question. This will include an exploration of Biological, Social and Psycho-Social Theories, which form the mid-range theory which underpin the background to ways of thinking about the means of supporting people with mental health needs.

2.6 Mental Health from a Theoretical Perspective

To understand the impact of severe mental illness in working-age people and the relevance of the theory which surrounds it, it is necessary to elaborate on this to understand the actual cost of mental ill health to individuals and societies. Mental ill health differs from physical ill health in that it has a gross impact on perceptions of the self and the way that "self" can interact with society. Thornton (2007) links the experiential aspects of mental illness with the ultimate theory of understanding the phenomenon deriving the ontology of comprehending the nature of things and existence, the epistemology of the questions around knowledge, truth, validity and the limits of reason, and questions of ethics in terms of how we characterise and assign value to the way we treat working-age people with long-term mental health needs. All these elements are vital to this study and need to be incorporated within its theoretical framework. Morgan (2014) provides a useful conceptualisation of the theoretical considerations within mental health through the following four questions:

- The first consideration is the distinction between social and medical theories – can we truly assimilate a person's experiences to neurological reactions or impulses?
- The second asks whether we should we classify and name mental ill health as a disease or diagnose psychological distress, or should we dispense with classification and see each experience as an individual narrative?
- The third is how far people who have never truly experienced Mental ill health can ever really understand and empathise with it.
- The fourth and final question is about the ethics of coercive and controlling care and how we rationalise these.

To answer these questions, it is necessary to contextualize the theory considered in this Background Chapter and to offer an initial introduction to the ways professionals view working-

age people with mental health needs. It is not proposed to provide an extensive summary of each theory here but to briefly outline each, apply them to the research matter and provide context as to how this study is oriented to theory by answering each of Morgan's (2014) questions in turn.

The first question above is related to the physical, biological, and neurological aspects of mental ill health and tends to relate to changes or disruptions in the brain and how these lead to psychiatric disorders (Andreasen, 1984; Andreasen and Black, 1995; Cowan et al 2000; Joffe 2001). This disease / medical / biological theory cannot be discounted in this research as it accounts for the way we treat mental health needs pharmacologically currently. It is a contemporary and significant part of the narrative within the assessment framework and so it is necessary that it is considered.

The second question is about classification of illness or diagnosis. This will be considered from a more physiological, psychological, psychodynamic, or existential theoretical perspective (Rogers 1951, Maslow 1943). This study does accept diagnosis as it is a vital element within the narrative of the assessment framework and does group people in terms of common characteristics. However, this does not disregard that people with the same diagnosis will have differing experiences or narratives. Dasgupta (2013) characterizes this as a pathway of development of mental ill health down a specific, pre-ordained path, with people trying to adjust and survive in accordance, with problems arising where they learn spiraling maladaptive responses to try to respond, so although the physiological presentation is the same the individual response may differ from person to person.

The third question relates to a more psychosocial or social learning theory (Erickson 1963), which suggests that people give meaning to their psychological processes and that this inextricably affects the relationship between their thoughts and social behaviour. According to Bandura (1977), people learn through observing and modelling other people's behaviour.

Thus, the assumption in the third question that people are either mentally ill or mentally well is not accepted within this thesis as the narrative within the assessment framework about the person's journey to long-term care is crucial and will provide information about inevitability of admission and its justification. Mental health and illness are viewed more as a continuum so as people veer from state to state they can understand and empathise to varying degrees, but as situations worsen, responses available become increasingly limited; this study aims to explore the catastrophic, self-perpetuating series of events that leads up to admission of a working-age person to long-term care.

The fourth question concerns itself with the social control and normative theoretical aspects; although overt control and its ethical implications are raised explicitly in the question, this chapter has outlined the way the Mental Health Act (1983) legalizes a whole gamut of coercion and restriction for working-age people with mental health needs. This is universally justified by the risk they present to themselves and others. This study will continue in subsequent chapters to investigate more normative and subtly applied social restriction and confinement (Bandura (1977), Lewin (1947), Festinger et al (1950). It will evaluate how the narrative within the assessment framework applies this to these individuals. These mid-range social theories introduce the reader to the normative aspects of the study and are developed in subsequent chapters to Satisficing Theory, which is intended as the conceptual element.

2.7 Conclusion to Background

The Background Chapter of the study has provided contextual and pre-requisite knowledge necessary to orient the reader to the thesis's content before evaluating the methodology applied to the content of the thesis. Firstly, practical aspects of background information to the admission of working-age adults to long-term care are considered. These comprise of the policy framework associated with long-term mental health care, the legislative framework, the economic context, and consideration of the paradigm shift inherent in the move from

institutional to community care. The chapter has been augmented by consideration of mid-range biological, physiological, psychological, and psychosocial theories which will be overlaid by the more substantive satisficing theory as part of the discussion, which will underpin the analysis of the layers of control working-age people with mental health needs are subject to. Having provided this background and context, the study will continue to scrutinize the literature to determine what research exists in relation to this topic before moving to the Methodology Chapter, which will outline the process by which working-age people with mental health needs enter long-term care and how this is determined and justified.

3.0 LITERATURE REVIEW

3.1 Introduction

A literature review was undertaken, which was focussed on the research question and contained the key elements, mental health needs, long-term care and working-age.

The scope of the literature review was necessarily expansive since the researcher wanted to include all core components of long-term care. Consequently, it was necessary to view the body of literature in an explorative way rather than rigidly defining the parameters, risking missing potential material. Dixon-Woods et al (2006) describe this approach as "critical interpretative synthesis" as it allows for the analysis of a large body of literature that includes a variety of methodologies whilst also deriving an understanding of the trends and themes within the literature reviewed. Key features of the literature are defined after the findings have been collated, allowing for greater exploration of what is available and thematic analysis of the papers. To achieve a comprehensive Literature Review in response to the research question, its purpose and scope are clearly stated below:

3.2 Purpose

A review of the UK literature (or studies relevant to UK practice) published in peer-reviewed journals since 1990 with the aims of:

1. Identifying key components of long-term care for people with longer-term mental health problems.

2. Evaluating the effectiveness of these components.

3. Undertaking a critical interpretive synthesis of the evidence to identify the domains of long-term care which make working-age people with mental health needs prone to enter such provision and to determine the unique contribution of the research.

3.3 Scope

1. Establish key components by identifying of the key elements of the literature using a questioning framework to identify and validate the inclusion and exclusion criteria.
2. Evaluate the effectiveness of components by employing them in the search strategy, which will produce the content of the literature review.
3. Schematically categorise the search strategy results, synthesising these into areas of interest and interpretively evaluating each to evaluate the theoretical frameworks they espouse, the unique knowledge they generate and positioning them in respect of this study in terms of influence and its potential merits and contribution.

Having determined what the literature review aims to achieve and the objectives by which these aims will be realised the Literature Review Chapter will examine the methods employed within the literature review. These aims and objectives will be achieved by firstly identifying exclusion and inclusion criteria, carrying out literature searches and applying an interpretive framework to these. Pautasso (2013) emphasises the importance of using a critical and consistent interpretive framework to the studies identified and suggests that the studies are reviewed in accordance with their structure, so the research question, research strategy, sampling strategy, study design, data analysis, and findings are analysed in turn. This study will adopt this approach as it is rational and appropriate for this research.

3.4 Method

Eligibility

Exclusion criteria

To meet the initial aim of the literature review and successfully identify key components of long-term care for people with mental health needs, it was necessary to identify a clear scheme by which studies would be utilised. Studies prior to 1990 were excluded as this year marks the advent of the National Health Service and Community Care Act (1990). This was

significant in that it marked a shift in policy and philosophy of care, emphasising the benefits of allowing vulnerable people to remain in their communities and understating the associated potential cost savings. This was superseded by the Care Act in 2014, which similarly declares promotion of wellbeing and independence whilst providing the substantive legislative framework under which these people lost independence and entered long-term care. The following post-1990 papers were included for further review.

- Studies of people with a diagnosis of a long-term mental health condition.
- Studies of admission procedures and frameworks in mental health.
- Studies of people of working-age living in residential care.

The chapter will continue to evaluate the search strategy as it has fulfilled the first aim of the literature review by establishing the key search criteria.

Search Items

The second aim of the literature review is to evaluate the effectiveness of the search terms. This was carried out by utilising the search strategy to identify the studies that would form the content of the literature review. To complete this, a glossary of terms which equated to the key concepts were developed as follows: mental health; mental illness; schizophrenia; psychiatric; long-term care; nursing home; residential home; institution; working-age; adult and specific age ranges where searches allowed for this. Terms were interchanged as appropriate, e.g., working-age and adult were alternated within the template search of mental health AND long-term care AND working-age. The AND was used so that all the characteristics of the research question could be addressed. The process adopted is outlined below:

All search terms were adapted for each database.

The following electronic databases were searched:

PubMed 1990- Current

PsycINFO: 1990- Current

CINAHL: 1990- Current

Social Care Online 1990- Current

Each database was viewed, and a return of 68083 was obtained. The exercise commenced with PubMed, which provided 67672 results, the first 2000 were viewed relevant studies were not found after the first 1500, but the researcher continued with another 500 studies to establish this incontrovertibly); CINAHL was then searched (age 18-44 yielded 53 studies and age 45-64 12 studies), PsycINFO was then searched and yielded 36 studies, and finally Social Care Online which yielded 324 studies. The Social Care database was utilised as the researcher wanted to review literature about societal and medical impacts on admission to long-term care. All the reasons for including or rejecting studies were recorded on a spreadsheet to enable the researcher to analyse what had been included/excluded and for what reason. Duplicates were included at this point as there were so many studies considered that it would be challenging to recollect which studies were duplicated, and these were excluded later in the process.

The titles of all the studies were reviewed in accordance with the schema of which would and would not be included in the Literature review. It was clear from the title and/or date that most of the studies were not eligible to be included. 65658 studies were removed by these means.

This refined search yielded 2425 studies, 14 of which were found to be duplicates and were removed via the “Mendeley” database, leaving 2411. The abstract of each was reviewed prior to any studies being retrieved, and if, at this point, the article still seemed appropriate for inclusion, the full text was scrutinised. In all, 2378 articles were excluded; this was a laborious process as mental ill health is not mutually exclusive of other human conditions, so it is not

possible to search for this in isolation. This left 33 studies which were included in the Literature Review.

Table One below details the number of studies excluded by prevalence of category and shows the 33 used articles. The research protocol is displayed below also in the PRISMA Diagram (Page et al 2021) (Figure One below), and the 33 pieces of research in included in the Literature review are shown in Table One below along with their associated themes.

Table One – Exclusions from Literature Review

Category	Rationale	Number
Older people	Although working-age was specified in the search, and in CINAHL and PsycINFO specific age ranges selected in the advanced search older people did feature as the associated search feature "Long-term Care" tended to primarily feature older people. It is expected that this was due to the titles of the studies not specifically mentioning age. This proved problematic as part of the literature search as it was often necessary to retrieve the entire paper to ascertain what age group it concerned in many cases, as this was unclear from the abstract. Some of the studies utilised did not strictly specify that they applied to working-age people, but these were not excluded if the content focussed upon long-term care for people with long-term mental health needs which were clearly not dementia.	495

Physical Health	This again resulted from the “long-term care” criteria and featured generic studies about people in long-term care, not clearly stating whether they had specific mental health needs and required the entire document to be retrieved.	437
Nursing Care or Practice	These were also generic studies that did not specifically mention mental health needs and were more concerned with ways of delivering care, nursing theories and particular models of care such as group work or alternative therapies within long-term care facilities.	324
Primary Care	These are the range of mental health needs that are typically dealt with via General Practice and do not need to be referred to specialist psychiatric services; although conditions such as anxiety and depression are undeniably distressing and debilitating, they do not result in admission to long-term care, unless they occur in association with other conditions.	248
Dementia	Dementia is not necessarily limited to older people, so the “working-age” or age range search criteria did not preclude them, and these studies were to be retrieved and evaluated.	183
Nurse education or the psychological well-	Such studies related to generic nurse education, and it was not possible to determine whether the students had	178

being of nursing students.	specific exposure to working-age people with mental health needs in long-term care.	
People under 18.	They are excluded because the way their conditions are treated differs from the adult population; the feature "long-term care" explains their prevalence as these studies are concerned primarily with "looked after" children.	175
People with Mental Health needs who are not in long-term care.	When these studies were retrieved, it became clear they were not in *long-term* nursing or residential care, although they may have had some contact with these types of services.	76
Maternity / Perinatal.	These studies relate to mental illness concerned with pregnancy or post-partum; although the study cohort may have experienced this form of mental ill health, there is no reference to it in their records as a factor in the decision-making about them being admitted to long-term care.	43
People in urgent or crisis care. Inpatients / Assessment	These studies concern people admitted for periods of assessment or treatment but not long-term care or potential permanent residence (typically NHS facilities or other acute psychiatric environments). Again, this is not strictly *long-term care.* For the purposes of the literature review, long-term care was determined by whether the facilities included had the option to admit	38

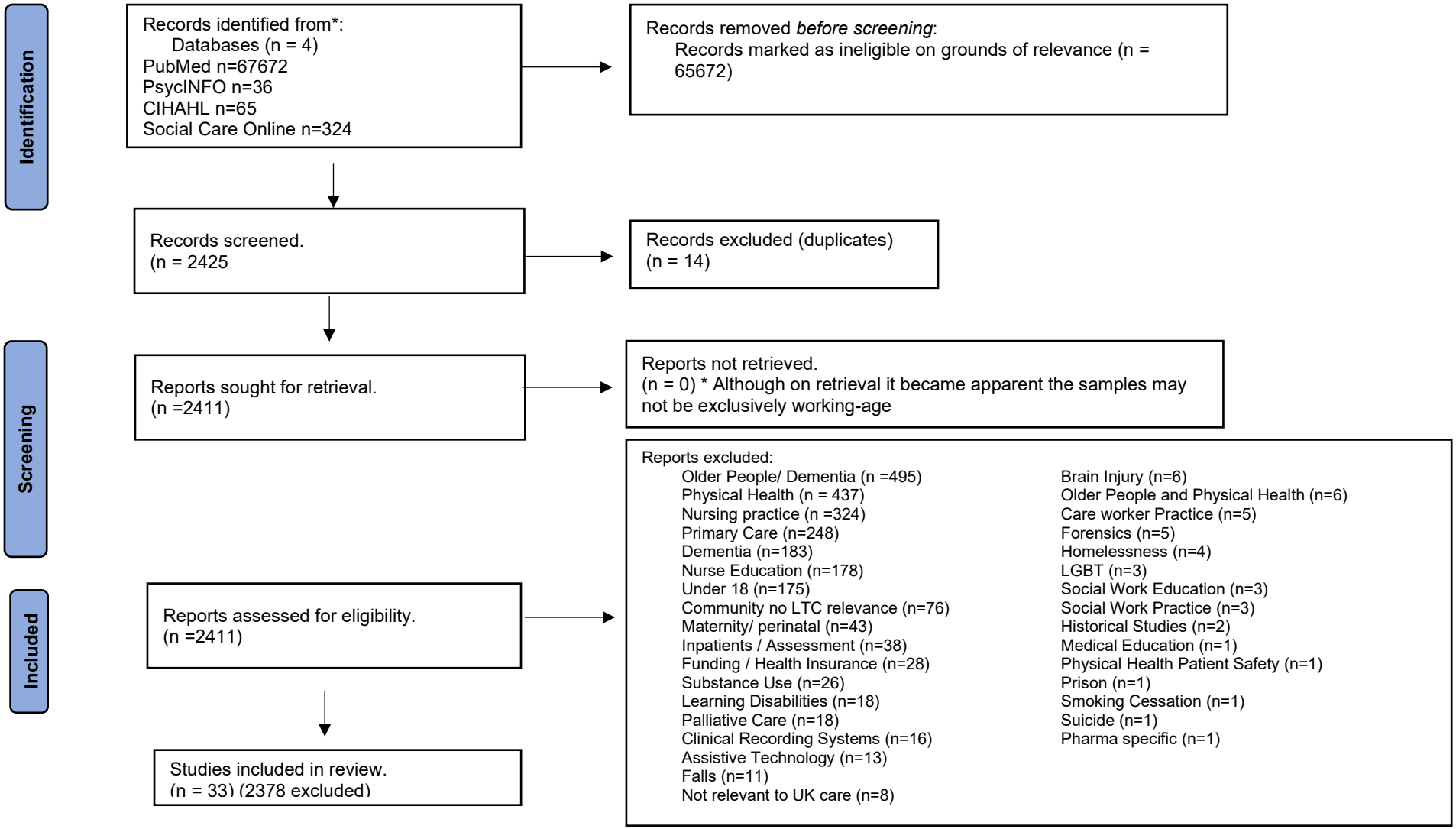
	people for the duration of their lives as opposed to an expectation that discharge would occur at some point – often to the kind of long-term care facilities that are included in the study.	
Healthcare funding systems not relevant to UK.	Not within the scope of the study. This group of studies place emphasis on private healthcare systems or insurance which does not occur in the same way in the UK. Studies which use registers of people on insurance schemes as a sampling measure but focus on the process and outcome of admission are included.	28
Substance use and addictions studies	Not within the scope of the study	26
Palliative care not specific to mental health.	Not within the scope of the study.	18
Learning Disability	Not within the scope of the study.	18
Clinical recording systems not specific to mental health.	Not within the scope of the study.	16

Telecare or assistive technology.	Studies where it was not clear this was to support mental health needs.	13
Falls not specific to mental health.	Not within the scope of the study.	11
Not specific to UK Care Delivery	No commonality or relevance to this study. Relating to care systems not as well developed as UK.	8
Brain Injury.	Not within the scope of the study.	6
Older people with physical health needs.	No specific reference to mental health.	6
Care worker practice not specific to mental health.	Not within the scope of the study.	5
Forensics / criminal justice	These people are subject to criminal law disposal not mental health services.	5
Homelessness not mental health specific.	Not within the scope of the study.	4
LGBT / Gender Psychological issues	These studies are related to sexuality or sexual identity not mental health specific.	3

Social Work education.	Not within the scope of the study.	3
Social Work Practice.	Not within the scope of the study.	3
Historical studies	These studies are related to long-term development/evolution of mental health services.	2
Pharmacological interventions	Not long-term care specific.	1
Medical Education.	Not within the scope of the study.	1
Generic Patient Safety.	These studies are not Mental health or working-age specific	1
People in prison.	Not within the scope of the study.	1
Smoking cessation.	Not within the scope of the study.	1
Suicide with no reference to mental health.	Not within the scope of the study.	1

Identification of studies via Databases and Registers

Figure One – Prisma Diagram



Having excluded the studies which did not meet the specific context of the research question (n=2378), the study then identified the main themes in the studies which remained and formed the content of the 33 studies in the literature review. These are contained in the table below which also provides the specific context attached to each theme and how the studies are relevant as part of the literature review regarding this study.

Table Two- Themes of Literature Review

Theme	**Specific Context/ Relevance of Studies**	**No.**
Decision-Making at or around the time of admission.	This will inform what the unique contribution of this study. This will identify what existing studies identified around decision-making leading to admission.	7
Quality of Care	This is relevant to the decision to admit as it informs whether people have a better quality of life in long-term care and will allow consideration as to whether this is an implicit contributory factor to admission.	7
Staff experiences of working with people with mental health needs in long-term care (LTC)	This is included as it explores what previous studies say about staff experience and whether LTC staff "absorb" the risks and burden of care previously experienced by society/community/families.	4
Models of Care	This allows evaluation of how long-term care is delivered and will facilitate the identification of optimum models of delivery which may be factored into recommendations.	4

Treatment of schizophrenia	Ruggeri et al (2000) indicate that this type of illness (schizophrenia / psychosis – see below) is prevalent in severe mental illness). The Literature Search around long-term care provided 3 “hits” about this diagnosis, and it was relevant to scrutinize these, as whilst the scope of this study is neither diagnostic nor medical, it is essential to position this study from the perspective of the mental health need to enable the study to report any findings which may connect to this.	3
Outcomes for working-age people with mental health needs in long-term care	This is relevant because it enables this study to determine how far decisions to admit to long-term care are made (or not made) because there is a belief that there will be better outcomes for people.	2
Relationship of staff with long-term care patients	People in long-term care necessarily do not have a home or cohabitees in the same way as most of the population. This is relevant in determining whether establishing or maintaining relationships may be a factor in the decision to admit or how this influences outcome following admission.	2
Non-Themed / Miscellaneous Studies (Not deemed as more prevalent as the themes are separate)	• Social Exploitation of staff – to determine whether staff shoulder the burden of care from a more macro societal level. • Cost of care after discharge – what impact does resource use have on decision to admit?	4

	• Physical Health and Mental Health co-existing – is the long-term care to manage mental or physical needs or both? • Out of Area Placements –How does this impact on outcomes and the decision to admit?	

The themed studies will be analysed in order of prevalence. Four of the studies did not fit into the themes so these have been grouped together to aid in structuring the chapter; these studies were concerned with mental healthcare utilisation following discharge from a psychiatric hospital, high-risk physical health behaviours among patients with mental health needs, the potential for social oppression of care staff in mental health nursing homes and out of area placements. Having grouped the studies thematically via evaluation of the research question, it is next necessary to construct an interpretive scheme by which to synthesize them to meet the stated aims. This was developed from the framework adapted by Taylor et al (2009), which advocates analysing the sampling strategy of studies, followed by the research strategy and design. For the interpretive scheme to be clear, distinctions are made between the different types of research data as identified by Cohen et al (2007). Quantitative data will be:

- Numerical data
- Concerned with demonstrating causal relationships
- Be used to test hypotheses.
- To appear in graphs or tables.

Qualitative data will be:

- Non-numerical
- Written descriptions, photographs or recordings
- A means of understanding situations which are not clear by reviewing descriptive material.

- About human behaviour, its context, description, exploration and discovery.

The Literature Review will then continue to identify the studies and how they were analysed. Subsequently, the findings of the study will be outlined, and each section will determine the ethical merit of the study, and any gaps or flaws in the study will be outlined. Each themed section of the literature review will conclude by defining the unique knowledge each study generates, exploring the theoretical stance and value of the studies and how this relates to the potential generation of understanding and theory from this study. By these means. the literature review will meet the final aim set out in the introductory section of this chapter and will provide a critical interpretive synthesis of the included studies, which will be summarised in the concluding section.

3.5 Assessment in the Period Immediately Prior to Admission

One of the more prevalent themes in the literature review was that which focussed on the decision-making prior to admission. The literature review will first establish what new knowledge each study aims to deliver. There are three distinct entities here; some studies seek to generate knowledge about the individuals admitted to long-term care; others examine the assessment process itself, and yet a further strand explores the attitudes of those admitted. Of the studies researching the characteristics of people admitted, Grabowski et al (2009) examine the appropriateness of admission and whether the purpose of admission was therapeutically sound or more geared towards removing the person from society. Fullerton et al (2009) aimed to identify the characteristics of people admitted for the first time to psychiatric hospitals and Aschbrenner et al (2011) reviewed age and diagnosis at the point of admission.

Of the studies that were examining the efficacy or completeness of the assessment process or framework, Hirdes et al (2019) carried out a study to determine the comparative effectiveness of assessment tools across 35 nations, Lovell et al (2018) explored the impact of training around assessment and decision-making on staff and Zargham-Borujenj et al

(2015) sought to understand how people with psychiatric disorders demonstrate their strengths as part of the assessment process, so the focus was on a slightly different aspect of the assessment in each of the studies exploring assessment frameworks. Sorkin et al (2018) took a somewhat different tack, examining the attitudes of people with mental health needs admitted to long-term care immediately following discharge from hospital and how satisfied they had been with the assessment which led to this admission.

The next part of the interpretive framework requires a review of the studies in terms of their sampling strategy and the efficacy of these. The majority of the studies were localised (as is this one) and this tended to be the case as researchers had access to their subjects, 3 of the studies sampled according to health insurance/provision areas (Medicare dataset (Grabowski et al (2009), Aschbrenner et al (2011) and Fullerton et al,2009)) another study surveyed people as they left an associated group of acute hospitals (Sorkin et al), a further localised study sampled staff in Community Teams in an NHS region (Lovell et al 2018), the final localised study examined took its sample from an acute inpatient psychiatric unit (Zargham-Borujenj et al 2015). Conversely, Hirdes et al's (2019) study evaluated assessments rather than individuals comparing assessments used internationally and found that systemic, cultural, and political differences made it difficult to infer conclusions as to the efficacy of one type of assessment over another. There is a potential issue with localised studies in that it could be argued that they are not transferrable, as findings are attributable to differences in systems and practice rather than the application of the assessment and review processes, but this needs to be balanced with the availability and accessibility of locality-based data. Potentially, if the data was obtained over too large a geographical footprint, then context can be lost and findings diluted, as was the case with the Hirdes et al (2019) study.

There were distinct differences in the nature of the sample in terms of who or what are being researched. In 4 cases (Sorkin et al 2018, Grabowski et al 2009, Zargham-Borujenj et al 2015 and Aschbrenner et al 2011) the studies feature the people in long-term care; in one case the staff are the subject matter Fullerton et al (2009) and in a further instance the assessment

frameworks themselves are analysed (Hirdes et al 2020), and in the final case the Community Mental Health Team are the subject of the research (Lovell et al 2018) . This study has the most commonality with Grabowski et al's (2009), and Aschbrenner et al's (2011) work as it evaluates the reason for admission but adds potential for new knowledge as it considers social and medical factors. The other studies explore various discreet aspects of the admission Sorkin et al (2018) deliberate on attitudes toward the home admitted to, Hirdes et al (2020) compare the efficacy of assessment tools, Lovell et al (2018) explore the influence of patients and carers on the decision to admit (as does this study, but this also evaluates other societal, political and professional factors), and Zargham-Borujenj et al (2015) review how strengths are demonstrated within the assessments of psychiatric patients, which is also considered within this study.

The literature review will continue according to the stated interpretive framework and will evaluate the methodology used in the studies. This will be achieved by firstly providing an account of the research strategy and design. Most of the "decision making prior to admission" studies employed a quantitative strategy with Grabowski et al (2009) comparatively determining if the persons' presentation matched a set of pre-existing conditions indicating admission. These data did not contain descriptive or exploratory qualitative elements. Both Fullerton et al (2009) and Aschbrenner et al (2011) utilised numerical minimum data sets and quantitatively identified the prevalence of demographics, length of stay and functional features of peoples' presentation. Hirdes (2019) utilises an inter-rater instrument to identify pre-determined indicators qualitatively and analyse prevalence without considering descriptive information. The remaining studies were qualitative with Lovell et al (2018) and Sorkin et al (2018) using open-ended questionnaires which sought views and opinions and Zargham Borujenj et al (2015) employing semi-structured interviews which asked respondents to describe their views.

Analysis of the data was carried out using software packages in the quantitative cases (Grabowski et al 2009, Fullerton et al (2009) and Lovell et al (2018) also utilised pre-prepared

software for the analysis as did Aschbrenner et al (2011) as they were able to code their qualitative information numerically. Hirdes et al (2019) developed a specialised inter-rater tool, a computer-generated means of numerically identifying data prevalence and care planning protocols. Zargham-Borujenj et al (2015) Aschbrenner (2011) and Hirdes et al (2019) were not able to group the results of their data analysis in this way due to its nature so they had to develop their own scheme for analysis, using a group of researchers who reached consensus about emerging themes and the meaning attached to these. This study is also based on Grounded theory which differs from the majority of studies in this theme group, and it will generate new knowledge because the thesis does consider the strengths-based aspect of the assessment but has a wider scope in that it aims to understand the overall reason for the admission and continued residence in long-term care.

The theoretical methodology of Grabowski et al (2009) Fullerton et al's (2009), Ascbrenner et al (2011) and Hirdes et al (2019) studies are based on a medical model, as they determine the medical characteristics within the assessment framework. The remaining studies have a qualitative, naturalistic, and ethnographic methodology with a more social focus being based on Lincoln and Guba's (1985) classification as they are based in their natural setting; humans are the research instruments, and the data is extrapolated from some form of case study. Having reviewed the methodology of the studies concerning the assessment frameworks and reviews, the interpretive framework employed makes it necessary to provide a summary of the findings.

The findings tended to naturally fall into two groups; those that based the focus of discussion upon the medical and care needs and those that interrogated the content and nature of the assessment and attitudes to it. The medical and care needs-based studies provided findings related to the reason for the person's admission to long-term care with Aschbrenner et al (2011) and Grabowski et al (2009) agreeing that the primary diagnosis associated with admission for working-age people was psychosis (concurring with this study). Fullerton et al's (2009) findings were somewhat different, attributing the primary diagnosis on admission to

depression. This may be explained by the fact that this did not distinguish between age groups, and as working-age people were a proportionately small number of the admissions, this could have skewed the overall reason for admission to illnesses other than psychosis. These papers also found some additional characteristics of admission to long-term care, with Grabowski et al (2009) concluding that people with mental illness are admitted to long-term care younger and do not recover, so they are not discharged.

Of the papers that explored the nature and content of the assessment and attitudes to it, Fullerton et al (2009) recommended that staff in long-term care facilities for people with mental health needs required more extensive training and Aschbrenner et al (2011) determined that people were admitted due to lack of psychiatric beds or other alternative provision. Sorkin et al (2018) and Zargham-Borujenj et al (2015) researched attitudes to admission to long-term care, Sorkin et al (2018) found that people with mental health needs were more likely to be satisfied with their care if it was near to their home address and they had received comprehensive information about it prior to admission. High satisfaction with care in hospital did not make the person more likely to be satisfied with the long-term care facility. Zargham-Borujenj et al (2015) found a correlation between high levels of strengths being recorded in the person's assessment and that person's recovery. Lovell et al (2018) found that staff training had little impact on levels of patient involvement in their assessment. Hirdes et al (2019) completed an international study of the interchangeability of assessment tools/frameworks. They found that although there was a shared language and common professional "jargon" within them, differences in political and social custom and practice limited inter-changeability. Consequently this study will provide new and unique knowledge as it will take a holistic view of the experience and social situation at the time of admission and provide insight into the systemic social reasons for the admission of working-age people to long-term care, it will generate knowledge about the *reason for* admission on a holistic basis and will not repeat the work completed in these studies about diagnosis, attitude to admission, merits (or otherwise) of assessment tools or staff training needs.

The main limitation of the papers about the nature and content of the assessment framework leading to the admission is that their scope is limited and so the findings are limited. Hirdes et al (2019) examine the whole scope of the assessment but this is through the somewhat limited lens of how holistic they are. Grabowski et al (2009), Aschbrenner et al (2011) and Fullerton et al (2009) present the most medicalised of findings determining that people with psychosis are most likely to be admitted out of the working-age -cohort (as does this study, although its remit is wider) with Fullerton et al (2009) finding that people with depression are more likely to be admitted resulting from them sampling all age groups as opposed to working-age people with mental health needs. Lovell et al (2018) conclude that the training around the assessment process was well received by staff in a community mental health team, but the impact this has on the people they support is not considered, Sorkin et al (2018) conclude that people have a better attitude to their long-term care facility if they have had greater influence in choosing it and Zargham-Borujenj et al (2015) lament the paucity of strength-based focus in the assessment process. The narrow scope of these papers limits them, leading the author to consider the wide scope of this study and to be mindful of the necessity that this was clearly structured to produce cogent findings.

Some of the other limitations were that all age groups were included in studies, so it was hard to ascertain which findings applied to older people only (Grabowski et al 2009; Fullerton et al 2009; Sorkin et al 2018; hence this study is concerned only with working-age adults. In other studies, the views of patients and carers were sought and not distinguished between in the findings, so it was not possible to determine whose views were presented (Sorkin et al 2018). Having explored the research about the assessment frameworks which led to admission to long-term care, this literature review will continue to review the papers which evaluate the quality of care in long-term mental health care facilities for working-age people.

The theoretical basis of the papers differs between the studies. Those which interrogated the reasons for admission tended to be based around medical models of care in terms of their diagnosis and the staff that support them. This theoretical framework is also heavily apparent

in the treatment of schizophrenia section of the literature review and is analysed in greater detail there. Of the papers that explore the content and nature of the assessment frameworks and attitudes to them, the studies are too varied to be able to assign a single theoretical framework. However, the emerging theme is the relationship or dialogue between the assessor and the person assessed and how this relationship is constructed which is theoretically based in social constructivism. This is concerned with the way one social group constructs meaning and structure for another in terms of shared forms of communication with common meanings. Having determined the social constructivist theoretical element of one of the most pervasive study themes, the literature review will continue to analyse the next most prevalent theme of studies: quality of care.

3.6 Quality of Care

An equally prevalent theme in the assessment framework papers amongst the literature was quality of care, with 7 papers basing their research question around this topic., Grabowkski et al (2010) explore the physical health characteristics that pre-dispose people to be admitted to long-term care and the quality of care they subsequently receive. This thesis does not replicate this work as it is based on societal factors, whereas Grabowski et al (2010) focus on the preadmission screening, diagnosis, psychological interventions, and medication the person has at the time of admission and how these affect the quality of care as opposed to the reason for admission. Nakram (2015) explores how organisational behaviours and values influence the quality of long-term care. Zhang et al (2016) pose a similar question on a more micro level, investigating how individual staff members' behaviours and the stress they experience due to their work influence the quality of care in nursing homes. Rysinka et al (2019) also investigate the characteristics of individual staff members, seeking to determine how their level of qualification correlates with the quality of care, Mårtensson, et al (2014) also research staff characteristics, inquiring how nurse's attitudes to mental health influence quality of care. Raes et al (2020) consider whether there is any correlation between the price of long-term care and the quality of care provided. Samartiz and Talias (2019) measured quality of care against 8

pre-determined domains. Consequently, this thesis will generate unique knowledge because it is concerned with social determinants of admission to long-term care as opposed to medical predications (Grabowski et al 2010) or characteristics of the staff within the homes (Nakram et al (2015), Rysinka et al (2019), Zhang et al (2016) Mårtensson,et al (2014) or the impact of the correlation between higher priced long-term care and levels of quality of care Raes et al (2020). The literature review will continue to follow the stated interpretive framework and will determine how the papers concerning quality of care derive their samples.

There are a several sampling strategies in this group of studies, with the predominant method being grouping people into geographical areas: Zhang et al (2016) utilise a group of nursing homes managed by one company across the USA; Nakram (2015) purposively sampled a group of nursing homes in a region in the USA; Rysinka et al (2019) and Raes et al (2020) used a Medicare database within a particular area; Martensson (2014) et al determine a sample group including all mental health nurses in a particular area of Sweden. Nakram's (2015) purposive sampling could be challenged on the basis that the assumption of the researcher could bias it, but the study does allude to a group of associates cross checking each other's sampling. The other sampling methods were geographically driven and could be challenged in terms of lack of transferable information, but as discussed above, cultural and regional differences can result in information not being meaningfully comparable if it is not localised to the boundaries of its context. The remaining studies are literature reviews, so they utilised available databases as their sampling strategy; Grabowski et al (2010) only utilised PUBMED for this search which potentially made it narrow, and Samartiz and Tallias (2019) used a wider search strategy which included Google Scholar, CINAHL and PUBMED in their literature review.

Consequently, the samples of the studies into quality of care utilise nursing homes as overall entities, with staff working in homes and the people living in them as their study cohorts, but keep varying degrees of separation between them, not exploring the potential

interdependencies within these groups, this study will generate new knowledge in that it focusses on the fundamental reasons for admission and also upon the normative societal effects of placing working-age people with mental health needs into long-term care.

Having established the research question and sampling strategies of the studies evaluating quality of care, the literature review will follow the interpretive framework by evaluating their method and methodology. The studies all share a qualitative research strategy. In terms of the study design Nakram (2015) carried out observations in the long-term care facilities and wrote transcripts of these, Zhang et al (2016) questioned staff using a written survey with free text sections, similarly to Raes et al (2020) who also use survey design but elected to carry this out face to face and add the results to a data base. Rysinka et al (2019) devised a research tool which they applied to the records. Mårtensson, et al (2014) compared a database containing staff qualifications, and Grabowkski et al (2010) and Samartiz and Talias (2019) carried out what they termed as a narrative literature review aiming to identify the quality issues in long-term mental health care. Consequently, there were a range of research designs utilised to determine the quality of care within the studies with a slight preference for survey methods.

In respect of data analysis, 3 of the studies analysed their data by a process of manual inference carried out by the researchers (Nakram 2015, Zhang et al 2016, Martensson et al (2014), Rysinka et al (2019) and Martensson et al (2014) use secondary data methods with Martensson et al (2014) exploring the relationship between levels of training and quality of care and) Rysinka et al (2016) employing a multiple cause approach to the relationship between nurse's attitudes to mental health and patient outcomes (based on personal experience of mental health and interest and knowledge in the field of mental health). Grabowski et al (2010) and Raes et al (2020) took theme-based approaches, with Samartiz and Talias tempering this by exploring more descriptive and subjective accounts of care received. All these studies are subject to researcher bias as they rely heavily on subjective

analysis by the researcher. To address this, they add a level of inter-rater reliability by providing cross-checks between the researchers or by other independent review of the results.

The findings of the studies into quality of care derived new knowledge in relation to both the home and the person. Nakram (2015), Rysinka et al (2019) , Raes (2020) and Samartiz and Talias (2019) all generated information about the homes which impacted on the quality of care: Nakram (2015) found that all the homes they researched had similar corporate identities, although some had a more pronounced learning culture than others; Rysinka et al (2019) found that there was a better quality of care in homes where the staff worked specifically in the long-term care facility (as opposed to bank or agency staff) and that outcomes were better where there was a prescriber on site. Raes et al (2020) disclosed that the quality of care was enhanced in nursing as opposed to residential care. Samartiz and Talias (2019) conclude that quality of long-term care is impacted by lack of alternatives to it, including lack of rehabilitation facilities, that there is a distinct overall absence of robust recovery or treatment plans, and no real patient engagement, all of which are characteristics of the homes which have an adverse impact on quality of care.

The next element of research around quality of care pertains to staff in the homes. Martensson et al (2014) found that there are better patient outcomes where staff attitudes to mental health are improved by having knowledge or interest in the area or by having a personal relationship with a person who has mental health needs. Zhang et al (2016) concern themselves with the impact of staff characteristics on job satisfaction and quality of care and find that where staff feel physically threatened by patients and have a poor work-life balance, the quality of care is negatively impacted. Grabowski et al (2010) also take a person-centred approach as opposed to focussing on the home and include patients and staff, finding that quality of care is impacted on by the skills and qualifications of the staff, the quality of preadmission screening and the diagnosis of the person (with diagnoses relating to psychosis having poorer outcomes). Consequently, all the studies reviewed have a narrow focus, in most cases separating the

home, the staff and the patients and drawing no inference about the relationship between them. This study is a departure from this in that it seeks to holistically explore the phenomenon of long-term care admissions and the interactions which initiate and sustain them from a broader societal perspective rather than forming conclusions about specific aspects of the long-term care system in isolation.

Despite this lack of scope, the studies pertaining to quality of care were of reasonable quality and had no significant ethical shortfalls; they all considered the person's confidentiality and consent to engage in the study. They are also sound epistemologically, using clear and schematic ways of generating knowledge. They are all humanistic from a theoretical perspective as they are concerned with human experience, and they are all qualitative in terms of strategy. The major limitations of the studies are that they unquestioningly accept the concept of long-term care; although Samartiz and Tallias (2019) accept that it arises from a lack of alternatives, none of the papers explore the phenomenon of the admission and the wider systemic social factors which define this care. Having explored the themes within the literature around initial assessment and quality of care the literature review will continue to determine what the literature concerning the working conditions for staff in long-term care settings for people with mental health needs adds to the overall knowledge base in this area as this has the next greatest prevalence amongst the studies identified.

3.7 Staff Experience of Working with People with Mental Health Needs in Long-term Care

The staff in long-term care settings for people with mental health needs are a key element in the provision of this care, and four of the studies focus upon this area. The interpretive framework identified for this literature review will be applied by first identifying the research question or topic. Song et al (2020) explore how working conditions cause staff to miss care tasks, Plessier et al (2015) review the damage caused to the mental wellbeing of staff working in the homes, Bjork et al (2014) compare the experience of student nurses placed in long-term care settings for people with mental health needs as opposed to community mental health

teams, and Ree (2020) reviews how leadership and management practices impact on staff working conditions. This study is a departure from these in that it does not consider staff working conditions. The inductive framework will now continue to be applied by evaluating the sampling strategy, research design and data identification and analysis. In terms of sampling, this is geographic in all cases except for Plessier et al (2015) who used a cross-section of staff nationwide. As stated above, geographical concentration may cause a lack of transferability, but this may impact on other variables such as local funding arrangements, social deprivation/affluence in particular areas or local characteristics of home staff, which may mean that the findings are not generalizable if the geography is too wide.

The research strategy in all cases is qualitative, which is expected in studies concerned with staff attitudes to their working conditions. These studies utilised a research design which incorporated face to face interviews; all of the studies except Bjork et al (2014) and Ree (2020) designed their own research or interview tool, Bjork et al's (2014) study involved administering the Learning Environment Inventory Tool and Clinical Learning Environment Tool Chan (2013) and Ree (2020) utilised the Short Measure of Transformational Leadership (Carless et al 2000) with both allowing opportunities for participants to provide extra information if they wished. It could be argued that utilising a pre-existing scale constrains the research and does not enable exploration of inductive learning .Conversely that a uniquely designed interview format could be configured in a way that is pre-disposed to the researchers reaching their anticipated findings but this was alleviated by allowing the extra or supplementary information.

In terms of the data analysis, the data, which was, in all cases, the interview transcripts. Song et al (2020) analysed content of transcripts using pre prepared data analysis tools, Plessier et al (2015) compared observed results with expected results (from a previous exercise), Bjork et al (2014) carried out thematic analysis and Ree (2020) analysed the relationship between leadership styles and staff satisfaction.

The literature review will continue to observe the stated interpretive framework and evaluate the findings of the studies concerned with staff conditions in long-term care facilities for people with mental health needs. Song et al (2020) found that workers in the homes tended to be females over 40 years of age, 57.4% of whom reported missing an essential care task, and 65.4% reported rushing care tasks, all of which caused them to experience accumulating stress levels. Plessier et al (2015) also found that working in long-term care facilities had an adverse impact on staff mental well-being, which was exacerbated by low levels of pay and lack of job security. Ree (2020) found that working in the long-term care settings has adverse effects as they found that the pace of work compromised patient outcomes, but that regular supervision and communication improved this. Bjork et al (2014) departed from the feelings of inadequacy of staff around their roles, finding that student nurses were equally as satisfied with placements in long-term care facilities as with community mental health teams. These findings are illustrative in terms of the emotional toll working in long-term care for people with mental health needs takes. Still, they do not detract from the originality of this study in that they do not seek to determine the reason for admission.

All the studies are ethically sound and make robust provision for preserving confidentiality and consent. Bjork et al (2014) took out all male respondents as the sample was predominantly female, which may have made them easier to identify, however, this may have impacted on the findings in that male nursing students may have had different perceptions about placements in nursing homes. The studies were all generally sound but none of them clearly identified the patients' age in the long-term care facilities, so it is assumed that they include under 18's and over 65's, which are not incorporated in this study cohort. These studies equally concentrate on the effect the work environment has on staff, so it is the transaction between the work and attitudes and effects of this work that is studied as opposed to the multi-dimensional discourse which takes place between individual patients and staff, and the institutions in which they work and the wider societal relations which make admission feel normal and generally acceptable.

All of the studies concerned with job satisfaction are congruent with theoretical frameworks. They comply with Herzberg's (1966) assertion that staff need "motivators" such as positive outcomes for their work (which they don't achieve as their workload is too high and the psychological distress of patients persists they also do not attain the balancing "hygiene factors" such as job security, and adequate remuneration as pointed out by Plessier et al (2015). Locke's value theory (1969) states that staff need to feel satisfied with the outcomes they achieve, Song et al's (2020) study finds that this is inadequate in this staff group as they report missing and rushing care tasks due to the pressure of work. Adams' (1963) equity theory stipulates that employees compare themselves with others and are satisfied when they have equal inputs and outputs; these studies indicate universally low levels of satisfaction with both inputs and outputs, which makes comparison with others a necessarily negative experience. Such social constructivist theory may explain why student nurses (Bjork et al 2014) did not have an adverse experience in the long-term care facilities; they were there to learn, which they were able to achieve and would have been much needed additional support to the existing staff, after their placements they would have returned to training having garnered experience as opposed to being permanently employed in long-term care settings. Having considered the studies themed in connection with staff conditions and work satisfaction the literature review will continue to consider the next most prevalent group of studies concerned with models of care.

3.8 Models of Care

Four studies are concerned with models of care, making this theme the next most prevalent in the literature. Of these studies, one of these is community based (Dieterich et al 2010) but is included here in terms of its potential to reduce admission to long-term care, the research questions the efficacy of intensive case management for people with mental health needs. All the other studies are concerned with 24-hour care, with Fletcher et al (2019) investigating the potential of sub-acute recovery services, McGonagal and Allan (2002) comparing behaviours

of patients in traditional psychiatric wards with those living in a more “home styled” bungalow in the grounds of the hospital and Ryan (2004) comparing for profit independent long-term care facilities for people with mental health needs.

In terms of sampling strategy, which is the next element of the interpretive scheme for the studies concerning models of care, all but one study is geographically based, in this case Dieterich et al (2010) utilise the Cochrane schizophrenia group clinical trials. The remaining geographical sampling strategies are as follows: Fletcher et al (2019) use 19 residential recovery-based facilities in Victoria, Australia; McGonagal and Allan (2002) examined a hospital ward and a bungalow in the grounds of the same hospital in Derbyshire and Ryan (2004) reviewed for-profit long-term care facilities in Regional Health Authorities in the Northwest, West Midlands, County Durham, and Tees Valley.

All but one of the studies used a qualitative research strategy. The study designs differed in all the studies, with Deiterich et al (2010) correlating outcomes of clinical trials utilising quantitative random-effects meta-regression to determine the probability of admission to hospital. Of the remaining qualitative studies, Fletcher et al (2019) used semi-structured interviews , McGonagal and Allan (2002) compared the behaviours of people in the ward and “home-style” setting from qualitative case descriptions, and Ryan (2004) asked managers of long-term care facilities to provide descriptive details and costs of their services identifying common factors within the descriptive data via thematic analysis.

As the study design varies, so does the data and data analysis: Dieterich et al (2010) utilised pre-identified characteristics of the study from the register of clinical trials analysing these via correlation of the outcomes; Fletcher et al (2019) used electronic responses to a questionnaire with free-text content and analysed them manually according to the following domains: living

(built) environment; therapeutic environment; treatments and interventions; self-management and autonomy; social interface; and human rights and recovery based practice (they then inter-rater evaluated these to ensure validity); McGonagal and Allan (2002) used case notes and compared their accounts of the behaviours of the patients in the two different types of care setting and Ryan (2004) used a pro forma completed by managers of the care facilities which contained descriptive information. Having evaluated the research question, sampling strategy, research strategy, study design data type, and data analysis of the studies concerning models of care, the literature review will now continue with the interpretive scheme by analysing the findings of this group of studies.

Two of the studies found positive outcomes from the models of care that they scrutinised, and the other two were less positive. Fletcher et al (2019) felt that sub-acute recovery was advantageous in that it promoted high levels of personal autonomy and social inclusion, however there were some discrepancies in the findings as there were differing interpretations of the concept of recovery, and the researchers recommended that clear outcomes which constitute recovery need to be further researched. McGonagal and Allan's (2002) study also had positive outcomes, finding that the provision of long-term mental health care in smaller homely units accentuated choice and a sense of patient autonomy. Of the studies with less positive outcomes, Dieterich et al (2010) found that intensive case management only slightly reduced the length of stay in hospital and made little or no difference in terms of reducing death by suicide and, therefore, was not good value in terms of the resource intensity this form of care demands. They recommended that no further trials into this model of care were required. Ryan (2004) found that a weekly expenditure of over £2.98 M was the cost of long-term care for people with mental health needs in the study cohort, with considerable variation in costs across and within client groups. Many people were placed at a distance from their original address, and links with care co-ordinators and commissioners were frequently not robust. Private providers dominate the independent sector and require strategic engagement as there was a lack of assurance around quality of care. The study concluded that improved

co-ordination between the independent sector, NHS provider trusts, care co-ordinators and service commissioners would more effectively utilise this significant resource. This study would concur with these findings, making it even more crucial to understand why working-age people with mental health needs are admitted to long-term care so we can better understand viable alternatives.

All the studies concerning models of care generate new knowledge as detailed in the findings and have no shortfalls in terms of ethics, but again, the age range of the study cohort is not clearly defined, meaning that they are not directly comparable with this study. Also as identified in the previously evaluated themed studies, the sampling study tends to be geographical (except for Dieterich et al (2010), which may limit the transferability of findings but is necessary to derive accessible and comparable data. Theoretically, the studies around models of care focus upon power; the McGonagal and Allan (2002) study is relatively old now and although it potentially generated new knowledge at the time it was completed it is now largely received wisdom that smaller, “home-style” care settings for people with mental health needs produce enhanced outcomes and the power differential is smaller between residents and carers than staff and patients. This power dynamic is manifest in the way the people with mental health needs are not concerned with shaping the models of care which support them.

Rowe and Calnan (2006) (p.1) reflect upon potential developments in long-term care which, “…present(s) a theoretical framework based on current policy discourses which illustrate how new forms of trust relations may be emerging in this new context of health care delivery” based upon a more reciprocal relationship between health care providers and patients. These studies indicate that this does not exist for people with mental health needs, with them not choosing whether they receive intensive case management (Dieterich et al 2010), sub-acute recovery services (Fletcher et al 2019) “home style” living and care arrangements (McGonagal and

Allan 2002) or long-term care close to home with access to local, familiar mental health services (Ryan 2004). Having reviewed the literature themed concerning models of care for people with mental health needs, the Literature Review will now continue to explore the next most prevalent theme, that of treatment methods for schizophrenia.

3.9 Treatment of Schizophrenia

Contextually, this element is included in the literature review as there was significant attention paid to the topic within the literature search, but the scope of this study will not be to provide a review of medical treatment of schizophrenia but rather to determine what the literature reveals about its relationship to admission to long-term care for working-age people with mental health needs, or the treatments or interventions available to them in those settings. Jones et al (2018) interrogate how Cognitive Behaviour Therapy compares with other treatments, Sariah et al (2014) research why people with schizophrenia relapse, and Fleischacker et al (2014) complete what they refer to as a report, which does not have a research question or hypothesis, but rather, is an account of the different ways people with schizophrenia can be managed, not an analysis of data which reaches findings and conclusions.

In terms of sampling strategies, Jones et al (2018) completed a systematic literature review utilising AMED, BIOSIS, CINAHL, Embase, Medline, PsycINFO, and PubMed. Sariah et al (2014) utilised a geographical sampling strategy, including all patients with a diagnosis of schizophrenia in a particular area of Tanzania. The final study (Fleischacker et al (2014) does not have a sample but forms recommendations as to the most effective management strategies for the illness.

All the studies derive qualitative findings, and the research differs in design in that Jones et al (2018) carry out a systematic literature review in which the data is the literature. The Fleischacker et al (2014) work is more of a report but could be loosely termed a literature review. Sariah et al (2014) carry out face-to-face interviews, the transcripts of which form the data.

The data are analysed in the Jones et al (2018) study by examining trials which included people with schizophrenia who received CBT and considered the following criteria: intention to treat; risk of relapse and overall presentation and the person's view. The systematic review authors Jones et al 2018), working independently, assessed trials for methodological quality and extracted data from included studies, there is no account within the study as to how inter-rater reliability was achieved. In the Sariah et al (2014) study, the interview transcripts were analysed against the following criteria: medication compliance, family support; community involvement, substance use, and life circumstances, with the reviewers working as a group and agreeing on findings to achieve interrater reliability. There were no data as such in the Fleischacker et al (2014) report so it is not possible to comment on design or analysis. The literature review will continue to apply the interpretive framework and will evaluate the study findings.

The findings of the studies were comprehensive in that there were no identifiable benefits of treating people with schizophrenia with Cognitive Behavioural Therapy as opposed to other talking therapies or medication Jones et al (2018) Sariah et al (2014) found that poor compliance with medication, substance use, adverse and stressful life events, and lack of or loss of employment were linked to relapse. This is congruent with the findings of this study but does beg the question of whether these conditions contribute to the development of schizophrenia as opposed to relapse when a degree of recovery has been achieved. Although

there were no findings (as there was no preceding questioning process) Fleischacker et al (2014) recommend that an evidence-based comprehensive care plan is provided, which enables people to remain in their communities with support for their carers and physical health care.

When considering the theoretical frameworks applying to the pathology of schizophrenia, it is necessary to refer to medical as opposed to social models of care. Theoretically, Goffman (1961) was one of the earlier critics of the reductionist nature of the medical model, limiting the experience of the person with mental illness to their physical symptoms; this medical theoretical framework is applied by Jones et al's (2018) study as they consider only medical and psychological interventions for schizophrenia ignoring social strategies. Both Sariah et al (2014) and Fleischacker et al (2014) consider social factors and contemplate mental health stigma theoretical frameworks, which explore the impact of mental health diagnoses on social outcomes (Sickel, Seacat and Nabors 2014) and account for the way peoples illness and disability leads to seeking help for it and this very presentation of needing help causing them to be excluded (albeit the latter paper is a report rather than research as stated previously). This study will generate new knowledge as whilst considering diagnosis as part of the study cohort's overall characteristics it will focus upon the impacts (both potentially positive and negative of the decision-making around admission to long-term care). The next most prevalent theme within the studies is that of outcomes for people with mental health needs concerning long-term care and this will be examined next as part of the literature review.

3.10 Outcomes for Working-age People with Mental Health Needs in Long-Term Care.

The literature review will continue to apply the interpretive schema by exploring the research question inherent in each in turn. Kohrt et al (2018) ask how community interventions impact

on admissions to long-term care.. Although they are not about existing long-term care they are considered here as a potential influencing factor. Grabowski et al (2010) also question the outcomes of long-term care for people with mental health needs, and as with this study cohort, people with dementia were excluded.

Following on, the next part of the schema will be applied, and the design, research strategy and data extrapolation will be evaluated. Both study designs were systematic literature reviews, the former study included sampling from PubMed, PsycINFO and Social Care online, However, this was rather limited as the search criteria only yielded two studies. The sampling strategy in the other study (Grabowski et al 2010) is also limited because it only used one database (PubMed).

The researchers systematically reviewed the literature using a slightly different methodology: Kohrt et al (2018) answered the questions in the domains separately and then grouped the studies by the nature of the mental health issues they addressed. They then used a risk bias tool, (Joanna Briggs Institute tool which is utilised for non-experimental, non-observational data) to provide assurance around reliability and validity. Grabowski et al (2010) analysed the data and agreed the on the findings as a group they applied certain criteria which they deemed to be of interest. These criteria were: level of professional training, preadmission screening, quality of Medicare data, use of sedative medication, use of other therapies than medication, comorbidity with physical health, and regulatory notices applied to services.

The findings of these studies are neither edifying nor do they provide assurance that long-term care is the optimum model of care for people with mental health needs. Kohrt et al's (2018) study was included as it was hoped that it would consist of findings as to how community services could avoid admission to long-term care, but as they were primarily related to primary care, they were not relevant to this study as the cohort have secondary care

needs (primarily psychosis and bipolar disorders). Grabowski et al (2010) provided a bleak picture of long-term care for people with mental health needs, finding that there was a high reliance on medication, and more specifically sedative medication, that preadmission screening was usually poor, there were high levels of comorbidity of physical and mental ill health and that many of the homes studied had been served regulatory notices.

The quality and contribution of these studies was limited in the Kohrt et al (2018) research in that it only contained two articles for review and had little relevance or unique contribution to this study. Although sampling from only one database potentially limited the research completed by Grabowski et al (2010) is of interest in this study as it provides unique insights into the poor outcomes in long-term care for people with mental health needs and adds import to the question this study poses as to why they are admitted. The next most prevalent theme identified within the literature search relating to this study with a small number of representation of papers (n=2) are those which explore the relationships of staff with the patients, and the literature review will continue to consider these.

3.11 Relationship of Staff with Long-Term Care Patients

Prior to conducting the literature review concerning the studies themed into those concerned with staff relationships with patients, it is necessary to clarify why a distinction has been made between this and staff conditions. Working conditions are deemed to be primarily dictated by the employer, the environment, wages and relationships with colleagues and managers. These papers concerning relationships are limited to those which specifically concern the relationship between the staff members and the people in long-term care who they aim to support as opposed to the relationship between staff and their employers or terms of employment.

This section of the literature review will also follow the interpretive framework and will begin with an analysis of the specific research questions. Ku and Minas (2010) seek to understand how nurses with general as opposed to psychiatric registrations differ in their relationships with patients and Leach et al (2020) explore the impact of the relationship of patients with their Community Psychiatric Nurses (CPNs) on admission rates. Although this focuses on relationships within the community, it is included due to the possibility it may provide information on these relationships and the likelihood of admission, thus indicating predisposing factors.

The interpretive framework indicates that the literature review will analyse the sampling strategy and design which will follow. Ku and Minas (2010) utilised a pre-determined list of databases having decided on a systematic qualitative literature review in which the data would be the studies identified in the search. Alternatively, Leach et al (2020) employed a qualitative interview design in which the transcripts derived from the responses were the data.

Ku and Minas (2010) analysed the data via a statistical package, and Leach et al (2020) took a different approach with an individual analyst carrying out a synthesis of the studies, which another researcher then verified. Having determined how the literature concerned with the relationship of staff with long-term care patients is hypothesised, strategized, designed, and analysed the literature review will continue to interrogate the findings of these studies.

Ku and Minas (2010) found that there are more negative attitudes overall to mental as opposed to physical illness and that general registered nurses had a lack of training and experience in mental health, which impacted their understanding of and relationship with patients adversely. Leach et al (2020) found that there was no correlation between having a good relationship

with a CPN and subsequent psychiatric admission which is useful for this study because it indicates that a lack of such relationships does not increase the likelihood of admission to long-term care for working-age adults with mental health needs. They also found that literature was scarce around long-term care for mental health needs, a finding shared by this study as much of the literature is concerned with older adults and dementia as opposed to working-age adults.

In terms of ethical issues there was no concern with the Leach et al (2020) study as all the papers within had ethical clearance. Still, there were some unclear areas within Ku and Minas' (2010) work with a lack of definitive information as to how the nurses had been recruited or whether any incentives had been offered to them. May (1992) raises an interesting theoretical point about the association between nurse and patient and highlights the dichotomy between the concept of a nurse-patient relationship and a nurse patient-interaction (for nurse read long-term care worker). The former is concerned with the emotional currency inherent in the relationship, which is a by-product of the caring relationship, and the latter is the transactional interaction by which the nurse is paid, contracted, and governed to deliver professional interventions.

3.12 Non-Themed Studies

This final group of studies are relevant to long-term care for working-age people with mental health needs, but without contriving common factors, it was not possible to attach them to one of the schemed areas above. These final 4 studies, which will also be analysed by the identified interpretive scheme of the Literature Review ask the following research questions: Muntaner et al (2018) enquire whether staff in nursing homes in the UK are exploited in terms of class, deemed to be separate to the "staff conditions" theme as it is about macro-level societal oppression as opposed to staff experience within individual homes or organisations; Roos et al (2018) query health care utilisation and cost after discharge from psychiatric

inpatient units; Bartlem et al (2018) interrogate physical health risk behaviours in psychiatric inpatients and Ryan et al (2007) study out of area long-term care for people with mental health needs.

The sampling strategy in all cases was geographically based (it is not deemed necessary to repeat the pros and cons of this sort of approach as this has been detailed above) with Muntaner et al (2018) utilising Nursing Home staff in a particular region of the USA, Roos et al (2018) investigating patients discharged from a specific psychiatric unit over 12 months , Bartlem et al (2018) examining those admitted to a similar unit over a different 12 month period and Ryan et al (2007) investigating people with mental health needs placed out of area by one local authority area at the point the data was extracted.

As previously mentioned, the interpretive scheme demands that the literature review now evaluates the research strategy, design, and data analysis. The research strategy is qualitative in all of the studies the design of the studies is 1:1 interviews in the case of Muntaner et al (2018) , Roos et al (2018) interviewed community and care home staff with the object of identifying of pre-identified characteristics (cost of care following discharge; days / hours of care following discharge; and types of intervention following discharge Bartlem et al (2018) designed their study around the administration of a group interview by nursing staff which was recorded and Ryan et al (2007) also used an interview approach which was validated against descriptive elements in the case record by the researchers.

Consequently, the data in all the studies are collected by transcripts: Muntaner et al (2018) used software to identify correlation in responses; Roos et al (2018) also used statistical software to identify common themes as did Bartlem et al (2018); and Ryan et al (2007) manually collated data from a spreadsheet. The Literature Review will continue to follow the

interpretive scheme by determining what new knowledge was generated by these studies, their relevance to this thesis and their theoretical significance.

The findings of the non-themed studies did generate new knowledge with Muntaner et al (2018) finding that staff from lower socio-economic groups did feel exploited and disempowered and showed signs of depression. Roos et al (2018) found that intervention from specialist community teams reduced re-admission length of stay and cost. Bartlem et al (2018) found that there was higher incidence of physical health risk behaviours in people with mental health needs (poor nutrition, smoking, hazardous alcohol use, and inadequate physical activity) and that over 50% of the study cohort engage in all 4 of these behaviours. Ryan et al (2007) found that: significant numbers of patients were not in receipt of a Care Program Approach (CPA) or multi-disciplinary review; most were locked within facilities although patients were not detained under any legal framework; clinical and treatment histories were absent in half of the cases; and many needed supported accommodation rather than independent hospital or nursing home care; also, involvement of patients and relatives in care planning was limited.

Of these findings, the most significant to this study were those of Ryan et al (2007) which highlight the poor quality of long-term care for people with Mental Health needs and feature on the need to question why they are admitted. It is not possible to identify a common theoretical basis for the non-themed studies; they all have merit and generate knowledge (although not new theory) they tend to be factually based on cause and effect. Roos et al (2018) consider the positive effect of specialist community support following an admission, Bartlem et al (2018) establish a link between long-term mental health care and high-risk physical health behaviour, Muntaner (2018) outlines the exploitation of nursing home staff due to social class and Ryan et al (2007) explores the generally poor standards of long-term care. None of these studies identified positive aspects of long-term mental health care, nor did their

predecessors in the themed categories; this creates a vital necessity to ask, “Why do working--age people with mental health needs enter long-term care?”

3.13 How This Study Will Generate New Knowledge

Detailed exploration of the available literature into long-term care and mental health indicates that this study will generate new knowledge as none of them specifically answer the question of why people with mental health needs enter long-term care, and this section of the Literature Review Chapter will explore each of the theme areas and identify what this study will add which is not already available. The details of the content of the themed areas of the literature review are examined above, and this will not be repeated in this section, which will focus on the principles of the new knowledge generated specifically.

The section concerning admission and assessment processes immediately prior to admission has the most in common with this study as it investigates the reasons for admission to long-term care. This study is not based on the assessment process but more specifically around the decision-making elements of this in relation to this study cohort, which result in the admission of the person to long-term care. This group of studies within the literature review does not pertain to specific decisions being made but is more concerned with generic assessment process issues such as the characteristics of the people assessed, the characteristics of the assessment, and the attitudes of those assessed. This thesis will focus on grounded theory to generate new knowledge around the way social and power relationships are constructed, which will enable the new knowledge to be derived from the data and the themes identified from the data rather than over-dependence on the already constructed assessment framework, with an emphasis on decisions made rather than the potential pros and cons of the assessment framework. Thus, this study will create new

knowledge as it will focus on this particular decision-making area rather than the assessment process prior to admission.

Some of the studies concerned themselves with quality of care; this was not an element of this study, so it will necessarily not repeat this research. Quality of care is viewed through a different lens in this study, as the emphasis is on people's freedoms and strengths rather than algorithms about the delivery of care in terms of safety, effectiveness, and experience; none of the papers explores the phenomenon of the admission and the wider systemic social factors which define this care which is the focus of the new knowledge this study will provide. This study will generate additional new knowledge to the identified studies around quality of care as it focuses on the pre as opposed to the post -admission experience and the nature of the decision-making process rather than the post admission experience alone.

This is also the case for the studies relating to staff experiences of working with people with mental health needs, this study is about a very clearly defined group of people who receive services not about staff conditions. None of the studies identified in the literature review clearly define a specific study group who are working-age, have mental health needs and are in long-term care so this study will generate new knowledge as it focusses on a very distinct and clearly defined study cohort.

This study is also a departure from the research featured in the literature review, which is concerned with analysing outcomes for people in long-term care. This study takes a totally contrasting standpoint, not looking at the outputs and consequences of long-term care but being concerned with the original decision-making processes at the point of admission and at subsequent review.

The studies which concern themselves with the relationship between long-term care staff and patients do have a level of commonality with this study as the relationship between the

person and their assessor is an aspect of this study. However, this study will generate new knowledge as, similarly with the outcome's studies above, it is concerned with pre and post admission. Also, this study will not focus only on the relationship between the cared for and caregiver. It will explore a wide range of societal, cultural, and political factors influencing the decision to admit people to long-term care.

This study is also a departure from those featured in the literature review that are not themed, as it focusses on pre rather than post admission. As stated above, this group of studies tends to explore cause and effect, or the products or aspects of long-term care, as opposed to the decision-making process that led to the admission.

Having detailed the unique contribution this study will provide in each theme area; this section of the literature review will conclude by itemising the holistic unique knowledge this study will provide:

- A holistic evaluation of the reasons working-age people with mental health needs are admitted to long-term care, including an analysis of decision-making at the time of admission.
- This study is focused on working-age people with functional illnesses (i.e. not dementia or degenerative mental health conditions).
- This study will examine risk factors which lead this to be considered untenable in the community by assessing professionals.
- Exploration and analysis of why working-age people persist in the risk behaviours despite the potential prognosis of admission to long-term care.
- This study will consider resource factors and how previous admission to acute psychiatric inpatient care may contribute to decisions to admit.

3.14 Areas of Strength within the Literature Review Studies

The studies within the literature had some considerable strengths, they had varied subject matter, and included societal, patient and staff perspectives of long-term care. They were essentially ethically sound, although it was not explicit in 1 of the studies whether participants had been incentivised (Ku and Minas 2010). A variety of methodologies were used in the studies which provided insight into how research into long-term care could be carried out and structured (some examples of this are as follows open-ended question interview method studies with descriptive content were completed by Zargham-Borujenj et al (2015), Lovell et al (2018), Muntaner et al (2018), Ree (2020), Sariah et al (2014), Zargham-Borujenj et al (2014), Nakram (2015), Zhang et al (2018)). A systematic literature review was carried out by Grabowski et al (2010), and quantitative studies were carried out by Aschbrenner et al (2011), Fullerton et al (2019) and Raes et al (2020).

There was also variety within the findings of the studies, and these provided a well-balanced spread of knowledge around the characteristics of long-term care. Examples of the variety of findings can also be found in the studies around outcomes of long-term care, with both positive and negative aspects discovered. Of the positive aspects the research found similar corporate identities between the homes (Nakram 2015); that outcomes in care homes were felt to be better in nursing homes than residential homes (Raes et al 2020); that outcomes were better where staff had higher levels of qualifications (Grabowski et al 2010) and that outcomes were better for people with mental health needs where staff had a special interest in this area (Martensson et al 2014). Of the more negative outcomes (Rysinka et al 2019) found that employment of bank and agency staff was associated with poor outcomes; Samartiz and Talias (2019) found that outcomes in long-term care are impacted by a lack of robust care planning and rehabilitation programmes; and Zhang et al (2016) found that outcomes were poorer where staff felt threatened by physical aggression on the part of the patients they aimed to support. Consequently, the variety in all aspects of long-term care was a strength of the

studies and informed this study in the nature of the establishments, but it also complemented this study (which focusses upon patients) with its emphasis on the experience, attitudes, and conditions of staff.

There was a particularly strong emphasis on the conditions, experience and working relationships of the staff within the included studies and this is not repeated in this thesis which focuses on patients' admission rather than staff considerations. Staff issues were significant in the literature review and are relevant as they are instrumental in providing the outcomes and services staff provide. Expectations around these may be instrumental in the decision to admit people to long-term care. A particular aspect of this was the conditions experienced by staff with Song et al (2020) exploring the way in which volume of work causes staff to miss tasks, Plessier et al (2015) detail the damage which occurs to the mental health of staff working in long-term care which are quite adverse outcomes for staff working in these settings. Bjork et al (2014) indicate that mental health-trained nurses' function better in mental health settings, with their general-trained counterparts having negative attitudes to mental health issues. Ree (2020) echoes Song et al's (2020) findings about the large workload of staff in long-term care and finds that establishments with robust supervision structures have better outcomes. Another group of studies concerned themselves with the relationships staff have with the people they care for in long-term care Ku and Minas (2010) found that psychiatric nurses are an advantageous specialism in mental health settings and that they were considered to have better rapport with patient as a result of their special interest in the field, Leach et al (2020) found that having a good relationship with the person's Community Psychiatric Nurse did not reduce likelihood of admission (but it was not clear whether this was as a result of them "opening up " to the nurse and relapse being more apparent). Muntaner et al (2018) evaluated long-term care staffing on a more macro societal level and conclude that staff in such settings are exploited, this study will look at elements of power, control, and resource from the patient perspective, but it was also interesting to consider whether staff in long-term care settings bear the brunt of the risks and behaviours which lead to the admission.

Having examined the strengths of the studies within the Literature Review, in terms of their variety of research question, methodology and findings and in their emphasis on the experience of staff working in long-term care the Chapter will continue to review potential areas for development within the studies in the Literature Review and how these lead to the unique contributions of this study.

3.15 Areas for Development within the Literature Review Studies

A potential shortfall of the studies was that they either did not clearly specify the age group and/or type of mental illness the people were experiencing, which made it difficult to gauge the level of correspondence with this study, which concerns itself solely with people who are working-age.

The section above extolls the variety within the studies and the fact that they contain both positive and negative outcomes of long-term care; however, where negative outcomes are identified, there are few or poorly identified recommendations made by which they could be addressed. For example, where Plessier et al (2015) identify the negative impact on the mental health of staff working in mental health long-term care facilities, it may be useful to look at how debriefing, training, supervision or counselling could support this: where Samartiz and Talias (2019) identify poor care planning there is no recommendation that audit takes to place provide detail of shortfalls and how staff can be trained and supported to improve care planning standards.

Another deficit of the studies is that other than work on the link between diagnosis and admission (Aschbrenner et al 2011) and the work around attitudes to care provided in hospital and long-term care (Sorkin et al 2018) the studies tend to be focused upon the organisations and staff and not upon the person's experience of long-term care. However, this does provide this study with an opportunity to make a unique contribution. The Fleischacker et al (2014) study was also felt to lack depth in that it was an adequate review of the literature around the treatment of schizophrenia but did not pose a research question or result in the generation of new knowledge or theory.

Consequently, the literature review has established that there are distinct bodies of work within the research around long-term care and mental health and these include decision-making mechanisms at the time of admission (though not why people are admitted, which is distinct and is the focus of this study); quality of care; staff experiences and work conditions; models of care; treatment of schizophrenia; outcomes of long-term care; relationships of staff with patients; and non-themed studies (cost of care after discharge, experiences of being placed in out of area long-term care; the impact of "double jeopardy" of physical and mental ill health; and the macro societal impact upon long-term care staff working in mental health). The studies are varied in research questions, method and methodology and findings and identify both positive and negative long-term care outcomes. However, there are aspects of the studies which could be strengthened, which include an emphasis on the person living in long-term care, provision of recommendations to address identified shortfalls, and clear focus on working-age individuals with functional mental illness who are denied the range of possibilities to be productive and contribute to society because of their illness.

3.16 Conclusion to Literature Review

Having applied the interpretive scheme identified at the start of the Literature review (which involved analysis of the Research Question, Research Strategy, Sampling, Study Design, Data Analysis and Findings, to each of the themed areas in turn, decision-making at the time of admission; staff work conditions; models of care; treatment of schizophrenia; staff relationships with people with mental health needs in long-term care; and studies that could not be meaningfully associated with others, it is next necessary to contextualise these in the light of the research design of this thesis. As stated previously, the data in this study are the case records of the working-age people with mental health needs, and these will be analysed via grounded theory using the case records.

The findings within the studies around the quality of care, staff conditions, and staff relationships with people in long-term care and patient safety contain a transactional interaction between the staff and the people in long-term care. This incorporates a sense of fairly superficial societal oversight and need for assurance and information about the characteristics and implications of long-term care for people with mental health needs based upon varying levels of theoretical social constructivism, which is articulated by Adler (1997 p.322) thus: “The manner in which the material world shapes and is shaped by human action and interaction depends on dynamic normative and epistemic interpretations of the material world”, this is relevant to these studies as they all explain aspects of long-term care for people with mental health needs, they rationalise and normalise the social constructs which regularise and assure its existence but they do not question the reason why these social constructs are accepted as norms as this thesis does.

The studies around treatment of schizophrenia and models of care, add a further dimension in that there is some level of moral or value judgement around the worth or benefit of the long-term care. These studies identify lack of benefit or disadvantageous outcomes of long-term care and recognise that help seeking behaviours lead to disadvantage or non-therapeutic interventions in long-term care. They characterise these factors as a set of unrelated outcomes which constitute new knowledge. Still, they do not go to the extent of this thesis by generating understanding of these phenomena by formulating the concept of the perpetuating cycle of long-term care, which in the Discussion Chapter will determine why working--age people with mental health needs enter long-term care. (Please note that the term “working--age” which applies to the study cohort in this thesis is not used throughout the literature review as in some of the studies the age of the sample population included older adults, or it was not possible to ascertain robustly what the ages of the sample population were).

The thematic study groups, treatment of schizophrenia and models of care are more interactional theoretically with more of an exploration of the cause and effect of response to

the behaviour of the people admitted, i.e. the admission and its outcomes, these studies do contain some element of questioning the merit of long-term care and are more phenomenological theoretically as they contain a fuller exploration of the structures and social constructs of power that “other” (Foucault 1965) people with mental health needs separated from the rest of society. However, they do not question why people are admitted as this thesis does and this will form the essential element of the unique contribution to knowledge that this study will achieve. Having completed the literature review, the study will continue to explore the methods and methodology of the research .

4.0 METHODOLOGY CHAPTER

4.1 Introduction

The purpose of this introductory part of the methodology/method Chapter is to contextualise the methodologies and methods with respect to the research question, “Why do working-age-people with mental health needs enter long-term care?” Thus, the study is concerned with individual characteristics leading to admission, as well as a more holistic understanding of the life experiences of the person around the time of admission and subsequently, and the societal justifications of these events.

This chapter will be organised into methodology and method sections. Bhosale (2021) concludes that the methodology section is a systematic and theoretical approach to the analysis and collection of data, whereas methods are the practical components of this, such as the sample or participants, the materials or data, and the procedures or processes used. The initial methodology will justify the mixed method strategy, the grounded theory research design, the constructivist ontology, and the interpretivist epistemology. This sector will then continue to rationalise the utility of grounded theory in generating knowledge and theory. The subsequent method section will detail the rationale around the sample generation. It will then continue to justify the data gathering process, including the use of secondary data and examine the coding and memoing process by which the data were analysed.

Methodology

4.2 Research Strategy – Mixed Method

This study employs a mixed method strategy purely because it is the best way to answer the research question. The source of the justification for admission is in the case notes. It is necessarily recorded in the electronic record format which includes mandatory fields with pre-determined responses (which form quantitative data) and some free text (which provides more qualitative data). (Please see more on the nature of the data and data collection in the Methods section below) Cohen et al (2017) characterise a Mixed Method Research Strategy as being best employed where there are both qualitative and quantitative data which applies to a research question which will be examined in one piece of research, where combining these approaches can provide more in-depth findings. Johnson and Onwuegbuzie (2004) explore different types of mixed method research but state that the ultimate principle is that researchers should collect multiple data using various strategies and approaches so that the data can be used to its fullest extent. This is clearly the case in the data employed in this thesis, where losing either qualitative or quantitative content from the case record for analysis would be losing vital parts of the information available.

Johnson and Onwuegbuzie (2004) make much of the distinction as to how and when data are organised and distinguish whether data are considered one after another (sequentially) or at the same time (concurrently or embedded), as does Cresswell (2007). The focus here is on the time of the admission, which can only be obtained from the case record, so that quantitative and qualitative data were analysed concurrently from the point of with interrogation going further back until all lines of enquiry required by the data collection (please see below) were achieved. Cohen et al (2017) also make distinctions as to whether one type of data was dominant or not; in this thesis this fluctuated, quantitative data were used to determine prevalence and commonality and qualitative data to determine what the rationale

for decision making was (for example, functions of behaviours and how these impacted on people – some people responded to disturbing delusions in which they felt people were harming them by being aggressive to others). Further detail about secondary data use is provided further on in the chapter.

An equally relevant justification for use of this data was their nature: this study does not derive knowledge from the exploration of people's thoughts, feelings or views of their admission but is concerned with the analysis of the series of events, situations and circumstances leading to admission; considering some opinions and descriptive matter provided by the professional. The Trust's Record Keeping Policy (2022) (and previous iterations) requires that factual and situational documentation be accurately and contemporaneously recorded, so it was deemed reasonable to expect this to appear in the electronic record. Having detailed the Research Strategy, the thesis will continue to explore the Grounded Theory Research Design.

4.3 Research Design – Grounded Theory

Grounded Theory is typically used to discover new concepts and relationships, so the research question is not approached with a theory in mind, but theory is generated from data. Grounded theory was first developed by Glaser and Strauss (1967 p.45) who describe it as "… the way data contribute to emerging theory, and its categories is a key criterion for further data collection and sampling" They continue to say that its focus is to develop a theory from continuous comparative analysis of data collected by theoretical sampling. This original inception, referred to as Classic Grounded theory, or Glaserian Grounded theory is a methodology of theory generation rather than simply analysis, in which everything is viewed as data, and is characterised by Locke (2003) as stemming from an inductive coding process which has less initial focus in the literature than other research strategies. The strategy section above has alluded to the development of quantitative and mixed method theory; this is deemed to be relevant in this study so that all the data within the case record (whether quantitative or

qualitative) can be utilised and that a mixed method approach can be used to compare different parts of the record with each other to develop new knowledge.

There are several types or varieties of grounded theory. Opoku et al (2016) say that choosing the correct approach for the specific study is vital and argue that this should be justified by consideration of: the existing literature; the research objective; the resources available and the researcher's philosophical view. To provide such justification, it is necessary to consider options available by which to conduct the grounded theory study. Cresswell (2007) identifies two popular approaches: firstly, the systematic procedures developed by Strauss and Corbin (1990, 1998) whereby a theory is established via the development of a process, action, or interaction; and secondly, a constructivist approach as established by Charmaz (2006) which is an interpretivist study of a single process. This study is based upon the constructivist approach of grounded theory, which can be justified according to Opoku et al's (2016) considerations in that the specific literature pertaining to admission to working-age people with mental health needs is scant and therefore, all aspects of the data and the knowledge they can yield need to be thoroughly analysed. The research objective is to develop knowledge about the reason for admission and the decision-making of the professional at the time, so the rich data which contemporaneously justifies this in the case record is crucial data that needs to be deconstructed in the coding process and reconstructed to provide meaning derived from this by categorisation, memoing and identification of themes. The researcher was the resource available to the study, which was ideal for this purpose as they had warranted and ethical access to the case notes which contained the vital decision-making around the admission.

Finally, this approach was congruent with the researcher's philosophical stance regarding the constructivist ontology and interpretivist epistemology explored below. The following paragraphs will examine how the grounded theory research design methodology will generate

theory from the data and the Methods section further on in this chapter will detail the practicalities of this.

This study adopted Strauss and Corbin's (1998) conception of modified or Straussian Grounded theory which involves a three-stage iterative coding approach, forming the central underpinning of the research design. Urquhart (2013) typifies this as structuring data by first creating codes inductively and then relating them with axial and selective coding. The justification for this approach was that it was a systematic, robust, and transparent approach by which to organise and present the voluminous and wide-ranging data. However, elements of other grounded theory iterations were used to supplement and compliment this. Charmaz's (2006) Constructivist Grounded theory was also incorporated as it helped to align with the thesis's epistemology, with the research design and analytical techniques. Inclusion of this strand of grounded theory was on the basis that Charmaz (2006) places emphasis on the role of the researcher and the participant data and the impact their values and beliefs have on the findings generated. This enriched the analysis as it afforded perspective on who had expressed views in descriptive elements of these electronic records, what was recorded and if there was relevance of these factors to the ultimate decision to admit the working-age person to long-term care.

Strauss and Corbin (1998 p.273) state that; "grounded theory is a general methodology for developing theory that is grounded in data (and) systematically gathered and analysed". By completing this process, theory is derived from the research matter. Moghaddam (2006) states that grounded theory is concerned with a set of relationships amongst the data and categories which explain them. In this study the data was deconstructed into its parts and thematic analysis of the content generated knowledge and theory. Flick (1998 p.41) argues that "…the aim is not to reduce complexity by breaking it (data) into variables but rather to increase complexity by including context. The case notes that form the data in this study lend themselves excellently to deconstruction as they are naturally divided into assessments,

reviews, care and support plans, progress notes, demographics and legal statuses, which provide factual and more descriptive free-text information which is more subjective and subject to opinion. To effectively generate emerging theory, theoretical sampling was determined upon to provide a robust and trustworthy framework for the study.

This was necessary to acknowledge the role of the researcher as having a direct relationship with admission to long-term care for this study cohort and to the staff who carried out the assessment framework, and due to these relationships, an integral part in the construction of the thesis. This involved person-by-person (or case-by-case triangulation of the quantitative and qualitative data). This was done on a case-by-case basis by examining the relationship between numerical data (numbers of admissions, section history, diagnoses, and comorbidities) and the descriptive information about behaviours and their functions, and the aspirations of the person.

However, the final memoing part of the analysis process mixed data most thoroughly as people had, narratives about what they enjoyed and protective factors). Examples of this qualitative data from the case record can be found in the Findings Chapter.

The justification for carrying out memoing in this way was to build a person-by-person documentation of ideas, application of categories and codes and to develop the thought processes around the meaning of codes in categories in the decision to admit the person to long-term care. This approach was congruent with the building and understanding of meaning as advocated by Birks and Mills (2015). Charmaz and Mitchell (2002) advocate the use of participants' own words (in this case, the recording of the assessing professional in the case record) as this adds an element of lived experience and personal reality to the research and was a key perspective in the orientation of the study. Johnson and Onwuegbuzie (2004 p.17) define this type of mixed method approach specifically combining quantitative data with qualitative discourse grounded theory and advocate its use in that it enables "approaches, concepts and language into a single study."

This kind of data triangulation facilitates truly grounding the study and enables levels of evidence that make the findings as robust as possible and generate new knowledge. Practically, this was done by being mindful of words behind codes and areas of commonality and co-existence and using this to locate quantitative data which provides levels of evidence about the assessing professional's options, decision-making and perceptions of the person they assessed through the lens of the researcher. This approach was necessary to ensure the study was truly grounded, all the data was analysed and every dimension of the social sphere which influenced layers of relevance culminating in the decision to admit the person to long-term care was examined.

The final consideration concerned how the characteristics and elements of note about the population under study were selected, this was completed in accordance with Glaser and Strauss's (1967) recommendation that emphasis should be placed on triangulation, contrast, and convergence between the groups or themes so that theory can be constructed around this. Having determined and justified the grounded theory approach utilised in the study, the chapter will examine how coding was employed to generate knowledge.

In order that initial comparison of incidents and data can be comprehensively applied it is necessary to devise a robust system by which this can be achieved via coding. Strauss and Corbin (1998) identify 3 stages of coding: open, axial, and selective, and these were adopted within the study design as this version of grounded theory had the largest influence on the study design as it provided a structured approach to the volume and variety of data. They typify open coding as a means of organising the data, with the option to combine and identify codes as the research continues. This was the first stage of this process. It enabled the initial review and analysis of the information and was followed by axial coding, which Ezzy (2002 p.9) describes as a means "…to integrate the codes around areas of central categories" This enabled different characteristics and behaviours of working-age people admitted to long-term

care to be allowed to speak for itself with linkages made during selective coding. Selective coding was then undertaken Cresswell (1998 p.57) writes that "…in selective coding, the researcher identifies a "storyline" and writes a story that integrates the categories in the axial model." Thus, the "storyline" of the actual admission contained within the case record is linked back to the person's characteristics, experience and events, behaviours, and personal circumstances to commence the inductive process of understanding the admission. This selective coding was achieved by pinpointing the key events and situations which were crucial to the admission decision and triangulating the quantitative and qualitative elements at these points to uncover the "story" of the rationale for the admission (Cresswell, 1998) and to enrich the analysis by utilising triangulation as advocated by Glaser and Strauss (1967).

Glaser and Strauss (1967) suggest the idea of memoing, which enables the researcher to collate their thoughts as they are coding, categorising, and generating theory. This forms the means of informing the theory and providing a substantive framework but also allows for elements which fall outside of variables which may not become apparent during coding so that the generation of new theory is not constrained by any limitations which may exist in the construction the researcher has applied to the coding. Lampert (2007) points out that null assumptions or findings should be recorded as part of the memoing so that such constraint does not occur. Memoing in this study enables a case-by-case analysis instead of the variable-by-variable approach taken in the coding process. This facilitates the key to understanding the status change of the person from independent to a long-term care home resident. It enables a view of how this study cohort are "othered" from most of society and how interaction with them and their experience changes during this transition. There is an example of a person's memo in Appendix One and more on the practical application of the memoing process in the methods section of this chapter below.

There are references in the literature to the use of mixed method and grounded theory used simultaneously as a methodology, and these are explored in the following paragraphs.

Johnson et al (2010) coined the term mixed method grounded theory as is used in this thesis and specifically detailed the epistemological and ontological considerations needed to apply these methods. They argued that a predominantly interpretivist epistemology aimed at assembling meaning from the common data and identified themes is advantageously combined with a constructivist ontology, which can accommodate the relativism between the professional and assessed person and the influence of the researcher on the findings (more of this in the sections below). The electronic record was used as the only trustworthy data set as to the admission (which did not rely on recollection of events which happened years or decades ago, staff members still being employed by the Trust, or exacerbating the distress of people admitted to long-term care).

Easterby-Smith et al (2002) state that utilising quantitative data in mixed methods grounded theory provides additional functionality to analysis by categorising, counting and coding of events that individuals are experiencing, which can then be expanded upon and enhanced by more descriptive information about descriptions of events in their natural settings (the more descriptive free text entries in the electronic case record), Miles and Huberman (1994) argue that introduction of quantitative data provides a platform by which to explore and evaluate more subjective qualitative data. Mixed methods have been found to be beneficial in other examples of its use; Heasley (2003), Jiang (2003), Robbins (2003) and Pavlovskaya (2002) found that qualitative data corroborated and enriched quantitative findings with explanation and meaning (as was the case with this study where the categories/codes derived from the quantitative data were triangulated in the memoing process with the quantitative data).

Having justified the use of a Grounded Theory Research design with a Mixed Method Research Strategy, the chapter will continue to explore the epistemology and ontology employed in the thesis.

4.4 Constructivist Ontology

Denzin and Lincoln (2005) define ontology as a form of reflection which raises basic questions about the nature of reality and the nature of being, whilst Levers (2013) characterises the essential dichotomy in ontological approaches as an understanding of the universe, which is constructed and exists within our thoughts, or one which occurs independently from our experience (which may not be comprehensible or familiar) and positions these two ontological perspectives as opposing points. Bergen, Wells and Owen (2010) take a similar reductionist approach, stating that emerging phenomena need to be evaluated as entities as we are not necessarily aware of the broader systems they operate within, which should not devalue the importance or impact of the identified phenomenon.

Constructivist ontology has been employed in this study as it is concerned with the social processes by which the decisions to admit people to long-term care are constructed. This type of ontology stems from the belief that knowledge is necessarily filtered through the lens of those who record it (in this case the professional), and those who interpret it (the researcher in this case) (Denzin & Lincoln, 2005, p. 21). This does not negate the concept of an external reality but is an ontology congruent with a constructivist approach which views knowledge as shaped by individuals, by their experience and knowledge and unique to them. Nakashima and Canada (2005) carried out a study into aspects of the meaningfulness of life for people in long-term care (in this case a hospice setting) and a subjective social constructivist approach was deemed valid in the development of conceptual frameworks around the removal of people from their homes and the impact of this. This has resonance with this study regarding the practice inherent in the decision-making that admission to long-term care is necessary. The goal of constructivist research is to develop an understanding of personal and social issues and to allow an analysis of how society may exert control over the individual (Denzin & Lincoln, 2005). This can be usefully applied to this study as it concerns power relations that enable one sector of society to admit another to long-term care. Having justified the constructivist approach, which harmonises with the interpretivist

standpoint of the ontology, it is next necessary to consider and justify the chosen research paradigm.

As this study is rooted in social interaction a social constructivist methodology has been utilised. Neimeyer and Levitt (1999, p. 2651) state that this type of approach is based on four basic tenets:

- They elucidate ‘local’ as opposed to ‘universal’ meanings and practices.
- They focus upon provisional rather than ‘essential’ patterns of meaning construction.
- They consider knowledge to be the product of social and personal meaning-making.
- They are concerned with the viability or pragmatic utility of its application than with validity per se.

This approach is eminently suitable for a study which is based in a particular locality, which aims to generate new knowledge about why working-age people with mental health needs enter long-term care via the social and personal processes which lead to this, and which also aspires to provide recommendations to alleviate the inevitability of this outcome. Having justified the methodological framework of the study in respect of its mixed method strategy, and social constructivist ontology, the study will continue to construct the outline of how grounded theory, constructive ontology and interpretivist epistemology will be utilised in the generation of new knowledge and theory.

Constructivist ontology indicates that reality lives within human experience, which inextricably links it with Grounded theory (Lincoln and Guba 1985); this approach is compatible with this study as its aim is a holistic understanding of the admission of working-age people to long-term care. Thus, this study will take a social constructivist ontological approach complimented with a mixed method grounded theory strategy concerned with people’s experience. Levers (2013) state that a constructivist ontology is an optimal means of achieving an understanding of subjective experiences of reality which may contain multiple truths, which is the very

purpose of this study - it focusses upon what people have recorded and written about other people. These data include both concise information and more descriptive content, and analysis aims to extrapolate multiple realities and truths culminating in a theoretical understanding of why working-age people with mental health needs are admitted to long-term care.

4.5 Interpretivist Epistemology

According to Denzin and Lincoln (2005), epistemological inquiry explores the relationship between the person who knows and the knowledge, and asks “how do I know the world?” (p. 183). To determine the epistemological approach of this study, it is useful to consider which stances were considered and provide a rationale about which have been utilised or rejected. This mixed method study aims to find the meaning between the data through rigorous and transparent interpretation; this is concerned with in-depth analysis of commonalities and differences between the situations of the people admitted to long-term care. Alharahsheh and Pius (2020 p.41) define interpretivist approaches as being concerned with in–depth variables which create meaning about human interactions or experiences. This is relevant to this research because the researcher interprets the situation constructed by the professional in the case record.

Alvermann and Mallozzi (2010) develop this further by arguing that the discovery of meaning of this nature allows for progression towards a conceptual framework on which to structure research. This is relevant to this study since the conceptual framework around social construction of admission to long-term care is the focus of the research, as it aims to use an interpretive approach to better understand the issues involved in the decision to admit to long-term care.

Interpretivist epistemology has been tested as a research paradigm concerning long-term care in previous studies, however, as is the case with the majority of this research, it tends to pertain

to the care of older people: Iwasiw et al (2013) used an interpretive approach to research resident and carer's perceptions of their first year in long-term care; Secrest et al (2005) took this slant in investigating the views of nursing assistants' in long-term care to their roles; Sussman and Dupius (2014) employed this theory of knowledge to explore people's experience of moving from home into long-term care similarly to Fitzpatrick and Tzouvara (2018) who also utilised an interpretivist epistemology to carry out a systematic review about this transition.

The study has been carried out using an interpretive paradigm regarded as thus by Holloway and Wheeler (1996 p.7) "The methodology centres on the way in which the researcher interprets the subjective reality through a set of lenses which focus upon risk, professional responsibility and how these are balanced so that a mixed method approach is able to utilise and derive meaning to generate theory from the data, rather than attempting to fit the data into preordained theory". In this instance the researcher is viewing the data through the lens of what the assessing professional(s) have documented (whether the electronic record requires that this be in quantitative prepopulated fields or more descriptive free text qualitative entries).

4.6 Method

Type of data and data collection

The data in this case is the patient's case record. This entails an analysis of the narrative therein. This is congruent with this study as the case record is a chronological account of the history of the person with mental health needs admitted to long-term care. The record contains several elements which were all considered in the analysis of the assessment framework. These include clinic letters, progress notes, assessments care plans and reviews as well as Mental Health Act (1983) documentation. From 07 April 20013 onwards, this is available on

the clinical system, prior to this information is scanned on to the system via the health portal. General Data Protection Regulations (EU1026/679) (GDPR) were met, and provisions were made to ensure that data was used appropriately.

Explicit Description of Data Collection Methods

In this research the data was the persons' case record (justification for the use of secondary data is provided subsequently in the chapter). The case record included both quantitative and qualitative data. Examples of quantitative data include risk scores/ratings, diagnosis, co-morbidities, resource used, (length of stay, number of sections under the Mental Health Act, type of section); and demographics (age, gender etc.). Examples of qualitative data included descriptions of behaviours, what people described enjoying, descriptions of where people went, what people said they wanted, rationale for behaviour, and explorations of the types and quality of relationships people had, reported by staff, the person or in some cases other individuals who had involvement with the person (relatives or other professionals).The case record is split into several different "documents" or "forms" examples of which are as follows: The Request for Social Work Support; The Social Work Adult Assessment; the Advocacy and Participation Support Form (Care Act 2014); the Employment and Accommodation Form; The Contact / Restriction / Access Form; Adult Social Care Section 117 Checklist; Adult Social Care Review Record; Care and Support Plan; Profile Risk Assessment; Progress Notes; and Mental Health Act Assessment Reports. There are also old paper documents scanned onto what is referred to as the "Health Portal" for documents that pre-date the electronic record. (Heavily redacted examples of some of these Forms / Documents can be found in Appendix Four) In order to utilise the data in the case records to accurately respond to the research question the different forms and documents which described the period leading up to the admission were read in order to gain and initial understanding of the "story" of the admission from the different data sources and to see if there were any common points in peoples' admission stories which would lead to an understanding of the decision-making in relation to

the admission. A short vignette of each persons' admission story was completed in a "Word" document. Although gaining an overall impression of the stories inherent in the admission was the purpose of this preliminary exercise, aspects of behaviours or the situation of the person were jotted down on paper and five bar gates used to begin to scope any common factors. The overall headline typical to all the admission stories was that the assessing professional had reached the decision that levels of risk were too high for the person to remain in their community.

Having reviewed the different forms and documents in the case record it became possible to identify different sources and types of information. The forms have been designed to be able to easily report on key performance indicators (which tend to be quantitative elements which the clinical system needs to determine are present), which appear as mandatory fields in the forms and do not allow the professional to continue to complete the form if these are not present. These are supplemented by "free text" boxes which allow for more descriptive or opinion-based information. The Progress Notes are different to this as they are the ongoing contemporaneous case notes and do not contain any mandatory fields.

After completing the vignettes, it became apparent that the information fell into different categories or concerned different subject matter, and a preliminary spreadsheet was designed to collate a database that could be manipulated. Initially, data were added in the order they appeared in the forms (looking at the different parts of the case record / forms in accordance with the most current or last to be completed). Quantitative and qualitative data were collected at the same time or concurrently as this was how they appeared in the case records, and the data were independent of each other at this point (although they were triangulated later) by Cresswell's (2007) triangulation or embedded mixed method approach. The data yielded and added to the spreadsheet at this point contained the following content: risk scores; descriptions of behaviours including issues such as substance use; numbers of admissions, length of stay; Mental Health Act Sections; relapse patterns; what relationships the person

had and who they were with; things people did such as accessing local communities and their strengths and protective factors and the aspirations of the person. . Data was not available concerning all these aspects for all the people in the study cohort, but it was collated where it was present.

As part of collating this data it became apparent that the information could be grouped into categories, which were historical information and included risk levels, description of risk, admissions to psychiatric hospitals and whether these were under the Mental Health Act or not; length of stay, diagnosis, co-morbidities and information about relapse; what the person said they wanted; relationships the person had including frequency of contact and the value of such relationships to the person; and what the person did e.g. interests, hobbies, and how they access communities outside of the care facility (these gave a sense of 'personhood' and what constituted the individual's unique personality). Completing this element of the data collection enriched the headline of the admission story that risk led to admission, but also began to provide a more detailed familiar storyline along the lines that working-age people with mental health needs who exhibit behaviour which is deemed to exceed a certain level of risk (in terms of frequency, severity and / or duration) require protection. This protection constitutes use of scarce ad hoc resource which becomes unsustainable so that professionals need to secure permanent support for this study cohort. The way professionals do this is congruent with a person and strength-based approach. The data collection had thus begun to form the basis for the data analysis and the coding processes, which will be examined further in the data analysis section below.

Selection of Data and Design (With Rationale for Use of Secondary Data)

This section of the thesis will be concerned with the use of secondary data. The central justification for use of this secondary data is to protect the interests of the study cohort. Wood et al (2003) indicate that people's memories of psychotic episodes are severely impaired (especially at the time of crisis, and other sources (Green 1996; Green et al 2000; Carrion et al 2011).

As we will see, the sample group includes all working-age people currently placed in mental health registered nursing or residential Care (as defined by CQC) who were placed there by a particular NHS Trust, thus it is possible that for some people admission took place over 47 years ago so relying on recollections of people in interviews, surveys or focus groups would not be trustworthy, and it would not be possible to retrospectively observe this. Yee and Niemeier (1996) argue that, as well as the convenience and appropriateness, this data is pre-existing and accessible it is useful for longitudinal studies as it is a contemporaneous record of events. Boslaugh's (2007) caution that the data may not be accurate or complete was mitigated to some extent by NHS data and record keeping standards, although there were some older records which had been scanned onto the system which were not legible or clearly recorded (these were not significant in number). The ultimate rationale for the utilisation of secondary data related to the people it concerned and their relationships. To gain primary information from staff (even where they were still in post and could remember the events) would call into question their professional judgement, where they had already been through stringent funding panels which ultimately resulted in oversight by senior leaders who signed off the care packages for long-term care. This was not conducive to relations with staff, or to the more universal / societal as opposed to the individual understanding of the phenomena under investigation. There was also concern about the potential for bias in primary data, shared by Cohen et al (2007 p150), whereby there could

be an unconscious tendency to include questions or topic areas which supported the preconceived notions of the researcher.

Lin et al 2022) indicate that psychotic disorders are associated with reduced levels of cognitive functioning in people with psychotic disorders. This is relevant in that there is evidence that psychiatric admissions, and especially longer-term admissions (although this is specific to hospital settings) are most prevalently associated with a diagnosis of psychotic illness (Thompson et al 2004; Tulloch et al 2008; Langdon et al 2001; Zhang et al 2015). These two factors are associated and compounded by the acuity of illness of people admitted (Thompson et al 2004; Kirkbride et al 2012; McCrone and Phelan 1994) which indicate that people's cognition and recollection is severely compromised at the time of admission when they are in crisis and incredibly psychologically vulnerable.

On a human level for the person being admitted, it is also vital to consider the extreme trauma experienced during a psychiatric hospital admission, with Tessier et al (2017) arguing that repeated patterns of disengagement and compulsory admission lead to a cyclical reduction of compliance with treatment regimes. Lecomte et al (2008) indicate that this is exacerbated as it is often linked to childhood trauma and lifelong attachment issues. Kaltiala-Heinio et al (1997) consider the dichotomy in values between the person with mental health needs who places primary value on their liberty and self-determination, and the professional who prioritises risk reduction and good mental health through compulsory treatment and pose the question as to whether this results in future lack of compliance and enhances risk of psychological distress. Thus, eliciting primary data where people do not necessarily have capacity to give informed consent to the impact of any memories, they do have being relived would be ethically questionable.

Information elicited in the literature review indicates that long-term care does not have positive effects for individuals and that this causes outcomes to deteriorate in the longer term.

(Grabowski et al 2010 ; Nakram 2015 ; Zhang et al 2016 ; Rysinka et al 2019 ; Martensson et al 2014 ; Samartiz and Talias 2019 ; Raes et al 2020). Most of the people in this study cohort foresee the rest of their lives in these settings, with less-than-optimal outcomes, so approaching them or the staff who placed them in these settings is not conducive to their wellbeing or to the prospect of obtaining trustworthy data. Consequently it is deemed that the use of secondary data which is readily available to the researcher, and which is appropriate as it necessarily complies with required data standards is justified in this study due to the nature of the interactions and data it contains, and to the jeopardy of the recollection, vulnerability and mental capacity of the study cohort primarily, and also to the sensibilities of staff who may have felt they had no alternative to this course of action due to the person's presenting needs and risks at the time. It is also necessary to be mindful that the researcher has a managerial working relationship with the staff and could potentially have contact with the potential study cohort as a practicing AMHP, which could present conflicts of interest. Also, the very nature of the study was to analyse the content of the case record in the context of admissions of working-age people with mental health needs to long-term care, and as Berg (2007) states this can be constrained around the pre-determined questions or subject areas in primary data. Having determined the nature of the data to be collected, the study will move on to consider the research design methodology.

Theoretical Sampling

It is recognised that theoretical sampling is mentioned above in the methodology section, which was in connection with the methodological principles of the theoretical sampling; this section will focus upon the procedure of theoretical sampling, which took place in practice. The theoretical sampling process begins with initial data collection and analysis (Glaser 1978) and this chapter will continue to examine how this occurs in this data analysis. Charmaz (2006) identifies that this type of inductive approach emerges after data collection begins, meaning that the researcher cannot predict the relevance of the different data in advance. This is why in this study, the data in all 72 cases which met the inclusion and exclusion criteria were analysed as the researcher could not be assured that new confirming or confounding data

would be found in the 72nd case. However, the data were somewhat over saturated (this will be expanded upon later).

Coyne (1997) indicates that theoretical sampling provides a helpful structure to data collection and analysis, based on the need to continually collect more data. Hence, the initial stage of data collection depends largely on the subject area and should not be based on preconceived theoretical assumptions on the part of the researcher. In the case of this study, it was vital that the case notes be deconstructed into the parts of their content and that the reasons for working-age people with mental health needs entering long-term care were holistically understood historically, contextually, situationally, and socially. Oppong (2013) points out a potential disadvantage of theoretical sampling in that it is particularly onerous and time-consuming; notwithstanding this, it is the only rigorous means of interrogating all the data to derive maximum meaning from its categories and their potential relationships.

This process identified categories of variable that applied to the working-age people admitted to long-term care : risk, diagnosis, Mental Health Act Status, level of independence with travel, relapse patterns/information recorded, protective factors, aspirations, adversities, strengths, and compliance. The open codes listed were then ordered on the spreadsheet into these categories.

Ragin (1992) stipulates that there should be two main criteria for initial data collection within theoretical sampling – the general sociological perspective and identification of the problem area. In this thesis, the sociological perspective is the social construct by which we justify admission, and the problem area or area of interest is the personal, financial, and societal high cost of the admission. (Breckenridge & Jones, 2009) advocate that thematic analysis needs to incorporate the following considerations: which groups are included in the study; why the groups are selected and how the groups are selected. It is useful to apply this type of analysis to the theoretical sampling in this study to ensure it is robust. The sample group are

necessarily working-age people with mental health needs admitted to long-term care, but there are groups within this, and these have theoretical relevance to the social construct of admission; for example, the people may have differing genders, diagnoses, histories, social networks, relationships and conceptions of their mental health and treatment all of which may impact on their outcomes and generate theory in connection with the research question. (The detail of how theoretical sampling was applied to generation of this study cohort is examined below in the sampling section) This list is not exhaustive and additional aspects were identified until the data was saturated towards the end of the analysis period.

In terms of why the groups are selected Silverman and Marvasti (2008) state that these should be about population scope (descriptors and markers relating to the study cohort) and at a more conceptual level (including the more descriptive attributes of the situation) and the relationships between these with the conceptual data and the population. Sandelowski (1998) defines purposeful theoretical sampling as the selection of participants who the researcher knows to have shared knowledge or experience of particular phenomena and advocates that the researcher establishes a set of inclusion and exclusion criteria which are based upon the research question and prior knowledge of the subject area and literature, so the study will continue to examine the nuances of working-age, mental health needs and long-term care which formed these criteria.

4.7 Inclusion and Exclusion Criteria

There is a detailed analysis of the exclusion and inclusion criteria below, but the two key characteristics that define the population of interest are that the person has mental health needs and are in long-term care. Mental health needs were determined by a person being present on the caseload of a specific Mental Health Social Care Service. For the person to be deemed to be in long-term care they resided in a nursing or residential home and did so for longer than six weeks. The population of interest lived in the community prior to entry to long-

term care and may or may not have been admitted to mental health hospitals before they entered long-term care.

Inclusion Criteria

- Mental Health Diagnosis which has applied consistently for more than 5 years.
- People in mental health registered nursing or residential care (as defined by CQC) who were placed there by a specific NHS Trust, acting under Section 75 agreements from a specific local authority. This applies to people who were in such settings by a report run from the clinical system 18.10.2018 (although the people may have been admitted prior to this (in some instances decades prior).
- The age range is 18-65 years which is referred to throughout the study and in the research, question as working-age. The Exclusion Criteria below provide further detail as to the justification for this.
- People may or may not have been admitted to mental health hospitals prior to admission to long-term care.
- People subject to Sections of the Mental Health Act such as Section 117 (Entitlement to aftercare) or Section 17a (Community Treatment Order, or those who have been recalled from such a Section or had their section revoked to a Section 3) are included.

Mental Health Diagnosis for More Than 5 years

The first inclusion criterion is that people would have their diagnosis for 5 years or more. It is clearly stated that this study is not primarily concerned with diagnosis, but as the study cohort are essentially people with mental health needs, there is little alternative but to use diagnosis as the primary indicator of the presence of such needs. The research question clearly identifies that the study is concerned with “working-age people with mental health needs”. It is consequently essential to determine what this diagnosis entails as part of the inclusion criteria as those people (within the defined age group) who have severe and enduring mental health

needs. Public Health England (2018) define a group of people who have significant mental health needs as being “Severely Mentally Ill” and explains that this refers to a degree of mental illness which results in severe impairment of daily functioning. This definition as opposed to any diagnostic framework will be utilised in this study as it does not have a medical foundation but is focused on experience and application of assessment frameworks. Brown (2011) discusses the concept of social diagnosis, which is a conceptual framework characterised by the circularity of diagnosis and the way in which medical diagnosis can impact on, contribute to, and maintain social conditions such as poverty and loneliness. This study would concur with this approach and does not seek to demonstrate a linear relationship between diagnosis and life experience; it instead seeks to understand the relationship between the two concepts in wider terms. The parameter of five years has been selected as this determines that the person’s psychological distress is not transient. Keys (2002) states that five years should be evidence of a long-standing mental health diagnosis as this allows time to exclude any conditions that the person could recover from either independently or with treatment. Having established how the sample meets the *mental health needs* part of the research question, the study will now appraise how the inclusion criteria encompass the person’s living arrangements.

Another inclusion criterion is that people are placed in their current residences by staff acting on behalf of the specific Local Authority and that these people were residing in that area at the time of admission. The responsibility of the Local Authority to make such arrangements on behalf of its citizens’ is enshrined in the Care Act (2014). The rhetoric therein is somewhat confusing as language such as “maintain wellbeing” (section one) and “Preventing need for care and support” (section 2) would seem to make admission to long-term care for this cohort to nursing homes a “never event”. The CQC (Care Quality Commission) (2017) equally does not recommend nursing home care, expressing the following concerns about safety in the facilities which are deemed to require improvement or be inadequate. As of 31 May 2017, 36% of NHS and 34% of independent core services were rated as “requires improvement” for

the “safe” key line of enquiry. A further 4% of NHS core services and 5% of independent services were rated as “inadequate” in this respect. The criteria applied, and the policies and practices of staff in this area are under local governance, so any anomalies in the application of the assessment framework will be a valid finding and cannot be attributed to variations in policy or process. Having established where the study cohort will reside, the study will continue to explore the age limits imposed on the cohort.

Age (Working-age)

The age criterion entails applying lower and upper limits and the rationale for this will be explored here. The lower limit is set at 18 because this is the age of majority in the UK. Also, the Section 75 agreement in the area in which the study took place which delegates all statutory Mental Health duties from the Council to the NHS Trust, deems that adult mental health services work with people aged 18 and over. The law states (Gov.UK, 2015) that for safeguarding purposes a child is defined as anyone who has not yet reached their 18th birthday, therefore the strategy employed by the study of excluding under 18’s is demonstrably appropriate in terms of policy and practice. Practically, there were no under 18’s in the initial sample which needed to be excluded. Had there been a case which was undergoing a transition from children’s’ to adult services in the initial sample this would have been excluded as the adult services, which are within the scope of the study, would have not exclusively carried out the initial assessment. Therefore, the way the assessment framework was applied could not be reliably compared with adult services. This criterion was applied by excluding those whose date of birth in the initial data find indicated they had not reached the age of 18 on 18.10.2018. The study will continue to explore the upper age limit of the cohort and the rationale for how this is applied.

The upper age limit of the study is determined upon as 65. The National Assistance Act (1948) determined that individuals should both reach the age of 65 *and* retire to receive their pension and that this remained the case for over 60 years until the Pension Act (2011) increased this age from 65 to 68. This meant that locally services were organised into working-age and older people's services with the cut off age for the working-age services being 65 (people with dementia type illnesses would be supported by older people's services at point of diagnosis regardless of age). This has now changed as of (March 2023), and people with functional illnesses remain with working-age services regardless of their age. The data find was created prior to this change so the age of 65 is deemed as the upper limit for people to be declared as "working-age" in this study as mental health services would not have supported them at the point the data find, or analysis took place so the assessment framework would not necessarily have been applied to them in the same way.

The second reason why the upper age limit is set at 65 years old is that the nature of mental illness can change with age, which results in differences in the way the assessment framework is applied. NHS England Digital (2020) use age 65 as a recording reference for dementia (this condition is discussed in greater detail in the exclusion section below) as this is seen as a key point in the inflation of diagnostic rates. This is adopted in the study as rates of people with this diagnosis over the age of 65 will produce a different dynamic in the reasons for admission and how the homes admitted to are registered by the CQC.

Older adults (over the age of 65) are also excluded from the sample due to the nature of their illness, which may include people with dementia type illnesses which have a different presentation and onset pattern to those of working-age people's mental health needs. The incidence of dementia increases as people age, with 2 in 100 people aged 65-69 having dementia rising to 1 in 5 aged 85-89 (Alzheimer's Research UK accessed 05.04.23). They may be experiencing what has been termed as "organic mental illness". Regan (2016) indicates that the use of the term "organic" is a misnomer and was used initially to differentiate

dementia-type mental health problems from conditions such as bipolar disorder and schizophrenia. Use of the terms persists but it is now acknowledged that dementia or disease processes are not a natural or inevitable part of aging. The scope of this study does not aim to debate the merits or other of psychiatric diagnosis, but in the interests of practicability, people with dementia-type illnesses are excluded from the study group as their experiences typically (though not exclusively) occur later in life and have a different impact on the way the assessment process is applied at the point of admission. Data sets, assessment processes and funding routes change when people reach age 65 (or this was the case when the study was carried out) so rigorous data comparison could not be undertaken if they were included. Having established the inclusion criterion for area of residence and age, the study will continue to establish the characteristics of the working-age person's mental health history, in the form of their admission history, and any mental health characteristics or relapse patterns they may experience.

Mental Health Act (1983) Conditions

The inclusion of working--age people with mental health needs who have had prior admissions to psychiatric hospitals is vital as they may have conditions imposed upon them which influence how the assessment framework is applied to them. The CQC (Care Quality Commission) (2017) indicates that admissions to mental health hospitals rose by 26% between 2012/13 and 2015/16. People experiencing these admissions may be Section 117 entitled which means their aftercare will be state funded, implying that finances are a lesser factor in the decision to enter long-term care (as care will be paid for by the state rather than self-funded); others may leave hospital subject to a Community Treatment Order (Mental Health Act 1983) which may stipulate a condition on the person that they must live in the care home. These factors will inevitably impact on the way the assessment framework is applied to people and the options for their care at the point they were assessed. It is vital that these

working-age people are included in the sample group so that impacts of these conditions can be evaluated. Having detailed the rationale for the inclusion criteria the study will now continue to detail the justification for the exclusion criteria.

Exclusion Criteria

This section of the study will detail why the exclusion strategy has been applied and the rationale for each part of the exclusion criteria. Initially, the criteria are listed below, and the detail of each will be analysed subsequently.

- Young people under of 18 and older people over 65 are excluded as the recorded characteristics of their experience can be expected to differ from working-age adults. 18 is the age of majority in the UK and this therefore excludes children who have different needs and treatment arrangements, so this is set at the lower limit. NHS England Digital (2020) use age 65 as a recording reference for dementia, as this is seen as a key point in the inflation of diagnostic rates. This is adopted in this study as rates of people with this diagnosis over the age of 65 will produce a different dynamic in the reasons for admission and how the homes admitted to are registered by the CQC. At the point the data was extracted and analysed, people over 65 would have been assessed by a different service, so the assessment framework may not have been applied in the same way.
- People who do not have what is deemed to be a severe and enduring mental illness.
- People who have a primary need of Learning Disabilities
- People in a nursing or residential setting for less than six weeks. (It is a practice requirement that review of new placements takes place at the point of six-week review).
- People who are not in Nursing or Residential Care as they may not meet eligibility criteria for regular review by the Community Mental Health Team on an ongoing basis, so no comparable data exists.

- People who have a Forensic History and Ministry of Justice conditions attached to their admission. (Part 3 of the Mental Health Act (1983)).

The study will continue to explain the rationale for each part of the exclusion criteria and how this was applied when conducting the analysis. Please note that the age criterion is not discussed here, as this has taken place in the inclusion criteria section above.

Severe Mental Illness and Exclusion Criteria

This has been defined above in the Introductory Chapter, and the nature of mental health needs has been defined as constituting a Severe Mental Illness (SMI). Having established these aspects, the study will continue to address what types of illness or presentation are not included in the cohort and the reasons for this. People who have a primary dementia diagnosis, alcohol and substance use issues independent of any SMI diagnosis, or primary need of learning disability or acquired brain injury are excluded. However, these conditions are included if there is a co-existing SMI. People who have not been in the residential or nursing home for more than 6 weeks are not included as they do not meet the stipulation of "long-term care" in the research question, nor are those not in 24-hour care or in shared-living types of support.

The initial presentation that is excluded is that of dementia type illnesses. Regan (2016) defines these illnesses as damage to the structure of the brain which causes impairment and continues to state that the diagnosis is predominantly but not exclusively associated with people over 65. This study does not seek to compare the pathology of SMI and dementia but excludes these people as the way the assessment framework is applied to them in the area the study was carried out differs from that applied to working-age people. People with dementia diagnoses are seen by specific teams and are admitted to different services (both

community and nursing / residential). The diagnosis of each person identified as being in long-term care was reviewed and persons with a dementia diagnosis were excluded.

People who have a sole presentation of substance use are excluded from the study. This is because the issues they experience are not due to *a mental health need,* which is a clearly stated characteristic within the research question. However, it is recognised that a significant number of people do use substances (alcohol included) to mitigate the effects of the psychological distress they experience. This is termed as dual diagnosis and is defined as follows: Viggars et al (2015) typify this as the constant or intermittent presence of substance use and mental illness in one person. A recent study has estimated that the prevalence of dual diagnosis in secondary mental health services is 20-37% (Carra and Johnson 2009), so these numbers are significant and those people with dual diagnosis are included in the study as to exclude them would be to reduce the cohort significantly based on behaviours which may have been undertaken to alleviate mental health needs. This exclusion was applied by checking the diagnoses in the original data and excluding those who do not have a clear mental health diagnosis and history.

People who have a primary need of learning disability, according to the clinical system, are also excluded from the study. Learning Disabilities are defined by NHS Digital (2020) as an inability to grasp or retain knowledge which started in early life. Again, these people are also excluded as the research question clearly states that the research cohort should have mental health needs. However, as was the case with substance use, learning disabilities can co-exist alongside mental health needs. Bernal and Hollins (1995) carried out a literature review which indicated that people with learning disabilities have a higher likelihood of a co-existing mental health diagnosis. They did not assign a categorical probability or incidence rate to this, as the rates varied widely across areas and settings. Where the record indicates that there may be such co-existing diagnoses, the judgement of the multi-disciplinary team as to the person's

primary need was utilised and those that are not “mental health” have been excluded. This is felt to be reliable as the same teams and individuals in the area where the study took place have applied consistent eligibility criteria to individuals which has led to the primary need being established.

The thesis has also excluded people who have a primary need of brain injury as defined within the clinical system. This is deemed reliable as eligibility criteria have been applied consistently in the same manner as with the Learning Disability criteria. The Headway Factsheet (2016) distinguishes between the two by stating that to be diagnosed with a mental health condition, a person will display symptoms defined by manuals such as the American Psychiatric Association (2013) Diagnostic and Statistical Manual of Mental Health Disorders (DSM-5) (American Psychiatric Association,) in contrast, people with a brain injury will have experienced a catastrophic event which led to reduced functioning. Again, the distinction between mental illness and this presentation is not clear cut as the two conditions commonly co-exist, and as Rogers and Read (2007) point out, people who have a brain injury are more prone to severe, long-term psychiatric disturbances, including personality change, post-traumatic stress disorder, anxiety, mania, psychosis, and depression, so it was important to apply the criteria as defined within the clinical system.

Having established the characteristics or presentation of people which led to exclusion, it is next necessary to outline the rationale by which people are excluded because of their living or care arrangements.

The first exclusion is people who have been in their residence for less than 6 weeks. The research question does specify “long-term care”, and it is accepted that the 6-week point is the point at which the first review is undertaken, and determines that the placement is suitable for the person. The Care Act (2014) states that any period of additional support or “re-

enablement" lasts up to 6 weeks and that this is the point at which The Local Authority have a duty to review to see if the person has returned to independent functioning or whether they will need more permanent and long-term support arrangements. The assessment framework is applied in this way in the area where the study took place, so it was possible to exclude those who have been in residence for less than 6 weeks by scrutinising the record and excluding those who did not meet the criteria. Having established how long the person will have resided in the home, the study will continue to determine what sort of support they will be receiving.

Consequently, the penultimate exclusion criteria applied to people receiving support in their own home. Policymakers have outlined their ambitions to provide joined-up care closer to home and enable people to remain independent in their own homes (NHS England et al 2014a Five Year Forward View for Mental Health; 2014b; NHS Long-term Plan.) Whilst the potential benefits of this model of care delivery are recognised, people receiving this type of support have been excluded from the thesis by not adding this model of service provision to the parameters of the original search. These people have not been removed from their communities; therefore, the impact of their support is not the same as for people who are admitted to larger-scale support environments. People living in supported living arrangements, who have tenancies and are supported by family units are also excluded in this way per the stipulation in the inclusion criteria that the cohort should reside in CQC Registered nursing or residential care.

The final condition regarding residence which would lead to people being excluded from the study cohort is applied to those who are detained under part three of the Mental Health Act (1983). This part of the Mental Health Act concerns people who are involved in criminal proceedings or under sentence. The Mental Health Act Code of Practice (2015, paragraph 22.25) states that these people will typically be housed in secure hospitals as opposed to long-term care. These individuals are excluded as certain restrictions would have been placed

upon their residence or lifestyle. Restrictions are placed on them by the Ministry of Justice or the court, not as part of the assessment framework as it is applied to other people. This cohort are excluded by examining mental health history in the clinical record and discounting those who have a Section which comes under Part 3 of the Mental Health Act.

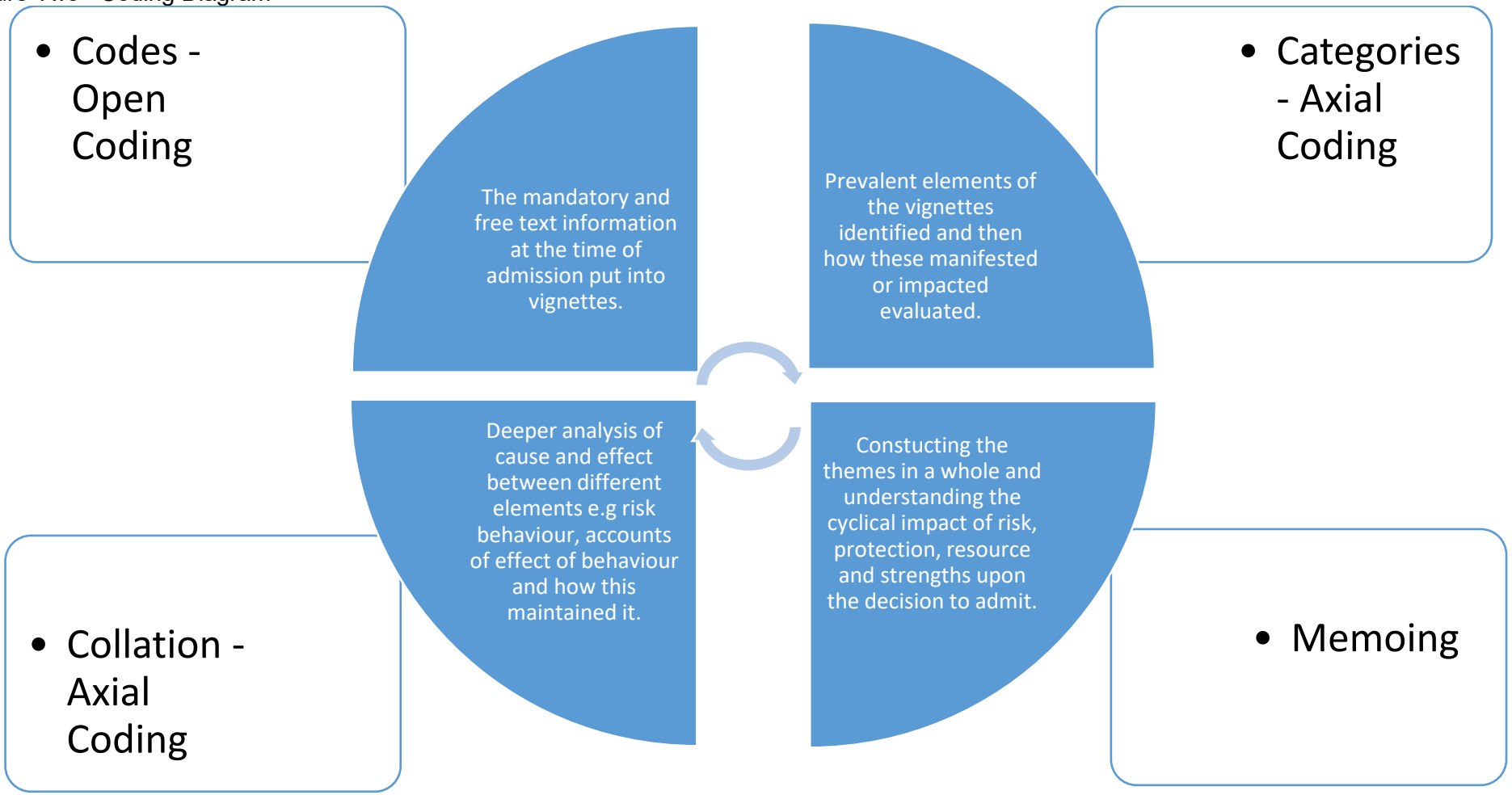
People who are not ordinarily residents of the area in which the study took place are also excluded, as our service would not provide them with support , as this would come from their own area of residence.

This section of the study has clearly defined the parameters of the research. Consequently, it has been detailed to meet the necessary standards of transparency, which is emphasized by Meline (2006). He indicates some of the features identified in this thesis as appropriate inclusion/exclusion criteria, including age, diagnosis, location and living conditions. Platino and Ferreira (2018) stress the importance of ensuring that the inclusion and exclusion criteria are intrinsically linked to the research question. This is why all elements of the inclusion and exclusion criteria are designed to determine whether a person has a mental health need and is living in long-term care. One of the most challenging aspects of designing the inclusion and exclusion criteria for this study is the cohort has the potential to have co-existing conditions, and it has been necessary to state which will take precedence and lead to inclusion or exclusion. Porzsolt (2018) discusses that defining inclusion and exclusion criteria is challenging in clinical trials with human subjects with complex characteristics. They advise that a standard approach must be taken and adhered to – a principle which has been utilized within this study. Having established the exclusion and inclusion criteria the thesis will continue to examine the data and its analysis.

4.8 Data Analysis

Data analysis has been referred to as part of the methodology to justify the appropriateness of its application to the study matter. The section will emphasise the practical application of the method which will commence with the practical application of the coding.

Figure Two– Coding Diagram



Coding

Allan (2003) argues that Grounded theory involves the application of inductive reasoning, in which ideas and concepts emerge from the analysis of the qualitative and quantitative data To evaluate how this was achieved, this section of the chapter will detail the practical methods used in the conduct of analysis. The method is primarily derived from Strauss and Corbin's (1967) version of Grounded theory, which employs open, axial, and selective coding, followed by memoing.

Open Coding

Initially the data was coded in an open manner to organise the data. The content was already and naturally organised to some extent as the case record is divided into sections with specific content; these are as follows: the contemporaneous progress notes (day-to-day recording), assessments, care plans; review; risk assessments, clinic letters, Mental Health Act documents, safeguarding information, and financial information. (This list is not exhaustive as some people had incidental information, such as historical items scanned onto the case note, which originated prior to the advent of the electronic record.) Within these categories there were 51 potential pre-populated mandatory fields which could potentially apply to individuals who were identified as the open codes. Adu (2019 a) refers to such processes as compiling codes or determining what the data's content reveals in relation to the research question. Glaser (2016) refers to this as line-by-line open coding and advocates it instead of commencing with a set of preconceived codes on the basis that… "Many descriptions emerge when coding data line by line. They are attached to nothing until a pattern emerges, so many can occur. But as soon as a pattern emerges, excessing descriptions should stop as only a few are needed to illustrate the emerging concept and its properties" (p.109). Initially these

open codes were listed on an Excel spreadsheet in preparation for devising a schema by which to organise them. Thus, the open coding comprised of deconstructing the case record into the sum of its parts and determining which information could be found in the risk assessment and progress notes, the front sheet and demographics, the care plan and review, and the historical and portal information and in collating this information into a short story of the admission combining mandatory quantitative information and free text qualitative information into vignettes rather than this being split into the categories dictated by the forms.

Axial Coding

Data had previously been separated into separate sections via the open coding process. This was organised into clear categories as recommended by Noble and Mitchell (2016) to add depth and structure to existing categories (Charmaz 2006). Thus, the axial element commenced, which aimed to code the narrative in the case record as to what was happening at the time of admission on the basis that the events leading to the admission would be the reason or cause for it. A good example of this is the risk levels assigned to each person as part of the Manchester Patient Safety Framework (MaPsAF) (Parker et al 2006). (More details about MapSaF and results of the coding are detailed in the Findings Chapter.) It became clear from this element that levels and different types of risk were an element in the decision-making process, as was the viability of mitigating this risk. This revealed a variety of circumstances, either risk that was increasing, risk that was of immediate concern and needed intervention, or there was a longer-term risk for which, at the time of admission, it was deemed that no mitigating strategy could be effective in assuaging the risk concerned.

This process identified categories of variables which applied to the working-age people admitted to long-term care. Examples of which were: risk, diagnosis, Mental Health Act Status, level of independence with travel, relapse patterns/information recorded, strengths or

protective factors, aspirations, adversities, co-production, and compliance and identified that these were all potential factors influencing the admission. Again, this combined both qualitative and quantitative information, for example, the risk level indicators, which were quantitative, were analysed in conjunction with descriptions of risk behaviour and diagnosis of schizophrenia was considered in terms of frequency, but this was analysed with descriptive information about what was recorded about possible functions of behaviours by professionals. This element of the process involved determining what elements of the vignettes were significantly common in terms of prevalence and then understanding their nature/meaning for the decision-making process from the descriptive elements of the case records.

Selective Coding

This element of the coding is carried out in accordance with Williams and Moser's (2019) approach to Selective Coding, which has the outcome of reducing a range of categories (optimally up to 20 – 11 in this study) to themes (optimally up to 7 – 4 in this case) which enables a dynamic and cyclical approach to analysis which incorporates constant comparison. In this case, the common variables associated with admission listed above were then viewed in terms of how they contributed or fed into each other. By selectively coding groups of variables and grouping those that influenced each other it was possible to identify themes.

This was achieved by comparing and triangulating key events and variables highlighted in the categories (quantitative data) with qualitative data recorded around the point of these instances. This was a more in-depth analysis and provided information about the holistic scenario and the recorded interaction concerning it. This was how the social processes inherent in the decision to admit were mixed so that there was risk level and prevalence from a quantitative perspective but then also further descriptive elements in the case record (e.g. risk behaviour function) entailed analysing how the assessing professional described the

behaviour and the outcome this behaviour achieved. This analysis was then developed further to determine the function of the behaviour for the person. For example, when a person responded violently to staff prompting them to perform personal hygiene tasks, and this then led the staff to desist from prompting the discourse indicated that the function of the behaviour was avoidance. The prevalence of avoidant behaviour is reported in the findings, but this is derived from descriptive material in the case record. This was not a simple linear reporting of frequency but was the beginning of an appreciation of the cyclical and co-incidental relationships between the themes of risk, protection, resource and strengths, which will be clarified in the Findings Chapter as there is clear indication that the themes co-exist.

Memoing

Memoing then took place on a case-by-case basis. This was a very reflective process. It aimed to reconstruct the information which had been deconstructed in the coding process and to look at information "in the round". This element contained a further two approaches to grounded theory. The inquiry around the source of the information was founded in constructive grounded theory which focuses on the impact the beliefs and experiences of the researcher and participants have upon the findings (Charmaz, 2006). As part of this constructivist approach, it felt essential to determine whose thoughts had been recorded in the case record, and who interactions took place between. It was also necessary to analyse the data on a person-by-person basis with an emphasis on description and the perceived importance of events, as opposed to identification of common or divergent variables, in accordance with the discourse grounded theory approaches. This differed from the original process of the vignettes (although they were referred to in this stage) essentially the purpose of the vignettes was asking "why the person was admitted" in terms of the events leading up to the admission, but the memoing was also interrogating the factors impacting on decision making. The grounded theory in the previous coding stages was built upon the identification of the separate themes of risk,

protection, resource and strengths as separate entities and memoing supplemented this by taking a social constructivist approach to the complex relationship between the themes. From this, the early stages of the generation of theory were able to be constructed from the relationship between untenable risk, the unpredictable / and or intensive need to provide protection, the scarce resource this demanded and the need to protect the strengths of the person within this. A constructivist approach was used to explore these relationships and how each theme impacted so that the cyclical impacts of each theme on the other could be understood.

The researcher also recorded any entries in the record which appeared particularly relevant or poignant to decision-making leading to the admission. One example of this is that a person said “I could not feel more lonely” following their admission to long-term care. This also included reflections on contact the person had with people or observations about the process. Practically, the memoing process entailed using a word art diagram (please see example in Appendix One) for each of the 72 people in the study cohort to visually memo their admission to long-term care and to enter observations about them. This continued “splitting down” of the themes and codes (in terms of risk level, behaviours, previous history, and protective and damaging factors) formed the analytical aspect of the memoing process, enabling the researcher to identify “themes within themes” which began to reveal the relationships between codes and themes and potential linkage between them which constituted the analytical part of the memoing process.

During the procedural memoing process, it was acutely apparent that the story of the working-age person with mental health needs was an account of the decision-making around why they needed to be in long-term care and highlighted a series of events and interactions between the person and professional in which the latter cannot reach levels of assurance about the viability of the person continuing to reside in their communities which ultimately leads to necessity for admission. The memoing process facilitated verification of identified themes as

being relevant from the perspective of the deconstructed variables but also in their causal application to the individual's admission and highlighted that all the themes co-existed when people were admitted as opposed to there being a commonality or frequency to the themes being present, all of the themes exist in common and impact upon one another.

Theoretical Saturation

As with many of the fundamental principles of grounded theory, the notion of theoretical saturation was originated by Glaser and Strauss (1967 p.11), and they describe it as the point where research into a particular area is concluded as sufficient insights have been reached, and further research is unlikely to generate any further theory. In this thesis, 72 cases met the sampling criteria, and no new information became apparent after around halfway through the data analysis (some additional nuances were identified up to this point in the memoing but not in the open or axial coding). Many authors, including Urquhart (2013), Given (2016) and Birks and Mills (2015), indicate that where no new codes or themes are emerging, then the data is saturated. However, as the author could not be assured that if they continued to the 71st case, something new would not emerge in the 72nd, all the cases were analysed. This was in accordance with Starks and Trinidad's (2007) assertion that it is not possible to be assured that saturation has occurred without analysing all the data. Thus, the entire 72 cases were analysed because of a reluctance to end the analysis due to a commitment to apply sufficient rigour to the analysis to ensure that no new data may emerge. This may, on reflection, have been a little overcautious.

4.9 Methodological Trustworthiness

A full account of the potential limitations of the study appears in the Discussion Chapter, as the author wanted to fully explore the overall limitations of the entire research considering the

findings, which could not be done until the point of discussion, but potential bias arising purely from the methodology will be considered here. Lincoln and Guba (1985) outline 4-part rigour criteria by which to identify methodological bias, and these will be applied in turn to this methodology to determine its trustworthiness.

- **Credibility –** The data is credible as it is the written account of the professional at the time of admission and at subsequent review. The recording has been made in accordance with organisational policy and professional standards.
- **Confirmability**– The methodology is dependable as it is repeatable, the record of the assessment framework is data which remain available and the way in which the researcher applied the research tool was tested by colleagues also applying this as part of the audit process and there was no significant difference in outcomes.
- **Dependability** – The study could be repeated with the same research tool and data, the research tool is clearly stated, and the data analysis meticulously recorded to enable review and tracking of the process.
- **Transferability** - This study was limited to the study participants due to constraints of ethical access to data. This may provide some limitations in terms of demographics, as this area will be different to others, limiting transferability, although it is not possible to establish how significant the limits to transferability would be or how these would impact in different areas / situations. This potential, however, is recognised within the study, and this research is centric to the area in which it took place. However, Shenton (2004) warns against assumptions that research is not transferrable when this has not been tested, determining that as most research cannot necessarily be universal, it is adequate to clearly state the boundaries of the study so that the reader can draw their own conclusions about transferability. There is the opportunity for the research to be replicated in other areas. Since January 2021 the researcher has access to data for an adjoining area, so this could be tested if required.

Another potential challenge to the trustworthiness of the study is that it is primarily carried out by the author and therefore could be subject to the bias of personal views or opinion. To mitigate this, a phenomenological approach was taken to the study's design, with a very structured coding process applied to each case and variable (albeit from the constructivist ontology based on the researcher's experience/perception/philosophy). This approach was very much in keeping with Nathanson's (1973) view of phenomenology as a description of phenomena in the context of their environment and the actor within interactions. Thus, an existential approach is taken to study elements of free choice and/or action within the situation of admission to long-term care (both for the assessor and the assessed). Conversely, the reliance on a single researcher could be viewed as a positive aspect in that their interpretation of the data will be uniform throughout the study to ensure that trustworthiness is also clear in regarding the data collection positionality, which will be specifically considered below.

4.10 Positionality

There is a detailed section on positionality in the Conclusion and Recommendations Chapter as it applies to the overall thesis, but due to the unique relationship of the researcher to the data and the impact of this on the method and methodology added value can be added by exploring this here. Holmes (2020) indicates that the way in which positionality impacts how the research is carried out arising from certain characteristics of the researcher, which will be explored in turn below:

Researcher Identity. The researcher is a manager of the service that has generated the data. This means that they have been party to designing the processes, supervising the workers, and financially approving admission to long-term care. This was one of the reasons why staff were not interviewed, as the researcher had been complicit (either singly or as part of a senior management team) in the decision-making.

Roles and Perspectives. The researcher's positionality also stems from their inherent roles and perspectives; these included the need to maintain personal and staff professional accountability and credibility, which meant that it was not tenable to allow people exhibiting this level of risk to remain in the community due to the responsibility to support them. This was also not an option considering the researcher's role as an agent of the state, as the community resource the person was using was not sustainable. Finally, there was no other viable alternative to admission open to staff, and the researcher has a role in supporting them, so this also impacted upon positionality. Gani and Khan (2024) explore how these characteristics position researchers in ways that are almost tribal within their professional and organisational experiences and loyalties, and they term this 'coloniality' (in the title of the paper).

This section of the chapter has explored how the researcher's positionality has impacted upon the way the methodology and methods were arrived at and will continue to explore the ethical implications of carrying out of the study.

4.11 Ethical Review

Several intrinsic ethical issues inherent in the methodology and method of the research which will now be considered. Kjellestrom et al (2010) advocate the importance of considering the risks and benefits of research for researchers, participants and others. This required consideration in connection with this thesis as the people directly concerned had been admitted and therefore would not directly benefit, although the recommendations included recommendations for future practice that may benefit them. Due to this, secondary data was used as opposed to interviews with either staff or people admitted as decisions had been taken, some of which were in the distant past and could not be changed. Staff were also not interviewed as the relevant people may not have been available. All decisions would have been signed off by managers higher in the organisational hierarchy than the staff member from whom the decision originated. Thus, the benefits of the study were deemed to be improvements in future practice which would arise from explicit knowledge of how and why decisions were made.

In this there was an element of conflict of interest because the researcher was the manager (not direct line but part of the structure) of the decision makers, and it therefore did not feel appropriate to be interviewing them or questioning them about decisions the organisation had agreed due to the power imbalance between the individual worker and the researcher. Also, the information on which decisions were made was clearly recorded, so there was no need to do this, and for some of the older admissions the worker would have needed to refer to this to refresh their memories about the basis on which they made decisions.

Bourne (2014) concentrates on the way data should be used in large health organisations and focuses on the data sharing and data impact aspects of research methodology. In this case, the data was already available to the researcher as part of their day-to-day work, and thus, no new or additional permissions were required (HRA and IRAS approval were sought and obtained). The confidentiality policies of the host organisation were also adhered to throughout the conduct of the research.

Drolet et al (2023) emphasise the importance from an ethical perspective of the honesty and integrity of the research. This includes avoiding plagiarism and being honest, accurate and objective. It was felt this was achieved in this thesis as the method and methodology was faithful to the data, and theory arose specifically from this. The thesis was also demonstrably objective as, working in the field for a considerable amount of time, the researcher had assumed that admission was an ending. This was proved not to be the case as the admission was the start of a new chapter in which the assessing professional strove to maintain the person's strengths in their new setting. Having explored the ethical implications of the method and methodology the chapter will end with a conclusion.

4.12 Conclusion – Methodology and Method

This chapter has been structured around the distinction between the method and methodology and has focussed on how the methodology forms the basis of and rationale for the method.

This has been achieved by first identifying how the mixed method research strategy, which was detailed to be a partially mixed, concurrent, schema, was couched in a constructivist ontological and interpretivist epistemological position. The data is the person's record, and the justification for the use of this form of data is the avoidance of tainting questionnaires or interviews with assumptions made by the researcher and of using appropriate secondary data which would not impact upon the study cohort or the staff group supporting them, by over-reliance on recollection of potentially distressing situations. Grounded theory was determined on as the method of knowledge and theory generation as this was the methodology most steeped in generating theory from the data appropriate to the research question. This methodology and method were particularly relevant as there is no significant previously existing body of knowledge on the topic area, so emphasis on the data is key to providing new knowledge as this cannot be achieved by comparison with previous work.

The methods section of the chapter analysed the process and practice of the study, detailing the sample generation and the theoretical sampling, which was used to form a cogent means of organising the data via the coding process, which led to the identification of themes and was followed by the memoing process. This memoing allowed for a reconstruction of the data and an acknowledgement that its essence was the justification for admission and aligned this to the complex relationships between power and protection, risk and resource whilst acknowledging and maintaining strengths and protective factors.

Having established that the study's methodology has informed and structured the methods employed, explored the potential limitations to trustworthiness (these will be further explored within the Discussion Chapter) the study will now continue to display the findings.

5.0– FINDINGS CHAPTER

5.1 Introduction

This findings section is structured around the themes which were identified via the data analysis, which are: high risk behaviours, the protection and restriction provided and experienced, the high resource used prior to admission and the support provided via long-term care, and the protective factors which people have to maintain their psychological wellbeing, both independently and as a by-product of admission to long-term care. These themes were the converging factors which were associated with the admission of working-age people with mental health needs to long-term care. These central themes are illustrated below. The decision-making is viewed in contrast with the way in which we expect people to behave in general society, it is an expectation that others do not exhibit high risk behaviours and do not require protection or restriction and that they will not consume large volumes of health care resource. The first three themes explore the need to compel and the lack of a shared understanding or reality and the absence of meaningful assurance that the person will be safe without inputting resource, protection, and restriction to reduce risk. The final theme considers the person's protective factors and inbuilt resilience. and it shows some convergence in thinking and shared reality but also highlights that this is limited and difficult to achieve.

The chapter will commence by orienting the reader to the findings by examining the sample characteristics. McAlpine and Mechanic (2000) carried out a study into how such demographics impact upon uptake of mental health services and found that, as with this study, people with severe mental illness tend to have psychotic illnesses, be male and be approaching or be middle-aged, these characteristics are well recorded and defined and as such have clearer parameters of reality than characteristics such as risk and behaviour, but it is deemed worthwhile to analyse them to determine whether these characteristics impact on each other in any way. This study was something of an outlier in terms of ethnicity. McAlpine and Mechanic (2000) find in common with Burnham and Young (1996), Garb (1997), and

Howard et al (1996) that people with mental health needs tend to be Afro-Caribbean or African, this is not the case in the study area as the demographic is different to the national picture, with comparatively low numbers of people from ethnic minorities (****Redacted*****County Council Evidence Base, 2019). The Findings Chapter will continue to evaluate the diagnosis and personal characteristics of the study cohort and to identify the correlation (if any) these have with the decision to admit them to long-term care.

Sample Characteristics

This part of the chapter will focus on characteristics of the person which may or may not impact on the likelihood of their admission to long-term care. This is in contrast with other sections of the chapter as rather than focus on characteristics which may make people more prone to admission (i.e. behaviours and diagnosis), this segment of the chapter will determine whether this group of characteristics contributes to the likelihood of admission or not. These characteristics will include age, ethnicity, gender, and sexuality.

Gender and Sexuality

Most of the study cohort is male as is illustrated in the table by below which shows the commonality of male gender and admission of working-age people with mental health needs to long-term care.

Table Three - Gender

Gender	Number
Male	51/72 (71%)
Female	21/72 (29%)

Total =72

Quantitative Prevalence Data from demographics screen.

Ethnicity

The second consideration in the demographics section of the Findings Chapter is concerned with ethnicity. The prevalent ethnic group in this study is White British. In the (2019) **** Redacted****Evidence Base: Population Demographics and Adult Social Care Needs Webpage states that: “Overall there is little ethnic diversity across *****Redacted*****with the population being predominantly White Data from the 2011 Census suggests that local concentrations of minority ethnic population are mainly within ****area redacted*****, with the single largest minority group in these areas being Pakistani so the characteristics of the study group mirror the demographic which is prevalent throughout the county, there is a tiny prevalence of Pakistani and White Irish people, but this is so small it can hardly be considered a meaningful finding. Table Four below shows the commonality of different ethnicities within the study cohort. The categories in the case record “mixed race” and “dual heritage” could be considered an anomaly (hence the? which follows them) as it is not clear how the assessing professional would have assigned these other than by asking the person.

Table Four - Ethnicity

Ethnicity	Number
Asian Indian	1/72 (1%)
Asian Pakistani	2/72 (3%)
Asian Nepalese	1/72 (1%)
Black Caribbean	1/72 (1%)
Dual Heritage?	1/72 (1%)
Irish / Turkish Kurd	1/72 (1%)
Mixed Race?	1/72 (1%)
White British	61/72 (85%)
White European	1/72 (1%)
White Irish	2/72 (3%)

Total =72

Quantitative Prevalence Data from demographics screen.

Age

Table Five below shows that comparatively lower rates of younger working-age people with mental health needs are admitted to long-term care than older working age people with mental health needs. This is encouraging as the incidence of admission for this group seems to be smaller, which is hopefully an indication that other alternatives than admission to long-term care are utilised where these are available.

Table Five- Age

Age	Number
18-25	1/72 (1%)
26-35	10/72 (14%)
36-45	18/72 (25%)
46-55	18/72 (25%)
56-64	25/72 (35%)

Total=72

Quantitative Prevalence Data from demographics screen

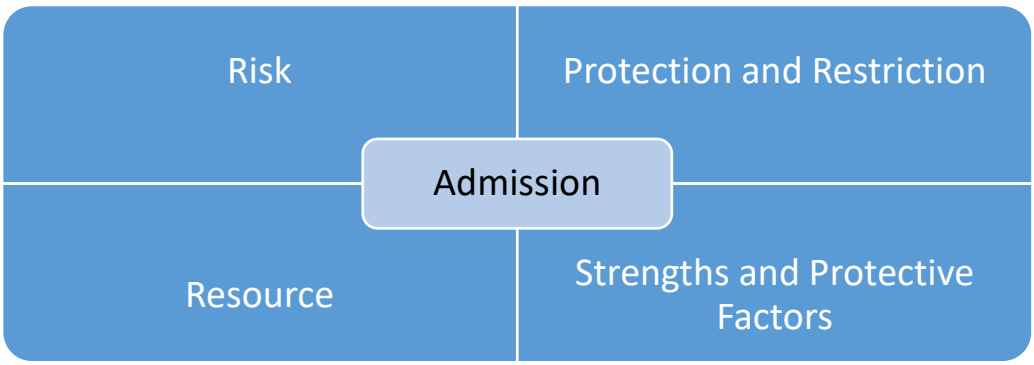
In conclusion, there is nothing in the findings of exception; the gender, ethnicity, and age of the study cohort are congruent with existing research and with the demographic of the study area.

5.2 Main Themes

Tie et al (2019) advocate the use of systematically organised themes, sub- themes, and, where appropriate sub-sub-themes, and this approach has been adopted within this Findings Chapter. The first theme to be considered is risk.

The main risk themes identified in the findings (Figure Three) contain sub-themes concerning the types of risk behaviour, the functions of these behaviours, which are why the person persists with them despite admission to long-term care and the contingent consequences of this. This risk part of the chapter will also consider the management of this risk and how the person's diagnosis and personal characteristics will impact on this. These sub-themes then drill down to sub-sub themes as illustrated in the charts below.

Figure Three Findings Master Diagram - Themes



The theme areas comprise Findings related to quantitative and qualitative data as outlined in the mixed method methodology outlined above. Where the data comprises pre-populated fields, only quantitative data is available, but where there is complimentary qualitative free-text data available, which provides further richness to the findings, this is provided wherever possible. The themes derived from the data indicate that admission came from four main themes: risk; protection and restriction, resource, and strengths and protective factors, and from these several sub themes emerge.

Figure Four – Subtheme Risk

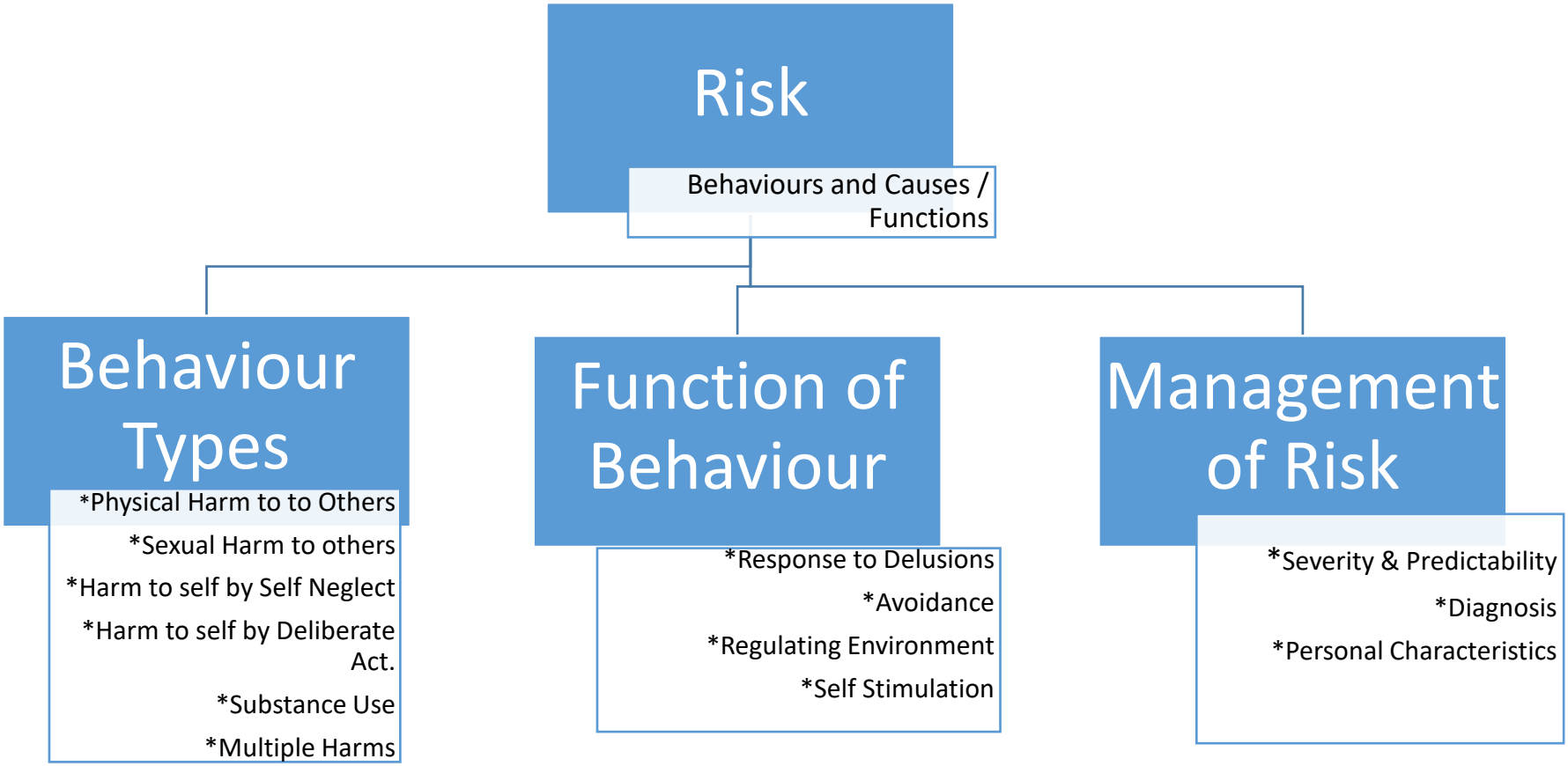
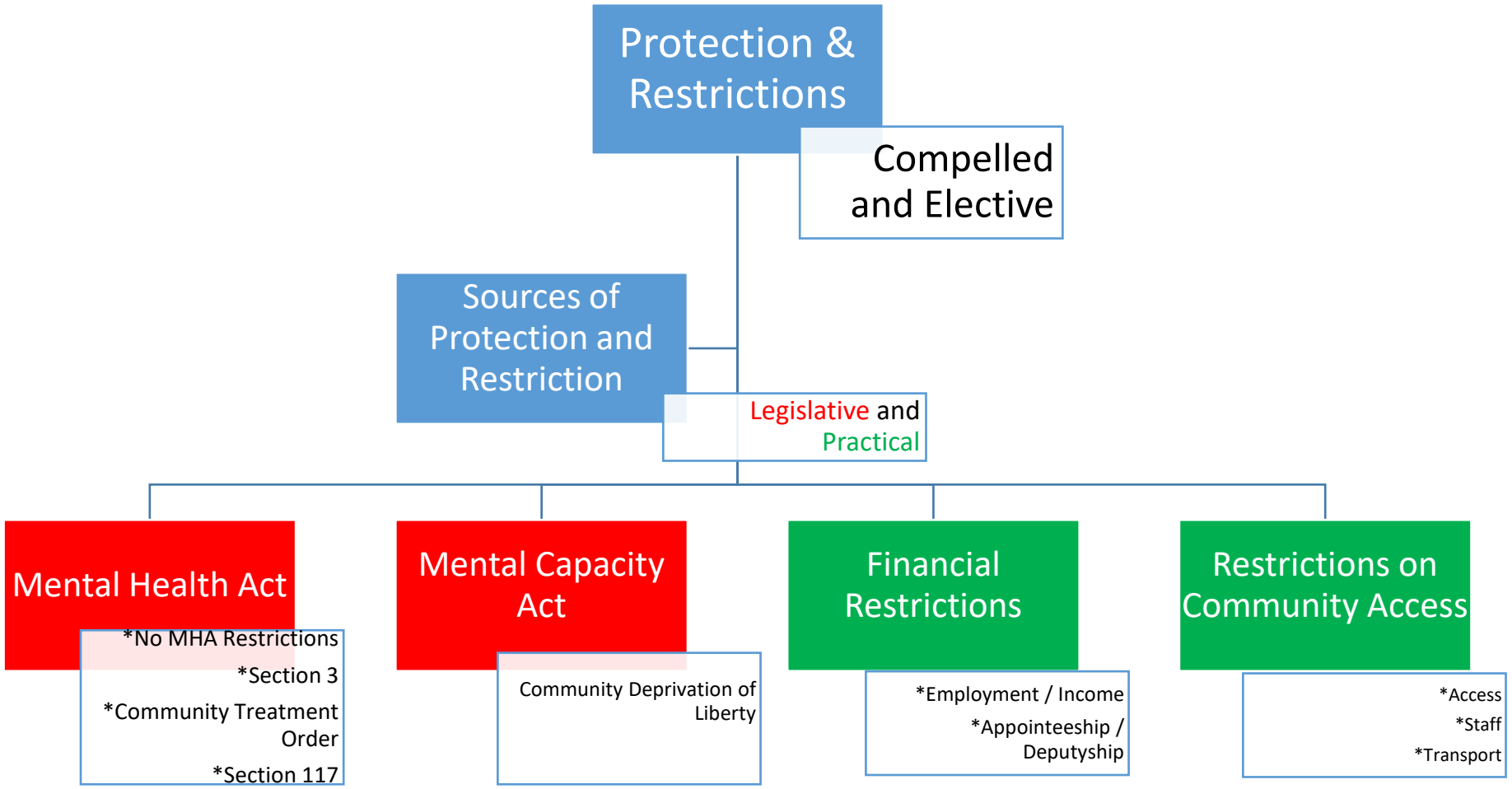


Figure Four above illustrates the subthemes which come under the main theme of risk, these include the types of risk, who they effect and their potential function or why people persist in them despite the consequence of admission to long term care.

Figure Five below illustrates the subthemes associated with the main theme of protection and restriction, which involve examination of the sources of protection and restriction as well as the legal frameworks which provide this.

Figure Five – Subtheme Protection and Restriction



This will be followed by the third identified main theme, which was that of resource and this part of the chapter considers the following sub themes: the resources the person has consumed prior to admission and what specific accommodation, care. and support the long-term care facility affords the person which is deemed to reduce their risk. These sub themes then split into the sub-sub themes illustrated in the chart below.

Figure Six below illustrates the subthemes of the main theme of resource. This is concerned with their resources prior to admission in regard to accommodation, community access and the resource they had used in respect of prior psychiatric hospital admission.

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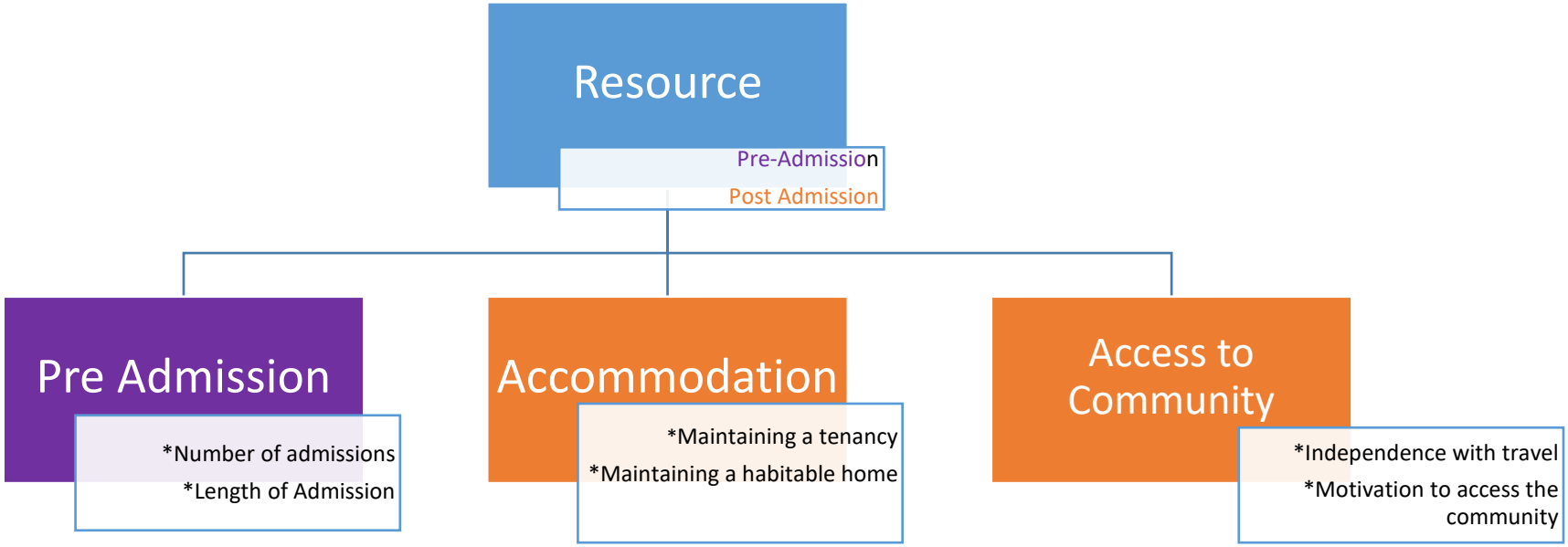
Figure Six – Subtheme Resource

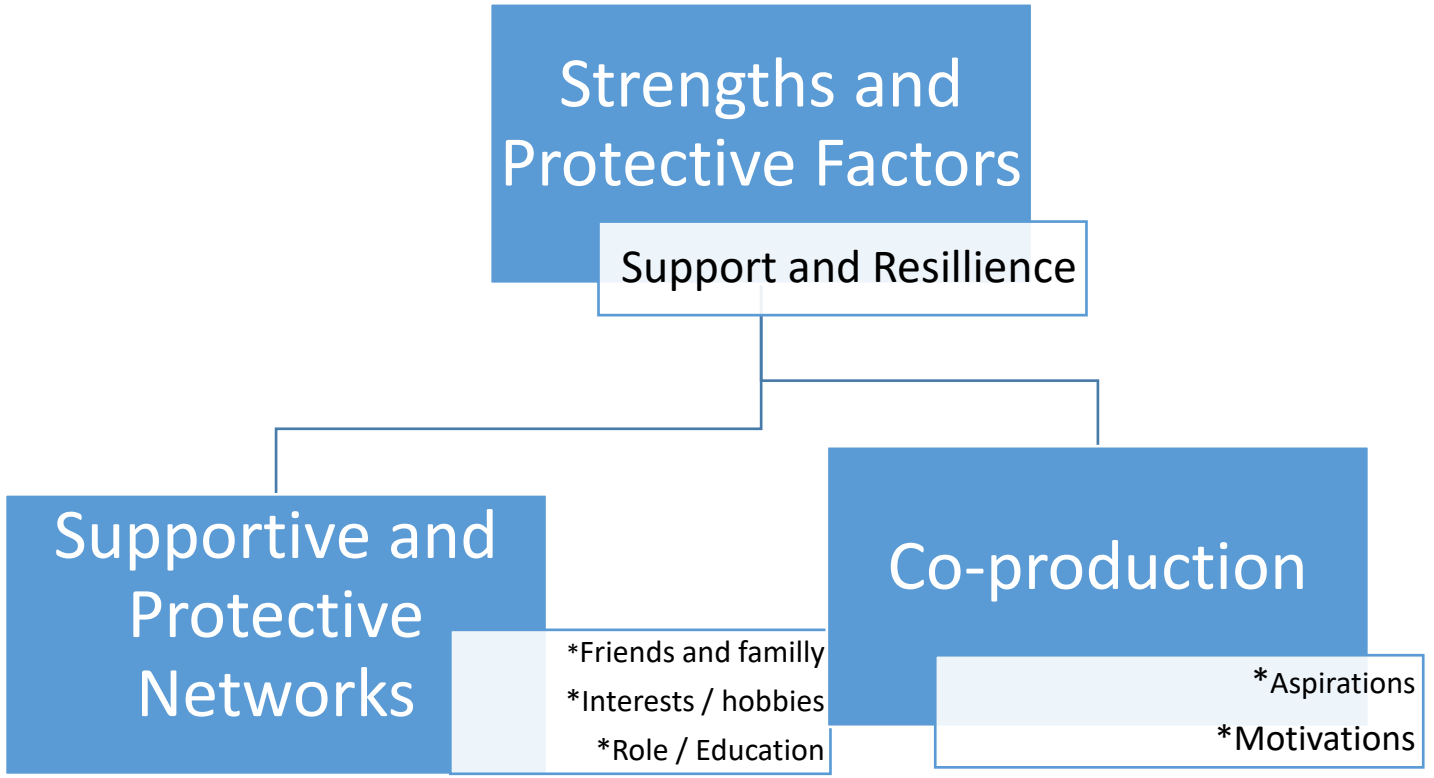


The final main theme was more positive in that it became clear throughout the data analysis that the working-age people admitted to long-term care had elements of resilience or strengths by which they preserved their individuality and uniqueness, and which served as protective

factors in their residence in long-term care facilities. These main themes then developed into sub-themes which are: the protective networks of family and friends which they maintain and may have been established prior to or after admission; interests, activities, and hobbies; also, their levels of self-determination and how they contribute to or co-produce their assessment, review, and ongoing plan of care.

Figure Seven below illustrates the sub-themes of the Strengths and Protective Factors themes, these illustrate the support people have to remain resilient, such as supportive and protective networks and co productive arrangements by which people can perpetuate their strengths and realise their aspirations.

Figure Seven – Strengths and Protective Factors



The chapter will continue to discuss the findings regarding each main theme and its sub and sub-sub themes in turn. After elucidating the findings, the Discussion Chapter will evaluate the literature about each of the identified themes, which will be developed further in the Discussion Chapter via analysis of the social construction of each theme.

5.3 Theme - Risk

Risk Behaviours

Behaviours, reasons for behaviours and issues around management

One of the main themes identified during the data analysis was risk. Lupton (2013) defines risk as the possibility of adverse or dangerous events coupled with the belief that prevention of these events may be achievable. The risk sub-themes which were apparent during the coding process fell into distinct category groups, which were as follows: the risk behaviour, the reason the person carried out the behaviour, and issues around managing the risk in terms of severity and predictability as recorded within the risk assessment and associated documentation. The Risk Section of the Findings Chapter will be structured accordingly.

In most cases, person was admitted was due to perceived levels of risk on the part of the assessing professional. This information was coded by correlating the risk behaviours and levels as scored by the assessing professional in the risk assessment and continuing this evaluation as part of the memoing process. This involved analysis of levels of risk to self and others. Risk Levels are assessed via what is termed a 5x5 risk assessment which amalgamates the likelihood and impact of the risk -to identify risk levels. This would be done on a practitioner level because the Risk Assessment document on the clinical system is constructed around this model of risk, but it is evidenced by Coleman et al's (2021) stipulation that such systematic approaches allow for consistent and objective risk analysis. This type of risk assessment system is based upon and mandated by the Manchester Patient Safety

Framework (MaPSaF) (Parker et al, 2006) and is a tool developed to help National Health Service Organisations to develop a safety culture.

Figure Eight – Manchester Patient Safety Framework

		Impact				
		Insignificant - 1	Minor- 2	Significant - 3	Major - 4	Severe -5
Likelihood	5. Almost Certain	Mid 5	High 10	Very High 15	Extreme 20	Extreme 25
	4. Likely	Mid 8	Mid 8	High 12	Very High 16	Extreme 20
	3. Moderate	Low 3	Mid 6	Mid 9	High 12	Very High 15
	2. Unlikely	Very Low 2	Low 4	Mid 6	Mid 8	High 10
	1. Rare	Very Low 1	Very Low 2	Low 3	Mid 4	Mid 5

The high, very high and extreme risk levels are grouped together as a person exhibiting more than a high-risk level would need treatment in an acute psychiatric inpatient facility and therefore, would be assessed under the Mental Health Act or recalled from their Community Treatment order and returned to the long-term care facility when the risk had stabilised to a high level. People are admitted to long-term care in respect of both harm to self and others, but the research does acknowledge that levels of risk are moderated and controlled via the levels of intervention afforded by 24-hour care.

The table below (Table Six) shows the levels of risk to self and others. This indicates that people who exhibit high and mid-level of risk to others predominate in the decision to admit working-age people to long-term care, but that mid and high risk to self is also a consideration. The risk to others is more likely to be deemed as high by the assessing professional. This is because the mitigating strategy in the care plan is for staff to intervene in self-harm reducing risk, but where people are violent to others and harm them the damage is more difficult to predict and prevent, thus increasing levels of perceived risk.

Table Six – Risk to Self and Others

Risk to Self		Risk to Others	
High	18/72 (25%)	High	26/72 (36%)
Mid	36/ 72 (50%)	Mid	22/72 (30%)
Low	9/72 (12.5%	Low	2/72 (3%)
0	9/72 (12.5%)	0	22/72 (30.5%)

Total=72

To deem that the person was a risk to themselves or others, the information would be garnered from the checklist, which the professional was required to complete to indicate the presence of risk, and this was considered in conjunction with the descriptions of this risk. It was noted from this that some people had features of risk to self and others, and the predominant risk was determined. 3 examples of risk to self and risk to others as described in the case notes are included below:

Risk to self

"XXX relocated to XXX and stopped taking his medication and disengaged with services resulting in a relapse in mental health, He was discovered sleeping rough and it was reported he had sent text messages saying he was going to kill himself…"

"In the past when XXX's mental health has deteriorated he has self-neglected. The provision of a residential care placement ensures that XXX's nutritional intake can be monitored, and he is supported to maintain a healthy dietary intake."

." Following this XXX's mental health deteriorated where self-harming was on a daily basis and heavily using alcohol as a negative coping mechanism."

Risk to Others

"…so, there is some evidence of a social side to XXXX I note from records that he does at times disengage from staff and can be aggressive especially towards females."

".XXX has a past history of being aggressive this was also linked to substance abuse, therefore, aggression and becoming verbally abusive, along with being quick to react aggressively in the past is an indicator."

"In the past, XXX has had episodes where he has been violent. He used to have fights at school and ten years ago grabbed XXX around her throat."

Levels of Risk to Self

18 people were deemed to be a high risk to themselves, which indicates that either because of deliberate acts or acts of omission, the person was at risk of experiencing serious harm or death and that the long-term care support could intervene to reduce this should the risk begin to escalate. Where the risk level exceeded high, the home would need to seek escalation to acute psychiatric inpatient care, hence the very high and severe levels not being present here. 3 of these people had historic behaviours which had included life-threatening suicide attempts, and typically, a risk rating of high stemmed from a history of ongoing damaging self-harm or catastrophic or spontaneous acts of self-harm or neglect, which placed the person at risk and contributed to the decision to admit.

36 people were identified by the assessing professional as being at mid-level risk of harming themselves, which indicated that they were considered at risk of causing themselves significant harm, either deliberately or by accident and that the likelihood of this occurring was mid-range. Again, this level of risk was present in the person's history and influenced the risk rating irrespective of how frequent the behaviour was which is reasonable (without any extenuating factors) as a person may repeat what they have done previously. Where the long-term care facility was unable to prevent such repetition (typically with behaviours such as absconding, lack of compliance with medication leading to relapse, and substance use), they were able to raise the alarm, refer to other psychiatric agencies or have the capacity to support through a crisis which would not be available to a person living alone or in a family setting.

The fact that the person lived in long-term care seems to justifiably enhance the perception of vulnerability with agencies such as police and community mental health services, so the response is more rapid, and risk reduced, which in turn contributes to the professional's decision to admit the person to long-term care as a means of reducing risk.

9 people were deemed to have a low level of risk to themselves; they are at risk of lower levels of harm to themselves and the likelihood of this harm to self is low. These risks tend to be associated mostly with issues around personal hygiene and maintaining a habitable home. However, the risk trigger as part of the decision-making to admit still stands as these people exhibit harmful behaviours to others. These issues have their own challenges in the long-term care facility as people may not appreciate staff prompting with personal and environmental hygiene (please see the "avoidance" behavioural function below). Still, the fact staff in the long-term care facility can and do intervene (even to the extent of doing things for the person) means that risks are reduced, and personal and environmental hygiene is maintained at acceptable standards.

9 people were deemed to be at no risk of self-harm, and the likelihood of this was deemed to be nil. This seemed to be something of an anomaly as it is hard to imagine a situation where a person could be entirely immune or protected from self-harm. However, when further examined, these were people who caused severe harm to others, and the decision to admit had been made according to the risk of harm to others, which was not mitigated by their ability to maintain their own safety.

Consequently, there is a clear association with a mid or high-level risk of harm to self with admission of working-age adults to long-term care. Long-term care establishments provide constant monitoring and the capacity to intervene to reduce risk or to make urgent referral to acute psychiatric or emergency services where risk levels exceed their remit. The chapter will

continue to analyse the impact of risk to others on admission of working-age adults with mental health needs to long-term care.

Levels of Risk to Others

26 people were identified by the assessing professional in the risk assessment as at high risk to others. This meant that they were at risk of harming or killing others. However, when risk escalated to high or very high levels, the person would need to be admitted to acute psychiatric care, so these risk ratings do not exceed high (as is the case with the level of risk pertaining to harm to self). The high-risk rating stemmed in all cases from the person's behaviour historically; they had either previously had a consistent history of harm to others or had carried out episodic or isolated severe harm to others. The assessing professionals have a low tolerance for the high risk of harming others, and this is associated with admission to long-term care because of the unpredictability highlighted above.

22 people were deemed to be of mid-risk to others. This type of risk typically manifests as mid to low-level physical assault, which is often associated with threats or other intimidating behaviour, such as shouting or encroaching on the personal space of others. This behaviour does persist in the long-term care facility in some individuals. Still, admission to long-term care is deemed to be a valid intervention as there are staff on hand to intervene if physical aggression does occur. It is possible to place more vulnerable residents away from their more violent and unpredictable cohabitees.

2 of the people were deemed to be of low levels of harm to others. These were people who did not carry out physical assaults but were unintentionally threatening to others, invading their space due to compulsion to carry out rituals rather than meaning to alarm or distress others.

Again, admission was deemed to be an appropriate intervention as there are staff on hand to divert the perpetrator of the behaviour and protect those who may be disturbed or distressed by it.

22 people were deemed to be at no risk of harm to other people. As with the risk to self-category, it seemed a little counter-intuitive that these people could be of no risk of harm whatsoever to other people. However, as with the harm to self-category these people were deemed to be of low risk to others as this was in stark contrast to the high levels of risk, they presented to themselves, and the decision to admit had been made on this basis, which the lack of risk to others did not mitigate.

Thus, the findings enable the study to identify how high levels of risk to self and others were. Mid to high risk of harm to self or others are considerations in the admission of working-age people with mental health needs to long-term care. The chapter will continue to detail the findings in respect of both: what behaviours of concern were; and how the assessing professional viewed these as having purpose or function for the person exhibiting them. Hence, the study will continue to evaluate the risk behaviours and why the person exhibits them (often despite) the consequence of admission to long-term care.

What Behaviours Lead to Admission to Long-term Care?

The emerging risk behaviours associated with the admission of working--age people with mental health needs to long-term care are as follows: harm to others (this is verbal, physical and environmental harm and includes people who exhibit these behaviours when their mental illness is cycling or relapsing; harm or neglect to themselves (in some cases to the extent that there is an expressed concern on the part of the assessor that they will, either deliberately or

not, end their life). As the table below shows, self-neglect is the predominant behaviour associated with the decision to admit; this is followed by physical violence, problematic substance use, self-harm, and sexual violence. Each behaviour will be evaluated in greater detail following some examples from the notes of one of the types of harm, to determine how they influence the decision to admit the person to long-term care.

**Please note some people exhibit more than one or multiple behaviours.*

Table Seven- Harm

Harm	Number
Self-Neglect	51/144 (35%)
Physical Violence	43/144 (30%)
Problematic Substance Use	23/144 (16%)
Self-Harm	22/144 (15 %)
Sexual Violence	5/144 (3%)

Total=144 as people may exhibit more than one form of harm to self.

The table above indicates the prevalence of the different types of harm, which is derived from the descriptions of the harm in the record. Three examples of such descriptions of one of the categories (self-neglect) are provided below to give the reader a sense of the nature of these descriptions.

> "XXX chronically self neglects. He often appears unkempt, but his hygiene is adequate. He requires daily prompts to have a wash and change his clothes, without this staff report he becomes increasingly unkempt and doesn't attend to his personal hygiene, but he complies with prompts. XXX's laundry is done for him by the staff, otherwise he wouldn't do it."

"XXX can fluctuate as to whether she is able to manage her personal care. This is dependent on how much she is distracted by what she is experiencing level of self-neglect can be high"

"XXX responds to auditory command hallucinations when he is awake and these impact on his Activities of Daily Living (ADL's) requiring two members of staff to attend to personal hygiene, dressing/undressing and application of cream for eczema"

Physical Violence Harm to Others

The Table Seven above indicates that a significant number of the study cohort (43) exhibit violence toward others, and there is also some more qualitative data available here in the way the assessing professional has described the person's behaviour, which was analysed as part of the memoing process. It is useful rather than to just deem people to be "violent" also to offer a further analysis of the multiple ways in which violence manifests. This detail was garnered from how violent behaviors are documented in the case note. There is evidence of harm to other residents, harm to staff and behaviours which are sexually violent. It is evident in the table below (Table Nine – Functions of behaviours) that it is a characteristic of some of the study cohort that they are not predatory but that they react violently when prompted to do things they do not wish to do (typically attending to personal hygiene or maintaining a habitable home). Violent behaviour and admission to long-term care tend to co-exist because admission contains violence in the long-term care facilities and enables it to be controlled by the staff in them (whether by physical restraint or the use of medication).

This qualitative data contains descriptions of delusions ranging from "command hallucinations" which are not specified to detail around belief systems, for example, a belief they are a popstar's girlfriend and people do not respond to them with due deference. These delusions are described factually and respectfully, which gives a sense that the assessing professional

aims to deny any sense of the ridiculous within them and avoid the person being mocked, and there is no judgement or value attached to these descriptions. This acceptance on the part of the assessing professional of the person's belief systems contributes to the decision to admit as the assessments indicate that the person is often potentially discriminated against or scorned because of them, which does not happen in the long-term care facility as people are accustomed to a variety of belief systems. There is a further protective element in that the person may be at risk of repercussions for their behaviour from others in the wider community, but the removal of the person to long-term care, which provides constant control and monitoring by staff, negates the risk of this.

Some of these qualitative data indicate that there are no triggers or accounts of delusions, or the person does not discuss these with carers or professionals, which again contributes to the decision to admit. The person is deemed to be unpredictable because their belief system is not understood, and there is a need for members of staff to be available to always intervene when the risk could occur, which is not sustainable in a person's own home.

The data also indicate that behaviours may be associated; there was a distinct link between the use of alcohol and / or substances and violent behaviour. It is also possible to determine an association between the person being prompted to do things and physical violence or other behaviours aiming to escape from this, such as withdrawing or disengaging. Again, control over these behaviours and resource to intervene is a key aspect in the decision-making to admit the person, as the assessing professional deems that the ability to intervene is always needed. There is also an indication in the assessment that constant staff presence is needed as people will not be conscious of the combination of circumstances which may cause their risk behaviours (for example, increased likelihood to be violent following alcohol consumption). The long-term care facility affords the possibility of removing antecedents to unwanted behaviours (e.g. alcohol or other substances), removing the person from the situation, or

providing medication in situations where it is not possible to identify what has caused behaviours to occur.

Some of the qualitative descriptions are of severe and harmful behaviours people engage in prior to admission, one person killed someone, and another broke his mother's arm. Others describe the breakdown of care arrangements prior to admission, such as the death or illness of a parent. These are varied and provide an emotive insight into events leading to admission, but they also provide evidence that the person cannot exist safely without a continued, constant staff presence to monitor and recognise increased risk levels and intervene when needed.

The finding that people with mental health needs will physically harm other people is a factor in their admission to long-term care, however, admission does not alleviate this risk. Assessing professionals do weigh up risks concerned and (from what is written in the record) genuinely believe that this setting is optimum for managing this risk and it is possible to remove more vulnerable people to areas designed for them. It should also be noted that not all harm is necessarily physical, and that risk of sexually harming others may also be a factor in admission. Thus, for people at risk of harming others, the decision to admit to long-term care is based around the availability of constant support and supervision for them, which provides monitoring of risk potential and intervention when it occurs.

Sexually Harming Others

A (small)l proportion of the working-age people (n=5) admitted to long-term care were placed in these settings because of their sexually harming others. Again, the presentations of this behaviour differ and vary. These descriptions of behaviours are taken from the case record and extracted from this as part of the memoing process. The decision to admit the person is

again aimed at risk reduction and containment as this allows the long-term care facility to limit the interactions the person has with others by restricting them within the home or accompanying them in the community, averting crises which could have catastrophic consequences for the people in the study cohort (where their behaviours would be viewed as abhorrent by others and may cause retaliation).

Having determined that constant staff presence to reduce harm to others (whether physical or sexual) is a factor in the damage limitation surrounding the decision to admit to long-term care, the Findings Chapter will continue to evaluate the risks this study cohort poses to themselves (intentionally or unintentionally) and how this influences the decision to admit them to long-term care.

Harm to self by Self -Neglect

A significant number of the study cohort (n=51) cause or have the potential to cause harm to themselves by self-neglect. These findings were taken from the data analysis of the risk assessment and whether the assessing professional had answered yes or no to the question about whether the person self-neglected.

This self-neglect typically manifests as not complying with medication regimes, personal hygiene, environmental hygiene or eating. The case record indicates that despite the efforts of community teams, episodic intervention was not sufficient to protect these people from harm because of self-neglect, and they were admitted to long-term care. (Please note that the self-neglect and self-harm data are not mutually exclusive as people may do both). It is interesting to note that there is no record of discussions with people in the case notes as to why they self-neglect or what their barriers to self-care are, but sadly, self-neglect in all the cases below was of severe enough an extent to contribute to the decision to admit the person as constant ongoing monitoring was needed to maintain self-care.

SCIE (2018) states that self-neglect has the following features: lack of self-care to an extent that it threatens personal health and safety; neglect to care for one's personal hygiene, health or surroundings; inability to avoid harm as a result of self-neglect; failure to seek help or access services to meet health and social care needs; inability or unwillingness to manage one's personal affairs, and indeed, all these presented in the coding and memoing processes which featured in the data analysis in this study.

The Care Act (2014) incorporated safeguarding (of which self-neglect is one of the defined categories) into statutory guidance, recommending that local authorities develop new approaches to working with people whilst recognizing that positive change would be a long-term, incremental process. Realistically, however, there are few real alternatives to admission to long-term care for people who will not and/or cannot self-care and require staff to do that for them. Thus, the person's behaviour affords the justification to admit, and this is validated by the assertion within the case documentation that the person is suffering, and this suffering will increase if they are not admitted, and support provided on a continual and ongoing basis.

Gunstone (2003) states that, typically people who neglect deteriorate steadily until complaints from neighbors, a decline in physical ill health, or maladaptive attempts to seek help culminate in an intense crisis, needing admission to hospital (either general or psychiatric) remedying self- neglect to the person and / or home. Lauder et al (2005) highlight the plight of people who cannot maintain their home in a habitable condition and who may also hoard, often loosing homes due to inability to maintain them. As well as home hygiene issues, this study found that there was fire risk associated with this study cohort (either intentional or unintentional) due to their smoking habits, which do not combine well with cluttered homes (more in the substance use section below). Friesenger et al (2019) carried out a study in Norway which highlighted prevalence of fire risk in this type of study cohort and the way people with mental health needs living in supported living settings felt their living environments were

abnormal due to the presence of fire points and extinguishers (they do acknowledge the protective factors of fire safety and that these need to take precedence).

Harm to Self

The analysis of data indicated that the risk of self-harm is also a significant theme in the decision to admit working-age people with mental health to long-term care (n=22). The data was extracted from the case record from the response by the professional completing the risk assessment as to whether the person was at risk of self-harm. These behaviours ranged from ingesting fluids or objects not considered appropriate for consumption, cutting themselves, or throwing themselves in front of cars. In some cases, it was explicit that the person was exhibiting this behaviour to end their life, but as analysis developed, it became clear the reasons for such behaviour were not always explicit. In all cases, the decision taken to admit was rationalized by a lack of assurance that the person could be safe in the community and the necessity for staff to be always present to monitor the person and to intervene when they do self-harm.

Substance Use

Another commonality apparent to working-age people with mental health needs admitted to nursing homes is that the assessing professional believed that they would come to significant harm because of their substance use combined with their mental health needs (n=23). It was not possible to split this into types of substance use (e.g. drugs, alcohol, smoking) as the record was not clear which substances or combinations of substances the person used. This may be because use altered depending on what substance the person could physically or financially access. The data pertaining to substance use was gathered during the coding

processes and was dependent on whether the assessing professional had indicated in the risk assessment or throughout the case documentation that the person used substances. One person is included in the data below, but it is something of an anomaly as they use energy drinks in a similar way that other members of the study cohort use substances. Again, the decision to admit is taken on the basis that the person needs to be constantly monitored, substance use prevented where possible and where this is not possible, there is a constantly available staff presence to intervene when the person has caused themselves or others harm.

Multiple Harms

It should be noted that many people in the study cohort may be subject to multiple harms, and some of the individuals present in a variety of ways, for example self-harming, self-neglecting, harming others *and* using substances. The numbers of harms a person is subject or vulnerable to was taken from the risk assessment completed by the assessing professional during the coding process. The risk assessment requires the assessing professional to answer whether they feel the person is at risk of the following: self-harm, self-neglect, substance use, and causing harm to others, (for aspects not already evaluated further, this will be completed below) and requires the assessing professional to list the diagnosis/diagnoses assigned to the person. , below indicates the numbers of multiple harms or conditions the assessing professional has as identified in the risk assessment. There are significant degrees of commonality of people having 2 or 3 co-jeopardies and their mental health condition may adversely impact their ability to adjust to these.

Table Eight - Multiple Harms.

Number of Harms	Number
4	5/72 (7%)
3	22/72 (30.5%)
2	22/72 (30.5%)
1	23/72 (32%)

Total=72

The identified theme of multiple harm risks to individuals is described as follows by the Royal College of Psychiatrists (2016 p.4); “Patients who present a risk to others may also be vulnerable to other forms of risk (e.g. self-harm, self-neglect, retaliation or exploitation by others)” this was undoubtedly a characteristic of this study cohort and the constant protective and containing capacity of the long-term care facility provided an allocated and available resource by which these risks can be limited and managed more easily than for people living in the community. Having determined behaviours which cause an increased risk of admission to long-term care for working-age people with mental health needs, namely harm to others. harm to self. self-neglect and substance use, it is next necessary to understand why they continue to exhibit such behaviours despite the impact they may have.

Function of Behaviours

Much of the research into behaviours viewed as a “challenge” to services focuses on the motivation for or function of that behaviour (Axelrod 1987, Mace et al 1991, Emerson 1993).Much of the work around challenging behaviour as a functional entity sits in the field of learning disabilities, and it was with this service user group that Smidt et al (2007) carried out a study whereby staff in a residential setting were given training on communication which was felt to be beneficial as behaviours were deemed to have specific functions or purposes which explain why the person persists in exhibiting them despite the risks associated with them. The impact of substance use and the potential for “self-medication” has been evaluated above and

there is correlation between substance use and risk behaviour with the links between the two already well-established (Regier et al 1990, Szuster et al 1990, Brady et al 1991, Kulich and Ahmed 1986).

The functions of risk behaviour were incorporated in the coding and memoing elements of the data analysis, and the prevalent themes were found to be a response to delusions (which featured sexual / relationship elements, persecutory or paranoid beliefs, and religious or spiritual components), an attempt to regulate the persons' environment or self-stimulation, avoidance and escape. Table Nine below provides evidence as to how common these themes were throughout the study cohort. It was also a notable feature that in the case of some individuals within the study cohort, it was impossible to determine the function of the behaviour. It should also be noted that for some people (as with the multiple types of risk behaviour, these behaviours could also carry out plural or several functions). The Findings Chapter will now continue to evaluate each of the behavioural functions; they are displayed in quantitative format in the table below (Table Six).

**NB some behaviours have multiple functions for people*

Table Nine - Functions of Behaviours

Function	Number
Response to Delusions	63/101 (62%)
Avoidance	18/101 (18%)
Regulate Environment	7/101 (7%)
Self-Stimulation	13/101 (13%)

Total= *101 *see note below table*

NB The total here is not 72 (the number of the study cohort) as behaviours may have multiple functions

The table above illustrates the prevalence of the functions of behaviours; these were determined from the description of the outcome of behaviours in the case record. 3 examples of how behaviours which functioned as responses to delusions are provided below for illustrative purposes.

> "During this time XXX was reported to be attempting to eat inappropriate objects, such as discarded cigarette butts and any sort of fluff or dirt found on the floor (he stated that he smoked the discarded cigarette butts). He also believed that people were trying to poison him and that the things he found on the floor were antidotes left for him to take."
>
> "Staff, however, report XXX is doing ok but there is evidence of an increase of him responding to unseen stimuli and talking to himself (seemingly telling them to go away), Mum & Dad also report that this has got worse."
>
> "XXX moved to XXX supported living flats in XXX. XXX was evicted for starting a fire in her bedroom, this was because she was distracted by her delusions about devils and hellfire, excessive smoking and not putting cigarettes out properly. She was readmitted to XXX Hospital"

Response to delusions

The case notes (in various documents) contained elements of the assessing professional trying to understand why the person persisted with their behaviours despite the consequences they had. There was a strong commonality of assessing professionals associating risk behaviours with responses to delusion or compulsions arising from them. This section of the findings will continue to analyse this further to determine why risk and delusional thoughts exist in common in this manner and arises from what staff have written in the person's record about the reasons for their behaviour.

. The reasons why staff attribute behaviours as responses to delusions are not overtly stated, but the inference is that this is due to a lack of a shared reality; none of the records contains a systematic framework of the person's belief systems but contains snippets of the more fantastical, bizarre, or impactful of their expressed thoughts. The record also contains accounts of behaviours or descriptions of the ways people withhold communication or express suspicion about others and their motives. Whether rightly or wrongly, we believe we have a common reality shared with other humans; humans are strongly motivated to share their understanding of the world in general and their social world in particular with others (Hardin and Higgins 1996), and they actively interact to share, compare, and associate their inner worlds (Higgins 2005, Nelson 2005, Terrace 2005, Tomasello et al 2005). So, it begins to emerge that whilst the assessing professional views admission as the only option to provide monitoring prevention and intervention, which cannot be provided in the community to alleviate risk, it is an indication that this risk is contained as it is not sufficiently understood to be mitigated.

This study does not seek to evaluate the medical, neuropsychiatric, phenomenological or philosophical nature of delusions, but during the data analysis some themes around the content of the delusions and the behaviours exhibited were recorded by the assessing professional, in common with the American Psychiatric Association (2013) Diagnostic and Statistical Manual of Mental Disorders American Psychiatric Association (DSM) these included Persecutory Delusions (which typically involved suspicious, mistrusting and aggressive and avoidant behaviours, often believing that others wished to harm them (one example of this is the person whose delusions involve the police which dramatically increase his distress when they need to be involved when he is detained under the Mental Health Act); Somatic Delusions ,in which the person felt they had a physical illness of deformity (one woman believes she has cancer and staff are concealing this from her despite several appointments with physical health professionals) ; Grandiose Delusions where the person felt they were superior to others and would become upset or angry if others did not defer to them

(another person believes he is God and the Devil and people are his disciples.); Erotomanic Delusions where described behaviours were contacting, following or making unwanted sexual advances to others (one person approaches men repeatedly she believes she is in a relationship with, although in fact she is not) ; Mixed Type Delusions where the person had one or more delusion contents and corresponding behaviours (one person has an Erotomanic Delusion that he is going to get married so he goes to the local church and unfortunately this is coupled with the Somatic Delusion that he needs to defecate to purify himself which he has done in the church premises) and Unspecified Delusions where the person did not give an account of their delusions or the assessing professional did not recognise it (these are typically presentations where the person withholds communication or expresses suspicious thoughts). The fact that examples of all types of delusions can be found within the study group and the extreme and devastating behaviours these lead to provide evidence of a link between delusions and challenging behaviours. Also, an element of control is exercised due to the sensitivities of the larger society to whom delusions can seem bizarre and frightening.

This is an evaluation of how the assessing professional recorded the content of the person's delusion and the way they behave. The degree of association between the two is not a predictor of how others would behave if they experienced the same delusions, or how they would experience distress but as the literature review carried out by Flores (2021 p.6293) indicates further work is needed in understanding and treating delusions and the response to them . Much of the literature on delusional disorders consists of small case series or reports of individual cases. Methodologically well-conducted, multi-centre trials are required to answer the questions posed in this thesis.

Consequently, exhibiting risk behaviours as a response to delusions (either positive or negative) has been found to be a theme within this study and the body of research on people with mental health needs This relates to the notion of a lack of "shared reality" between working-age people with mental health needs admitted to long-term care and professionals,

where this long-term care is seen as the only way to support or control them. Admission to long-term care does not correlate with the extinction of behaviours associated with responding to delusions. However, analysis of the content of review documents shows increased assurance that this can be monitored, as can mitigating strategies such as access to medication and professionals, which could not be provided to a similar extent or level of assurance in the community. It is acknowledged that there is no control or comparison as to what would have happened should the person have remained in the community. Avoidance as a function of high-risk behaviour was also a theme that emerged as part of the analysis, which will now be scrutinised.

Avoidance

Staff completing this case study documentation analysed attributed some of the high-risk behaviours to avoidance, which was captured during the coding and Memoing processes and is illustrated in Table Nine above. This avoidance was usually a reaction to staff in the long-term care facility prompting the study cohort to maintain their personal hygiene or environment to the standards those staff felt acceptable. This may include verbal or physical aggression or removing themselves from situations.

Regulating Environment

Joyce (2006) characterises regulatory type-high risk behaviours as functioning so that the person can exert some control over an environment which they find overwhelming or distressing, typically the types of environments which are constructed around a “majority shared reality”. These may say little to inmates of long-term care facilities about their worlds, and Joyce (2006) also states that this is typically associated with people with conditions such as OCD and autism. Over a third of this study cohort had these diagnoses in conjunction with their primary mental health diagnosis. Where the person has these types of presentation, the assessing professionals throughout the case note found a significant amount of commonality

between the study cohort exhibiting high-risk behaviours to regulate their environment (although, as with other behavioural functions, the behaviours may have multiple purposes).

Self-Stimulation

13% of the study cohort engaged in self-stimulatory behaviours. Lovaas et al (1971) state that self-stimulatory behaviour is common in people with autism (around a third of this study cohort) and typically involves rocking, arm twirling and flicking objects in front of the eyes and some of this study cohort exhibit these behaviours. These are study cohort members that the staff identified as carrying out high risk behaviours which are self-stimulatory in case documentation. The case records also indicate that self-stimulation is also associated with some high-risk behaviours including (as with examples of this study cohort) very frequent touching of light switches and plugs and compulsively drinking fluids indiscriminately, some of which are harmful. Barron-Cohen (1995) refers to these types of reactions to alien environments as “mind-blindness” and questions whether it may be that it is a misapprehension of the majority’s reality to view these behaviours as odd or deviant when they function for the person as adaptive and protective. This area of commonality is of interest as high-risk behaviours, which function as self-stimulation typically occur in isolation from other high-risk behaviour functions.

This study has found that the sample population carry out high-risk behaviours as a response to delusions, as a means of avoiding prompts, or to attempt to regulate their environment or as a means of self-stimulation. However, the reason for admission is the ability of the long-term care facility to manage the high-risk behaviours, so The Findings Chapter will continue

to evaluate the conventions in mental health risk management to determine how this impacts outcomes and maintains the majority shared reality.

Management Factors in Risk Behaviours

The risk assessment was incorporated in the data analysis process. The Trust risk assessment in common with mental health risk assessment includes the recommended elements in such assessment, history including the severity of risk in the past, how far repetition of risk behaviour can be anticipated, mitigating factors and confounding factors Smith et al (2015), Busch et al (2003), Kapur et al (2005) Deering et al (2019), and indeed the data in the analysis did include these factors and featured robust relapse and contingency plans which capitalised on protective factors and strengths but due to the severity and unpredictability of the risk they could not provide assurance that the risk would not recur and could be managed safely within the community.

The coding and memoing processes indicated that the assessing professional, in most cases, could not precisely indicate triggers or thresholds for the advent of risk behaviour. They felt that the person was unpredictable, which posed significant difficulty in managing risk, again suggesting that we cannot share reality with the person or understand their perceptions. The assessing professionals recorded high levels of commonality of unpredictable high-risk behaviour with them responding “yes” to the risk assessment requiring the professional to determine whether the person was unpredictable. Indeed, only two of the study cohort were deemed to be predictable and these people had been in the long-term care facility for many years and had been in the, now defunct, long-stay psychiatric hospitals prior to this. Again, this indicates that the assessing professional does not understand triggers to behaviours and is not able to enter the reality experienced by the person, so feels that admission which

provides constant supervision and control is the only means of keeping the person and others safe.

The assessing professional is also required to determine whether they view the impact of unmanaged risk as severe as part of the risk assessment. This severity is a separate entity from the impact x likelihood matrix discussed above, which is used by assessing professionals to determine levels of risk as high, mid, or low. It is a discreet element of the risk assessment which requires the assessor to evaluate the prognosis of the risk, or what the likely outcome of the risk would be. Most of the study cohort are identified as having a “severe” risk level (indeed, the same two people who were deemed to be predictable did not have severe unmanaged risk indicators, and these people had resided in mental health institutions for most of their lives). This seems to be incongruent with people having a low or mid impact x likelihood score. Still, it should be noted that the assessor in this part of the risk assessment is asked to consider what the outcome of the risk behaviour would be without intervention. In contrast the impact x likelihood score is completed taking into consideration interventions and mitigations. This indicates that the assessing professional cannot prognosticate when or why the risk will occur but that they do predict that the outcome will be significantly disadvantageous, leading to the decision that admission is the only means of averting this.

Slemon et al (2017) carried out a literature review into risk management in psychiatric inpatient settings (long and short-term, NHS and third sector) and concluded (p.1) that “Confinement arose from safety: out of both societal stigma and fear for public safety, as well as benevolently paternalistic aims to protect individuals from self-harm. Practices that accord with this value are legitimised and perpetuated through the safety discourse, despite evidence refuting their efficacy, and patient perspectives demonstrating harm.” The view that admission takes place to remove risk and from a desire to protect the person is a distinct finding of this study in common with several others including Breeze and Repper (1998), Kidd et al (2014), Larsen

and Terkelsen (2014) and Manuel and Crowe (2014). This study develops this further in evaluating the lack of any shared reality between the person and the assessing professional. This causes a lack of understanding and an absence of any ability to negotiate and mitigate risk leading to the decision to admit.

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Diagnosis

All the working-age people in this study cohort have a diagnosis of mental illness. The diagnosis of psychosis/schizophrenia is prevalent (in its many guises) within this study group. Tsuang et al (2000) review the history of the diagnosis of schizophrenia and psychosis and the numerous subtypes of these conditions and conclude that the degree of distinction exists because of attempts to understand the aetiology of the disease to better treat it. They argue there is sufficient commonality within the presentation of the disease to group it as one entity, as has been done in this study because its focus is an inquiry about reasons for admission to long-term care as opposed to diagnostics. However, this study demonstrates that sophisticated and scientifically advanced treatment regimens are not alleviating the condition of this study group as they cannot continue to live in their communities. Only 8 of the study cohort of 72 are diagnosed with an illness characterised other than schizophrenia or psychosis, Table Ten below evidences the commonality of schizophrenia and psychosis-type illness within the study cohort.

Table Ten - Diagnosis Does not add up to 100% as so many quantities were 1 and these were rounded down from 1.4

Diagnosis	Number
Bipolar Disorder	1/72 (1%)
Chronic Schizophrenia	4/72 (5.5%)
Chronic Schizophrenia and autism	1/72 (1%)
Depression, Anxiety and OCD	1/72 (1%)

Total =72

Dissociative Amnesia	1/72 (1%)
Emotionally unstable personality disorder	1/72 (1%)
Korsakoff's Disease with psychosis	2/72 (3%)
Obsessive Compulsive Disorder	1/72 (1%)
Obsessive Compulsive Disorder and Depressive Disorder	1/72 (1%)
Obsessive Compulsive Disorder and Schizophrenia	1/72 (1%)
Paranoid Schizophrenia	22/72 (30.5%)
Paranoid Schizophrenia and Learning Disability	1/72 (1%)
Psychosis	3/72 (4%)
Psychosis with Asperger's	1/72 (1%)
Psychosis / mild learning disability	1/72 (1%)
Psychosis / Schizoid Affective disorder	1/72 (1%)
Psychotic disorder very severe	1/72 (1%)
Schizophrenia	12/72 (17%)
Schizophrenia and Autism	1/72 (1%)
Schizoaffective disorder	1/72 (1%)
Schizophrenia / Autistic spectrum disorder	1/72 (1%)
Schizophrenia Mar fans syndrome	1/72 (1%)
Schizophrenia schizoaffective disorder	1/72 (1%)
Schizophrenia, Eating disorder, PD OCD	1/72 (1%)
Simple Schizophrenia	3/72 (4%)
Treatment resistant Schizophrenia	6/72 (8%)
Unstable personality disorder borderline type	1/72 (1%)

Information taken from Diagnosis on Front Screen (Prevalence)

As mentioned previously, the purpose of this study is not an exploration of the features of psychosis or schizophrenia (more about the nuances of these terms follows), or a quantitative analysis of disease prevalence. Still, it is necessary to understand how these conditions impact on working-age people and lead to their admission to long- term care from a qualitative perspective. Walsh et al (2016 p.607) define schizophrenia thus: “Schizophrenia is a serious mental illness characterised by abnormal patterns of thought and perception” they carried out a meta-synthesis into the lived experience of people with the diagnosis and found five major themes reported: the debilitating and pervasive experience of the symptoms; difficulty accepting the illness and the stigma attached; the adverse impact this has on personal relationships; treatment experiences including restrictions and side effects of medication; and the impact invasive thoughts and stigma has on the person practising their religion or faith.

The coding process revealed that the professional completing the assessment framework described or defined the pathology attached to the person’s illness, and analysis of the words they used (and how these were interchanged) within the case record indicated that there was not a universal understanding of differential diagnosis nor an acknowledgement that the person’s presentation may change over time. The terms psychosis and schizophrenia are used interchangeably as the assessment framework is completed, so it is necessary to understand the level of distinction between them and why these diagnoses and presentations impact on a working-age person’s liability to be admitted to long-term care. As far back as 1911 Bleuler described psychosis as a group of symptoms which can include hearing or seeing things which are not perceptible to others or having belief systems which the experiences of others cannot substantiate, whereas schizophrenia is the mental illness which causes psychosis. However, depression, bipolar disorder, brain injury and neurological disorders can also cause psychosis. Consequently, schizophrenia is the underlying condition and psychosis the manifestation and provides a reason why the person persists in behaviour which is at best undesirable and at worst a risk.

Consequently, the research question of why working-age people with mental health needs are admitted to long-term care can be answered on a very superficial level by the response "…because they have psychosis" as it is this very psychosis which the assessing professional views as the cause of distortion of their reality and the disconnect which causes the inability to communicate and negotiate about risk and behaviour . It is this lack of understanding, which almost amounts to an unwritten contract of what can be expected of the person, which leads the assessing professional to determine that a degree of control needs to be exerted over them, which can only be achieved by admission to long-term care.

5.4 Theme -Protection, Restriction and Confinement

The chapter will continue to explore the next main theme, which is that of protection, the content of this theme is concerned with the statutory and informal means utilised to protect the person in long-term care, which will impact on the person as restrictions to their free will and expression. These protective restrictions granulate into the following sub and sub-sub themes: The Mental Health Act (1983); The Mental Capacity Act (2005); Financial restrictions (due to poverty and those attributable to use of Appointeeship) and the degree of independence the person has to access their community as illustrated below.

This study finds that protection is, ultimately, the risk management strategies employed to mitigate the risks outlined in the previous section. The difficulty with compliance with treatment in people with mental health needs is well documented: Young et al (1986); Byerley et al (2007); Karrow et al (2007); Sparr et al (1993) and Bartlett and Sandland (2007) identify some of the kinds of protective measure exerted over people with mental health needs in the UK, which are very much in line with the findings of this analysis and include: admission (the person's tenure in the nursing home); legal restrictions both in respect of the Mental Capacity and Mental Health Act; financial restrictions and restrictions on accessing the wider community, this part of the Findings Chapter will continue to determine how each in turn impact

on the study cohort and how these restrictions are deemed to be part of the necessity of the person's admission to long-term care. This will determine the risks from which the person and society are managed and how such protection results in restriction. As the desire to protect is risk driven this section will commence with the most restrictive Mental Health Act Protections and will then consider Mental Capacity Measures, Financial Restrictions and Protections which restrict the person's access to their wider community.

Mental Health Act Restrictions

There is commonality among individuals within the study cohort, which is based upon the levels of constriction they are placed under stemming from the Mental Health Act (1983) (MHA). The following categories of restriction will be evaluated to determine how they impact the person's admission: no mental health restriction; people under Section 3 MHA; people on Community Treatment Orders and People who are entitled to S117 aftercare. The proportions of people under each restriction are shown in Table Eleven below.

Table Eleven - MHA Restrictions

Restriction	Number
CTO	3/72 (4%)
S117	55/72 (76%)
None	12/72 (17%)
S3	2/72 (3%)

Total=72

Prevalence of restrictions taken from Legal Status on case record.

People under No Restrictions

A proportion of people are subject to no Mental Health Act (1983) restrictions indicating that they have never been detained on any Section of the Mental Health Act (1983). A notable characteristic of these people is that they came from long-stay institutions, and when this model of care ended, they were transferred to long-term care settings. This applied to 10 of these people. A further 2 were compliant with treatment, assumed to have capacity to make the decision, and were willing to go to the long-term care facility so no compulsion under The Mental Health Act was required. Historic documents have not scanned onto the record legibly, but from more recent reviews these people have little ability to manage their activities of daily living and require staff to do it for them. This has been a key element in the decision to admit them to long-term care, even when they are compliant and low risk, they would not survive without the support offered in long-term care, making the decision to admit them inevitable.

Section 3 of the Mental Health Act

2 of the study cohort are recorded as on S3 at the point of admission to long-term care. Section 3 is a detention which allows the person to be treated in hospital for a period of up to six months. This can be reviewed for a period of six months and then for subsequent periods of one year. These people reside in private hospitals and have been on Section 3s, which have been successively renewed for up to twenty years. The table above (Table Eleven) shows the commonality of this amongst the study cohort, with one of the people being under this restriction following the attempted rape and murder of his daughter over 20 years ago and the other person killing a fellow patient in physical health hospital 15 years ago. Due to the considerable mental health needs which feature diagnoses of paranoia experienced by these people, they were not dealt with via the criminal justice system.

Community Treatment Orders (CTO)

There is commonality within the study cohort regarding people being on a CTO, which is illustrated by Table Eleven above. A CTO or Community Treatment order follows a Section 3 and allows people to be discharged from their section which means they do not need to be detained in a psychiatric hospital, but they are required to adhere to certain conditions in the community, if they do not comply they can be recalled to hospital for 72 hours and if not stabilised by this intervention their CTO is revoked then they revert to being on Section 3. For all the people on a CTO in this study cohort, the most common condition is that they continue to reside in their current long-term care setting with all the people on a CTO being subject to this condition; additionally, many of the others are required to take medication and allow access to visits from professionals) as their presenting high-risk behaviours feature absconding and non-compliance.

Section 117

Most of the study cohort are subject to Section 117, this means that these people have been subject to Section 3 in the past, and the S117 gives people entitlement to mental health aftercare at no charge to them. Although on initial observation, this may appear to be a boon, these people are not likely to object to their admission as they will be financially penalised, and all these placements are publicly funded. Of the people in the S3 and S117 groups all of these had at least 3 and in one case 10 admissions to hospital under sections of the Mental Health Act (please see Table Eighteen below). Nothing in the data indicates when the “final straw” in terms of repeat admissions takes place, as we will see in the next section. This is dependent on the person’s circumstance. In terms of S117 it is worthy of note that there is no stipulation within the statute that the aftercare must take place in a nursing or residential facility, domiciliary care could be offered, but due to the high level of need, this often proves more costly than 24-hour care settings and is thus not viable as it is not cost-effective. The commonality of need this within this study cohort arises from their pattern of resource use –

more on this in the resource section below, but in broad terms this is brought about by admission(s) which are lengthy, frequent or both, and have required an element of compulsion upon the people. Again, there are no overt statements in the case record about how S117 influences decisions to admit. Whilst this does avert any financial dilemmas or worries about affordability for the person it should be balanced by the consideration that to be on S117 the person would necessarily have been detained under S3. Hence, they have a history of severe mental illness which has presented a risk that is not effectively understood, negotiated or managed.

Mental Capacity Act Restrictions

Community Deprivation of Liberty

6 of this study cohort are required to reside in long-term care because of Community Deprivation of Liberty Safeguards which are legislated for under the Mental Capacity Act (2005) which allows restrictions upon the person's liberty.

In these circumstances the care home has applied for authorisation from the Local Authority for deprivation of liberty safeguards which require the person to remain at their current address. These stipulations would necessarily form part of the decision to admit to long-term care as the person would need an address where staff could monitor and support them. Series (2021) states that the intention of DoLs was as a less restrictive alternative to the Mental Health Act where detention was not needed, but that support was required where a person was in need of support due to lack of capacity (although not due to poor or eccentric decision-making) and that use of this legislation is deemed to be less restrictive than use of the Mental Health Act as the restrictions can cover only certain aspects (e.g. to be required to take medication (medication compliance is the main reason for the DoLs application in this study accounting for 3 of the 6 instances).

Financial Restrictions

None of this study cohort were in paid employment. The protection afforded by admission to long-term care results in what Guhne et al (2021) term occupational exclusion, which leads to poverty. Practically, with reduced benefits as a result of their long-term care placement, they are left with £24.90 (correct at the time of writing – 09.07.21) Personal Expenses Allowance, which they typically spend on toiletries, snacks, or drinks. GQ Magazine (accessed 09.07.21) indicated that median weekly earnings for full time employees were approximately £585.50, so people in long-term care receive 4.25% of the income of most of society seriously limiting their capacity to choose and consume. Table Twelve below shows the financial restrictions faced by the study cohort.

Table Twelve - Financial Restrictions

Financial Restrictions	**Number**
Benefits only	57/72 (79%)
Appointeeship	9/72 (12.5%)
CoP Application	1/72 (1%)
Deputyship	4/72 (5.5%
Safeguarding only at time of writing	1/72 (15)

Total=72

NB This data is taken from the Employment part of the Accommodation and Employment Status form, an example of which can be found in the Appendices (Appendix Four)

Additionally, these people do not have access to the protective beneficial aspects of employment in terms of structure, aspiration, and social interaction. Brouwers (2020) states that people with severe mental illness are 3 times more likely to be unemployed than people with no such disorders. Van der Noordt et al (2014) evaluate the positive aspects of employment in the form of increased financial affluence, social status, self-esteem, a forum in which to socialise with others with common interests, provision of a meaningful pastime, and

providing structure and argue that these aspects are protective to mental health so that lack of employment exacerbates the mental health difficulties of these working-age people. Kilian et al (2011) explore a further aspect of this: the fewer activities a person completes independently the less choice and self-determination they have, which has an adverse effect upon self-esteem and mental health, which is impactful for this study group who typically have meal choices, daily structure, and environmental choices determined by staff.

More formal restrictions are in place for a significant number of the study cohort as they are deemed unable to manage their financial affairs and appointeeship is held for them by the Local Authority. This effectively allows the person's social worker to oversee their financial matters, and they need to apply for all the monies they spend via their social worker. In these cases, the person has been vulnerable to others, they may have given away their money to predatory individuals. From a statutory perspective appointeeship provides protection but does not address the emotional impact of this as the perpetrators of the financial abuse were often people the victims believed to be friends, family members or people they were in a romantic relationship with. One person is subject to a safeguarding plan in which they have agreed they will be supervised in all financial matters.

Another group of the study cohort are under deputyship as this is required when capital amounts to more than £16000.One person is currently awaiting the outcome of an application to the Court of Protection for deputyship, and another person is undergoing a safeguarding investigation in respect of their finances. All these people are given a weekly allowance, and if they want to spend any greater amounts, then their social worker must apply to a manager who is delegated financial responsibility for the person on behalf of the Local Authority. As Mackenzie and Wilkinson (2020) point out, such restrictions are in place because the person is deemed to be vulnerable either to self-harm because of substance use or abuse by others who will misappropriate their money. This set of circumstances also applied to this study cohort.

Financial matters are not a primary reason for the admission of working-age people to long-term care, but a lack of ability to manage financial matters contributes to an overall picture of chaos and risk. The study cohort cannot be taught to budget in the same way as most of society, again the shared reality or communication between the person and the assessing professional is unsatisfactory and there is no assurance or contract between the two meaning that control is taken by one over the other to reduce risk and maintain safety.

The Restrictions People Live Within – Access to Communities

Another constraint on this group of people is their level of ability or motivation to access their local community; lack of ability or motivation effectively means that the person remains within the confines of their long-term care facility. A proportion of this study cohort are identified as having no desire to leave the facility, and there is no plan to try to work on increasing independence and widening horizons. Most of the cohort need staff to travel with them (either due to mental health needs, behaviours, or perceived risk) and some do not go anywhere except to medical and health appointments with staff. 48 people have limited access to the community or there is limited recording about their access, 22 people have less restricted access with some restrictions and 2 people are independent in respect of community access.

For those people who need staff when they go out, this effectively means that they are restricted to the long-term care facility unless there are staff available and willing to accompany them, so they cannot to spontaneously leave the long-term care facility. The commonality of this restricted access to the community is illustrated in Table Thirteen below, and this shows the lack of independence experienced by these members of the study cohort and the high levels of dependence on the long-term care facility staff. However, it should be noted that a feature of the case record is the stipulation that staff are available to support individuals who wish to access their local community to do so, this would not be the case in psychiatric

inpatient care. Lack of ability to access communities does feature in the decision to admit to long-term care. Where people need staff support there are considerable logistics involved in matching staff availability to the person's need, and this may be impossible where the person needs to go out in emergencies, this difficulty is immediately surmounted in long-term care where staff are constantly on tap. 48 of the study cohort need such staff support and the detail appears in Table Thirteen below.

Table Thirteen – Limited Access to Community or Not Recorded (Support Needed)

Community Access	Number
Does not engage	1/48 (2%)
Doesn't go out on own not motivated	10/48 (21%)
Only goes out with staff	21/48 (44%)
Does not go out on own due to offending history / behaviour	3/48 (6%)
Only goes out with staff. Goes to parents- taken by staff	3/48 (6%)
Record states person goes out without staff but not where they go	2/48 (4%)
Record states person he goes to appointments with staff	8/48 (16%)

Total=48 as this is the total number of people with limited access to the community not the overall cohort total

The table above illustrates the prevalence of the support people need to access their communities, which was determined from the description of the support needed to access the community in the case record. 3 examples of this support as responses are provided below for illustrative purposes

> "XXX asked about seeing her mom again. Her Mom has been contacted and said she does not feel well enough at the moment, but we reassured XXX that as soon as her Mom feels better, we can support her with visiting"
>
> "XXX regularly goes to the local shops Aldi and the hairdressers. XXX enjoys going out stating "it makes me feel normal". XXX requires support from staff when out to budget her money as she will often spend it all and will then have nothing left for the rest of the week. this results in her becoming restless or argumentative towards staff."

> “I often feel I needed to manage my anxiety by drinking one or two cans of lager before I went out. I understand that XXX staff and my social worker is worried about this becoming a habit, but I'm not drinking very much and don't think there's anything wrong with enjoying a drink in moderation.”

There is another commonality within the study cohort shown in the table below (Table Fourteen n=22) of people who can and do access their local community independently but not as freely as most of the population. These people do not drive (potentially due to mental illness and lack of finances for transport) and so their community access tends to be limited to local activity, commonly visits to family, coffee outings and shopping trips. Conversely, this can be viewed as a positive element of their tenure in long-term care as this gives them a sense of “hometown” which provides a locality and a sense of belonging to a community, although there are restrictions on this.

Table Fourteen - Facilities Accessed

Facilities Accessed	Number
Enjoys XXXX	1/22 (5%)
Goes to town for coffee	2/22 (9%)
Goes on train to see parents to the pub to the supermarket and to do voluntary work.	1/22 (5%)
Goes out independently, goes to XXXX	1/22 (5%)
Goes out independently, travels to XXXX to college to study	1/22 (5%)
Has a bus pass and goes nearby and to XXXX independently	1/22 (5%)
Walks into next town independently and has a coffee	1/22 (5%)
Goes out to local shops independently	8/22 (36%)
Goes into local town by himself	1/22 (5%)
Goes to parents house every other week and goes on outings.	1/22. (5%)

Total =22 as this is the number of people who access the community not the cohort total.

Travels independently across a big county on public transport to see her mum when she is well but does not do this when she is less well	1/22 (5%)
Walks into town on her own and goes to the shops when well	2/22 (5%)
Mentions trying to increase independence but not the detail.	1/22 (5%)

2 people are not restricted whatsoever in terms of community access; these people travel nation-wide. One of them travels daily to XXXX to go to college, and the other can use public transport to travel freely, negotiating travel plans with professionals and the long-term care facility.

Table Fourteen above shows the prevalence of the community facilities accessed from descriptions of this found throughout the case notes (most often in the assessment or review) 3 examples of such descriptions are provided below for illustrative purposes.

“XXX enjoys spending time with XXX and going to the local shop”

“She visits her mum twice a month which goes well”

“XXX continues to go to the shop independently to spend his daily allowance, continues to smoke and abides by the smoking policy”

Consequently, the study has found that legislative and situational protection and restriction are carefully considered as part of the assessment process and that in the light of levels of risk and alternative provisions available, there is little option but to admit this group of working-age adults with Mental Health needs to long-term care.

5.5 Theme- Resource

Reference has been made to the reduction in psychiatric acute hospital inpatient beds. This may be a contributing factor to admission to long-term care, however, to understand why people are admitted it is necessary to recognise exactly what resource is offered to long-term care residents in terms of accommodation, care, and support and how this provision alleviates risk.

Accommodation

Part of the support offered in long-term care is accommodation. Most people lived with their parents prior to admission, as Table Fifteen below illustrates; this is further discussed in the element of the Findings Chapter, which evaluates the care component of the resource theme. Another, relatively small number of people lived with carers other than parents prior to admission to long-term care as shown below.

Table Fifteen - Pre-Care Residence

Residence	Number
Parents	51/72 (71%)
Other Relative (previous generation)	2/72 (2%)
Spouse	7/72 (10%)
Own Home	8/72 (11%)
Homeless	4/72 (5.5%)

Total=72

NB This data is taken from the Employment part of the Accommodation and Employment Status form an example of which can be found in Appendix Four

Prior to admission, around a quarter of the study cohort had their own homes, the majority of which were tenancies, and 2 were homes inherited from deceased parents. None of these people who did have their own homes were able to maintain their homes in a habitable

condition, there was a fire risk, or they would leave their homes and go and sleep on the streets of their own volition (in some cases associated with substance use).

Another small number of people (4) were homeless prior to admission as they had not been able to maintain their homes and had lost their tenancies.

Table Sixteen - Support Needs

Independence Level	Number
Independent	22/72 (30.5%)
Partial Support	8/72 (11%)
Total Support	42/72 (58%)

Total=72

Table Sixteen above shows the assessing professionals stated impression of the levels of support/independence the person needed /had taken from the prevalence of the box ticked in the assessment form.

22 people were deemed to be independent in terms of support needed, so additional analysis was needed to determine why they had been admitted to long-term care.14 people had high risk behaviours such as fire risk or absconding with associated histories of problematic substance use, 7 did not take medication if this was not assertively administered to them and 1 person had a history of mental health relapse when living alone.

8 people were deemed by the assessing professional to be able to manage activities of daily living with some or partial support from the staff in the long-term care facility or to have fluctuating ability in this area.

The assessing professionals deemed that 42 people needed total support with one or more activities of daily living (examples of such activities from The Care Act (2014) are as follows:

maintaining personal hygiene; maintaining a warm and habitable home; attending to personal hygiene; fulfilling nutritional needs). This support varied, with some of the people below needing to be prompted to self-care in this manner, with staff typically doing this to maintain as much independence as possible despite the hostile responses this may elicit from the study cohort to a small number of people (the 2 who had come from long-stay psychiatric hospitals where such approaches were not taken) who were totally dependent and could not carry out daily living tasks despite prompts.

The assessing professional does not state why the people do not manage activities of daily living independently, other than in the case of the 2 individuals who had been in long-stay institutions and are institutionalised and irrevocably deskilled. This lack of ability to cope seems to be viewed as incidental to the high-risk behaviours the person exhibits and a part of the self-neglecting set of behaviours they exhibit. These behaviours pose risk but are viewed as an additional consideration to the harmful or immediately (potentially) damaging risk behaviours the person exhibits. Again, it appears that no interaction can take place in which the person and assessing professional can agree or understand why the person is averse to or not motivated to self-care, and the long-term care facility must take on the role of controlling or cajoling to ensure that activities of living and self-care take place.

Care and Support

Another key aspect of admission to long-term care is the support provision associated with it. Davies et al (2011) characterise this type of support as help with medication, physical health care and mental health care and note that physical health outcomes are often compromised with people with mental health needs. This part of the chapter will explore how people come to require support, and how the need for support increased to the point that long-term care was required.

Most of the study cohort currently reside in Nursing homes (n=68). This commonality is shown in Table Seventeen below. 2 of these people have moved from Independent Psychiatric Hospitals to long-term care, and a further 2 are currently planning to move to less restrictive Supported Living arrangements. There had been similar plans for an additional 4 people, but these have been delayed due to lingering restrictions caused by the COVID-19 pandemic.

Table Seventeen - Support Type

Support Type	Number
Nursing	68/72 (94%)
Residential	4/72 (6%)

Total=72

Taken from the category of support in the Service Provision Form (prevalence)

4 of the study cohort (shown in the table above) are in residential long-term care; there are no plans for any changes to this, as recorded in the case record. Some of the facilities are "mixed" nursing and residential but this study cohort tends to be admitted to the nursing areas.

The significance of the predominance of nursing care requires further examination to determine why this is the case. In its Guidance for Service Providers and Managers, the CQC broadly defines nursing care as having a nurse qualified by, and registered with, the Nursing and Midwifery Council present on site always. The purpose of this would be to either personally carry out or to delegate and oversee nursing care, but this does not clearly define what nursing is and what support is provided. Iwasiw (2013 p.1) defines nursing thus: "Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups, and communities, sick or well and in all settings. Nursing includes the promotion of health, preventing illness, and caring for ill, disabled and dying people. Advocacy, promoting a safe environment, research, participation in shaping health policy and inpatient and health systems

management, and education are also key nursing roles." Flaubert et al (2021) contend that the desirability of nursing care rests with the professional accountability nurses hold because of their training and registered status and argue that this desirability increases with the risks associated with the people they care for. The prevalence of nursing care provided for the study cohort is congruent with the high levels of risk they pose and the need to ensure that a professional level of accountability is provided with the care they receive.

Having established that the long-term care offer includes accommodation, support with activities of daily living and (typically) nursing care, it is interesting to consider the impact of the person's admission to long-term care. The data analysis indicated that (other than the people who had come from long-stay institutions) the study cohort had lengthy psychiatric acute inpatient stays, large numbers of "revolving door" admissions or a combination of the two. Table Eighteen below shows that there is a high degree of commonality between people in the study cohort having between 1 and 3 admissions to acute psychiatric inpatient care. Of these admissions, only 3 were voluntary, so for all the others, the people were detained under The Mental Health Act (1983) with the associated emotional and financial costs discussed previously. Table Nineteen below provides details of the duration of the longest admission and indicates that the most common duration of admission is between one and 6 months, which is congruent with the duration of Section 2 of the Mental Health Act, having 28 days duration, and Section 3 6 months duration. This detail around the frequency and duration of admissions illustrates the huge amount of resource this study cohort has consumed in terms of acute psychiatric inpatient capacity.

Table Eighteen - No of Admissions to Acute Hospital

Frequency of Admissions	Number
Frequency of admission not recorded	15/72 (21%)

Total=72

No admissions	4/72 (5.5%)
1 admission	22/72 (30.5%)
2 admissions	9/72 (12.5%)
3 admissions	14/72 (19%)
4 admissions	4/72 (5.5%)
5 admissions	0/72 (0%)
6 admissions	1/72 (1%)
7 admissions	2/72 (3%)
8 admissions	0/72 (0%)
9 admissions	0/72 (0%)
10 admissions	1/72 (1%)

Count of number of the admissions from case notes.

Table Nineteen – Duration of Longest Admission

Duration of Longest Admission	Number
Not recorded	15/72 (21%)
Less than one month	5/72 (7%)
1-3 months	20 (28%)
3-6 months	16/72 (22%)
6-9 month	1/72 (1%)
9-12 months	5/72 (7%)
12 months +	10/72 (14%)

Total=72

Prevalence of duration of admission from case-notes.

These lengthy and/or frequent admissions are known to be associated with repeated admissions to psychiatric inpatient wards (Pridmore et al 2004, Geller 2000, Heeren et al 2018) and this study (whilst not aiming to provide a quantifiable length of stay: frequency ratio) do find that lengthy and/or frequent acute psychiatric inpatient stays are associated with admission to long-term care for working-age people with mental health needs so the severity

of mental health need is a key factor in admission. It is next necessary to understand how the care and support provided as part of admission promotes compliance, treatment, and stabilization of mental health needs.

The issue of non-compliance with treatment in mental health is well documented (Hiday 2003 Hodgson et al 2007, O 'Keefe et al 1997, Swanson et al 2000) this section of the findings will focus on appointments with professionals and medication, although more strength-based and alternatively protective interventions are considered below. Non-compliance is also a feature with this study cohort for whom the relapses which lead to admission discussed in the previous paragraph often transpire after disengagement and non-compliance. Table Twenty below shows the commonality between the study cohort regarding compliance with medication, interventions to maintain levels of independence, visits from professionals, therapies offered, and other support provided by the care plan. People identified in the case record as compliant are those who do agree to all these aspects without some degree of compulsion or prompting; those identified as partially compliant would adhere to one aspect of their support but not others (e.g. they would engage with visits from their social worker but would need medication to be administered intra-muscularly). People deemed as not compliant would not comply with any part of their care plan without compulsion. These included some of the people on Community Treatment Orders who would not comply with any part of their care plan without the prospect of recall to a psychiatric hospital.

Table Twenty - Compliance Level

Compliance Level	Number
Not Compliant	41/72 (57%)
Partially Compliant	7/72 10%
Totally compliant	24/72 (33%)

Total=72

Taken from prevalence of tick box entries in assessment

Another aspect of care offered to working-age people with mental health needs in long-term care is support with their physical health needs or other types of morbidity. The concept of multiple jeopardies has been discussed above in the risk section in terms of the commonality of multiple jeopardy, but this section of the Findings Chapter will provide more detail on these jeopardies and the relationship between them and admission to long-term care. The main or primary mental health diagnosis will not be evaluated as the chapter has already found that the primary mental health diagnosis leading to working-age people being admitted to long-term care is typically psychosis/schizophrenia. Table Twenty-One below shows the commonality of other morbidities with this diagnosis amongst the study cohort. It is of note that Learning Disability, Autism, Asperger's Syndrome and OCD are common co-existing cognitive or psychological conditions. These types of adjustment disorders must make toleration of psychosis incredibly difficult, and the co-existence of these conditions exacerbates the distress experienced. There is also a degree of commonality with skin integrity issues, which may be a by-product of self-neglect and poor attention to personal hygiene. (45 people had co-existing conditions, 27 had none)

**N.B. people may have several or no co-existing conditions.*

Table Twenty-One - Co-Existing Conditions

Co-Existing Conditions	Number
Anxiety	1/45 (2%)
Asperger's Syndrome	2/45 (5%)
Autism	5/45 (11%)
Depressive Disorder	1/45 (2%)
Diabetes	2/45 (5%)
Disassociative Amnesia	1/45 (2%)
Eating Disorder	1/45 (2%)
Eczema	1/45 (2%)
Kidney Failure	1/45 (2%)
Korsakoff's Syndrome	1/45 (2%)
Incontinence	1/45 (2%)
Learning Disability	9/45 (20%)

Total=45 as not all people had co-existing conditions

Lymphedema	1/45 (2%)
Marfan's Syndrome	1/45 (2%)
Memory Deterioration	1/45 (2%)
OCD	5/45 (11%)
Oculogyric Crisis	1/45 (2%)
Obesity	2/45 (5%)
Parietal Degeneration	1/45 (2%)
Personality Disorder	1/45 (2%)
Polydipsia	1/45 (2%)
Temporal Lobe Epilepsy	1/45 (2%)
Skin Integrity Issues	3/45 (7%)
Tourette's	1/45 (2%)

Taken from the prevalence of "other conditions" in assessment and review.

This section of the Findings Chapter has evaluated how the resource theme identified in the data analysis impacts on the study cohort, or how the resource provided in the long-term care facility manages the risk these people present. The initial mitigation is that of accommodation; the study cohort has their basic needs for shelter, warmth and food met and monitored. Aspects of how they live such as fire risk and absconding, are also alleviated as the regulated and monitored environment within long-term care provides checks and measures and more rapid responses and interventions than would be available if these fail than there would be for people living (often alone) in the community. As well as accommodation, the long-term care facilities provide care and support for the person. This may be because of the breakdown of a previous carer (usually parents), relapse or deterioration of self-care leading to mental health relapse and general deterioration of mental health, often due to non-compliance and lack of engagement. The long-term care facility is also able to provide dedicated support for co-morbid conditions such as multiple mental health needs or associated learning disability or physical health needs, which may not be accessible or available to people in community settings. Thus far, the Findings Chapter has appraised the risk the study cohort presents, the

lack of a shared reality between the person and the assessor which leads to constraint and disengagement and creates an inequitable power relationship between the person and the professional and long-term care staff. This arises from the restrictions placed upon the study cohort to protect them, as well as the resources provided to them in long-term care. However, to provide balanced findings, it is also necessary to determine what strengths or protective factors these individuals have in terms of how far they can influence their future in the form of their self-determination, what networks and relationships they have, and what they value as protective mental health behaviours and attributes.

5.6 Theme- Peoples' Strengths and Protective Factors

Thus far, the Findings Chapter has focussed on the themes emerging from the data analysis: the risks which led to admission, the protection and restrictions this affords, the care and support offered to people and the implications of the lack of a shared reality between the study cohort and those who support them. All these aspects are appropriate to an appreciation of the reason for admission, but to provide a fully rounded and nuanced response to the research question, it is also necessary to consider the protective factors or strengths the person has as well as their needs. These protective factors or strengths are the characteristics that supported them living in their communities for as long as they did and allow them to support their psychological wellbeing in the long-term care setting. This section will conclude by evaluating how far long-term care fosters and accentuates these strengths and protective factors and whether this can be considered part of the complex rationale for admission to long-term care. Hammond (2010 p.3) defines a strength-based approach thus: "A strengths-based approach is a specific method of working with and resolving problems experienced by the presenting person. It does not attempt to ignore the problems and difficulties. Rather, it attempts to identify the positive basis of the person's resources (or what may need to be added) and strengths that will lay the basis to address the challenges resulting from the problems" so, for

completeness, strengths as well as needs will be considered as part of the findings, the first of these will be the persons supportive and protective networks.

Supportive and Protective Networks

A significant number of study cohort have no relationship with anyone outside of the home. There is a substantial body of work around the adverse effects isolation and loneliness have on people's physical well-being (e.g. Umberson and Montez 2010, Hawkley and Cacioppo 2010), so it is reasonable to conjecture that this lack of relationships and isolation has adverse effects on the study cohort Table Twenty-Two below shows that 24 members of the study cohort have no identified significant other noted within the case documentation.

Table Twenty-Two - Supportive Networks

Supportive Networks	Number
No Supportive Relationships	24/72 (33%)
Parent(s)	31/72 (43%)
Parent(s) and Sibling(s)	5/72 (7%)
Aunty	1/72 (1%)
Parent Sibling and Offspring	1/72 (1%)
Sibling and Offspring	1/72 (1%)
Sibling	5/72 (7%)
Offspring	1/72 (1%)
Partner / Ex Partner	3/72 (4%)

Total=72

Taken from Accommodation and Financial Status Form and assessment and review (prevalence)

Those members of the study cohort who do have regular contact with others predominantly have these relationships with people they met before they became mentally unwell or lost the

reality they shared with others. Table Twenty-Two above illustrates that relationships people have are typically family ones (where there is a history of shared reality) and these were almost exclusively established prior to admission, indicating the limited prospects of developing and sustaining relationships within long-term care settings. It is not possible to determine the quality of these relationships via the case notes. Where contact has a pattern or regularity (e.g. weekly visits to the home or trips home for Sunday lunch) this is recorded, but where it is not the case, the study is reliant on the fact that the assessing professional has recorded the relationship, to deduce that it has some significance to the person in the study cohort. The case notes do indicate that for two of the people contact is restricted due to previous safeguarding issues, another person only speaks to his father on the phone as the father has dementia and is no longer able to visit and another person goes to see his elderly mother in her nursing home with staff assistance. 3 of the study cohort have contact with partners or ex partners, but again, these are relationships established prior to admission to long-term care.

A small number of the study cohort have developed friendships and relationships within the long-term care facility; the scarcity of these associations seemed remarkable as so many people were together in close quarters. *(n= 5)*. The “friendship” is recorded as such by the assessing professional in the case documents. It is hard to determine how much of a shared reality these friends have, or how strong friendships are as little detail about this recorded in the case record.

The data analysis indicated that some of this study cohort did value opportunities to participate in sports, hobbies (including craft and watching favourite TV programmes) and one favourite pastime was accessing local towns for shopping (either independently or with staff support). The differing activities are shown in Table Twenty-Three below and were deemed to be hobbies or interests if the assessing professional deemed them to have significance to the individual in the case documentation. It is notable that these hobbies or interests could be

deemed as “low-key” to most of the population, but they were deemed by the assessing professional to have significance to the individuals concerned.

Table Twenty-Three - Activities

NB This is not 100% as each item that is one (with a value of 1) is rounded down from 1.38%

Activity Type / Description	Number
Enjoys watching TV on own	1/72 (1%)
Enjoys Crafts	1/72 (1%)
Likes football & cricket	1/72 (1%)
Watching TV going to XXX and XXXX	1/72 (1%)
Enjoys going to local town for coffee	4/72 (6%)
Enjoys going to local town for coffee / TV	1/72 (1%)
Enjoys TV in lounge	4/72 (6%)
Likes talking to grandma on phone	1/72 (1%)
Enjoys short breaks to XXXX and XXXX	2/72 (3%)
Enjoys cans of beer	1/72 (1%)
Enjoys smoking and attending groups when well enough	1/72 (1%)
Enjoys smoking	2/72 (3%)
Enjoys football and Star Wars	1/72 (1%)
Enjoys smoking. Enjoys 80's music and going for coffee.	1/72 (1%)
Takes self for trips on train.	1/72 (1%)
College daily? What for?	1/72 (1%)
Enjoys going to XXXX on public transport	1/72 (1%)
Enjoys gong to local town for coffee, likes talking to staff	1/72 (1%)
Enjoys contact with family	1/72 (1%)
Enjoys going to local town shopping.	7/72 (10%)

Total=72

Enjoys going to "groups"? What	1/72 (1%)
Enjoys going to local town for shopping and hairdresser	1/72 (1%)
Enjoys shopping in local town but energy drink issue	1/72 (1%)
Enjoys group activities in the home and going on holiday with them	1/72 (1%)
Nothing recorded.	34/72 (47%)

What the person enjoys was taken from qualitative descriptions within the case notes. 3 examples of this can be found below

> "She says that he can be sociable but also enjoys his own company and spending time in his home, listening to music, or watching tv."
>
> "…she would like to renew her relationship with her son who lives in ,X, he can use public transport and will visit her."
>
> "XXX manages her own medication and uses buses to visit nearby towns to go shopping. XXX enjoys shopping …"

This protective engagement in activities is positive for the study cohort, especially as factors such as high-risk behaviour (Bow Thomas et al 1999, Lehman 1988, Brier et al 1991), short staffing (Kasckow 2001), limited financial and transport resources (Cohen 1990) often limit the access of people with severe mental illness to pursuing hobbies and interests.

Consequently, the study cohort have protective factors in terms of relationships, hobbies and interests they have in and outside of long-term care (albeit these may be limited by the factors outlined above), and they also have varying degrees of ability to determine their outcomes. Lack of a shared reality does feature in that many relationships deemed to be significant within the notes are those forged prior to the onset of mental illness.

Co-production and the Voice of the Person

The study cohort's levels of self-determination and aspiration were part of the data analysis. In many cases, the opinions of the assessing professional were predominant (n=37). Where the views of the assessing professional were deemed to be predominant, this was because there was no mention in the case record of the person's wishes or aspirations. It should not be assumed that the assessing professional did not seek to elicit these. The person may not have wished to engage or may not express any such aspirations, but it would not be possible to determine this from the case record as the professional would not be likely to record that they had omitted to consider this.

The table below (Table Twenty-Four), however, shows that the person's views were sought and recorded in the case notes of other individuals. This involvement of the person and their representative is termed co-production, and this is defined as follows: "The idea of co-production can be seen widely across health and social care It can also be seen in the concept of 'shared decision-making', an approach that has a developing evidence-base in terms of its potential impact" Clark (2015 p.3.) The purpose of this study is not to quantitatively assign proportionate ratios of decision-making influence within the case documentation, but it is pertinent to note that in much of the documentation, the voice of the person is apparent, even when this is not complimentary to the long- term care facility or assessing professional.

Table Twenty-Four below contains evidence of the person's wishes and efforts to co-produce their care with them 35 people did so. Notably, that there is a considerable degree of commonality of people wanting to remain in the home (n=14), and the assessing professional stating they are "happy" there. This is a significant finding regarding any inherent assumption within the research question that admission is necessarily detrimental to the person. Still, more work is needed around what alternatives have been offered to the person and how this has

been communicated or discussed. This indicates that there is some degree of shared reality and opinion about the person being in the home as this enables risk management and self-care. This risk management comes in the form of the monitoring and control afforded by the long-term care as opposed to any meaningful negotiation, shared reality or unwritten contract about their behaviours, risks, wellbeing, and independence making it challenging to determine what actual levels of co-production are achieved.

Table Twenty-Four - Expressed Views

What the Person Expressed	Number
Wanted to move but this was prevented through COVID - trying again	1/35 (3%)
Wants own home marriage and family but sexual delusions prevent	1/35 (3%)
Wants to remain in home	14/35 (40%)
Wants a boyfriend one of her delusions is that she has one	1/35 (3%)
Wants driving licence job and flat back.	1/35 (3%)
Would like to live more independently	6/35 (17%)
They are quoted "I could not feel more lonely"	1/35 (3%)
Wants their own home with carpets	1/35 (3%)
Wants flat and car and relationship	1/35 (3%)
Wants to live in XXXX - would have been area of origin	1/35 (3%)
They would like to be more independent but thinks any move would be unbearably stressful	1/35 (3%)
Would like more holidays	1/35 (3%)
Wants to stay where they are and feels their current situation is due to the childhood trauma, they experienced	1/35 (3%)
Wants to stay in the home and learn skills then move to more independent living	1/35 3%)
Social workers want them to move to a more independent setting, but they feel safe where they are	1/35 (3%)
Telephone contact with dad important - not sure how far they understand his dementia	1/35 (3%)
Only wants to interact with mum and dad	1/35 (3%)

Total=35 as not all expressed a view

What people have expressed is gathered from descriptive qualitative information which can be found throughout the case-notes 3 examples of this are provided below for illustrative purposes.

> “It has been established that I no longer require the rehabilitation placement at XXX but due to ongoing support needs, I need to move to a supported living complex to

enable me to continue to develop / improve & reintegrate into the community effectively"

"He acknowledged that he has made significant progress since his placement at XXX, and feels he is generally happier and more settled in his mental health"

"…he doesn't know what benefits he gets, how much, or how much savings he has. When asked about it, he just says, I don't know, I'm not really interested. He picks up £30 from the office every week and says he is happy with the arrangement. He pays a contribution to his care but doesn't know how much and says he's not interested."

5.7 Conclusion to Findings

The study has found that risk behaviours are associated with the admitting of working-age people to long-term care. The types of risk identified are those which cause harm to self or others and include physical and sexual harm and self-harm, whether deliberate or through self-neglect; it is not uncommon for the person to engage in more than one such behaviour.

The person will continue to persist in the behaviours due to addiction, the need to self-stimulate or regulate their environment or as a response to auditory or other hallucinations or delusional thoughts; on a level these themes explain the behaviour, but the data analysis has shown that beyond these broad themes, there is little understanding or shared reality around how delusions, substance use, environmental regulation and self-stimulation actually function for or impact upon the person and there is, therefore, little or no meaningful negotiation about the risks and behaviours leaving the assessing professional no alternative but to arrange admission to long-term care to monitor and control the risk behaviours.

Following admission, the behaviours also function as a means of avoidance of unwanted interactions or expectations, and/or because of addiction or self-medication associated with substance use. These behaviours constitute how the person objects to monitoring and control and manifest a lack of a shared reality about how to behave and what risks professionals

deem to be acceptable. These behaviours present management difficulties as they are severe in nature and unpredictable, requiring the type of constant resource to manage them, which is only available in long-term care on an ongoing basis. The risk associated with the diagnosis of the person also arose in the analysis with a predominance of people who have psychotic illnesses entering long-term care and an unexpectedly high level of associated diagnoses of learning disability and autism. All these diagnoses feature altered or atypical perceptions of reality, which do not coincide with the reality of much of the population. This results in severely risky behaviour which is not understood, and which professionals cannot assure themselves about so must reach an inevitable decision to admit the person to long-term care.

Another strong theme emerging from the study was the requirement to offer protection to the person exhibiting the behaviour and to society by imposing some restriction on the person in long-term care. Those people who did not have Mental Health Act restrictions tended to be people who had moved there from the old long-stay psychiatric hospitals and were quite passive in their acceptance of the long-term care regimes. At the other end of the spectrum, other individuals are on Community Treatment Orders, which enable them to be returned to Psychiatric Hospital under Section 3 of the Mental Health Act if they do not comply with treatment plans, which include residence at home and compliance with medication schedules.

All the study cohort were subject to some level of financial restriction, whether due to formal arrangements such as an appointeeship to manage their finances, which restricted access to money, or due to poverty associated with their condition and being unable to maintain employment, which would provide them an income. These restrictions are the legislative and financial frameworks which compel the person to remain in the home (or be returned to it should they leave it) they formalize and legitimize the admission, and the control exerted over the person.

The level of resources the person had consumed and continued to require was a further theme emergent from the data analysis. The study cohort tended to have frequent or long (or both)

periods as psychiatric hospital inpatients, or in the case of a smaller number having had a catastrophic event (such as a serious suicide attempt) which led to admission to hospital under the Mental Health Act and admission to the long-term care facility on discharge. It is of note that in the area in which the study took place, the numbers of the study cohort are considerably greater than the number of psychiatric inpatient beds, so admission to long-term care for "revolving door" patients is a necessity as they cannot be accommodated longer term within the available resource.

Admission allocates the long-term care resource to that person for their use, adding an element of stability to the resourcing of mental health support for those people with severe and enduring mental illness. The type of resource provided to the person as part of the long-term care service offered includes accommodation, care and support. The accommodation offered meets the needs of people who cannot maintain a habitable home or are vulnerable without care and support. Long-term care offers them practical support, guidance, and ongoing monitoring, all of which contain and restrict the risk behaviours which bought about the initial admission to such a setting. This resource rationalization is a key element of the decision to admit, but this admission is often the ultimate event in a fluctuating or deteriorating mental health crisis experienced by the person and although mental illness may (and does) persist in long-term care, admission brings about an element of certainty and predictability, it is the final response to high-risk behaviours and ends the (intense, frequent or both) series of mental health crises experienced by the person. This is arguably why some of the study cohort who expressed wishes about their future wanted to remain in their current setting.

Another theme which became apparent throughout the data analysis on a positive note was the relationships and activities the person participated in which supported their resilience and psychological well-being. These factors include friendships and relationships, activities and hobbies and how the person inputs planning and influencing care delivery with professionals. The familial relationships analysed had all been forged before the person was mentally ill and

had shared realities with family members or memories of shared realities. The references to “friendships” within the record contained little detail about the nature and quality of these friendships to whether working-age people with mental health needs shared an overarching or fragmented shared reality with these friends because of their tenure.

The thesis will now continue to be developed in the Discussion Chapter. This will evaluate the extant literature on admission to long-term care, the social constructs of risk, shared reality and risk perception and will explore how this influences the balance between protection and restriction, which will, in turn, appraise the social construction of adequacy of resources and how people can meaningfully co-produce their care offer within these constraints. It will also pose the question as to how the accepted reality difference (evident in avoidant behaviour, substance use, response to delusions, self-regulation, and self-stimulation) results in a kind of equilibrium in long-term care settings which cannot be replicated in the broader community. The Findings Chapter has identified themes or conditions that dictate that a decision to admit must be made. The Discussion Chapter will continue to review extant literature in relation to these and determine a theoretical framework as to how the decision is made and the inherent factors that influence the decision.

6.0 - DISCUSSION CHAPTER

6.1 Extant Literature Pertaining to The Themes in the Findings

The initial part of the Discussion Chapter will concern itself with the extant literature about the themes identified in the Findings. Each of these areas will be examined in turn, followed by an analysis of the generation of the theory arising from the thesis.

Sample Characteristics

Gender and Sexuality

McManus et al (2016) state that in the general population, one in five women have been diagnosed mental health problems, and one in eight men experience this. They also report that diagnosed mental health problems are increasing in women. However, when we begin to look at this study cohort, where the prevalent diagnosis is schizophrenia, it is typical that the male gender is in the majority. Seeman (2018) states that schizophrenia also presents earlier in males and attributes it to genetic factors and the lack of protective factors afforded by oestrogen. The information documented within the assessment framework makes no reference as to how the person perceives their gender identity, although Rajkumar (2014) argues that Gender Identity Dysphoria (GID) is more prevalent in people with schizophrenia than in the general population (in his view, both are neurodevelopmental disorders). There is also little evidence in the case records of any discussion with working-age people admitted to long-term care about their sexuality or need for intimacy, De Jager and McCann (2017) carried out a systematic review of the literature, which indicates that this omission is typical in the experience of people with serious mental illness.

Ethnicity

This picture in the Findings is not in line with national trends in the diagnosis of people with serious mental illness, in particular, schizophrenia. Halvorsud et al (2019) carried out a systematic review which found that the risk of a diagnosis of these conditions is elevated in black ethnic groups but is higher for all ethnic minority groups. The lower numbers in this cohort reflect the demographic of the study area. It was noted during the memoing process that where people came from backgrounds other than white British, that people living in long term care would mainly go and visit their relatives and friends in their homes as opposed to the loved ones or friends coming to the long-term care facility.

Badger et al (2009) carried out a literature review around the role of ethnicity in long-term care (again for older people at the end of life, but comparable studies are not available for this study cohort) and indicated that there is no data as to the numbers of BME (Black and Minority Ethnic) people in long-term care or what cultural support is made available for them. It was also noted at this part of the analysis that people from a BME background were reported as exhibiting certain behaviours around food, such as hoarding it or not keeping it in a manner staff thought appropriate (typically not refrigerated). Delving into the record indicated that the type of food concerned was not recorded, but it was considered that this was not food routinely served, or there would be no need to keep it separately. Evans et al (2019) carried out a series of interviews with older adults living in Birmingham (again not a direct “match” with this study group but there was no more comparable data available). They found that having culturally appropriate food was an essential part of people’s identity and sense of self, as was the way food was eaten and observation of different “Sabbath days” as opposed to simply providing Sunday dinners was another crucial factor.

Age

The psychosis data report (Public Health England (2016) indicates that women tend to be referred to professionals at a later age (40-49) than males (30-49). However, age of

admission is not deemed to be a crucial factor in this study which focuses more upon the unpredictable nature of psychosis and the associated risk levels.

Having discussed the sample characteristics of the study cohort the Discussion Chapter will continue to examine how the extant literature about risk contributes to the knowledge and theory generation of this thesis.

Theme – Risk

In terms of the extant literature linking risk and admission, Monahan and Steadman (1994) point to the lack of community-based risk assessment reliability studies, possibly due to adversity to risk, which precludes high and severe risk people from the community. They reference a study by Lidz, Mulvey and Gardner (1993), which indicates that only 53% of people admitted to Emergency Departments with mental health needs enacted the “worst case scenario” risk levels identified in their risk assessments. It is acknowledged that this study is not about admission to acute psychiatric facilities. Still, this thesis has found that admission to an acute psychiatric hospital is a precursor to admission to long-term care, in common with Talaslahti et al (2016), who found that 27% of people admitted to long-term care had at least one hospital admission (albeit this study sample was older adults so the phenomenon was not as pronounced as it is in working-age people). The chapter will continue to evaluate the risk levels of the working-age people admitted to long-term care in respect of both harm to self and others, but the research does acknowledge that levels of risk are moderated and controlled via the levels of intervention afforded by 24-hour care.

Aggression or Harm to Others

Much of the literature around aggression or harm to others' views this as a multi-dimensional construct which echoes the findings of this study (Coie and Dodge 1998, Dodge 1991, Dodge and Coie 1987, Frick 1998, Pulkinnen 1969, 1996). Researchers have distinguished between types of harm to others, including direct, overt, physical, verbal and environmental as opposed to indirect, relational, social, and material harm to others, all of which were found in this data. They also identify functions of harm to others including proactive, offensive, and instrumental harm to others, which contrast with reactive and defensive aggression in terms of their antecedent. Again, these were apparent in these findings in the distinction between violent behaviours, which are an overt attack on others and those used to escape from unwanted interactions. There is a prevalence of violent and aggressive behaviours in long-term care settings for people with mental health needs. (Flannery 2001, Hodgkinson et al 1984, Snyder 1994, Carmel and Hunter 1993) which is unsurprising in view of the characteristics of the people who reside in them, and the multiple functions violent behaviours provide to them.

Merrifield (2017) carried out a survey of mental health employees in acute psychiatric settings, and 36% of these individuals had been subject to violent attack during the preceding 12 months. The staff attributed this to several factors including inadequate numbers of staff and overuse of agency staff who do not know patients (and do not know what will trigger them to become violent); lack of training and supervision; and the increased acuity of patients. This is congruent with the staff preventing the risk behaviours and thus bearing the brunt of them. There is also evidence that there is a correlation between having schizophrenic syndrome (as is the case for most of this cohort) and increased rates of antisocial behaviour in general and violence in particular; Hodgins (1992); Hodgins et al (1996); Wallace et al (1998) Angermeyer (2000); Arseneault et al, 2000) and Walsh et al (2001). Existing research also evidences that such associations are not just statistically but clinically and socially significant (Hodgins and

Muller-Isberner 2004). Taylor and Gunn (1984) carried out a study in the USA that indicated that 11% of people who committed murder and 9% of non-fatal violent offenders had a diagnosis of schizophrenia. Thus, there is an evidence base that would substantiate the concerns of assessing professionals about the risk of harm to others. However, the studies cited above and the data in this thesis do not indicate that admission to long-term care itself reduces the risk of harm to others, so it is reasonable to state that this intervention moves the risk to a place where it is perceived to be managed via constant staff presence as opposed to alleviating or removing it.

It is also valuable to note that harm to others does not occur only to staff, as some of the findings presented above illustrate. However, it could be (cynically) argued that they "put themselves in harm's way" by their choice of career and are aware of this when they choose to work in mental health. Marzuk (1996) argues that the prevalence of people with mental health needs harming each other when housed together in long-term care facilities and psychiatric wards is a result of the trauma they have historically faced and continue to face. Mullen et al (1993) attribute the phenomenon to poorly developed or impaired social functioning paired with reduced tolerance due to mental illness and the behaviours exhibited by others. However, such incidents should not be viewed as an inevitable by-product of admission to long-term care, and it is pertinent to state that one of this study cohort assaulted and killed a fellow patient. Thus, the risk that working-age people with mental health needs will physically harm other people is a factor in their admission to long-term care. However, admission does not alleviate this risk. Assessing professionals do weigh up the risks concerned and (from what is written in the record) genuinely believe that this setting is optimum for managing this risk. It is possible to remove more vulnerable people to areas designed for them. It should also be noted that not all harm is necessarily physical and that the risk of sexually harming others may also be a factor in admission. Thus, for people at risk of harming others, the decision to admit to long-term care is based on the availability of

constant support and supervision for them, which provides monitoring of risk potential and intervention when it occurs.

Sexually Harming Others

Drake and Pathe (2004) found that there was an increase in sexually harmful behaviours in males with schizophrenia but that the relationship between the mental illness and the offending behaviour was poorly defined. Consequently, they produced a four-element typology as follows; pre-existing sexually deviant behavior, those whose behavior arises as part of the context of their illness, those whose sexual behaviour is part of a picture of overall deviant behaviour and finally factors other than those preceding. Within this cohort the offending behaviour arises as part of the person's illness (although this is not meant by any means to denigrate the devastating effect this can have on victims) 2 of the people in this study cohort believe that their advances are welcome and the third has a belief system which causes him to think strangers are his sister and display affection to them. The long-term care setting does not cause delusions to cease but allows them to be medicated and the residents' access to people they may harm is restricted. The knowledge generation in respect of sexually harmful behaviour focusses more on the person's belief systems and the clinical record explains at great length how the person had no intent to sexually assault another person, but that their alternative belief systems or delusions led to this.

Self-Neglect

Self-neglect constitutes a risk which requires a resource intensive response from services. It may result in the person being admitted to a psychiatric hospital or long-term care. However, as Braye and Preston Shoot (2015) point out, this does not necessarily end self-neglect but allows staff to monitor this to limit damage. This may be necessary where the person's

condition means they do not have capacity to appreciate the risk their behaviours pose which Naik et al (2008) state may be a byproduct of their mental health condition. Although the monitoring and risk reduction approach can be viewed as beneficial, Day and Leahy-Warren (2008) draw attention to how this may be received by people in the study cohort who may feel that their freedom is impinged upon. George and Gilbert (2018) find, similarly to this study, that this may result in the person becoming angry and verbally or physically assaulting staff who are prompting them to carry out activities of daily living (please see a prevalence of this in this study in the section on violent behaviour in the Findings Chapter). Consequently, self-neglect, similarly, to harm to others, is not remedied by admission to long-term care but it offers the only apparent option to intervene to try to manage this.

Self-Harm

Hawton et al (2012, p.2373) define self-harm succinctly as follows: “Self-harm refers to intentional self-harm or self-injury.” There are various types and manifestations of self-harm, and this study will be structured around the distinction between the use of self-harm as either a means to end or preserve life. This distinction is expressed by Mangnall and Yurkovitch (2008) in that those who self-harm with the intent to kill themselves do so from far different antecedent causes and with far different expectations than those who self-harm without the intent to kill themselves. Favazza (1998) agrees and describes self-harm behaviour as a morbid form of self-help that is contrary to suicide. In fact, one model of self-harm (Suyemoto 1998) named this the “anti-suicide” model and focuses on deliberate self-harm as an active coping mechanism used to avoid suicide. Indeed, Mangnall and Yurkovitch (2008) speculate (p.1) that “the reason that a true understanding of deliberate self-harm remains elusive is because researchers have been attempting to study deliberate self-harm as if it were one phenomenon that included any attempt at self-harm when in reality suicide and deliberate self-harm are two completely different phenomena.” This was borne out in this study with little or

no evidence in the case notes that the assessing professional had asked the person why they exhibited these behaviours and what was their desired outcome.

There is little research about deliberate self-harm, which is not carried out with the aim of completing suicide in nursing home settings, and what does exist tends to be focused on older people. This indicates that disinhibition due to dementia causes such behaviour (Mahgoub et al 2011; De Jonghe-Rouleau 2005; Low et al 2004). None of these studies provide any explanation as to how the nursing home alleviated the phenomenon of deliberate self-harm. The care plans in this study did include risk mitigation strategies such as completing alternative activities when compelled to self-harm, or for some people, a strategy of seeking support from staff when they felt distressed. This comfort may not be “on tap” if the person was living alone in the community. This provides some justification of the support 24-hour care provides, which offers validation for the admission.

Barak and Gale (2014) and Mezuk et al (2014) carried out a literature review into suicidal behaviour in older people in long-term care. They concluded that loss of autonomy and separation from one’s spouse was a contributory factor to suicide. These studies state that information about the suicides is sparse, and data does relate to factors about ageing, such as declining physical health, so it is not possible to draw parallels between these studies and the experience of working-age adults entering long-term care. Unfortunately, similar studies for working-age adults could not be found at the time of writing, so the experience of people admitted to acute psychiatric wards was considered (although the findings of this study below do indicate that some of the study cohort are separated from friends and family). Hagan and Hjelmeland (2017) and Bohan and Doyle (2008) attribute this to a loss of hope and autonomy. Cutliffe and Stevensons (2007), however, point out that people are at their most unwell when admitted to psychiatric wards and can also be “unknown quantities” to the staff, which

increases risk. The intervention of admission to long-term care for members of the study cohort who self-harm (with the intent of suicide or not) has a similar profile to that of people who are admitted as a result of the risk of harm to others or self-neglect; there is more work to be done in harm reduction around finding what people seek as an outcome of these behaviours and whether alternative means of achieving this can be sought. However, admission is a means of damage limitation and risk management as people can be protected in such settings as eventualities are expected, contingencies are planned, staff are available round the clock, and such episodes do not necessarily present as emergencies or crises to services resulting in admission to acute psychiatric services.

Substance Use

Cook (2009 p.2) defines problematic substance use as "…the element of subjective compulsion, defined within the dependence syndrome in such a way as to include both craving and control over substance-related behaviour." Lubman et al (2010) state that people with schizophrenia have higher rates of alcohol, tobacco, and drug use than the general population they also remark that having a mental disorder in childhood or adolescence can increase the risk of later drug use and the development of a substance use disorder, and it has undoubtedly been a feature in this study that use of substances and alcohol between the ages of 18-30 coincides with a decline in mental health which leads to admission to long-term care.

Kelly and Daly (2013) point out that stress is a known risk factor for mental illness, and the cyclical relationship between the psychological distresses associated with the financial, social, and practical implications of procuring substances has a detrimental impact on mental health which leads assessing professionals to feel admission is the only option. Whilst alcohol and substance use are forms of self-harm (explored in depth by Jung 2001) they are also associated with other sorts of self-harm and other risky behaviours such as violence and multiple sexual partners (Baskin Sommers and Sommers 2006). It has also been documented

that mental illness can contribute to drug use and addiction, leading to a multiple jeopardy effect, and it is frequently hypothesized that individuals with varying degrees of mental disorder may use substances as a form of self-medication (Ross and Peselow 2012).

The view of the assessing professional that substance use needs to be controlled or eradicated by admission to long-term care is understandable, considering the correlation which exists between mental health and the tendency of people self-medicating with other drugs not to take prescribed medications as described by Santucci (2012), and this is apparent in the case notes of this study population. However, as is the case with harm to others, self-harm and suicidality, the decision to admit to long-term care does limit risk and damage. The long-term care facility devises considered and tried responses to these behaviours and can prevent people from going out and procuring substances (CTOs and DoLs) as well as withholding access to money (potentially by appointeeship, or via safeguarding where the person is financially vulnerable – please see below) they can also monitor substance use. Consequently, levels of protection are wrapped around the person and long-term care facilities are in a much stronger protective position to respond to substance use crises than community services who may need to intervene in multiple crises at any given time and may not have the resource to do so. It is also a consideration that people residing within the long-term care facilities are protected by the fact they live in them and are easily accessed by staff who can intervene.

Functions of Behaviours

Response to Delusions

Buchanan et al (1993) state that people exhibit aggressive or violent behaviours because of delusions for two main reasons: firstly, trying to find evidence for their delusions or to challenge others who are refuting their delusions, and secondly as a form of exhibiting anger or distress because of their delusions. The findings provide examples of just such phenomenon with one person becoming aggressive to others as they do not display due deference to her despite

her perception that she is a deity and a popstar's girlfriend and another person believing he needs to pre-empt with violence to prevent people harming him. Zangrilli et al (2014) explore the dilemma of working with people with delusions - as not making direct reference to them may be seen to be colluding with them, which is not helpful, or equally, people may find questioning about their delusions challenging and distressing - they conclude that a range of approaches may need to be taken in accordance with the nature of the delusion and the impact it has upon the person with more work being needed to understand distinctions and optimum approaches.

Avoidance

Michelbaum (1971) typifies avoidant behaviour as behaviours that lead a person to avoid situations they do not want to enter or to leave interactions or situations which have commenced and become uncomfortable. In this some situations which were encountered in the data analysis, a violent reaction to a member of staff did reduce staff prompting long-term care residents. Eaton and Banting (2012) characterise this disconnect between the normative behaviour expected in the care home and the lifestyle the person would choose as a key aspect of aggressive behaviour. They favour a more negotiated approach to achieve optimal outcomes instead of the staff "instructing" the person to carry out task. In this thesis, it was apparent that the study cohort must abide with the standards of cleanliness (both environmental and personal) of the care home and cannot make personal lifestyle choices in the same way most society can. Again, evidence of a lack of "shared reality" or standards around maintenance (medical, social, personal, and environmental) needs between the admitted person, the assessing professional, and the home staff is apparent.

Sidman (2006) refers to this type of avoidance as negative reinforcement, where the person continues to exhibit behaviour as it functions to extract the person from a situation and recommends where avoidance is the function of the behaviour there is an understanding of what and why the person is avoiding so that mitigating measures can be put into place

where possible. Williams (2009) examines the exacerbation of the disconnected “shared reality” here and how these spirals into ostracism and constructs a power disconnect between the groups with the strongest shared reality and others for whom this shared reality is fragmented. There is evidence in the case notes that avoidance of tasks is an issue for the person and there are several good examples of this being negotiated with them so that it can be done in the most conducive way for the person (for example, it is agreed one person can have a shower weekly rather than the preferred daily of the care home, this is a contract which is adhered to by both parties, albeit reluctantly). The data analysis indicates that the people who do become distressed or angry when feeling the need to avoid tasks and situations are those who have neglected aspects of their self-care or care of their environment prior to admission. The consequent physical and psychological health deterioration has been an aspect of the decision to admit them, so the admission has not reduced incidence or severity of the risk behaviour. Still, it has increased the ability to monitor and manage it, whilst not achieving a meeting of minds or “shared reality” as to what should take place or why.

Regulating Environment

Laurent and Rubin (2004) describe how people with mental health needs, learning disability or autism are adversely emotionally impacted by over-reliance on routine or structure and the distress that forced or threatened diversion from these means of self-regulation causes. Compton et al (2010) outline the importance of regimes and routine as a means for autistic people to emotionally self-regulate and carry out a study into the distressing outcomes for people who are placed in large facilities with other people who exhibit high-risk behaviours which may prevent them from carrying out their strategies to control their environment (albeit it in a study concerning older as opposed to working-age people). They advocate specialist training in autism and careful induction to long-term care.

Most of the long-term care facilities this study cohort reside in provide specialist autism training where required. Phased adjustment periods are contraindicated as admission is urgent due to people's circumstances or the need to vacate a psychiatric inpatient hospital bed. Much of the risk behaviour associated with attempts of people to regulate their environment, which may include harm to self or others, are described as "meltdowns" in the case record, indicating the extreme distress experienced by the person when they cannot exercise their control strategies. This term is also very descriptive of the person's ultimate distress and an element of dismay about this. It is also redolent of some regret that this cannot be soothed or alleviated as there is not a sufficient degree of "shared reality" by which to achieve this. As with the other identified risk behaviours, admission to long-term care does not reduce the behaviour, and indeed may exacerbate it, but it does provide an assured means of monitoring, containing, and controlling it, though sadly not fully understanding it.

Self-Stimulatory Behaviour

Koegal and Covert (1972) determine the functions of these behaviours as either providing pleasure to the individual carrying them out or masking less desirable stimuli, hence the protective and adaptive elements alluded to above. Thus, the function of these behaviours in this study cohort could be that they are pleasurable, to avoid adverse interactions or situations, or to assist with emotional regulation. Knippenberg et al (2022) show that the impact of long-term care on self-stimulatory behaviour is contingent upon its function (again in a study based upon older people). Where people are carrying out the behaviour as a means of deriving pleasure this may be that they are under-occupied in the long-term care environment, which is redolent with the numbers of people who are not identified as having interest or hobbies in the facilities (please see the strengths / protective factors section in the Findings Chapter).Where people are carrying out the behaviours to mask other situations or interactions this may be as a direct result of distress caused by staff or other residents of the long-term care facility. Self-stimulatory behaviour does persist in long-term care facilities, and

there is little real option in terms of managing the behaviour than admission to long-term care where the levels of risk warrant this, although again, this does not enhance the ability of caregivers to understand or to meaningfully interact about it. Having examined the implications of risk to the decision-making process, the thesis will continue to explore how protection is afforded in response to the risk.

Theme – Protection and Restriction

People Under No Mental Health Act Restrictions

This thesis has found that people in long-term care who are under no legal framework or restriction tend to be those who originated from the historic long-stay hospitals. Holloway (2003) carried out a study around outcomes for people whose care was provisioned from long -stay psychiatric hospitals to small group home type settings of up to 6 individuals and reports good outcomes regarding reduction in high-risk behaviours. However, this group of people all live in long-term care facilities which house 20+ people. As Leff (2002) points out, the number of psychiatric inpatient beds decreased from over 150,000 to less than 40,000 between 1991-2001. Thus, the necessity to find support for these people outweighed considerations about which may have been the most conducive alternative making larger establishments preferable as they could benefit from economy of scale. The Local Authority which has jurisdiction over the study area (2020 p.6) acknowledge in their market position statement that there is a need to “improve capacity in ****redacted****to meet a diversity of accommodation and care and support needs of those with challenging and/or complex needs, including forensic needs” .This would also apply to people willing to enter long-term care, but without additional funding to develop such facilities larger long-term care providers continue to make such economies of scale to operate within viable financial resources and make profits.

Assessment and Treatment Under the Mental Health Act

Zhang et al (2015), Kallert et al (2008), and Wood and Alsawy (2016) have produced studies highlighting how distressing the experience of being assessed under the Mental Health Act is, which is a consideration in the light of the fact that these people have experienced this multiple times. However, closer scrutiny of this group of individuals as part of the data analysis reveals that they are people who have very entrenched delusions, often including thoughts that they are being poisoned or that their medication is a harmful substance being administered to them for malicious, nefarious purposes so that Section 3 is the only viable option by which to treat their mental health needs. Plahouras et al (2020) carried out a systematic literature review of 18 qualitative studies into the experience of people with paranoid-type presentations who were legally mandated to receive treatment, and their feedback was that this treatment was necessary and beneficial. The treatment was focused upon medication, but for this study cohort if they were not required to remain in the long-term care setting for treatment, they would have left and/or refused medication, so admission was necessary to provide treatment. Due to the difference in perceptions between assessors and those assessed, it is not possible to agree on levels of compliance or to expect that agreements will be kept, making compulsion to do so under the Mental Health Act necessary. This compulsion needs a setting, and as the person is unable to maintain or remain in a habitable home, there is no alternative but for this to take place in long-term care.

C.T.O

Studies including Vergunst (2015), Churchill et al (2007), Dawson and Mullen (2008), Burns et al (2009) argue that CTOs are ineffective because they may cause people who are mentally unwell to avoid mental health professionals. This may have the outcome of leading them to relapse and to be recalled compulsorily to hospital, which engenders a cycle of mistrust with the mental health system. This is not a factor for individuals in this study and applies to people

residing in the community as opposed to long-term care, as staff in the nursing homes allow mental health professionals in and provide residents with their medication (albeit they do not take it sometimes and are recalled to hospital – this has occurred 3 times in a twelve-month sample period (22.7-20-22.-07.21) so is not a common occurrence). Schwarz et al (2010) argue that patients on a CTO are more likely to attend appointments, less likely to present at Accident and Emergency Departments, to be violent, to be subject to abuse and to have a better quality of life than people not on a CTO.

Other studies argue that CTOs are necessary for people with psychotic illness as their insights into their illness require a degree of compulsion and control to enable them to engage with treatment O'Reilly (2006), Dawson and Mullen (2008), Gibbs et al (2005), and O'Brien and Farrell (2005). Similarly to other Mental Health Act protections and restrictions, the use of CTO does appear from this study to be a resource of last resort. None of the case records overtly state how CTOs influence the decision to admit, but for all this study cohort they do stipulate a variation of three conditions: that the person resides at a specified address, that the person allows access to professionals, and that the person takes medication. As in the case of Section 3, where a person cannot maintain a habitable home environment or cannot exist in the community without significant or unmanageable risk to themselves or others there is little alternative to admission to long-term care as the person needs to be provided a home address (in a home that provides support and control) and staff to administer medication and admit visiting professionals.

Section 117

Wilkinson and Richards (2018) carried out an audit of the planning of aftercare for detained patients discharged under S117 and found that discharge planning could have been improved. Analysis of the factual and definitive data within the assessment framework and reviews in relation to this study cohort illustrates that the emphasis is on risk-reduction and on keeping the person safe. The professional completing the assessment framework has few alternatives

to admission to long-term 24-hour care in terms of providing the best value and sustaining their professional integrity in the face of lack of assurance around risk management, as they are unable to satisfy themselves that the person can adhere to management plans leaving a residual significant and uncomfortable level of risk. Briner and Manser (2013), Crowe and Carlyle (2003) and Maden (2007) concur with these findings with respect to the lack of options for admission to long-term care for this study cohort. The power or influence of the assessing professional is limited by risk and lack of alternative provision for long-term care. Consequently, analysis of the most protective and restrictive legal provisions under the Mental Health Act are found to be used where there is little or no alternative, where constraints of risk and alternative provision offer no appropriate interventions other than admission to long -term care. This part of the Discussion Chapter will continue to evaluate the next “layer” of legal protection and restriction; those imposed under the auspices of the Mental Capacity Act (2005).

DoLS (Deprivation of Liberty Safeguards)

Irwin Mitchell (2014) outlines the case of P vs Cheshire West, whereby the restriction of a person under continuous supervision and not free to leave was deemed unlawful as there was no legal framework to vindicate the controls placed upon the person. It was argued that legal frameworks should be applied so that the people subject to such restrictions have rights to appeal and regular review. All the DoLs in this study have come into force following this ruling. This study found that Community DoLs were used for 3 people who absconded from the long-term care facility. This gives staff an effective legal basis by which to tell them to remain, which the people in this study cohort have complied with up to the time of writing. It is not clear from the record what proactive work is ongoing with these people about the reasons they need to leave their homes, and it is questionable how being forbidden from doing so supports these underlying problems, but the approach does ultimately afford protection.

Many studies about the use of DoLs are ambivalent about whether they afford genuine benefits for people or provide a technical “workaround” to legal complications inherent in the Mental Capacity Act (2005) associated with the assumption of and an assessment of capacity: Emmett et al (2013); Phair and Manthorpe; (2012); Raymont et al (2007) Williams et al (2012). It is hoped that the new Liberty Protection Safeguards, should they come into force, will realise SCIE’s (2022) aspirations that they will afford greater clarity, co-production, and access to advocacy. For people who abscond, there is little alternative but admission to long-term care, typically these people are either vulnerable when they have left home (if they have no means of accessing food or shelter) or they steal or enter other people’s property, it is not so much that they are homeless, but that they leave home when they are stressed or mentally unwell and present as such making them unwelcome in local communities.

Financial Restrictions and Protection

Chan et al (2009) completed a study of people who lacked mental capacity about finances (albeit older people) and concluded that people without such capacity are vulnerable to abuse as they cannot challenge their situation as they may not be able to verbalise their concerns; they may be socially and emotionally dependent on their abusers; they may not want to disclose their situation due to shame of being duped; or they may not wish to disclose substance use. This was very much the case for this study group as they were vulnerable to giving away money to develop and sustain relationships.

From the perspective of financial restrictions, this study cohort is not employed and is unlikely to be in the future. This does impact in terms of the choice and self-determination they have, and employment has been shown to be a protective factor in terms of mental health. However, this impact needs to be balanced against the severe risk factors. There is also human cost for those who have been financially exploited, emotionally, for substances or both and these measures do provide a degree of protection against this distress. However, it should be noted that (as found by Ware and Goldfinger (1997) Wilton (2003), Caplan (2014) and Standing

(2014)) people with severe mental illness are more likely than the general population to experience poverty for those living in long-term care, that facility will ensure that basic needs such as heating, and food are provided.

Limits on Access to the Community

Brekke et al (2014) argue that lack of independent access to social and health care contributes to the phenomenon that people with serious mental illness die, on average, twenty-five years younger than people who do not have a serious mental illness. This lack of access is not necessarily imposed but has a practical impact on admission. Webber et al (2013) discuss how this disadvantage becomes cyclical as people with severe mental illness are not able to access communities and experience stigma and discrimination when they do, making them less likely to utilise social capital, and thus further impeding potential for recovery. The protective properties of access to social capital will be explored further below, but these findings indicate in common with Van der Linden (2003), Muntaner (2004) and Sartorius (2003) that a phenomenon exists whereby increased involvement with and access to mental health services corresponds to a decreased contact with universal community services accessed by much of the population. It is acknowledged that some of the study cohort do not want to access mental health support and have not agreed to the stigma this brings. Still, the risk they pose constitutes a “double bind” which restricts them from access to universal community support which could, potentially have a protective impact. However, there is no study data available to determine how far the social networks they may access within long-term care facilities function as protective entities other than the person stating they enjoy these (Please see Table Fourteen above and Table Twenty-Three above).

Accommodation

Accommodation is a key part of a person's protection, and where there are issues with the person, these individuals can become vulnerable. Ayano et al (2019) carried out a systematic review and meta-review which revealed that schizophrenia and psychotic conditions are highly prevalent among homeless people and that this, coupled with the person's difficulty in maintaining their home, leads to a cycle of inevitability that people will need to be admitted to a supported setting. There is a lack of research into long-term care for working-age people with mental health needs, however, there is a wealth of knowledge about how transitions to long-term care impact upon older people as a status passage by which they lose autonomy and self-determination Wilson (1997), Ellis (2010), Oleson and Shadick (1993). There is similarity between older people and the people in this study sample in that they are admitted as a result of being unable to maintain their own homes, and this transition is a rite of passage and an acknowledgement (a least by the assessing professional) that the person cannot manage independently so admission to long-term care is the only viable alternative as it is not possible as part of the interaction between the person and the assessing professional to gain assurance that the person will not put themselves at significant risk by the way they live and the choices they make.

It became apparent that it was not just the "bricks and mortar" element of accommodation in long-term care that reduced risk for this study group. Zinn et al (1998), Lucas et al (2005), Castle (2004) and Kane et al (1997) indicate that long-term care also offers people warmth, food and personal and environmental hygiene, and monitoring of these activities of daily living. Issues around the affordability of heating, people's motivation to cook, eat and store food appropriately, and motivation to maintain hygiene were clear in the data analysis and the need to intervene in these areas featured in the decision-making to admit people to long-term care.

Having determined what kind of support people require, the study will continue to explore the levels of support needed.

The data analysis also indicated that accommodating people alleviated two particularly high-risk behaviours, one of which was fire risk, and the other was risk associated with leaving the home, and that the risk associated with these behaviours was a factor in admission. Previous studies have established that people with mental health needs are more prone to experiencing domestic fires than most of the population Anderson and Kragh (2009), Beck (1992). Of the 8 people noted in the case record by the assessing professional as a fire risk, 6 were assessed in this manner in connection with an accidental risk as a byproduct of smoking and 2 of intentional fire setting.

There are a variety of reasons for fire risk associated with mental ill health in the literature, including cluttered environments or hoarding (Clark et al 2015), smoking (Lupton 1999), and deliberate fire setting (Dolan et al 2011), and indeed all these factors contributed to the risks posed to this study cohort. Admission to long-term care meant that hoarding, smoking and deliberate fire setting can be monitored, and interventions are undertaken to reduce the risk of fire. Al-Hajj et al (2022) carried out a systematic literature review which determined that interventions typical of those employed in long-term care settings included use of alarms (smoke and fire), monitoring and inspection, and adherence to fire regulations, significantly reduce the risk of fire.

The other significant risk linked to accommodation was of absconding (n=6). The assessing professionals state this varies from a desire to leave the long-term care facility for reasons which are unclear or unstated to responses to delusions such as going to churches with an intention to get married.

Bowers et al (2003) define absconding as people leaving their residence without permission or informing relevant others of their whereabouts. People with schizophrenia are prone to absconding (Bowers et al. 1999; Carr 2006; Dickenson & Campbell 2001; Farragher et al. 1996; Manchester et al. 1997; Meehan et al. 1999; Quinsey & Coleman 1997; The Joanna Briggs Institute 2007a) as are people who use substances (Andoh 1999) and people who self-harm (Bowers et al. 1999; Carr 2006; The Joanna Briggs Institute 2007) all of which are common features of this study cohort. Bowers et al (1999) detail the risk people with mental health needs face when they abscond, both because of their vulnerability and the break in their treatment during the time they are absent. This study cohort place themselves in harm's way when they leave their residence; examples of this include one person who sleeps rough in a local beauty spot in inclement weather conditions, and another who will walk until his feet bleed and become severely infected.

Provision of accommodation in long-term care functions to alleviate this risk as monitoring alerts staff to the fact people have left (Dickenson and Campbell 2001), and protective/restrictive measures such as DoLs, Section 3 and CTOs mean that there are legal frameworks to return people to long-term care (Williams et al 1999). Consequently, admission to long-term care does reduce risk and risk behaviour as the provision of accommodation and monitoring safeguards this study cohort. Here again, there is no clearly stated rationale as to why the person exhibits these high-risk behaviours. There are examples in the case notes of people's stated reasons for absconding, which may be linked to delusions; one person says he leaves his home to find a person to marry and another to find his sister. (The former is unlikely to be successful in this, and the latter has no siblings). These examples are "seeking" behaviour and in another example, there is a suggestion that the person is fleeing (but not quite what from).

Again, we see the increasingly familiar “disconnect” between the person and the assessing professional, with no or limited shared understanding of why the behaviours are exhibited and no agreement as to how they can be managed. This leaves a somewhat conflictual situation of the person persisting in them and the assessing professional deciding to admit the person to long-term care so that staff can control them.

Care and Support

For a significant number of people, the advent of need for long-term care coincided with carer breakdown where parents had provided this care. Table Fifteen above indicates that 51 people lived with their parents prior to admission. Kelly and Kropf (1995) indicate the typical age of onset of psychotic illness means that this occurs when a person is living with parents, and exacerbation of the illness means that they are unable to live independently, as described in the paragraph above, so offspring remain with parents for as long as they can offer support. It is estimated that between 35%-75% of people with severe mental illness in the UK live with their families (there is a large margin in this estimation due to variations in the definition and scope of the different variables Bengtsson-Tops and Hansson et al 2001), but the numbers are still significant at the lower range. Kaufman et al (2010) discuss the strain this care giving places on families and the trauma that occurs when the caring arrangement breaks down and establish that this is often followed by a compulsory hospital admission where the parent/carer (Nearest Relative under the Mental Health Act) must indicate they do not object to the admission as part of the Mental Health Act Assessment. Consequently, admission to long-term care fills a gap in care and support when parents or family members are no longer able to provide this.

Compliance Issues and Relapse

Emsley et al (2013) carried out a study into relapses in severe mental health. They identified that although some indicators of relapse and disengagement can be identified in individuals

predicting this or the severity of the relapse is virtually impossible, thus prevention of relapse in the manner afforded by long-term care is often the only means of protecting recovery and reducing risk. An international survey conducted by the World Federation of Mental Health (2006), cited a figure of 69% of people being hospitalised following relapse.

O'Brien and Farrell (2005) state that around 30% of people with severe mental health needs drop out of services following their literature review of the topic and continue to point out (p.565) "Associations with disengagement are complex, encompassing sociodemographic variables such as young age, ethnicity and deprivation, clinical factors such as lack of insight substance misuse and forensic history and variables related to service provision such as service model" some of these characteristics are typical of this study cohort. The majority do have a history of losing contact with services. Admission to long-term care circumvents this as the person lives where the care is delivered, so they have no real option to disengage from it. Medication and support are provided and where people refuse to accept these intra-muscular medications and re-admission to acute psychiatric hospitals are considerations. This reduces the extent of relapse progresses; indeed, a minority of the study cohort have been compulsorily admitted to hospital whilst their mental health condition is stabilised.

As Zhang et al (2015) state, compulsory admission is disempowering and often frightening, but choice (autonomy for good and ill) is removed, and this is effectively the deterrent to disengagement exercised by long-term care facilities. As well as there being an absence of shared reality between the person and the assessing professional, staff exert control over residents. This may be the root of the adversarial relationship between staff and residents which may lead the residents to exhibit/persist in the undesired high risk-behaviours and the professional (and/or long-term care staff) to continue to control and monitor this. The lack of a shared reality creates a perpetuating cycle where the person resists by disengaging further polarising the protagonists with residents complying or resisting and staff controlling.

The Impact of Co-Morbidities

Stein et al (2022) carried out a literature review which indicated a significant correlation between physical and mental ill health and a devastatingly detrimental effect of each upon the other. Kessler et al (1998) outline the impact physical impairment has on self-care and the way this causes mental health to deteriorate, Simon et al (2005) and Sareen et al (2006) detail the impact of lack of insight and anxiety on being able to self-care and maintain positive mental and physical health outcomes.

Whilst conditions such as Korsakoff's syndrome are a clear by-product of substance use, this was associated with other co-morbidities within the study cohort, such as kidney failure, anxiety, skin integrity and diabetes. Roth et al (2006) consider the poor outcomes in both mental and physical health for people who use substances, and the side-effects of medication (especially anti-psychotic types) indicate poor physical health presentations such as obesity and cardiovascular disease (Jacobi et al 2004, Merikangas et al 2007).

This study cohort has a range of conditions from which they receive support from the long-term care facility, which range from Chronic Obstructive Pulmonary Disorder, complications of severe obesity, kidney failure, Tourette's, and Marfan's syndrome, as well as some individuals having more than one mental health diagnosis (typically obsessive-compulsive disorder linked with psychotic illness). It is also worth noting that a significant number of this study cohort have additional diagnoses of autism or learning disabilities (evaluated in detail in the "regulating environment" section of the function of risk behaviour discussion above), Cooper et al (2015) analysed primary health-care data relating to 424,378 adults with learning disabilities registered with 314 GP practices and found that only 31.8% of them had no additional co-morbidities.

Maulik et al (2011) also detail that people with co-morbid conditions may have difficulty locating, communicating with, and navigating services, which effectively means that aspects of their needs remain unmet if they are not supported, as is the case with this study cohort. These multi-jeopardy characteristics of the study cohort entail that they have extensive and complex care and support needs which may combine and exacerbate unpredictably making the dedicated resource in long-term care a more reliable way to support them as opposed to the more fluid and scarce resource in community mental health care. Yet again, there is no evidence of a shared understanding or reality as to how the person's behaviours (whether by commission or omission) have a negative impact on their well-being and a sense of inevitability of admission that this is the only way of ensuring that the person receives the support they need which stems from their mental health, and/or their lack of motivation or inclination to manage activities of daily living and co-morbid conditions. These risk behaviours are not understood, nor are their likely manifestations or escalations, which means they are a significant drain on acute psychiatric inpatient services, which are usually accessed following distressing and resource-intensive Mental Health Act Assessments. Where such a lack of shared reality persists the only way the assessing professional has to provide any form of stability is to admit the person to long-term care, where ongoing support and control are available to the person on a permanent basis. Having examined the extant literature around the resource theme, the Discussion Chapter will continue to consider this in respect of the theme of strengths and protective factors.

Theme – Strengths and Protective Factors

Supportive and Protective Networks

Rhodes (2005) considers the experience of psychiatric inpatients (albeit in acute wards) and concludes that they face a combination of social isolation and lack of perceived social support, and this is certainly the experience of the people who feature in this study. As the context of these relationships does tend to focus upon family, the damage to these supportive networks

(often because of caring for a person with mental health needs) mentioned earlier should be considered, as the relationships can be considered protective for the working-age person but may be damaging to family members providing care. It is also of note that for a number of these people they are bereaved of parents so are contending with grief as well as with the social isolation their loss brings.

Although social isolation per se is accepted to be detrimental to psychological wellbeing (Jason et al 2010, Shaw and Gant 2002, Jaremka et al 2014) there has been little work completed on how this impacts in long-term care settings. However, Choi et al (2015) carried out a systematic literature review into the impact of social isolation on behavioural health in older people in long-term care and found that isolation was associated with difficulty sleeping, depression and anxiety, which for this study cohort would intensify the psychological distress they already experience.

Topor et al (2016) discuss the cyclical nature of social isolation, poverty and severe mental illness. They depict the way lack of resource dictates that people with severe mental illness are limited to the resources they can spend on a social life and are often only able to maintain relationships with people who will interact within these restrictions or fund activities. They also outline case studies in which people regret that their social lives are curtailed in this way. Davidson and Strauss (1992) discuss how people's symptoms and behaviours impact adversely upon friendships, even though the sense of "having something to look forward to" socially is beneficial to the person, whilst Yanos et al (2007) point out that social stigma associated with severe mental health problems also limits the opportunities people have to interact with others despite the protective functions of these interactions. Consequently, access to the protective feature of contact with others is limited within this study cohort but should not be underestimated where it does exist.

However, friendship in long-term care is explored by Casey et al (2018) (in a study concerning people with dementia) in that people's mental health needs limited their interactions and that people were trying to function in previously learnt ways to establish supportive relationships, which did not function effectively in the social context of the long-term care setting. Saunders et al (2011) (again in a study about people with dementia, as there is a lack of such material concerning working-age people who do not have dementia) found that the majority of interactions tended to take place in long-term care in communal areas such as dining rooms or activity areas and that people tend to be "put" into groups or areas rather than gravitating towards people they have an affinity or shared reality with which limits relationship building. Rowland (2016) carried out a study into friendship patterns in a state mental health hospital in the USA and found that although there was difficulty establishing and maintaining friendships due to the factors mentioned above, these friendships were strong and beneficial to the persons' well-being, so where such connections have been made, they should be highly valued.

As well as the benefits of social and emotional connections the research agrees upon the protective psychological benefits of engaging in activity (Hayes et al, 2017 and Naylor et al, 2012), and especially in physical activity (Firth et al 2016, Lederman et al 2017) Thus it is somewhat concerning that a considerable proportion of the study cohort have no interests, activities or hobbies recorded within the case documentation (n=34 – see Table Twenty-Three above)

Co-Production and the Voice of the person

Studies such as those carried out by Dickinson (2014), Bee et al (2015), and Durand et al (2014) indicate that taking a co-produced approach has better outcomes for engagement, compliance, and recovery so evidence of co-production is a protective factor for working-age individuals admitted to long-term mental health care. It is thus reassuring that the aspirations of the person are recorded and that efforts are made to support them to realise them but due

to the lack of any evident or meaningful sharing of reality between the assessed and the assessor, it is not easy to envisage how meaningful co-production will be achieved, where there is no shared understanding of risk and harm.

Thus, although there is no existent literature which explores the impact of admission to long-term care for working-age people with mental health needs, there is a reference in literature to the themes identified in this thesis. Risk, protection, resource and strengths and protective factors have universally influence people's ability to remain living in their communities. As well as identifying the themes, thesis has found little material change in their impact over the decades on the decision-making to admit people to long-term care.

The Impact of Passing of Time on Admission of Working-age People with Mental Health Needs to Long Term Care.

Although not a theme as such it would be remiss to neglect to consider how time has impacted upon the phenomenon under discussion in the thesis. It was difficult to pin-point the exact date of admission of many of the study cohort as the new financial tracking system was introduced on 07.03.13 and all admissions on or prior to this day are recorded as being on this date on the electronic system. However, there are references to people being in the old long-term psychiatric hospitals or to the person being in care at the start of the electronic record. The data was extracted on 18.10.18 and it was apparent that of the sample of 72: 41 people were admitted to long-term care between April 2013-4 (including the historic ones transferred en-masse onto the system where the exact date of admission could not be identified in many cases); 12 between April 2014-5; 7 between April 2015-6; 5 between April 2016-7 and 7 between April 2018 and the point the data was extracted (October 2018) . This does indicate that year on year admissions do not vary greatly and so admissions to long term care have remained impervious to advances in mental health care and admission remains the only option for some people. The section on Age in the Findings Chapter does indicate that

fewer younger people have been admitted as time has gone on, but this may be because people have not established a significant enough mental health “career” or history until they have reached a certain age. Having reviewed and discussed the extant literature concerning the findings and themes and the impact of time on admission, it is necessary to generate the theory that underpins the thesis.

Theory Generation

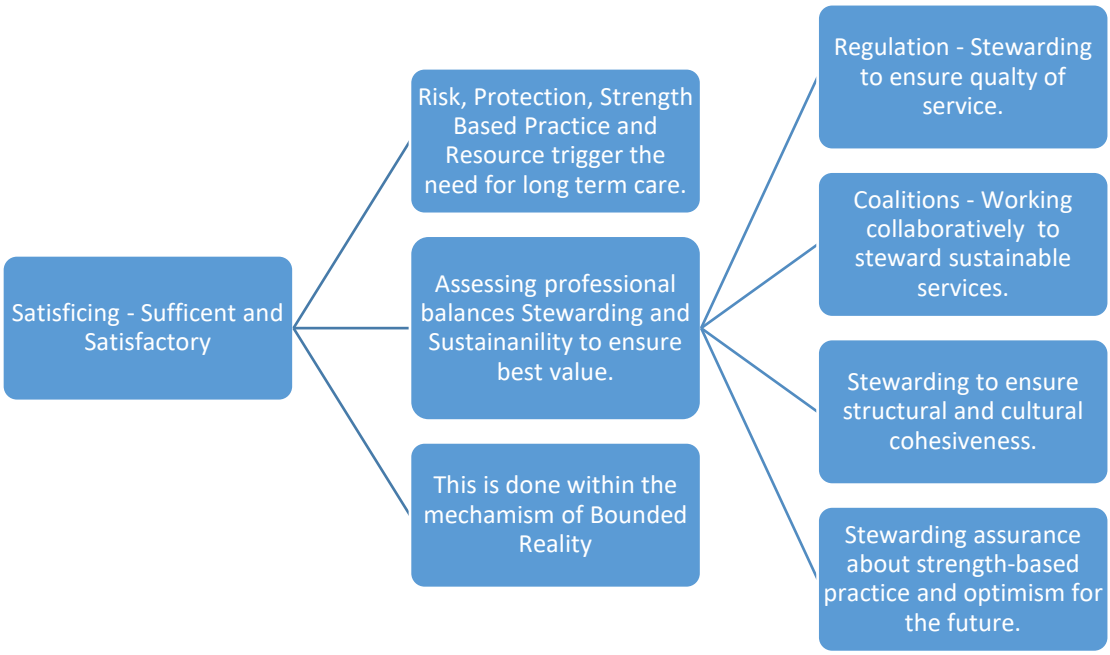
When considering theory, it is necessary to have an appreciation of the potential limitations of grounded theory as a vehicle for theorising. Observers such as Atkinson et al (2003), Blumer (1979), Dey (2004), Emerson, (2004), Layder, (1998) have challenged the process of theorising from grounded theory analysis based on the process employed, stating that this is inexact and can be considered to be illogical, but as Charmaz (2006) p.131 states the art is in locating “Where is the theory in grounded theory ?” . This is inherently rooted within the data, the method and the methodology and will vary between studies, highlighting the importance of clarity as to what is being studied and receptiveness as to what the analysis reveals. Charmaz (2006) answers Burawoy’s (1998) criticism of grounded theory that it is abstracted from time and place, responding that grounded theory is applicable across substantive areas, that its functionality allows for analysis of macro levels of situation and interaction and that it provides insight into power, society, and difference.

The previous chapter presented the findings from applying grounded theory to the case record, and the main themes identified were risk, protection, strength-based practice, and resource. These themes are the matter about which the decision is made and constitute the reason a decision needs to be made at a point in time. This chapter will continue to provide a theoretical framework for how the decision is made and what factors influence the professional making that decision. The need to decide (the need to protect, manage risk, protect the person

and society and to work in a strength-based manner) are the triggers for the intervention. This chapter will determine the theoretical framework by which the intervention is determined, and the bullet points below show the discreet stages and elements of this theoretical framework.

- The triggers for the intervention are the themes identified in the findings: risk; protection; resource; and strength-based practice. These dictate that the person needs to move to long-term care.
- The assessing professional then carries out a balancing exercise: they weigh up the cost of the long-term care (sustainability) with its quality and viability (stewarding).
- The mechanism by which they do this is bounded reality – they carry out this balancing exercise considering their knowledge, experience, professional and cultural background in accordance with social, political, and economic forces which act upon them.
- The outcome of this is satisficing – they provide a sufficient and satisfactory service for the person assessed, this is illustrated in the diagram below.

Figure Nine – The Elements of Satisficing



The theoretical framework of satisficing with its sub-theories balancing stewarding and sustainability via the mechanism of bounded realty already exists, which would make it disingenuous to contrive another similar theory to provide a framework by which to structure the elements of a decision identified in the findings. This theoretical framework incorporates the decision-making, context or toolkit comprised of the assessment framework the professional applies as well as the professional and organisational milieu in which they operate. All these factors are considerations in the decision to admit to long-term care and are well represented within the overall extant theory of satisficing.

Charmaz (2006) clearly states that existing theory can be used as a framework in grounded theory, arguing that researchers cannot make themselves unaware of the literature, theories, concepts, and hypotheses they have been exposed to. The key is to acknowledge when extant theory meets the needs of the data and to acknowledge this whilst also being open to allowing new theory to emerge where this is appropriate.

The decision to use these theories as opposed to generating a new one is based upon the constraints placed on the decision-making of the assessing professional. The decision to admit is triggered by the need to manage risk and protect the person and society whilst managing resource and maintaining peoples' strengths.

Having determined how the theory arises from the data it is next necessary to provide a clear account and justification of how theory has been generated from the Grounded theory Methodology to provide clarity that the Methodology, Findings and Discussion follow a reasonably well-defined scope and structure.

6.2 Justification of Theory Development from Grounded theory Data

Having discussed 'why' the theory supports the decision making the chapter will move on to how it achieves this to balance these elements. Generation of theory from the themes extrapolated from the data required determination of how the themes interacted to influence the decision to admit. As per the research epistemology this is not from a positivist perspective which would seek to explain and predict how the themes influence the decision to admit but from an interpretivist perspective which aims to understand as opposed to explain the phenomenon in accordance with Ritzer and Goodman's (2004) definition of theory, which has strong interpretivist elements in its emphasis on understanding and scope. Developing this understanding involved reconstructing the codes, themes and memos derived from the data into substantive theory to respond to the research question as the Literature Review Chapter demonstrates that this question has not been previously asked, so it has not been possible previously to identify formal theory which can be drawn on to serve this purpose. The themes which were identified from the data were irrefutable in understanding the phenomenon of theoretical framework behind the necessity to make a decision about admission of working-age - people with mental health needs to long-term care, but the way they combined, the presence of all or some of them, and their frequency, severity and duration were all variable

which was congruent with Mead's (1934) symbolic interactionism which allowed for the multiple realities, provisional truth and complex social processes.

Charmaz (1990, 1995, 2000, and 2001) emphasises the necessity of considering the context of findings in developing theory which is congruent with the Constructivist Grounded theory by which the findings and consequent theory are constructed. This is further developed in Silverman's (2004) stipulation that the construction people put on their actions and decisions will lead to the reason for the actions they take. In this study the assessing professional considers the prevailing conditions and situation at the time of admission as part of the decision-making and that there are significant differences and distinctions which contribute to the decision which need to be accommodated within the theory. This required consideration of the data, findings and social constructions from which theory was identified, to determine the conditions and situations which produced the decision to admit. Constructivist Grounded Theorists including Bryant (2002), Charmaz (2000), Hall and Callery (2001) and Thorne et al (2004) concur with this, construing theory as an entity which is situated in time, place, culture, and situation.

This study required analysis of how certain behaviours and characteristics contributed to the decision-making processes resulting in admission to long-term care. Glaser (1978) terms this type of approach 'theoretical sensitivity', which embodies the Findings of the study into a construction of their meaning and impact upon the phenomenon being researched. In this case the central themes arising consisted of the risk the person admitted poses (whether this be unsustainable in terms of severity, frequency, duration, or some or all of these factors) the assessing professional's need to protect the person, the assessor's commitment to strength-based practice principles and the limited resources they have to call upon to manage these factors. Thus, the concept of "satisficing" Simon (1955) Stirling (2016), Stern (2007), Piras et al (2007) in which decisions suffice in terms of the ability to manage risk, protect the person

and are satisfactory within limited resource and are deemed to be the only available outcome in the circumstances.

Satisficing represents a theoretical framework by which the assessing professional balances the decision-making process, incorporating elements of ethical and professional behaviour, and obligations to organisations and the state as well as to the individual. It was essential to ensure that the empirical knowledge generated by application of this theory could be integrated with as opposed to constrained by this existing theory. De Vaus (1996) argues that valid grounded theory can be reformulated or developed from middle range theory, in the case of this study the theoretical knowledge generated is not merely to artificially fit the findings into existing satisficing theory but to test the theory against the research question and to explore how satisficing influences decision-making around admission of working-age people with mental health needs to long-term care and how the professional can to inject hope despite the constraints they face.

This chapter will explore the decision-making leading to admission and will evaluate the concept of satisficing, arising from the inherent, first-dimension, concepts of balancing sustainability and stewarding via the mechanism of bounded rationality operating in decisions arising from the necessity to satisfice. It will also consider the constant challenge to satisficing and the emphasis on the individual and their strengths on the part of the assessing professional. It will be structured around the stages of the way the decision is made commencing with the initial elements of balancing sustainability and stewardship to produce best value.

6.3 Sustainability – Future Proofing Care to Meet Need

Achieving sustainability entails meeting a person's need by providing care which will continue to meet that need within available resource. This element of the Discussion Chapter will establish how the assessing professional determines that services are sustainable, so that

they can then go on to steward the quality of the service to satisfice. The concept of sustainability demands that professionals garner what is available to meet need by procuring a service, but it is also essential that need continues to be met in the longer term, or any stability achieved will be void and the satisficing concept will not be met as the outcome will be neither sufficient nor satisfactory.

The Community Care Act (1990) highlighted the concept of “need” as the key factor of what is necessary to provide care for a person. This was seen to encompass the following: “Social and practical assistance with daily living …help with personal and domestic tasks such as cleaning, washing, and preparing meals with disablement equipment and home adaptations, transport, budgeting, and aspects of daily living. Suitable good housing is essential, and the availability of day care, respite care, leisure facilities and employment will all improve the quality of life enjoyed by a person with care needs.” (Community Care Act paragraph 2.4). Consequently, providing care is the way in which need is met, in this case the care provided is admission to long-term care.

Langan (1998) discusses the typical local authority approach to the concept of need and links this back to the concepts of risk and protection which were indicated in the Findings Chapter, with necessity for provisions of services linked to the risk of substantial risk or harm to the person or others if the service is not provided. Thus risk, protection, and maintenance of strengths trigger the admission to long-term care. This combines with how the person uses resources prior to admission. Their mental health is in a general trajectory of decline, and the resultant need is met by calling upon collective services available to all people living in the community with mental health needs However, when the levels of risk and the need for protection become unsustainable (either due to frequent, prolonged, extensive or all of these) use of community facilities the assessing professional must make a decision that the person is provided with their own resource which is earmarked for them and is sustainable for their future care.

There are several studies outlining the debate around rationing of care, unsurprisingly pro-rationing content originates from think tanks such as New and LeGrande 1996 and Harrison and Hunter 1994. However, there is significant challenge to this by proponents such as Draper (1995) who argues that priorities need to be revisited to provide adequate care to the whole of society. This debate aside, the assessing professional is faced with the duty to make a decision triggered by the themes of the Findings Chapter and has to ensure that the care provided to meet needs is sustainable into the future when the person's presentation requires that tapping into existing universal (or available to all as a matter of course in the community) mental health resource is no longer viable due to levels of need and risk.

The way in which decisions about sustainability are made are also complex constructions: Williams et al (2012) consider whether satisfactory or optimal provision should be sought; and whether priority should be given to maximising the overall health of the population with some adjustment for particular minorities (Williams 2009); or whether 'rule of rescue' should take precedence i.e. those with urgent or life-saving needs should be prioritised (Hadorn 1991, Jagsi et al 2004); combined with these are principles of access and the remit of what is available via the NHS. To resolve this dilemma Klein and Williams (2000) argue that a *process* should be employed which can evaluate each instance in a consistent way and this takes place as part of admission to long-term care as the assessment process is utilised. Part of this process requires verification that the admission is triggered by levels of risk and the need to afford protection and maintain strengths which are not sustainable via universal community services so that the only sustainable outcome for the individual is admission to long-term care. Having established this the assessing professional must now undergo the stewarding process to ensure that the quality of the service is also sufficient, and that the admission constitutes best value.

6.4 Stewarding or Stewardship – Resource to Meet Need

The concept of Stewarding is included within this substantive theory as a sub or contributory theory as it explains why workers make the decision to admit people to long-term care as universal community resources cannot sustainably support them. This a social process which is ethically bound in a desire to use resources responsibly, accepting the necessity to meet need and maintain quality of care and governance.

As well as the team or area in which the decisionmakers operate, they are part of the behemoth, which is the NHS and Local Authority and, as such, have duties to steward the assets of that organisation. stewardship, as a means of ethically protecting resource is defined by Sanders and Wood (2014 p.4) as a means of "maintaining (natural) resources at sufficient quality and quantity to remain viable for use by future generations". The case records evidenced that decision makers did deliberate upon outcomes and wanted these to be justifiable; decisions were not made on a binary "to admit or not to admit" basis but from a complex process of balancing the need to manage risk and offer protection where the person was not able to carry out these functions themselves. There is also evidence in the findings that the decision maker has considered the person's strengths attributes, networks and interests and has made efforts to preserve these within the long-term care setting.

The remit of this study essentially focuses the concept of stewardship concerning matters of state, with a specific emphasis on health and social care resource. The World Health Organisation Report (2000 p.3) defines stewardship as system-wide ownership of the structure, which concerns the consideration of long-term strategic planning which will allow delivery of the day-to-day operation of services; it is this report which links stewardship with governance and the administration of care and support by actors functioning on behalf of the state and larger organisation (in the case of this thesis, the decision makers).

Kass (1990) envisages this as a form of agency theory where society has authorised the decision maker to carry out this task and has an expectation that they will do so effectively and ethically, and that this decision-making can be trusted. Armstrong (1997) adds a further dimension to this by characterising the decisionmaker or agent as being willing to take on responsibility for the wellbeing of the organisation as well as individual tasks and decisions, indicating that all their actions must be oriented to the ongoing prosperity of the organisation. Armstrong (1997) uses this widened concept of stewardship to justify how the self-actualising aspects of agency theory translate into the organisational behaviour we see in decision makers as the prosperity of the organisation culminates in rewards for the decision makers, which fosters an ongoing cycle of collectivism, commitment and a notion of the decision maker receiving direct benefits from decisions which protect the interests of the organisation. However, this would seem to be more pertinent in “for profit” organisations as NHS and Local Authority employees do not typically receive payment by results.

The World Health Report (2000 p.291) identified some outcomes which are consequent to stewardship which provide assurance around heath care resourcing and procurement as follows and these appear in Figure Eleven above:

- Regulation - Ensuring tools for implementation: powers, incentives, and sanctions.
- Building coalitions and partnerships.
- Ensuring a fit between structure and culture.
- Optimism and developing intelligence around hope for the future.

The Discussion Chapter will consider each of these to determine how assurance is provided that the decision to admit to long-term care is sustainable.

Regulation

The World Health Report (2000) is very clear that as well as identifying health need and the means of alleviating this, that part of the management of sustainability involves delegated

responsibilities from other organisations in the implementation of incentivising, regulating, and sanctioning those from whom they procure services. Preker and Langenbrunner (2005) consider the dilemmas inherent in procuring health services for disadvantaged people such as the individuals in this study cohort, recognising that they are typically unable to provide information about their own needs which leads to assessments which are essentially the perceptions of others and an inability to challenge aspects of support offered which they may not agree with. They clearly state the importance of the delegated function of the procurer (or assessor / broker) in ensuring that services are of an acceptable standard and thus sustainable. Assessors of working-age people with mental health needs do have such powers; they process or steward the person's level of risk, need for protection and strengths and are instrumental in identifying the long-term care provider, which incentivises providers in that the weekly rate for this type of support is currently surplus of £800. Assessing professionals utilise previous experience of providers (from their own experience and the reports of others forming part of their bounded reality or decision-making skill set).They also have recourse to sanctions, whether this be to require improvement in support offered as part of the review process, to simply not use the home again and share their experiences with peers or to refer to the Local Authority Quality Assurance Framework (potentially via Safeguarding Investigations which may lead to criminal investigations) or via recourse to the CQC.

However, as Preker and Langenbrunner (2005) also point out, there is a balance in making decisions which lead to outcomes which satisfice and not optimise. Oikonomou et al (2019) carried out a study which highlights the multiple covert and overt layers of regulation within the NHS and public services. They identified 126 organisations that exert some regulatory influence on providers as well as 211 Clinical Commissioning Groups (it is acknowledged these are now replaced by ICBs/ ICSs) and concluded that these regulatory systems have evolved as opposed to having been designed, and that as such they are complex and virtually impossible to navigate.

This local de facto regulatory system is an essential part of ensuring sustainability. Authors including Gunningham (2012), Braithwaite et al (2007) and Berwick (2013) indicate that the national overarching regulatory system is something of a colossus which does not function smoothly, and this increases the impact of the localised regulatory function exercised by assessing professionals. This can lead to the identification of a lack of resource within preferred providers where the standard of care is deemed to be better, so to manage risk and afford protection, the decision maker may have to rationalise and utilise provision where care is available, requiring a satisficing outcome to maintain overall sustainability. Consequently, the best solution is determined on within available resource within long-term care at the point admission is needed. This does not lead to consideration of other alternatives or ways of working and so as an unintended consequence admission to long-term care produces a niche "cornered market" group of providers whose services are brokered by co-dependent assessors with this means of support being the only option considered for the person. This is not to say that intentions are nefarious on behalf of anyone concerned but that long-term care is an easily realisable satisfactory sufficient resource whereby satisficing may come at the expense of the possibility of optimising the situation for the person.

Building Coalitions and Partnerships

Murdock (2004) discusses this type of unintended coalition and partnership and coined the term "public sector bargains" by which to characterise them. These kinds of bargains arise from the need to satisfice on the part of the assessor and provider. Hood's (2000) stakeholder theory has relevance to this type of partnership activity as the stakeholders currently in the market dominate to the exclusion of any other potential means of satisficing which may have better outcomes for the working-age person. Hood (2000) described the rise of New Public Management as the coinciding of command-and-control attitudes to value and spending with "business" principles of efficiency and quality. Hood (1991) argues that this gives rise to a paradox whereby public services are de-politicised but remain rigidly regulated by the state via a series of "public sector bargains" delivered through coalitions, partnerships and

stakeholders which he uses to mean “any explicit or implicit understanding between senior public servants and other actors in a political system over their duties and entitlements relating to responsibility, autonomy, political identity, and expressed convention or formal law or a mixture of both” (Hood 2000 p.8). The “public sector bargain” in the instance of admitting working-age people with mental health needs stems from an agreement between stakeholders including communities, professionals, publicly funded institutions and the privately run concerns which form coalitions and partnerships which determine that such long-term care is the only readily available vehicle by which to address the themes identified in the findings.

Thus, in the business transaction of admission to long-term care, the person purchasing or commissioning the product (the long-term care) is not the actual recipient of it. This is termed as “Principal Agent Problem” (Ross 1973, Arrow 1985) and characterises the situation as an instance which occurs where services are contracted by public officials on behalf of end users. Monroe (2001 p.18) indicates that this may lead to a satisficing approach whereby “…differences of interest and information between the two parties mean that the agent may not always act in the interests of the principal, and the costs and difficulties of selecting an agent and monitoring his performance mean the principal may not be able to enforce her will on the agent.” This characterises the way in which the assessing professional will elect to commission long-term care as it is the only option available within resource to manage risk and provide protection within resource but may need to use the “best available” facility in terms of quality of care and strength-based approach. Moore (1995) terms this kind of stakeholder relationship as the creation of public value, as market realities, demand, and supply lead to the creation of profit in the private sector.

In terms of building the layers of theory the professional will initially use the underlying or associated theories and will: be triggered to make a decision by the presence of the themes identified in the findings (management of levels of risk and the need to offer protection and maintain strengths); they determine that the person cannot be supported by services offered

within the community so the person needs to be admitted to make their situation sustainable; they utilise stewarding resources to understand what is available, exercise some regulatory control over the privately owned but publicly funded facility they purchase on behalf of the person with mental health needs and ensure they are sustainable both in terms of quality and cost; the mechanism by which this is done is the bounded reality within which the professional operates. The outcome of balancing sustainability and stewarding through the lens of bounded reality is best explained by satisficing theory according to which the assessing professional must work within the market to provide an outcome which is sufficient and satisfactory. This incorporates the dilemmas and conflicts by which assessing professionals make “public sector bargains” (Hood 2000) daily without necessarily being aware of the influences operating in these interactions. These types of interaction are influenced by structure and culture, so the chapter will now continue to look at the theoretical elements of these aspects of the satisficing outcome.

Ensuring a Fit Between Society and Culture - Society, Control and Mental Health

This element of the Discussion Chapter will consider satisficing through the lens of the decision-making culture around how we respond to mental health needs and how we assure ourselves that these decisions are personally and professionally appropriate and ethical. Although we need to steward resources in sustainable ways as part of the satisficing process, it is necessary to examine how we determine outcomes that are satisfactory and sufficient and not sub-optimal to these standards. Bhugra et al (2021) place emphasis on how cultural determinants influence mental health and contest that culture may influence and contribute to the causation of mental health issues, affect presentation and symptoms, and make some groups more vulnerable to mental ill health as well as modifying beliefs and explanations of mental illness.

Ethics and culture are also incontrovertibly intertwined. Tseng and Strelzer (2004) refer to the “health care culture” which mental health professionals immerse themselves in and in which

this study has found in the universal practice of satisficing via a shared bounded reality experienced by professionals. Culture plays an essential role in shaping a professional's ethical values whilst that specific culture it is not shared with the people they support. The history of mental health care and legislation have been fully explored in the Background Chapter; it is not proposed that this be repeated here. As Ikkos et al (2023 p.154) point out The Community Care Act (1990) was an optimistic response to exposure of poor conditions in mental hospitals and calls for de-institutionalisation but led to (in their view) "…the system splintering into dissociative chaos, with the assets of mental hospitals sold to support medical services elsewhere, divorce of forensic services into separate enclaves, unconstructive arguments about power and control in community services, downgrading of expert experience and creeping privatisation of care when bed reduction became excessive".

These central dichotomies exist in mental health care because its aim is to control people to manage the risk they pose to themselves or others but to make this palatable there is a need to couch it in terms of the benefits this provides for those people. This is because assessing professionals are not able to socially contract with people to manage their own risk, and the only means at their disposal is to move these people out of society. In a very simplified sense, a social contract is a system where people engage in reciprocally beneficial behaviour to receive rewards Freeman (1990). Thus, where a social contract cannot be made by both parties, a decision must made by the assessing professional. The theoretical framework of satisficing with its associated sub theories provides a means of processing and justifying decision-making.

People who do not (or cannot) engage in such contracts experience some degree of exclusion from society and this type of removal is termed "Total Confinement" and takes its roots from Goffman's (1961) seminal text on *total institutions* and Arrigo and Milankovitch's (2008) work on *the society of captives.* It is recognised that this study cohort is not imprisoned in long-term care, and the findings identify that they are able to access their communities to greater or

lesser degrees depending on their need or circumstances, but they are denied the opportunity to live within their communities. The scope of this type of confinement is congruent with what Saks (2002) terms as relaxed civil commitment statutes where people have some limited freedoms. As in the case of this study, social control operates to manage risk Beck (1992, 2009); this type of social control in response to risk has also been identified by (Hudson 2003; O'Malley ,1998; 2004).

This type of social control promotes safety and security for the collective good but often operates at the expense of the individual's human liberty. This type of confinement also results in social harm for those exercising and subject to this confinement. As this situation is far from optimal but is a satisficing outcome how do we therefore justify this type of social control? Arrigo et al (2011) argue that this is due to dominant ideologies which operate in society and mandate decisions to admit working-age people to long-term care (or some degree of confinement). They classify these ideologies thus: the *clinical* perspective, whereby mental ill-health is pathologised as disease so that medical intervention is justified; the *law, psychology, and justice model* whereby the law is a justified vehicle to protect both the person with mental health needs, provide a framework by which to manage their mental health needs and deliver justice by not totally imprisoning people (allowing that they are mad not bad); and the *law and social science* orientation whereby the state and society have a moral and legal duty to provide support for these people and to protect them and the rest of the population from the risk they pose. The nexus of these dominant ideologies is that satisficing is justified as the best (and only) current decision-making framework to address the conundrum of how risk and protection are afforded for this study cohort within existing resources. This allows us to ethically justify the practice as the person's confinement is the only means of providing protection as opposed to punishment or imprisonment. However, this is something of a dreary conclusion, and to balance this the Discussion Chapter will now continue to explore possible grounds for optimism and developing intelligence around hope for the future, which may be

based in strength-based practice and emphasis on the view of the person with Mental Health needs.

Optimism and Developing Intelligence around Hope for the Future

This study has found that in all cases assessing professionals considered what people could do as well as their needs as part of decision-making and that they had evaluated their relationships, and interests (or identified the lack of these as appropriate) whilst taking measures to ensure these could be sustained in the long-term care setting. This is the positive aspect of satisficing and evidences the efforts on the part of the assessing professional to ensure that the long-term care is the best possible fit for the person and that their lifestyle and connections can be maintained whilst managing risk and affording protection. In essence, this is how the assessing professional bought hope to their interaction with the person being assessed, hope counterbalanced satisficing because although the assessing professional had limited options in terms of outcomes, the individualised and optimal outcomes for the person were considered. Authors such as Ikkos et al (2023) acknowledge that marginalised people (including people experiencing homelessness and those with mental health and substance use needs) do experience a degree of confinement but express optimism for the future in the form of an enhanced service user involvement programme termed “meta community Psychiatry”. However, this is highly medically determined and does not acknowledge support from community mental health services other than medicine. Maitland (2001) found that mental illness was highly socially determined and argued that people with mental illness are de-humanised as they are not listened to, so it is edifying to see in this thesis that assessing professionals do look for the voice of the person as part of assessment and this seems to be an integral part of the way the justification of admission and is assurance that this is beneficial as opposed to a punishment. There was also a focus in the satisficing practice of tipping the balance more to what was satisfactory than sufficient to maintain the person’s strengths.

Rose (2017) identifies the juxtaposition of dominant ideologies of medicine, law, society, and state responsibility, which justify our control over people who manifest behaviours which indicate they cannot control themselves as highlighted in the paragraphs above. He laments the increasing role of mental health services in this control. However, this study has found that power is balanced with a will to understand the best interests of the person and that there is evidence that efforts have been made to engage the person with mental health needs and to include them in satisficing decision-making by endeavouring to determine what would be satisfactory to them. Mental illness does have an adverse effect on people, Link et al (2001) found that schizophrenia often coincides with reduced self-esteem, and it has been observed that poor quality of life and poor psycho-social functioning typically co-occur (Brekke et al 2001; Gureje et al 2004). The means of balancing this with the satisficed outcome of admission to long-term care is the adoption of strength-based practice. This thesis did find observance of a commitment to understand what is important to people and what they can do.

Saleebey (2006) views strength-based approaches as the strengths everyone possesses that can be utilised to improve their quality of life and states that where that people can be motivated to use these strengths quality of life is improved. This study had found that although admission takes place, identification and maintenance of strengths is integral to the assessment process and includes the following elements which have been found to be beneficial: access to community Degan et al (2020); access to family and friends Peplau (1992); personal stories (Epstein 2003; Peterson and Seligman 2004;) so a commitment to the working-age person with mental health needs and their outcomes is evidenced in this satisficing process. Having discussed the balance between sustainability and stewarding which the professional must provide a service which constitutes best value, the chapter will continue to discuss the mechanism by which this balance is achieved which is bounded reality.

6.5 Bounded Rationality – The Decision-Making Mechanism

This decision-making mechanism is based upon the assessor's access to knowledge, and their environment and culture (bounded rationality), the nature of the choice they must make, the alternatives available to them, the chronicity of the situation (including the professionals' previous experience) and the social constructs and power differentials operating. The decision taken results in admission of the working-age person with mental health needs to long-term care, which meets the requirement on the part of the assessing professional to satisfice by stewarding resources in a sustainable manner within the bounds of their rationality and in a manner which satisfies the constructs of the society in which they function. This Discussion Chapter will continue to consider the concept of bounded rationality and the influence this has on the decision to admit working-age people with mental health needs to long-term care.

Mellers et al (1997) consider bounded rationality as the 'computation process' undertaken by human beings as they evaluate the information by which to make decisions. The way in which this information is ordered is based upon their perceptions, their memories, their attention, and their information processing abilities. As a result of these potential complexities, it is not surprising that they employ what Gigerenzer and Todd (1999) term fast and furious heuristics which exploit structural regularities in the environment (in this case the power imbalance between the assessor and the assessed) which influence the social and emotional world. Decisions to admit people to long-term care are intensely emotive. The Findings Chapter has shown that this often results from intensely risky situations around risk to self or others and is a costly option which the assessing professional must justify. Authors such as Damasio (1994) outline the catastrophic effects of the inability to express and comprehend emotion, and Frank (1988) outlines the economic advantages of emotion in reinforcing the social contracts we make and in the case of working-age people with mental health needs, they are admitted because no such contract exists. They are unable to provide the assessing professional with assurance that they will modify and constrain their risk levels (as the majority of society does) so the decision to admit is made to supersede this consensual contract with one based upon

protecting and restricting them, whilst making efforts to ensure the that their strengths and attributes are also protected and perpetuated within the long-term care environment. This begins to lead credence to the notion that emotionally charged decisions are not illogical, ill-informed, or intrinsically inferior, but more that they are essential where social contracts cannot be made to inform decisions.

The heuristics of justifying decisions and the difficulty where there is no universally satisfactory option is explored by authors such as Bettman et al (1993) and Einhorn and Hogarth (1981) and the ways people extend the bounds of their rationality by doing more research or trying to find other options Tversky and Shafir (1992) Dhar (1997). However, in the case of the decision to admit to long-term care, there are no other viable options. Therefore, the decision-making strategy favours weighting the most important attribute (as found by Tversky et al 1988), in this case, the need to moderate and manage risk takes prevalence. Thus, the most significant impact upon the person (risk of harm to self or others) takes prevalence in the heuristic process of decision-making, underpinned by the reaction of the assessing professional, and is the prevalent reason for the admission of working-age people with mental health needs to long-term care. The consideration of bounded rationality and the way in which the decision to admit to long-term care is made takes place within a social order or context and the way in which this bounds the rationality of the decision maker as a stakeholder in or steward of will be considered in the section below.

This study indicates that the decision to admit working-age people to long-term care is socially driven and formed. Mellers et al (1997) discuss the influence of such heuristics as “What do the majority think?” or “What do the most successful / highest status people think?” there are also considerations in decision-making as to what has been done in similar situations or by other people. These types of heuristics can be used either in a linear way or lean towards a more “Delphi” type (Dalkey 1975, Dalkey and Helmer 1963) approach whereby individual views are expressed and received by the group, considered and then individual opinions

expressed again as the thinking processes of the group influences the ultimate decision. The decision to admit is apparently made by a lone social worker assessing a person, but actually they are part of teams of people, assessing similar people and reaching similar decisions. These decisions are approved at Resource Allocation and Quality Assurance Panels peopled by similar individuals who hold a higher position in the hierarchy of the organisation. This is how assessing professionals receive support and assurance that these highly significant decisions are justified and ethical. Thus, bounded reality in the decision with which this study concerns itself is formed from the knowledge of individuals but is ratified and justified socially by the group structures of the assessing professional. These are all aspects of how decision-makers work within their bounded reality but are also influenced by wider systems.

6.6 Satisficing – The Parameters and Scope of the Decision

The Discussion Chapter has established what satisficing is and how this arises from the need to balance sustainability and stewarding via the mechanism of bounded reality apply to the research question and constitute a theoretical framework for the decision-making undertaken. Simon (1955) originated the concept of satisficing as a decision-making process which resulted in a “good enough” outcome which incorporated options which were satisfactory, and which sufficed in response to the situation they were intended to address (combining the words “satisfactory” and “sufficient”). This was essentially an economic theory based on the assumption that people make decisions which they believe will have the best outcomes based upon what is available to them at the time the decision is made. Simon (1955) argued that this theory is associated with and constrained by bounded rationality, which is built on the premise that people rarely have complete information about alternatives when making decisions, nor do they have total knowledge about their preferences (or alternatives) but that they learn about both through their search for information and the deliberation inherent in the decision-making. Simon (1997a) clarifies that in ‘satisficing’, various considerations are undertaken until the person making the decision is satisfied that the *aspiration level* for the aim was sufficiently achieved, and no further efforts are needed. As a social process in mental health care

‘satisficing’ explains how decision-making about resources involves being satisfied criteria for quality care have been met while sufficing with available resources. ‘Satisficing’ while making decisions about financial, social, and environmental resources, is intended to strengthen the level of sustainability within mental healthcare.

Hence the satisficing process incorporates levels of responsibility and assurance which are undertaken as part of the decision-making process. The assessing professional has identified the risk posed by the person; the protection and restriction this requires them to have; the resource available to manage this; and strengths the person has. This then triggers a decision to admit to long-term care which will suffice to provide what the person needs and will be satisfactory to the person and society in terms of cost and outcome. This is influenced by three associated or sub-theories (balancing stewarding and sustainability via bounded reality) as illustrated by the visual at the start of this chapter (Figure Nine). The Findings Chapter identified the triggers for the decision which are the need to manage risk, provide protection, maintain resources and maintain strengths. The professional must then balance sustainability and stewarding to ensure the service provided is sustainable in the long-term and is best value, and the mechanism by which this is achieved is bounded reality. The outcome of this is a satisficed decision which is satisfactory and sustainable, but which does hold an element of optimism by considering the strengths and aspirations of the person who is being assessed.

6.7 Conclusion to Discussion

The Findings Chapter identified themes as separate entities which bought about the necessity to decide about admitting working-age people with mental health needs to long-term care. It will conclude by determining that satisficing provides a theoretical framework which explains how the decision is made and the factors and forces which determine the decision. This theory encompasses the way assessing professionals acknowledge that the outcome will be sufficient and satisfactory. This outcome theory also involves three associated sub theories in

which assessing professionals: use their bounded reality “decision-making mechanism” to balance information as a stakeholder in a public management or stewarding system and make their decisions based on sustainability (with all its system-wide elements). This process is assured via dominant ideology, which allows for a counterbalance between control, protection and risk management and a focus on the person in the form of strength-based practice. The theory is not newly generated but has been tested against the outcome of the data analysis and it has been found that there are elements of satisficing within the decision to admit working-age people with mental health needs to long-term care, indeed Layder (1998) argues that extant theory should not be disregarded in grounded theory where this affords relevant and accurate appreciation of social-structural or systemic aspects of society. This study has ultimately found that although satisficing does run through the professional decision-making analysed this is coupled with a practice of instilling hope which constitutes a form of augmented satisficing which ensures that an emphasis is placed upon optimising the strengths of the person whilst working within the constraints of public management.

This Discussion Chapter has focussed upon the current state of satisficing and will continue to the Conclusions and Recommendations Chapter which will provide a concise answer to the research question; identify the key points derived from the study; and provide a synthesis of these points. It will then identify limitations of the research, will consider reflexivity and positionality, and will make recommendations concerning education policy and practice. The thesis will then conclude by to exploring recommendations for future research.

7.0 CONCLUSION AND RECOMMENDATIONS

This chapter will provide a key synthesis of all the significant points in the study by answering the research question concisely; this will be followed by a summary of the main points of interest to take away from the study, namely the impact of high-risk behaviours, the lack of assurance these behaviours will cease or decrease; the desire to protect peoples strengths, the importance of the diagnosis of psychosis; and the permanent tenure in long-term care of the person admitted. Subsequently, an evaluation of the limitations of the research will take place. The next part of the chapter will comprise a statement of reflexivity and positionality, and the study will then conclude with recommendations for education, practice, policy, and further research.

7.1 Answer to the Research Question

This thesis has found that working-age people with mental health needs enter long-term care because assessing professionals find this is the only satisfactory and sufficient response to the risks they pose, the protection they need, the resource they consume and a means of maintaining the strengths they possess.

7.2 Main Points to Take Away from the Study

i) Admission results from behaviours which cause risk or neglect for which there is no recourse to criminal law.

In all but 2 cases of the study cohort, the admission was due to behaviours that could not be tolerated or sustained in the community. These 2 people had historically been admitted to the old state-owned long-stay mental health institutions and moved to long-term care when these had been closed. It was not possible to determine from the record why they had been originally admitted decades ago. They are currently deskilled to such an extent that the view is they could not be returned to living in the community safely.

ii) There is no assurance that the working-age person will desist from these risk behaviours.

Events prior to admission vary from person to person, and in some cases, the admission is a result of one catastrophic event as opposed to a response to a series of incidents. Nonetheless, the admission occurs because the assessing professional is not assured that the person will cease to carry out high-risk behaviours. Seigrist (2000) discusses the importance of trust in risk assessment, whereby levels of risk are perceived to be higher where the assessor can gain no assurance from the assessed about repetition of risk activities. Conversations about risk and repetitions of behaviours or circumstances or situations are not recorded verbatim in the case record, but the assessor has alleviated the impact of, or prevented, repetition of undesired behaviours by admission to long-term care (or enabled the situation to be monitored and managed).

iii) A desire to monitor long-term care and promote the person's strengths therein.

The Discussion Chapter explored the nature of strength-based practice and the how this is employed to ensure that the satisficing outcome of admission is made as optimistic as possible by guaranteeing strength-based practice is undertaken. A positive and edifying aspect of the study is the conclusion that although the admission is a result of satisficing, the assessing professional displays an awareness that the person will need to be continually monitored via the review process and that there is an intention to make the admitted persons' experience as constructive as possible. Clark (1998) discusses the utility of such an approach in navigating difficult situations from an aspect of hope, whilst acknowledging the construct may seem a little contrived where its recipients are reluctant to engage and ambivalent or unaccepting of outcomes. The way in which assessing professionals practiced in the cases explored was encouraging, as they had documented

a real sense of the person as an individual and had made efforts to describe their strengths, needs and wishes.

Cooper (2019) indicates that whilst strength-based approaches maximise the utilisation of the persons' resilience, networks and coping strategies, facilitating the sustainable delivery of adult social care, there is concern that this will limit access to support for people who need it as it is an extra element to the support and requires more work and resource. This did not appear to be a consideration in this study; the level of risk did indicate admission to long-term care was appropriate. It was also encouraging that the assessing professional did not see admission as an "end point" or the solution of a problem but as provision of support which would continue to be reviewed, and the suitability of the situation regularly monitored.

iv) The working-age people admitted to long-term care predominantly have a diagnosis of psychoses.

This study found that 89% of the working-age people with mental health needs in long-term care had a diagnosis of schizophrenia. Hewlett and Moran (2014) found that expenditure on mental disorders is one of the highest areas of health expenditure, representing between 5% and 18% of all health expenditures when comparing a variety of countries. Mental illness is responsible for 23% of England's total disease burden but receives 13% of the National Health System health expenditures.

v) Working-age people with mental health needs admitted don't come out of long-term care.

None of the study cohort was discharged from the long-term care facility over the period of completion of this thesis, although 2 people had plans to move to supported living (N.B figures correct at the time of data analysis and will have changed subsequently), which is a tenancy-based living arrangement which focusses upon the accommodation the person needs where they will have non-medical support according to their needs. This is still long-term care, but it

is not nursing or residential and is cheaper and less restrictive. It also allows the person to have their own tenancy and thus a sense of home.

7.3 Key Synthesis

This thesis has determined that working-age people with mental health needs are admitted to long-term care because this is the only resource available to manage risk, offer protection, which is sustainable and maintains strengths. This outcome is not optimal but is satisfactory and sufficient. However, there is evidence that although this is all that is available, assessing professionals do have a commitment to maximising peoples' strengths and acknowledge that satisficing solutions are not "good enough". The Local Authority Good Mental Health Strategy (2023) constitutes a platform for working towards achieving the recommendations itemised below and ensuring that the person is a valued part of their community which is a positive move from the perception of them as being cared for in their community. There is a considerable way to go including resource and "hearts and minds" challenges remain, but completion of the study has been encouraging in indicating the dedication of individual professionals and partner organisations to "raise the bar" of satisficing to optimising and maintaining hope in mental health services. This final chapter will now continue to explore some of the potential limitations of the research prior to providing recommendations and a reflexive section; the chapter will then conclude with recommendations.

7.4 Limitations of the Research

The thesis's conceptual model is very much concerned with understanding the elements of the decision-making that led to and rationalised admission to long-term care for working-age people with mental health needs. This is of particular interest as the Literature Review Chapter indicates that long-term care does not have positive effects on individuals and that this causes their outcomes to deteriorate in the longer term. (Grabowkski et al 2010 ; Nakram 2015 ; Zhang et al 2016; Rysinka et al 2019; Mårtensson,et et al 2014; Samartiz and Talias 2019 and Raes et al 2020).

Evaluation of the research plans indicates that the research question has been answered by stating that working-age people with long-term mental health needs are admitted to long-term care because this is the only available sufficient and satisfactory response to the risk they pose to themselves and others. This should be caveated by asserting that the assessing professional does take steps to maintain the persons' strengths and there is an individual and organisational will to expand the market and improve the satisficing offer. However, the study does have the following limitations:

- The data is relevant to the Trust area in which the study took place only. This may impact the transferability of the findings, but it would not be ethical to access information from other areas as the researcher had authorised access to this area only at the time the sample was generated. There is no evidence as to whether (or not) findings would be transferrable, but this is a consideration.
- The researcher is integral to the analysis of what is recorded throughout the electronic record and carried out the research. The thesis acknowledges that this may have an impact on trustworthiness due to perspectives, beliefs, expectations, or emphasis placed by the individual researcher (Young 2009, Galdas 2017) To mitigate this, random case records (the 7th successive case) were checked / compared with colleagues as part of the practice audit process to provide assurance that there was interrater reliability and that there was no undue influence on the findings from any assumptions or preconceptions on the part of the researcher.

The chapter will now continue with a statement on the reflexivity and positionality of the researcher.

7.5 Reflexivity and Positionality

This part of the study will provide a positionality statement which provides an intentional reflection of the identity, life history experiences, and the personal and professional priorities of the author which will explore the basis of ultimate position taken in the thesis, consequently this section is written in the first person. Positionality describes my overall perspective and my position about the research and its social and political content (Holmes, 2020, p.1). This involves taking stock of 'where the researcher is coming from', [and] concerns ontological assumptions (an individual's beliefs about the nature of social reality and what is knowable about the world), epistemological assumptions (an individual's beliefs about the nature of knowledge) and assumptions about human nature and agency (individual's assumptions about the way we interact with our environment and relate to it) (Holmes, 2020, p.1-2)

Bourke (2014) suggests that it is useful to structure such a Reflexivity and Positionality Statement as follows, and this will be observed here.

- Identity characteristics (e.g., age, gender, sexuality, ethnicity, social class, disability status, citizenship, immigration status, religion, marital status etc.)
- Life experiences (previous or current job, volunteering activities, membership in advocacy groups, etc.)
- Relationship to phenomena of interest (insider and/or outsider status.)
- Political, philosophical, and theoretical beliefs (the perspective by which the researcher views and interprets the world.)

Identity Characteristics

Of the identity characteristics which were felt to be relevant to the positionality of this study were age, gender, and citizenship and immigration status of the researcher. This study is concerned with a specific area, which is demographically a predominantly white area with few

migrants in which 1 in 3 people are in employment, and those who are not are predominantly over 65. This study cohort are working-age, but none of them are in employment, which is a factor in which they differ from most of society (Information from Local Authority 2021).

This recognition of an “otherness” of the study cohort was one of the main drivers for the completion of this study. Although this anecdotally felt linked to risk and protection, this had not been systematically studied despite the poor personal and financial outcomes of admission to long-term care, which were identified earlier in the study. Thus, the difference of the study cohort to most of the population was an important aspect of positionality, but there was also a curiosity about reflection upon where I fit into this dynamic.

I am a white, female, British citizen and over the age of 50. I am employed and live in my own home. The XXX Workforce database indicates I share these characteristics with most of the Social Work workforce. Thus, the assessing professionals (and I) differ from the people we are assessing, who are predominantly male, all are unemployed and none of them live in their own homes.

Life Experiences and Work Role

My work roles as a manager, an employee and a senior manager of the service greatly influenced the positionality of this study.

As an individual who is a manager, organisational priorities are integral to my role in that I have a level of responsibility for the cost of long-term care, which is significant because of the length of time people remain in such settings. This is a significant financial burden on the local health system finances, however, the findings of this study identified that there were no viable alternatives to admission and that continued annual reviews monitored that this remained the case. This has led me to take a position of continued enquiry as the status quo is not optimal,

and more work needs to be done around more efficient and effective means of care provision for this study cohort.

My role as a senior manager was also impactful. This placed upon me the duty to address any issues around practice which arose during the conduct of the study. Thankfully there were no issues arising in respect of this and no evidence that people are admitted to long-term care as a means of solely excluding or confining them. Admission removes the risk the study cohort present to society but and they are proactively reviewed and any potential alternatives to their support proactively considered despite there being few viable alternatives to admission to long-term care. The positionality of the research was also influenced by the researcher's relationship to the phenomenon which will be explored below.

Relationship to Phenomenon

Bourke (2014) identifies this positionality as being characterised very much by insider or outsider status. My position has significant insider elements which are focussed very much within a desire to protect both the working-age adults and the workforce. This arises from a need to ensure the best outcomes for the working-age person and to question and research the reasons for their admission to long-term care. There is also a desire to protect the workforce as the inevitability of admission assumes they have a lack of professional autonomy; however, this will be countered by a conscious and overt recognition of the lack of alternatives for this study cohort and an acknowledgement that this as a system issue as opposed to a shortfall in practice.

Political, Theoretical and Philosophical Beliefs

The lens through which the study was completed was very much a social one; its essence is an evaluation of how one part of society controls and restricts another under the auspices of providing care and protection. This ontology is based very firmly in constructing meaning in the processes and systems by which power and confinement takes place and in making this overt in a way which can be articulated to professionals, and which can form a justification of admission to long-term care.

The interpretivist epistemology centres on the way in which the subjective reality was interpreted through focus upon risk, professional responsibility and how these are balanced when decisions are made. This decision-making is best understood by the bounded reality of the assessing professional best understood by the bounded reality of the assessing professional best understood by the bounded reality of the assessing professional and the requirement upon them to balance their responsibilities as agent of both the working-age person and the state to steward services in such a way which will be sustainable for this individual and others into the future. The aspiration is that this will lead to provision of services which are satisfactory and sufficient. The balancing of stewarding and sustainability by the means of bounded reality leads to phenomenon of admission to long-term care which is best explained as the “endpoint” theory of satisficing, although this is supplemented by regular review to ensure the satisficing outcomes are still met.

Conclusion to Reflexivity and Positionality

This study has been greatly concerned with sensitivity to “how relations of power operate in the research process” (Reid et al 2017, p. 50) and how these affected my relationship with, and perspective of, the subject. The subject of social research is complex, dynamic, and this was especially apparent in this thesis which was conducted upon a population with which I have close relationship with and a significant stake in the outcomes for working-age people,

staff, and service provision. Thus, it was edifying to determine that satisficing in practice is not “less than” as an enterprise, that strength and person-based practice is a consideration and that by articulating and acknowledging the present position in this way it is possible to identify recommendations for future improvements and hope for this study cohort.

Recommendations

Having answered the research question and outlined the main key points of synthesis with the study the chapter will now continue to offer recommendations and will conclude. These recommendations lead from the key points of study and are organised into recommendations which pertain to education, practice, and policy respectively. This will then be followed by recommendations for future research which could further enrich the conclusions to this study. Some of the recommendations may fall under more than one section heading, so each will be preceded with a brief rationale as to what will be incorporated therein.

7.6 Recommendations for Education

These recommendations are actions which can be addressed by providing the workforce with education or training which will provide awareness of the aspects identified below. This education or training could be either pre or post professional qualification (and would need to be both initially to incorporate the entire workforce). It will also be necessary to provide targeted sessions for non-professionally qualified colleagues in the Floating Support and Personalisation and Social Inclusion Services as these staff members will not be directly making decisions to admit but may be supporting people prior to or at the time of admission.

- That the principles of satisficing as arising from bounded reality and comprising sustainability are incorporated into professional education so that this is a conscious and overt process for which professionals recognise the reasons for their decision-making and the potential constraints which influence them.

- That market influences which impact upon practice are considered as part of professional education so that strength-based practice and stewarding are not opposing forces but that the influence of one on the other is understood and professionals are empowered to articulate and document how these impact upon decision-making.

7.7 Recommendations for Practice

Recommendations for practice concerning individual practice and the ethos within the service and within teams that the persons supported are at the centre of practice. This encompasses principles of practice which inform strength-based and person-centred practice, which are carried out in a conscious way and are positively impactful on continued professional curiosity and service development.

- That the assessing professionals maintain their professional curiosity, continue to strive to optimise as opposed to satisfice and to continue to gather and promote intelligence about optimal service provision and long-term proactivity as opposed to short term reactivity and sufficiency. The focus should remain upon optimising as opposed to satisficing and the views of people receiving services should be sought as part of professional practice so that unmet need is well understood and documented.
- That current good practice within Adult Mental Health Services in the study area is recognised and perpetuated. There is evidence that there is a firm intention to work with people to achieve their best outcomes, and whilst there is little alternative to admission to long-term care for this study cohort, care and compassion is shown within the case record. This was encouraging as a concern at the start of the study was that admission may be a means to confine or remove people from society. Conversely, this study has demonstrated that assessing professionals have a commitment to evaluating what strengths people have and how these can be utilised as opposed to perceiving risk as a motivator to exclude the study cohort from society.

7.8 Recommendations for Policy

The recommendations for policy are based around aspects of service development which will require additional investment and system-wide agreement about changes to the way the service is delivered. This would also include quality and performance assurance measures which need to be incorporated to measure the effectiveness of changes to service delivery.

- That intensive support in people's home is facilitated including assertive outreach approaches so that they do not need to leave their homes and communities to be supported unless this is the only option, so they maintain a consistent and stable community presence.
- That temporary rehabilitative care be incentivised even if this means continuing to fund support that may not constantly utilised in the short term in order that rehabilitation and recovery can take place, and admission is not necessarily forever. This should include "step up and down" care so that people get what they need at the point they need it and that there is movement within the mental health care system.

7.9 Recommendations for Future Research

This section of the recommendations is distinct from recommendations that promote changes to education, practice, and policy because of this thesis as it details considerations for further research that were outside the scope of this study but constituted queries which arose from it.

a) Trust levels - How do levels of trust and assurance between assessing professionals and people assessed impact upon outcomes in mental health care? Do people who are unable to contract with their assessors in this way find they are subject to the most restrictive alternatives?
b) Diagnosis – who has best rates of recovery and why? Which illnesses do assessing professionals find it easier to work with and what is it about alternative belief systems, hallucinations or other alternative realities that cause barriers to engagement? For

example, do people discuss their ideations and beliefs, if so, how fully and how does the way they are received or challenged impact on engagement?

c) The levels of “hope” in secondary mental health professionals or beliefs that things can improve. How do these impact on people’s aspirations and can they move beyond satisficing? The objective would be to provide some goal-oriented SMART lived examples of successful interventions to prevent admission to guide and inspire others.

7.10 Final Summation

This thesis has explored the decision-making which leads to working-age people with mental health needs being admitted to long-term care. At the point of planning the study the assumption made by the researcher was that decision-making was limited by lack of resource and was intrinsically limited and a rather shallow and process driven interaction. Conversely the research has found that assessing professionals do show a commitment to incorporating the voice of the person and strength building but that they could be better supported by a wider range of options to admission to long-term care. Assessing professionals evidently work with the strengths of the person; there is recognition that admission satisfices, but that hope remains that there could be less restrictive models of care, and this study recommends that there is potential to bring this hope to fruition and that outcomes for this study cohort can be optimised as opposed to satisficed.

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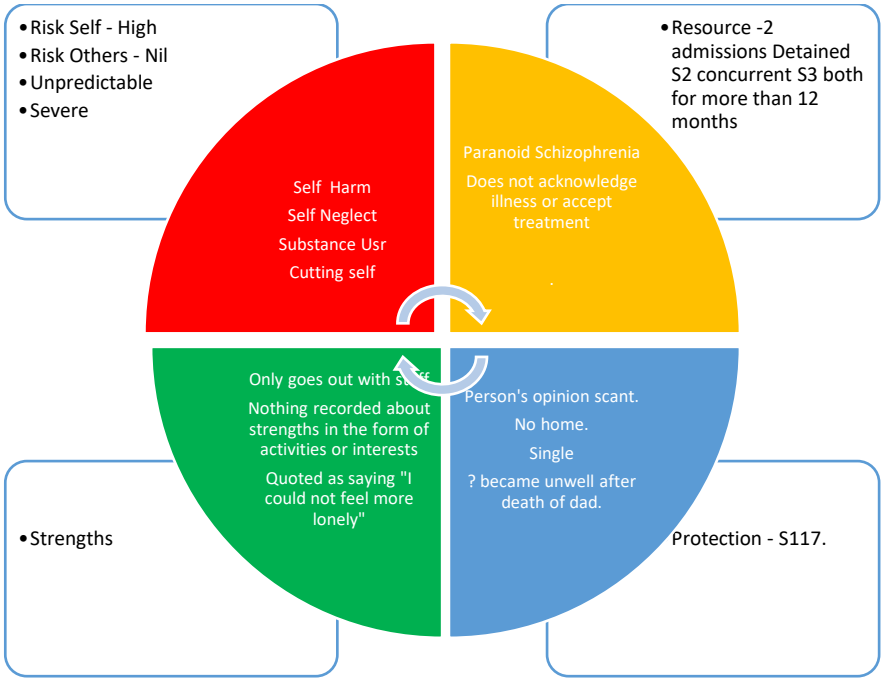
APPENDICES

Appendix 1 –EXAMPLE OF PERSON 19's MEMO

Person Nineteen



Very limited roles.
Person's view not heard.
No insight into condition.
No carer who could do so full time.
No assurance re: future relapse.
Voice does not come through in documentation.
Quote from person "I could not feel more lonely".
Went home in 2016 unable to care for self or home? deteriorated after death of dad.
Had 7 brothers and sisters only one sister in touch others estranged or deceased.
No evidence to substantiate complaints about staff.

Appendix 2 - HRA Approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Miss Mary Williams

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

15 May 2019

Dear Miss Williams

HRA and Health and Care

Study title:	**Why do people with Mental Health needs enter long-term care: A retrospective study.**
IRAS project ID:	**263289**
Protocol number:	**NA**
Sponsor	**Staffordshire University**

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The attached document *"After HRA Approval – guidance for sponsors and investigators"* gives detailed guidance on reporting expectations for studies with HRA and HCRW Approval, including:

- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **263289**. Please quote this on all correspondence.

Yours sincerely,

HRA Approvals Manager

Email: hra.approval@nhs.net

) **List of Documents**

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
HRA Schedule of Events	1.0	15 May 2019
HRA Statement of Activities	1.0	15 May 2019
IRAS Application Form [IRAS_Form_07052019]		07 May 2019
Research protocol or project proposal [IPR with university clearance]	V1	03 May 2019

Summary CV for Chief Investigator (CI) [CV]	1	03 May 2019

Appendix 3 - IPR Approval

INDEPENDENT PEER REVIEW APPROVAL FEEDBACK

Researcher Name Mary Williams

Title of Study **A retrospective analysis of the reasons why adults with long term mental health conditions enter permanent residential or nursing care**

Award Pathway PhD

Status of approval: **Approved**

Thank you for forwarding the amendments requested by the Independent Peer Review Panel (IPR)

Action now needed:

You must now apply through the Integrated Research Applications System (IRAS) for approval to conduct your study. You must not commence the study without this second approval. Please note that for the purposes of the IRAS form, the university sponsor is Professor Nachi Chockalingam, N.Chockalingam@staffs.ac.uk .

Please forward a copy of the letter you receive from the IRAS process to ethics@staffs.ac.uk as soon as possible after you have received approval.

Once you have received approval you can commence your study. You should be sure to do so in consultation with your supervisor.

You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal.

When your study is complete, please send the IPR coordinator (Dr Peter Kevern) an end of study report. A template can be found on the ethics BlackBoard site.

Comments for your consideration:

Signed: Dr Peter Kevern
University IPR coordinator

Date: 4.3.19

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
There is only one participating NHS organisation therefore there is only one site type.	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study.	A statement of activities has been submitted, and the sponsor is not requesting and does not expect any other site agreement to be used.	External study funding has been secured from Midland Partnership Foundation Trust.	A Principal Investigator should be appointed at study sites of this type	As a non-commercial study undertaken by local staff, it is unlikely that letters of access or honorary research contracts will be applicable. Where arrangements are not already in place, researchers undertaking any of the research activities listed in A18 of the IRAS form would be expected to obtain a Letter of Access.

Other information to aid study set-up and delivery.

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

1. ASSESSMENT EXCERPT

Full Name: xxx	**NHS Number**: xxxx
Preferred Name:	**CareDirector ID**: xxxx
Gender:	**Date of Birth**: xxx
Home Address: xxxx	**Ethnic Origin**: White British
Post Code: xxx	**Religion**:
Borough: XXXX	**Marital / Civil status**:
Telephone Number:	**Occupation/School**:
Client Group: ☐ Dementia ☐ Dual Diagnosis ☐ Learning Disability ☒ Mental Health ☐ Older Person ☐ Physical Disability ☐ Substance Misuse ☐ Young Person (U18)	**Status Prior to Assessment**: ☐ S2 ☒ S3 ☐ S4 ☐ S5(2) ☐ S5(4) ☐ S13(4) – NR/MHA Request ☐ S135(1) ☐ S135(2) ☐ S136 ☐ CTO ☐ Guardianship ☐ Informal ☐ PACE ☐ None ☐ Other

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	1 / 1	

2. CARE AND SUPPORT PLAN

PRIVATE AND CONFIDENTIAL
XX

XXXX

Please find enclosed a copy of your Care and Support Plan that we discussed at your last appointment.

Yours sincerely

If you require an Interpreter/communication support or if you require this document to be translated into a different language or format (eg easy read, large print or audio) then please contact us on the following:

Telephone Number: insert Email Address: insert

My Care and Support Plan

Placement at xxxx to meet all identified eligible needs. xxx manages her finances independently but receives support to manage all other ADL's due to the impact her MH has upon her being able to keep herself safe and meet her needs. Reviewed xxxx - remains appropriate.

Need:	Social Care
Whose Need:	Client
Start Date:	XXXX
My Goal Is: -	
Goal type:	-As above
What will help me:	-As above
Who would support me:	-As above
Person responsible:	-As above
Progress since last review:	-As above
When will this happen:	-As above
When will this be reviewed:	-As above
Last updated:	-As above

3. REVIEW

ASC - Review Record

Client

Date/time
XXXX
Please remember to consider the following 6 principles at every stage (Care Act, 2014):
• Mental Capacity
• Participation and Advocacy Support
• Impact on the Family and Carers
• Safeguarding
• Strengths Based Approach
• Ensuring review is proportionate and appropriate (this enables clinical/practitioner discretion).
No

Ordinary Residence if known:
xxxx

If not XXXXshire ordinary resident please seek advice as appropriate from a senior social care member of staff and summarise area and advice sought in the below box:
(no data)

Contact/Restriction/Access form last completed:
Last completed on: Aug 15, 2024
CLICK HERE to view/edit/create Contact/Restriction/Access form
Employment &Accommodation Status form last completed:
Last completed on: Aug 15, 2024
CLICK HERE to View/Create/Update the Employment & Accommodation Status form
Planned
Is this a joint review with a carer?
Yes
Date of Review:
XXXX(C) Both
Annual/Scheduled

Date of Completion
26 April 2023
Does the Adult/Carer require support to participate in this review?
No
Advocacy and Participation support form last completed:
Not completed
If Yes, CLICK HERE to View/Create/Update the Advocacy and Participation support form
Is a carer identified?
No

If yes, does the carer have a support plan and what is the plan to review?

Since the death of XXXX father (November 2021) (person) has increased her independence skills and her mother has reduced her caring role, although she continues to support (person) with the caring of her young son.
XXXX now lives independently in her own flat with XXXX and is coping well with this transition. (person) and her Mum continues to have a good relationship, she will visit every night after school with (person's son) and XXXX takes care of XXXX each Wednesday night for a sleepover. XXXX has recently looked after XXXX whilst XXXX has gone on holiday XXXX.
Views of your family and carers. Is the carer willing to continue? Is there anything that needs to be changed
Yes
PRACTICE NOTE:CONSIDER THE PROPORTIONALITY OF THIS...
Who was involved in this review?
Role
Details
Action
Adult
XXXX
Care Coordinator
REMEMBER click ADD to save
Have your circumstances and/or care and support needs changed recently?
Yes

Details:

Planned appointment at home address to facilitate s117 review
XXXX greeted me outside home address at Housing Associat (Domestic Abuse) scheme.

XXXX advised that she has a viewing with XXXX Housing next week having received support from Housing Associat during her time in the refuge. Review took place privately in XXXX flat, XXXX have already started to pack boxes in anticipation of their move. Both advised that they are looking forward to having a more private, quieter, more spacious

15/08/2024, 11:27 ASC - Review Record

living environment however they have felt safe and secure in current arrangement.
XXXX advised that since having a non-molestation order in place, she has not had any contact from her ex-partner. Previously, he would not leave XXXX Mum's driveway, would approach XXXX at school and did not want to accept that the relationship had ended.
(person) stated that she has a good relationship with her Mum and she visits her regularly with (person's son). (person's son) now sleeps over at his Nan's house every Wednesday and (person)/(person's son) will go to visit each day after school for an hour.
XXXX reported that (person's son) is sleeping much better now and feeling more settled at school. XXXX will continue in current school for his last year of primary education before moving into secondary school.
XXXX advised that generally her sleep is fine, there have been a couple of issues of disrupted sleep however XXXX has been proactive in contacting Dr xxx for a short prescription of zopiclone to support with this.
XXXX stated that she had found it helpful being re-allocated to a nurse in the IMHT to monitor for any break-through symptoms during the initial move into Housing Associat refuge - IMHT happy with the ongoing stability of XXXX mental health and discharged from team. XXXX expressed no concerns with relation to any signs/symptoms of relapse and no concerns observed during discussions.
XXXX advised that would like to have a review with Dr XXXX to look at the most appropriate dose of Quetiapine as there have been some changes to this over the past 12 months and she is struggling with getting the correct prescription from pharmacy too - aware that she may need blood tests done as part of process.
XXXX advised that she has been able to go on holidays with XXXX this year and also on her own to xxx last week when (person's son) spent a week with his Nan. XXXX advised that they are going to Local attraction next week and are planning to book in some activities for the rest of the holidays. They report enjoying going to the park together and have both got XXXX garden memberships.
XXXX continues to drive, she takes XXXX to school/picks him up, completes shopping, cooking and cleaning tasks all independently.
XXXX is proactive in making contact with myself via email should she have any concerns.
S117 remains appropriate, no additional intervention required from Social Care Pathway at present. Further visit to be facilitated when XXXX has moved house/once review has been completed with medic and then plan for case to be closed under review on s117 pool unless any issues arise.

Your Medication

Your Medication

Type
Prescribing Action
Subject to ESCA
Subject to CTO
Medicine
Dose
Frequency
Efficacy

CLICK HERE to View/Edit/Update Medication

Do you have any concerns about your medication?

No

Has your medication achieved the desired outcomes?
Yes
Have you been able to take your medication as prescribed?
Yes
Safety and Risk
Are any changes to your medication or a review indicated?
No
If yes to any of the above, please enter the details below (please include any details of the action plan to address and consider any assistive technology):

XXXX mental health appears to be currently stable and she presents with good insight into her mental illness and symptoms.
XXXX manages her own medication and reports that this is still going well.
XXXX and her consultant, Dr XXXX have made changes to her Quetiapine over the course of the past 18months, this initially reduced down and then was titrated back up. XXXX has requested an OPA to review and amend her prescription accordingly.
Looking back to your care& support plan, are the things that made your others feel less safe still apparent? Are there any other factors that make you or others feel less safe?
No
Has your safety and the safety of those around you been maintained?
Yes
Do you have any concerns about your safety or the safety of those around you?
No

If yes to any of the above questions, please enter the details in the box below.

I feel safe living at the Housing Associat refuge with my son XXXX and the support of the team there.
FACE Risk Profile Mental Health v6 last completed:
Last completed on: Mar 03, 2022
Where appropriate CLICK HERE to update the FACE Risk Profile Mental Health v6
FACE Older Persons Profile last completed:
(no data)
Where appropriate CLICK HERE to update the FACE Older Persons Profile
Are there any Safeguarding concerns identified?
No
Adult Safeguarding Form(AS1 form) last completed:
Last completed on: Nov 25, 2015
If yes, please CLICK HERE to View/Create/Update the Adult Safeguarding Form (AS1 form)
Do you have a contingency plan in place?
No
Care and Support plan' last completed:
Last completed on: May 15, 2020

CLICK HERE to View the Crisis/Contingency Plan in ‘Care and Support plan’
15/08/2024, 11:27 ASC - Review Record
CLICK HERE to Create/Edit the Mental Health Assessment
Are any changes to you rplan required to ensure your safety or the safety of those around you?
No

Details

N/A

Views of your Family and Other People Who Support You

This is the first s117 review that XXXX has participated in without the support of her Mum having moved into her own accommodation with XXXX. XXXX Mum was in contact with ASC when XXXX initially moved sharing her concerns about this and consequently increased contact was had with XXXX has since shared no further concerns and is aware of how to raise these if required.
XXXX son, XXXX, sat in with today's review and contributed. He advised that he has found it okay living where he is, he enjoys living with his mum and still seeing his Nan and is looking forward to living in a quieter space with their own garden if possible. XXXX sleeping has improved significantly which has positively impacted on his attendance/engagement at school.
Who, What is Working and What is Not Working?

XXXX would like to move into her own property via social housing, Housing Associat have been supporting with this.
XXXX has an appointment to view a house in XXXX next week which her and XXXX are hopeful about.
XXXX is really pleased with the progress that XXXX has made with regards to his sleep/behaviour alongside how well he has adjusted to the move in house.

What Personal Outcomes are most important to you and how would you like me to enable you to achieve these changes?

Remaining well.
Caring for my son
Maintaining my independence
- Long arm support via email should any queries arise
- Maintaining contact with my care team
- Review of medication when indicated.

Include physical health/personal care assistance/mobility/current support. Consider if adaptions, equipment or rehab can assist.

Have your support needs changed? If yes, how does your support plan need to be changed?

n/a

Please review needs arising from the mental or physical impairment or illness against all 10 eligibility criteria/outcomes set out below. Please summarise your review and explain your decision-making rationale in the space provided:

Outcomes (eligibility criteria)
Managing and maintaining nutrition

Can you do this alone within a reasonable time and without significant pain, distress, anxiety, or risk to yourself or others?
Yes
Provided under s117?
Yes
Review Summary/Comments including what's working well, what you have achieved i.e. views, wishes, aspirations and achieved outcomes.

Please also include details of any continuing impact on your wellbeing

In the past, XXXX required a great deal of input from her Mum and late father with regards to food shopping and meal preparation. This was when XXXX mental health was not as stable as it is now and previous side effects to MH medication too.
Now XXXX mental health is stable, she is able to complete food shopping independently - going to local supermarkets and also ordering online. XXXX prepares meals for herself and XXXX and is encouraging XXXX to develop his skills in this area too. XXXX recently prepared a roast beef dinner in the communal area of Housing Associat with the support of the team there.

Maintaining personal hygiene

Can you do this alone within a reasonable time and without significant pain, distress, anxiety, or risk to yourself or others?
Yes
Provided under s117?
Review Summary/Comments including what's working well, what you have achieved i.e. views, wishes, aspirations and achieved outcomes.

Please also include details of any continuing impact on your wellbeing

XXXX is able to maintain her personal hygiene and takes great pride in her appearance.
As she was previously a beautician XXXX likes to paint her nails and visits the hairdressers regularly to have extensions and colour in her hair.
However, when unwell XXXX is unable to maintain her personal hygiene and requires support, prompting and encouragement from her mum in order to complete this task.

Managing toilet needs

Can you do this alone within a reasonable time and without significant pain, distress, anxiety, or risk to yourself or others?
Yes
Provided under s117?
Review Summary/Comments including what's working well, what you have achieved i.e. views, wishes, aspirations and achieved outcomes.

Please also include details of any continuing impact on your wellbeing

No issues

Being appropriately clothed

Can you do this alone within a reasonable time and without significant pain, distress, anxiety, or risk to yourself or others?

Yes
Provided under s117?
Review Summary/Comments including what's working well, what you have achieved i.e. views, wishes, aspirations and achieved outcomes.

Please also include details of any continuing impact on your wellbeing

XXXX is always appropriately clothed and she takes pride in her appearance.
XXXX will go shopping for her clothes independently and since living independently of her Mum, she will launder her clothes too.
When XXXX is unwell she has no insight to the appropriateness of her clothes.

Being able to make use of your home safely

Can you do this alone within a reasonable time and without significant pain, distress, anxiety, or risk to yourself or others?

Yes

Provided under s117?

Yes

Review Summary/Comments including what's working well, what you have achieved i.e. views, wishes, aspirations and achieved outcomes.

Please also include details of any continuing impact on your wellbeing

XXXX has recently moved to live independently in a flat with her son, XXXX, in a Housing Associat refuge. XXXX mental health is currently stable,and she is able to make use of the property safely including using household facilities and maintaining the standard of the property. XXX ensures the property is secure, not cluttered/no fire hazards and is coping well with the transition out of her family home
Previously, XXXX lived with her mother and young son to ensure her safety due her mental health and previous relapse.
When unwell XXXX has little insight into the need to maintain the home safely due to her severe and enduring mental illness. Historically, XXXX attempted to use the cooker in the middle of the night and wake her young son up when she is not feeling well.

Maintaining a habitable home environment

Can you do this alone within a reasonable time and without significant pain, distress, anxiety, or risk to yourself or others?

No

Provided under s117?

Yes

Review Summary/Comments including what's working well, what you have achieved i.e. views, wishes, aspirations and achieved outcomes.

Please also include details of any continuing impact on your wellbeing

Until November 2023, XXXX lived at home with her Mum and young son. XXXX Mum previously took the lead in terms of maintaining a habitable home. When XXX mental health dips, she does require support in this aspect due to a lack of motivation. Following the death of XXX s father in 2021, XXXX supported her Mum with more tasks around the house.
Since moving into her own accommodation following the recent breakdown of her relationship, XXXX has managed/maintained her own property well. XX has been supported with some aspects by Housing Associat in terms of securing tenancy etc however in terms of day-to-day maintenance of the property - XXX is managing this well with no intervention from others.
On observation aside from some clutter in the living room that (person) reports to have been boxing up in anticipation of an upcoming house move, the house is maintained to a good standard.

Developing and maintaining family or other personal relationships

Can you do this alone within a reasonable time and without significant pain, distress, anxiety, or risk to yourself or others?

Yes

Provided under s117?

Review Summary/Comments including what's working well, what you have achieved i.e. views, wishes, aspirations and achieved outcomes.

Please also include details of any continuing impact on your wellbeing

(person) has a close family network that provide a considerable amount of support to her. (person) visits her Mum regularly (most days after picking (person's son) up from school) and (person's mum) (Mum) also looks after (person's son) overnight every Wednesday.
(person) also has a supportive friendship network and maintains regular contact with them.
(person) recently ended a long term relationship with her ex-partner and has been supported by police/Housing Associat to have anon-molestation order put into place. (person) reports that she has had no contact with him since this order was implemented - he would sleep in his car outside (person)'s mum's house, turn up at (person's son)'s school and send various texts/calls as he was not accepting of the ending of their relationship.

Accessing and engaging in work, training, education or volunteering

Can you do this alone within a reasonable time and without significant pain, distress, anxiety, or risk to yourself or others?

No

Provided under s117?

Yes

Review Summary/Comments including what's working well, what you have achieved i.e. views, wishes, aspirations and achieved outcomes.

Please also include details of any continuing impact on your wellbeing

(person) has recently moved into living independently with her son, (person's son). (person)'s mental health is currently stable and is able to manage independent living well for both herself and whilst caring for (person's son). (person) has engaged with IMHT to support/monitor any breakthrough symptoms of her mental illness whilst experiencing relationship breakdown/move and no deterioration in mental health noted. (person) has also had increased contact with social care to support.
Previously when unwell, (person) received support from XXXX Senior Care Agency to access the local community prior to Covid. However (person) no longer receives this support. At present, (person) does not wish to consider engaging with work, training, education or volunteering as she is currently focusing on adjusting to living independently/running own home, looking after (person's son) and hopefully moving into a rented property away from Housing Associat.

Making use of necessary facilities or services in the local community
(including public transport, and recreational facilities/services)

Can you do this alone within a reasonable time and without significant pain, distress, anxiety, or risk to yourself or others?

Yes

Provided under s117?

Yes

Review Summary/Comments including what's working well, what you have achieved i.e. views, wishes, aspirations and achieved outcomes.

Please also include details of any continuing impact on your wellbeing

(person) accesses the community independently. She drives her car, supports (person's son) to school/appointments and on daytrips. (person) and (person's son) are going to Local attraction next week which they are both looking forward to.
(person) has recently got back from a holiday to xxxx and frequently travels abroad with and without (person's son), with no additional support.
(person) is confident in communicating with others, asking questions and accessing recreational facilities. (person) and (person's son) enjoy going to local parks and they now have a XXXX gardens pass.

When (person)'s mental health deteriorates, she does not have the motivation to engage with these activities and would need support from others.

Carrying out any caring responsibilities for a child
Can you do this alone within a reasonable time and without significant pain, distress, anxiety, or risk to yourself or others?
Yes
Provided under s117?
Yes
Review Summary/Comments including what's working well, what you have achieved i.e. views, wishes, aspirations and achieved outcomes.

Please also include details of any continuing impact on your wellbeing

(person) has recently moved into her own accommodation within a Housing Associat refuge with her son, (person's son).
Prior to this, (person) lived at her mother's home where she has been supported for all of (person's son)'s life by her Mother and late-Father.
(person)'s Mum, (person's mum) has joint parental responsibility for (person's son) and still maintains regular contact and supports with sleepovers/looking after (person's son) when (person) is away.
(person) has adapted well to living alone with (person's son), she takes on a full parenting role in their home and has support from her Mum most days after school/sleepovers on Wednesdays. (person) completes food shopping/meal preparation/laundry/household tasks and enjoys taking (person's son) out on activity days/keeping him busy.
(person) advised that (person's son)'s sleep has improved, (person's son) stated that he drinks sleepy tea before bed, plays less on games before bed and goes to bed earlier and this has all improved his sleep. He wears a Fitbit tracker to bed and his sleep has improved from 4-5 hours a night to 9-10 hours per night. This has had a positive impact on his concentration, mood and willingness to go to school.
(person) is proactive in seeking support with (person's son). She has sought support from Childrens Social Care Family support worker during the transition into the current flat, she continues to do so with the support of Housing Associat too however no intervention appeared to be necessary at the moment.
(person) is also proactive in contacting CAMHS for support/guidance.
(person) advised that (person's son) was having challenges with his eating previously as he was being bullied at school for his weight. (person) stated that she sought support from CAMHS however interventions were limited. (person's son) is now at a stable weight and his dietary intake normal as (person) addressed the concerns around bullying with th school and this has stopped.
(person's son) has a diagnosis of Autism and has additional support at school of 25 hours per week. (person's son) reports that he likes his SEN assistant at school and although he does not want to go to school, he does and recognises that he does enjoy it when he's there.
(person's son) is only allowed letterbox contact with his biological gather. (person's son)'s biological father was abusive towards (person) and there was an extensive court case to prevent his contact. (person) was supported with this by her Mum, (person's mum).
CLICK HERE for more information on CHC eligibility
Does eligibility for continuing health care require further consideration?
No

Details:

PLEASE COMPLETE THE RELEVANT REVIEW FORMS APPROPRIATE TO THIS REVIEW- SEE THEFOLLOWING SECTIONS:
15/08/2024, 11:27 ASC - Review Recor
Activity type
Reason for Review/Re-Assessment
Route of Access to Services
Outcome of Review/Re-Assessment

Direct payments last completed:
Last completed on: May 15, 2020
CLICK HERE to View/Create/Update the Direct payments
Domiciliary Care last completed:
Last completed on: May 29, 2018
CLICK HERE to View/Create/Update the Domiciliary Care
Residential/Nursing Review last completed:
Not completed
CLICK HERE to View/Create/Update the Residential/Nursing Review
s117 Aftercare last completed:
Last completed on: Aug 09, 2024
CLICK HERE to View/Create/Update the s117 Aftercare
Carer's review last completed:
Not completed
CLICK HERE to View/Create/Update the Carer's review
Joint Carer's review last completed:
Not completed
CLICK HERE to View/Create/Update the Joint Carer's review
Appointeeship Review last completed:
Not completed
CLICK HERE to View/Create/Update the Appointeeship Review
RAG Status
Guidance for RAG status completion:
Person Primary Category Types
Start Date
End Date
Action
No data to display
Short and Long Term Support
Existing Client
If you complete a review or re-assessment for a adult/carer in receipt of one of these services; Domicillary care; Day care; Direct Payments; Residential/Nursing Care but the assessment is not holistic you should select 'existing client/new need'
1) Planned
Community/Other route
No change in long term support
Date Outcome Known
15 August 2024
Declarations and Comments

I agree that the information in this review may be shared as necessary to support my care.
Do you consent to sharing your care and support plan and risk assessment with your Carer?
Yes
Is there any significant other you would like to share your care and support plan and risk assessment with?
No

Reviewer's general comments

For full details please see review above.
(person) is proactive in contacting Social Care and MH team with any concerns and has adjusted with to living independently and being the lead parent for her son (person's son) as they live together.
(person) hopes to have an OPA soon to review and confirm medication moving forward/prescription.
(person)'s s117 remains appropriate and she will remain open to SCP for ongoing professional support until settled in new accommodation/OPA has occurred then plan to close under review to pool.
Date
15 August 2024
Reviewer's details:

Information and Advice Given?
No
Click here to view the IAG
I have reminded the citizen of the County Council's charging policy
No
Adult Social Care is a service that some people will need to pay for. How much you need to pay will depend on how much XXXX Council works out what you can afford. We will look at this as part of a financial assessment. More information can be found by clicking the link below:
www.XXXXshire.gov.uk/adultsocialcarefees
Does the citizen require a financial re-assessment?
Declarations and Comments
I agree that the information in this review may be shared as necessary to support my care:

Details of any limitations:

4. EXAMPLE OF HISTORIC GP LETTER FROM PORTAL

GP letter (Redacted taken from historic Health Portal prior to electronic notes)

I am glad to inform you that XXX is overall stable in his mental health and has been in XXXX since 1998 with the diagnosis of Paranoid Schizophrenia. He currently does not have any active symptomatology and even on exploration he does not complain of any auditory delusions or any other psychotic symptoms.

He is really fond of sports and discussed football and cricket with us during the review. It seemed to me that he has got minor learning disability, but I am not sure, and I will review his past records.

His parents are now getting old, and they used to visit him every Christmas, and this was the first Christmas when they could not visit him. His mum was tearful when XXX called them on Christmas day.

Unfortunately, XXXX has ended up with a conditional caution when he had hit one of his fellow residents on her face and gave her a black eye. The Police was involved and his caution for 12 weeks lapsed on the 6th of January 2020, and the condition was that if there are any further incidents then he would be charged with the offence, but fortunately there had been no further incidents.

I checked with him whether he was happy to continue with the medications, and he said that the medications are doing him good, although he could not explain further how they were doing him good to him.

I checked for any side-effects, and none were observed or reported either by XXXX himself or XXXX.

The staff are aware of and our historical notes confirm that he has a mental health diagnosis of Schizophrenia and also a physical diagnosis of Marfan's syndrome. Historically his behaviour towards his mother was unusual in that he had a sexual attraction to her. His parents, who are teachers are now elderly and do visit from time to time. His relationship with them can be abrupt and rude, as can his manner towards the nursing home staff at times.

5.EXAMPLE FROM PROGRESS NOTES

Social Care Entry

Visit to XXXX at XXXX together with XXXX (student social worker) as planned to complete social care review.

XXXX was engaging throughout the review, however, did advise that he is experiencing some pain in his chest when swallowing foods (''bad chest''); advised XXXX to make contact with his GP about this (said he has been avoiding doing this when staff have offered to make him an appointment - ''it is just worrying me, I am worried it might be cancer so have been putting it off'') and advised staff member, XXXX, of the same who advised she would book in an appointment for XXXX (he was in agreement with this).

XXXX reported that he remains settled and well-supported at XXXX, voiced that he would not want to move on (''I wouldn't cope in the community''). XXXX enjoyed his nephew's wedding in September and was watching the England football match in his bungalow at the time of our visit with one of his peers (review completed in XXX).

Review to be completed in full in the social care pathway.

I shared with XXXX that I will be leaving the team and XXXX will be his allocated social worker moving forward, overseen by XXXX (social worker). XXXX accepted this and agreed with XXXX for a check-in around January, aware that he can make contact through the SCP/his care coordinator should he have concerns or require support prior to this.

On leaving XXXX we were approached an individual who introduced herself as the new operational manager (registered manager's manager) and advised that she is currently looking at placement costs - she referenced the change/uplift in the placement base fee which I have discussed with XXXX (manager) previously - same advice given if that the request is around an uplift in base fee she needs to contact Local Authority Commissioning. It was then mentioned that XXXX might need some 1:1 hours (for activities/tasks not covered by base fee), advised that we did not identify a change in need during our review, however, to send us a breakdown of proposed hours to review (advised that if we were in agreement we would have to approach RAQA to request agreement for any appropriate 1:1 hours, nothing can be agreed until this process has been followed).

6.EXAMPLE OF APPROVED MENTAL HEALTH PROFESSIONAL REPORT

APPROVED MENTAL HEALTH PROFESSIONAL (AMHP) REPORT

Type of Assessment

☐ Approved Mental Health Professional (AMHP) Report

Person to be Assessed

Full Name: XXXX	**NHS Number**: XXXX
Preferred Name: XXXX	**CareDirector ID**: XXXX
Gender: Male	**Date of Birth**:
Home Address: NFA	**Ethnic Origin**:
Post Code: NFA	**Religion**:
Borough: XXXX	**Marital / Civil status**: Single
Telephone Number: None	**Occupation/School**: Unemployed although does a small amount of casual work
Client Group: ☐ Dementia ☐ Dual Diagnosis ☐ Learning Disability ☒ Mental Health ☐ Older Person ☐ Physical Disability ☐ Substance Misuse ☐ Young Person (U18)	**Status Prior to Assessment**: ☐ S2 ☐ S3 ☐ S4 ☐ S5(2) ☐ S5(4) ☐ S13(4) – NR/MHA Request ☐ S135(1) ☐ S135(2) ☐ S136 ☒ CTO ☐ Guardianship ☐ Informal ☐ PACE ☐ None ☐ Other

Languages spoken in order of preference: English	**Person(s) with Parental Responsibility**: NA
Communication Difficulties: None	**Responsible Local Authority**: XXX

Interpreter/Translator required? ☐ Yes ☒ No ☐ Not Applicable	
Interpreter/Translator Name: NA	**Interpreter/Translator Telephone Number**: NA
Company Name: NA	**Sourcing Details**: NA

Advance Directive/Choice: ☐ Yes ☒ No ☐ Not Applicable	
Details:	**Location**:

Person's GP

GP Name: Person does not have a GP by choice
GP Telephone number:
GP Address:

Person's Care Co-Ordinator/Key Worker

Referral

XXXX	**Time of Referral**: 14.00
XXXX	**Address**: XXXX
XXXX	

Professional Role:

☐ Consultant
☐ Crisis
☐ GP
☒ Key Worker
☐ Mental Health Nurse
☐ Nearest Relative
☐ Psych. Liaison
☐ Other

If 'Other' please provide details:

Information given at referral (Including risk indicators i.e., is Police attendance required; RAVE risk assessment to be completed for s135(1)? infection control considerations): We have received a request for a CTO renewal for the above person on the below details.

CTO meeting is scheduled for the 06/02/2023 at XXXX

AMHP Details

AMHP Name: XXXX	
AMHP Telephone number: XXXX	**AMHP Address**: XXXX

Is AMHP Assistant Required:

☐ Yes
☒ No

AMHP Assistant Details

AMHP Assistant Name: NA	
AMHP Assistant Telephone Number:	**AMHP Assistant Address**:

Nearest Relative Details

Nearest Relative identified

☒ Yes
☐ No

If no Nearest Relative - please outline your explorations and next actions required:

Name: XXXX	**Address**: Not known has moved since last assessment
Relationship: Mother	**Telephone Number**: Not known has moved since last assessment
Identified as per Section 26 definition: ☒ Yes ☐ No ☐ Not Applicable	**Why identified as Nearest Relative?** Only parent in contact in recent years no partner

Consultation with Nearest Relative

Has Nearest Relative been consulted?

☐ Yes
☐ No
☒ Uncontactable

Any objections from Nearest Relative?

☐ Yes
☒ No

Consultation with Nearest Relative: Not able to locate

Details (including decision making, reasons, actions taken or if appointment/displacement is needed):
XXXX is not speaking to his mum currently and does not want her involved she has moved house following an inheritance and details are not available previous land line and mobile are not recognised.

Has Carers Assessment been considered?

☐ Yes
☒ No

Please outline decision making re Carers Assessment: Has no caring role

Consultation with Others

Please provide details of consultation undertaken with others

(including contact with other carers, professionals, assessing Doctors, triangulating accuracy and where this information has been gathered from i.e., / Health & Social care records – including names, involvement and views).

Prior to attending the assessment, the author considered the AMHP Report completed as part of the previous assessment for the CTO. Renewal in 2023. This provided me with an insight into the presenting concerns i.e. repeated Hospital admissions, not taking prescribed medication, and self-neglect. It also detailed the rationale for applying the CTO, and conditions attached to this.

The record provides the following information about the persons recorded mental health history

XXXX had previous Hospital admissions (detained under the Mental Health Act (MHA), 1983) and it seemed to be becoming a pattern, whereby he would be admitted to Hospital, get recommenced on medication and get better, and upon discharge would stop taking medication and experience deterioration in mental health.

The CTO was implemented to manage this issue and ensure concordance with medication. Medication was also changed from oral to depot form, which XXXX was not in agreement to.

The previous risks were noted to be self-neglect i.e. not eating or drinking for protracted periods, not taking medication, and not agreeing to meet with professionals.

XXXX continues to visit XXXX monthly to administer the depot, and he continues to be ambivalent as to whether he needs it although does have the depot.

XXXX's observations are that XXXX continues to be guarded with his views and presents as not being motivated to engage beyond a certain point.

.

Social and Personal Circumstances

Please include employment, housing, family, finances, access difficulties – key safe, protection of property and pets, significant life events, mental capacity issues, cultural, spiritual, equality, diversity, protected characteristics and identity considerations etc.

I understand from previous AMHP Reports that XXXX began experiencing mental health concerns some four years ago and following Hospital admission (under Section 2 of the MHA) was diagnosed with having paranoid schizophrenia. Since then, he has had three further admissions, facilitated each time via detention under the MHA. During this time, XXXX has been under the care of the Community Mental Health Team (CMHT) but tends to decline their support/input.

XXXX is a single man, in his thirties. He identifies as being of white British ethnicity and does not have any particular religious or spiritual beliefs.

He does some sanding and waxing of pine furniture. He is also in receipt of benefits, PIP with which he budgets for himself, but he does have issues around money due to proportions spent on substances.

Referral to Breathing Space:

☐ Yes

☒ No

Date of Referral: NA

Details of Referral: NA

Mental Health Circumstances

Please include if previously or currently known to mental health services, any diagnosed mental disorder, forensic history, index offence(s), and previous admissions to hospital - formal or informal.

The depot has enabled XXXX to achieve some stability with his mental health. So, without the CTO, there is a very high likelihood that he would stop taking medication and deterioration in mental health – in fact
Again, today, XXXX informed us that he would not take his depot if the CTO was not in place.
There is also a concern that if XXXX were to start self-neglecting again
(in relation to nutritional intake) then feasibly his physical health could also be compromised.

Previous AMHP reports indicate that the risk of self-neglect has been a significant feature in previous episodes of relapse. They also indicate high risk of XXXX not eating for weeks, and he and neglecting his personal care.

XXXX is also saying that he uses substances including cocaine, alcohol and cannabis as the former stops him from feeling tired and lethargic.

Protection of others – this is not a current concern.

Physical Health Circumstances and Other Considerations

Please include specific health concerns, mobility/disability, allergies, dependency/use of substances/alcohol, dietary needs etc.

XXXX states he has one half gram of cocaine per week.
He will drink 3-4 cans of alcohol sometimes in the day.

Assessing Doctors

If GP not attended provide reason:

☐ GP declined to attend
☐ GP was unavailable
☐ Urgent Response Needed
☐ Unable to contact GP
☒ Other

If 'Other' please provide details: Does not have GP

If a Doctor with a particular specialism is required, please provide details of the actions taken to secure this (include reason when only one doctor is involved in the assessment):

Doctor's Name: Dr XXXX

Specialism (if required): NA	**Telephone Number**: XXXX	**Address**: XXXX
Section 12 Approved: ☒ Yes ☐ No	**Known to service user**: ☒ Yes ☐ No	**Consultation Type**: ☒ In Attendance ☐ Via Telephone

Doctor's Name: NA		
Specialism (if required):	**Telephone Number**:	**Address**:
Section 12 Approved: ☐ Yes ☐ No	**Known to service user**: ☐ Yes ☐ No	**Consultation Type**: ☐ In Attendance ☐ Via Telephone

Interview

This section should focus on the person's strengths, their perception, perspective and views and wishes, and where appropriate details of advance decision or treatment preferences.

XXXX who knew XXXX introduced me to him and explained the purpose of our meeting.

XXXX states he is sleeping relatively well but sometimes wakes in the night to go to the toilet. He states his typical day is to get up and light the fire at the place where he works. He does one- or two-hours work. Sometimes he walks into town XXXX where he enjoys visiting XXXX. He says he is tired and attributes this to his medication despite the dosage being reduced he does not seem to accept that this may be a negative symptom of his illness.

He was ambivalent about whether he would attend appointments or take his depot if not on a CTO and it appeared he became increasingly agreeable to this as the interview was lasting nearly an hour and he was tiring of the process.

Mental Capacity Act 2005 (See MCA Code of Practice)

Was the mental capacity of the Service User considered as part of the assessment process? ☒ Yes ☐ No ☐ Not Applicable	**Are there any advanced decisions to refuse treatment or "treatment preferences"?** ☐ Yes ☒ No ☐ Not Applicable
Does anyone hold lasting power of attorney or act as a court appointed deputy? ☐ Yes ☒ No ☐ Not Known	
Do we assume the person has capacity? ☒ Yes ☐ No	
Provide evidence of decision-making rationale: XXXX was able to rationalise why he was ambivalent about a CTO and that he felt that this offered him more support with ensuring that he had his depot and was supported to attend appointments.	

Risks

Have doctors consulted with each other?

☐ Yes
☐ No
☐ Not Applicable

If not, please provide details:

To specify risks identified, whether current/historical, likelihood of occurrence, mitigation, signs of safety and protective factors, harm that is likely to occur, and how it satisfies the criterion for detention i.e. health, safety and protection of others.

The previous risks were noted to be self-neglect i.e. not eating or drinking for protracted periods, not taking medication, and not agreeing to meet with professionals. These have recurred historically and as XXXX is hoping to move accommodation to live in his own property by himself for the first time and to move from the XXXX to the XXXX it seemed appropriate to continue the supportive framework of the CTO currently as XXXX was indicating he was ambivalent about taking his depot.

Summary of Assessed Needs

Must include AMHP analysis and observations, co-production with the service user and discussion with Doctors. Please consider Human Rights.

It was agreed that there is a likelihood that without the CTO in place,
XXXX will stop taking his medication and will refuse to meet with professionals.

All professionals in agreement that although XXXX has made steps to recovery the
Current climate of change could jeopardise engagement and negate progress made.

Conditions will include accepting depot injection and attending medical appointments

Guiding principles of the Mental Health Act Code of Practice

Please describe how each principle has been adhered to

Least restrictive/maximising independence	Extent of recovery has been recognised but there is still risk in light of the changes it is likely XXXX will experience in the coming months.
Empowerment/involvement	XXXX was fully consulted about his wishes but was ambivalent.
Respect/dignity	XXXX was interviewed in an appropriate and confidential manner and request to go for a cigarette respected.
Purpose/effectiveness	The assessing team recognised that after a certain point we were “going round in circles” to an extent and that XXXX seemed to be telling us what we wanted to hear in respect of compliance.
Efficiency/equity	XXXX was asked at this point if he had any questions for us and he confirmed that he hadn’t and that he was comfortable with the interview coming to an end.

Outcome of Assessment, Actions and Reasons for Decision

If outcome is Section 4, this must be raised with relevant AMHP lead. Where applicable incident form to be raised

Outcome:
☐ S2
☐ S3
☐ S4
☐ S7 Guardianship
☐ S135(1)
☐ S135(2)
☐ CTO
☐ CTO recall
☒ CTO renewal
☐ CTO revocation
☐ Informal admission
☐ Remained in community
☐ Remained in police custody
☐ No bed available
☐ Other

Please provide details:

Additional actions required? (tick all that apply):
☒ Not Applicable
☐ Referral to Adult Safeguarding
☐ U18 referral to First Response
☐ Referral for Care Act Assessment
☐ Referral to Voluntary Sector
☐ Referral to Health Care
☐ Referral to Universal Services

☐ Other
If 'Other' - please provide details:
Date:

Was a S135 warrant required or applied for as part of this assessment? ☐ Yes ☒ No	
Date:	**Please specify**: ☐ S135 (1) ☐ S135 (2) ☐ Returned if not used

What is the current Plan of Action and Intended Purpose? To continue to monitor at the XXX and to transfer to XXXX when XXXX moves.

How will risks be managed? Via monitoring as part of CTO.

Any further actions required? Rough Sleepers Team are currently referring to Rethink

Was the Nearest Relative informed of the outcome of the assessment?

☐ Yes
☒ No
☐ Not Applicable

If not, please provide details: No contact details available.

Was the nearest relative advised of their right to discharge or object?

☐ Yes
☐ No
☒ Not Applicable

If not, please provide details: No contact details available

Bed Delays and Conveyance

Bed delays:

☐ Yes
☒ No
☐ Not Applicable

Out of area:	**Bed manager informed**:
☐ Yes ☒ No ☐ Not Applicable	☐ Yes ☒ No ☐ Not Applicable
Name of admitting hospital: NA	**Time taken to secure bed**: NA

Reasons for delay: NA

Transport to hospital:	
☐ Ambulance (West Midlands) ☐ Ambulance Other ☐ Secure Transport ☐ Police ☐ Other	NA
If 'Other' – please provide details:	

Any other avoidable delays, e.g., difficulties with conveying, doctors' availability, ambulance and police delays, etc. ☐ Yes ☒ No	
Length of delay: ☐ 1-3 Hrs ☐ 3-6 Hrs ☐ 6-9 Hrs	**Cause of delay**: ☐ Alcohol/Substance ☐ Ambulance ☐ AMHP

☐ 9-12 Hrs ☐ 12-24 Hrs ☐ 24-36 Hrs ☐ 36-48 Hrs ☐ 48+ Hrs	☐ Bed Availability ☐ Clinical Reasons ☐ Doctors ☐ Interpreter ☐ Person not at address ☐ Police ☐ Warrant ☐ Other
If 'Other' - please provide details:	

Escalation required?

☐ Yes

☒ No

Who has this been escalated to and what was the outcome?

Doctors Decision Not to Detain

Details of Doctors Decision: NA

Print Name:	**Print Name**:
Signature:	**Signature**:
Date:	**Date**:

Care Arrangements

Are there any Care Arrangements?

☐ Yes

☒ No

☐ Not Applicable

Has someone been nominated to take responsibility for children, and/or dependant adults? Do any home care arrangements need to be cancelled, future contingency plans?NA

Arrangements for money/valuables/bank books etc.

☐ Yes

☐ No

☒ Not Applicable

Details of Arrangements:

Protection of Property and Pets

Has someone taken responsibility for the accommodation? If not, make appropriate arrangements to safeguard the property. Have pets been secured? NA

Key safe at person's property? ☐ Yes ☐ No	**Key holder address if applicable**: NA
Key holder name if applicable:	

Any further actions required?NA

Individual Rights/Advocacy

Rights under Mental Health Act explained ☒ Yes ☐ No ☐ Not Applicable	**Rights information leaflet given**: ☒ Yes ☐ No ☐ Not Applicable
Issues relating to service user's understanding/exercising rights: ☒ Yes ☐ No ☐ Not Applicable	**Leaflet re: AMHP role given**: ☒ Yes ☐ No ☐ Not Applicable
IMHA referral required/completed: ☐ Yes ☐ No ☒ Not Applicable	**Leaflet - comments/complaints**: ☐ Yes ☐ No ☒ Not Applicable – Not wanted
Service user summary given: ☒ Yes ☐ No ☐ Not Applicable Wanted to leave so via care co	

If any of the above have not been given, outline the reasons for this and requisite actions to ensure person receives this information: As above

Identify where copies of the report have been sent: To mental health law team and a copy anonymised for AMHP record

Assessment Timings

Assessment allocation start date: 06.02.24

Assessment allocation start time: 13.00

Interview start date: 06.02.24	**Interview start time**: 14.30
	Interview end time: 16.00
Location of assessment: ☐ Accident & Emergency ☐ General Hospital ☐ Psychiatric Hospital ☐ Independent Hospital ☒ Community ☐ Place of safety ☐ Police station ☐ Other	**Assessment type**: ☐ EDS Assessment ☐ Twilight Assessment ☐ Assessment continuing past 5pm ☐ Assessment taking place 8.30am – 5pm ☒ Planned Assessment (e.g., Guardianship or CTO) ☐ Out of area
If 'Other' - please provide details:	

Assessment completion date: 06.02.24	**Assessment completion time**: 18.00

Summary and Outcome for the Person

Summary and Outcome of Assessment:

XXXX

XXXX I interviewed you today in regard to your CTO Renewal. We spoke for a considerable time, and you told us that you were not bothered if it was renewed or not but found it quite supportive in ensuring you had your depot. You said you were disappointed you would be transferred to another team even though XXXX would joint work with your new CPN for a while and were a bit unsure if you would take your depot or not with a new CPN. We carried on exploring this as we wanted to provide the least restrictive alternative and to discharge you if we felt this would be safe for you, but the longer we went on it felt you were tired of the interview and were agreeing to things you may not do on reflection (you had said you were tired at the start). In view of your history of relapse and your ambivalence to the CTO being restrictive for you we did renew it with the hope this could be reviewed again after you had settled subsequent to your move.

I wish you well for the future.

Signatures

Signed by AMHP XXXX	**Receiving Nurse**: NA
Print Name: XXXX	**Print Name**: NA
Date: 06.02.24	**Date**: NA

Which authority is the AMHP acting on behalf of?
XXX County Council

Please ensure the Person's legal status is updated to reflect the responsible local authority and outcome of assessment

If admitted to a Hospital Ward

Copy - to be given on admission, to the Nurse on duty
Copy - to be sent to Care Co-ordinator for Service User's file
Copy - to be uploaded to CD / Health record
Copy - Assessment Summary to be sent to Client
Copy - Assessment Summary delegated to other

NB: AMHP to retain an anonymised copy, for reapproval purposes

Addendum

Is an Addendum required?

☐ Yes

☒ No

Addendum Date: NA

Details:

Signed by AMHP:

Print Name:

Date:

Appendix Five – Data in One Table

Number	Total Sample	%	Category	Qualitative Examples from Case Notes
Male - 51 Female-21	72	Male - 72% Female-29%	Quantitative	NA
Asian Indian - 1 Asian Pakistani- 2 Asian Nepalese -1 Black Caribbean - 1 Dual Heritage (?) -1 Irish / Turkish Kurd - 1 Mixed Race (?) - 1 White British -61 White European - 1 White Irish - 2	72	Asian Indian - 1% Asian Pakistani- 3% Asian Nepalese -1% Black Caribbean - 1% Dual Heritage (?) -1% Irish / Turkish Kurd - 1% Mixed Race (?) - 1% White British -85% White European - 1% White Irish - 3%	Quantitative	NA
18-25 - 1 26-35 - 9 35-45 - 17 46-55 - 17 56-64- 24	72	18-25 - 1% 26-35 - 13% 35-45 - 25% 46-55 - 25% 56-64- 34%	Quantitative	NA

Risk to Self-High- 18 Mid - 36 Low - 9 Nil - 9	72	Risk to Self-High-25% Mid - 50% Low - 12.5% Nil - 12.5%	Quantitative for prevalence but qualitative descriptions of risk behaviour included for completeness	“XXX relocated to XXX and stopped taking his medication and disengaged with services resulting in a relapse in mental health, He was discovered sleeping rough and it was reported he had sent text messages saying he was going to kill himself…” “In the past when XXX’s mental health has deteriorated he has self-neglected. The provision of a residential care placement ensures that XXX’s nutritional intake can be monitored, and he is supported to maintain a healthy dietary intake.” "Following this XXX’s mental health deteriorated where was self-harming on a daily basis and heavily using alcohol as a negative coping mechanism.”
Risk to Others High- 26 Mid- 22 Low- 2 Nil- 22	72	Risk to Others High- 36% Mid- 30% Low- 3% Nil- 30.5%	Quantitative for prevalence but qualitative descriptions of risk behaviour included for completeness	“…so, there is some evidence of a social side to XXXX I note from records that he does at times disengage from staff and can be aggressive especially towards females.” “.XXX has a past history of being aggressive this was also linked to substance abuse, therefore, aggression and becoming verbally abusive, along with being quick to react aggressively in the past is an indicator.” “In the past, XXX has had episodes where he has been violent. He used to have fights at school and ten years ago grabbed XXX around her throat.”
Self-Neglect-51 Physical Violence-43 Substance Use - 23 Self Harm-22 Sexual Violence-5	144	Self-Neglect-35% Physical Violence-30% Substance Use - 16% Self Harm- 15% Sexual Violence-3%	Quantitative for prevalence but qualitative descriptions of risk behaviour included for completeness	E.G.s concerning self-neglect “XXX chronically self neglects. He often appears unkempt, but his hygiene is adequate. He requires daily prompts to have a wash and change his clothes, without this staff report he becomes increasingly unkempt and doesn't attend to his personal hygiene, but he complies with prompts. XXX's laundry is done for him by the staff, otherwise he wouldn't do it.” “XXX can fluctuate as to whether she is able to manage her personal care. This is dependent on how much she is distracted by what she is experiencing level of self-neglect can be high” “XXX responds to auditory command hallucinations when he is awake and these impact on his Activities of Daily Living (ADL's) requiring two members of staff to attend to personal hygiene, dressing/undressing and application of cream for eczema”

4-5 3-22 2-22 1-23	72	4-7% 3-30.5% 2-30.5% 1-32%	Quantitative	NA
Due to delusions-63 Avoidance-18 Reg. Environment- 7 Self Stimulation - 13	101	Due to delusions-62% Avoidance-18% Reg. Environment- 7% Self Stimulation - 13%		Examples of behaviours due to response or delusions - descriptions from case record "During this time XXX was reported to be attempting to eat inappropriate objects, such as discarded cigarette butts and any sort of fluff or dirt found on the floor (he stated that he smoked the discarded cigarette butts). He also believed that people were trying to poison him and that the things he found on the floor were antidotes left for him to take. "Staff, however, report XXX is doing ok but there is evidence of an increase of him responding to unseen stimuli and talking to himself, Mum & Dad also report that this has got worse." XXX moved to XXX supported living flats in XXX. XXX was evicted for starting a fire in her bedroom, this was because she was distracted by her delusions, excessive smoking and not putting cigarettes out properly. She was readmitted to XXX Hospital"
See Table in Appendix XXXX will not fit in spreadsheet (Diagnosis Tab)	72	See Table in Appendix XXXX will not fit in spreadsheet	Quantitative	NA
CTO-3 S117-55 None-12 S3-2	72	CTO-4% S117-76% None-17% S3-3%	Quantitative	NA

Benefits only-57 Appointeeship-9 CoP Application-1 Deputyship- 4 Safeguarding-1	72	Benefits only-79% Appointeeship-12.5% CoP Application1% Deputyship- 5.5% Safeguarding-1%	Quantitative	NA
Not Engage- 1 Not motivated- 10 Only with staff -21 Restricted/ behaviour/ offences-3 Staff take to parents-3 With staff? Where-2 Appointments with staff-8	48	Not Engage- 1% Not motivated- 21% Only with staff -44% Restricted/ behaviour/ offences-6% Staff take to parents-6% With staff? Where-4% Appointments with staff-16%	Quantitative for prevalence but qualitative descriptions of community access included for completeness	Examples of how people access the community / what they do... “XXX asked about seeing her mom again. Her Mom has been contacted and said she does not feel well enough at the moment, but we reassured XXX that as soon as her mom feels better, we can support her with visiting” “ XXX regularly goes to the local shops Aldi and the hairdresser's. XXX enjoys going out stating "it makes me feel normal". XXX requires support from staff when out to budget her money as she will often spend it all and will then have nothing left for the rest of the week. this results in her becoming restless or argumentative towards staff.” “I often felt I need to manage my anxiety by drinking one or two cans of lager before I went out. I understand that XXX staff and my social worker is worried about this becoming a habit, but I'm not drinking very much and don't think there's anything wrong with enjoying a drink in moderation.”

Redacted 1 - 1 Local Town -coffee-2 Train/ Pub/ Shop- 1 Independent to town-1 College independent-1 Local on bus-1 Next town café-1 Independent shop-1 Parents & trips-1 Parents independent some distance-1 Town & Shops-1 Increasing independence? detail-1	22	Redacted 1 - 5% Local Town -coffee-9% Train/ Pub/ Shop-5% Independent to town-5% College independent-5% Local on bus-5% Next town café-5% Independent shop-5% Parents & trips-5% Parents independent some distance-5% Town & Shops-5% Increasing independence? detail-5%	Quantitative for prevalence but qualitative descriptions of where people go included for completeness	Examples of community facilities accessed… “XXX enjoys spending time with XXX and going out to the local shops/town daily. He went for a holiday to XXX arranged by his care provider last year and is keen to do this again this year.” “…she visits her mum twice a month which goes well” “xxx continues to go to the shop independently to spend his daily allowance, continues to smoke and abides by the smoking policy”
Parents-51 Other relative-2 Spouse-7 Own Home-8 Homeless-4	72	Parents-71% Other relative-2% Spouse-10% Own Home-11% Homeless-5.5%	Quantitative	NA
Independent-22 Partial Support-8 Total Support-42	72	Independent-30.5% Partial Support-11% Total Support-58%	Quantitative	NA
Nursing- 68 Residential-4	72	Nursing- 94% Residential-6%	Quantitative	Quantitative

Not Recorded-15 No Admissions-4 1-22 2-9 3-14 4-4 5-0 6-1 7-2 8-0 9-0 10-1	72	Not Recorded-21% No Admissions-5.5% 1-30.5% 2-12.5% 3-19% 4-5.5% 5-0% 6-1% 7-3% 8-0% 9-0% 10-1%	Quantitative	NA
Not Recorded -15 > one month -5 1-3 months-20 3-6 months- 16 6-9 months-1 9-12 months-5 <12 months 10	72	Not Recorded -21% > one month -7% 1-3 months-28% 3-6 months-22% 6-9 months-1% 9-12 months-7% <12 months-14%	Quantitative	NA
Not Compliant- 41 Partially Compliant- 7 Totally Compliant- 24	72	Not Compliant- 57 Partially Compliant- 7 Totally Compliant- 24	Quantitative	NA

Anxiety-1 Aspbergers-2 Autism-5 Depression-1 Diabetes-2 Amnesia-1 Eating Disorder-1 Eczema-1 Kidney Failiure-1 Korsakoff's-1 Incontinence-1 Learning Dis. -9 Lympedema-1 Marfan's Syndrome-1 Memory Loss-1 OCD-5 Oculogyric Crisis-1 Obesity-2 Parietal Degen. - 1 Personality Disorder-1 Polydipsia-1 Temp. Lobe Epilepsy-1 Skin Integrity-3 Tourettes-1	45	Anxiety-2% Aspbergers-5% Autism-11% Depression-2% Diabetes-5% Amnesia-2% Eating Disorder-2% Eczema-2% Kidney Failiure-2% Korsakoff's-2% Incontinence-2% Learning Dis.-20% Lympedema-2% Marfan's Syndrome-2% Memory Loss-2% OCD-11% Oculogyric Crisis-2% Obesity-5% Parietal Degen. - 2% Personality Disorder-2% Polydipsia-2% Temp. Lobe Epilepsy-2% Skin Integrity-7% Tourettes-2%	Quantitative	NA

None-24 Parents-31 Parents & Siblings-5 Aunty-1 Parent & Sibling & Offspring-1 Sibling & Offspring-1 Sibling-5 Offspring-1 Partner / Ex -3	72	None-33% Parents-43% Parents & Siblings-(7%) Aunty-1% Parent & Sibling & Offspring-1% Sibling & Offspring-1% Sibling-7% Offspring-1% Partner / Ex -4%	Quantitative	NA

TV alone-1 Crafts-1 Football/ Cricket-1 TV and town-1 Town / Coffee shop-4 Coffee Shop/TV-1 TV in lounge-4 Phoning Grandma-1 Short Breaks -2 Cans of Beer -1 Smoking & Groups -1 Smoking-2 Football&StarWars-1 Smoking/Coffee/80's music-1 Train Trips-1 College-1 Shops on bus-1 Coffee with staff-1 Family Contact-1 Local Shops-7 Groups-1 Local Shops/Hairdresser-1 Shops ? energy drinks-1 Groups/ Holidays-1 Nothing Recorded-34	72	TV alone-1% Crafts-1% Football/ Cricket-1% TV and town-1% Town / Coffee shop-5.5% Coffee Shop/TV-1% TV in lounge-5.5% Phoning Grandma-1% Short Breaks - 3% Smoking&Groups-1% Smoking-3% Football&StarWars-1% Smoking/Coffee/80's music-1% Train Trips-1% College-1% Shops on bus-1% Coffee with staff-1% Family Contact-1% Local Shops-17% Groups-1% Local Shops/Hairdresser-1% Shops ? energy drinks-1% Groups/ Holidays-1% Nothing Recorded-47%	Quantitative for prevalence but qualitative descriptions of what people do include for completeness	“She says that he can be sociable but also enjoys his own company and spending time in his home, listening to music, or watching tv.” “…she would like to renew her relationship with her son who lives in Redditch, he can use public transport and will visit her.” “ XXX manages her own medication and uses buses to visit nearby towns to go shopping. XXX enjoys shopping …”

To move-1 Own home marriage-1 Remain as is-14 Boyfriend-1 Driving and Flat-1 More independence-6 Express lonliness-1 Own home with carpet-1 Flat car relationship-1 Wants to move area-1 Independence but worried about coping-1 More Holidays-1 Can't move/trauma-1 Slow move after learning skills-1 Social worker wants them to move they don't -1 Telephone contact dad-1 Interaction mum&dad-1	35	To move-3% Own home marriage-3% Remain as is-40% Boyfriend-3% Driving and Flat-3% More independence-17% Express lonliness-3% Own home with carpet-3% Flat car relationship-3% Wants to move area-3% Independence but worried about coping-3% More Holidays-3% Can't move/trauma-3% Slow move after learning skills-3% Social worker wants them to move they don't -3% Telephone contact dad-3% Interaction mum&dad-3%	Quantitative for prevalence but qualitative descriptions of what people say included for completeness	“It has been established that I no longer require the rehabilitation placement at XXX but due to ongoing support needs, I need to move to a supported living complex to enable me to continue to develop / improve & reintegrate into the community effectively” “He acknowledged that he has made significant progress since his placement at XXX, and feels he is generally happier and more settled in his mental health” “...he doesn't know what benefits he gets, how much, or how much savings he has. When asked about it, he just says, I don't not, I'm not really interested. He picks up £30 from the office every week and says he is happy with the arrangement. He pays a contribution to his care but doesn't know how much and says he's not interested.”

Appendix Six – Diagnosis

(Would not fit into single excel sheet so on separate sheet the excel will be sent in as attachment)

Diagnosis	Number
Bipolar Disorder	1/72 (1%)
Chronic Schizophrenia	4/72 (5.5%)
Chronic Schizophrenia and autism	1/72 (1%)
Depression, Anxiety and OCD	1/72 (1%)
Dissociative Amnesia	1/72 (1%)
Emotionally unstable personality disorder	1/72 (1%)
Korsakoff's Disease with psychosis	2/72 (3%)
Obsessive Compulsive Disorder	1/72 (1%)
Obsessive Compulsive Disorder and Depressive Disorder	1/72 (1%)
Obsessive Compulsive Disorder and Schizophrenia	1/72 (1%)
Paranoid Schizophrenia	22/72 (30.5%)
Paranoid Schizophrenia and Learning Disability	1/72 (1%)
Psychosis	3/72 (4%)
Psychosis with Asperger's	1/72 (1%)
Psychosis / mild learning disability	1/72 (1%)
Psychosis / Schizoid Affective disorder	1/72 (1%)
Psychotic disorder very severe	1/72 (1%)
Schizophrenia	12/72 (17%)
Schizophrenia and Autism	1/72 (1%)
Schizoaffective disorder	1/72 (1%)
Schizophrenia / Autistic spectrum disorder	1/72 (1%)
Schizophrenia Mar fans syndrome	1/72 (1%)

Schizophrenia schizoaffective disorder	1/72 (1%)
Schizophrenia, Eating disorder, PD OCD	1/72 (1%)
Simple Schizophrenia	3/72 (4%)
Treatment resistant Schizophrenia	6/72 (8%)
Unstable personality disorder borderline type	1/72 (1%)

Appendix Seven -Example of Vignette

Vignette Person 55
Taken from Social Care Assessment and Care Plan
55 has a historic diagnosis of Paranoid Schizophrenia dating back to 1979.

She has lived at XXXX for over 11 years and appears to be thriving within the supportive environment that is offered. 55's mental health continues to fluctuate but this is managed appropriately by staff within the care component part of the home.

55's mental health remains relatively stable however often she will not attend to her personal care, become accusatory towards staff members stating that they have stolen her personal belongings/finances, appear pre-occupied thus lacking concentration and motivation and demonstrate obsessive thoughts with regards to laundering.

When 55 presents as low in mood she appears very lethargic, preoccupied, neglects her personal hygiene, has spent long periods in bed, declines meals and presents as defensive, flat, argumentative, accusatory and delusional.

She is promoted to engage in socially inclusive activities on a weekly basis in addition to attending regular holidays facilitated by the home. 55 considers XXXX as her home, she has built a good rapport with staff and other residents in addition to being in close proximity to family members to maintain those relationships.

If 55 were to move from XXXX it would be likely to have a detrimental impact on her mental health as she has built secure foundations within the home and positive relationships with both staff and other residents. We have discussed alternative opportunities for accommodation with 55 however she does not wish to explore these - different nursing placements. Less restrictive alternatives such as residential or supported living have been considered but would be unable to meet her needs and as a result 55 would be at high risk of relapse and the requirement of hospital admission.
55 currently lives at XXXX Nursing Placement and has done since August 2007. Initially, 55 moved to XXXX under a Guardianship order, however this is no longer required.

55 is originally from XXXX and reports having a happy childhood. She has two brothers XXXX and XXX - of whom she continues to see as and when they are able. 55 met her ex-husband, XXX in her early 20's when an inpatient at XXXX. They have a child together, XXX but separated after 4 years as they had grown apart. 55 has weekly telephone contact with her son who also visits regularly.

55 has built a positive therapeutic relationship with the staff at XXXX and a broad network of friends. 55 is supported to maintain positive relationships with her son, XXXX and mother who currently resides in a care home in XXXX Historically, 55's mother has relied on her heavily for support and 55 continues to provide a great deal of emotional support on her weekly visits. 55 will generally visit her mother independently

via public transport having been supported by staff to progress to this point, however when she is unwell 55 will avoid visiting or makes use of the local taxi service.

55's mental health frequently fluctuates. When well, she will engage with recreational activities, is compliant with medication, no concerns with eating and drinking, engages with rehabilitation tasks, presents as bright in mood and displays a good sense of humour. 55 will walk down to XXXX Town Centre independently to access the shops and is supported to attend local groups, to attend appointments and has recently attended a resident holiday to XXXXXX

55's family and friends are important to her. She enjoys engaging with recreational activities including craftwork, baking and gardening when her mental health is stable. 55 has aspirations to cut back on the number of cigarettes she smokes and has been supported to attend appointments with her GP to discuss on numerous occasions and worked with staff to plan to reduce however she has not followed this through to date. 55 has expressed consistently in CPA reviews within the past 2 years that she wishes to continue to reside at XXXX.

When 55 is unwell, she will become extremely withdrawn, refuses food and drink on the basis of paranoid thoughts (believes she is being poisoned), neglects personal care and the upkeep of her living environment, refuses medication and to partake in having her clozapine bloods taken - this has led to verbal confrontation with staff within the past year. 55 has not displayed physical aggression towards staff since November 2014.