

**Experiences of voluntary psychiatric admissions to acute
wards in east London: An Interpretative Phenomenological
Analysis**

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ABSTRACT

Background: Voluntary Psychiatric admission was introduced almost a century ago and has become an increasingly popular method of admission, aiming to promote patient autonomy within the admission experience. A burst of literature over the last decade indicates that, contra to this aim, experiences of coercion and injustice are common in voluntary admission. However, relatively little research explores the individual's nuanced experience and understanding of these admissions in depth.

Aims: To explore patient understandings of their experience of voluntary admission, the concept of "voluntary", and how these understandings change over time.

Method: Five female participants were recruited from acute psychiatric wards and completed a semi-structured interview within eight weeks of discharge from a voluntary psychiatric admission. Interviews were transcribed and analysed using Interpretative Phenomenological Analysis.

Findings: Three themes were generated to describe participant's understanding of their experience of voluntary admission: Need, Boundaries, and Identity. Participants experienced admission through needs of safety and validation, and whether these were met. Whilst dialogue, inclusion, and trust facilitated meeting these needs, coercion and inconsistent boundaries led to experiences of powerlessness and mistrust which prevented needs being met. Stigma was implicated in perpetuating experiences of judgement and negative sense of self on the wards. Being "voluntary" was associated with increased freedom, choice and agency, creating the possibility of experiencing empowerment in admission. However, it also invited comparisons and promoted "othering" between patients on wards which led to experiences of both gratitude and fear.

Implications: The findings promote the need for increased dialogue during admission, further transparency of information about patient rights and employment of practices which reduce the impact of stigma on wards. This increased dialogue and understanding, may serve to increase feelings of safety and validation on the ward and help to harness the opportunity given through voluntary admission for positive experiences of empowerment and change.

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1.0. INTRODUCTION

1.1. Chapter Overview

To introduce this study, I begin by defining the concept, context and socio-political history of voluntary psychiatric admission. I lay out the processes and aims involved in voluntary admission and discuss the ethical dilemmas surrounding them. I explore and critique the existing literature on experience of voluntary admissions and consider gaps in the research. Finally, I outline the rationale, aims and research questions that I hope to answer through this study.

1.2. Voluntary psychiatric admission in the UK

Voluntary psychiatric admissions are admissions to psychiatric wards whereby a person admits themselves to the ward by choice instead of being legally detained against their will. In some cases, a patient may request to enter a psychiatric ward, in others they may present for support at a different health service (i.e. General Practitioner, Community Mental Health team or Accident and Emergency services), and be advised to admit themselves to a ward. Voluntary admissions to inpatient settings would be granted or advised in cases where a person feels at risk of harm to or from themselves or others, and do not feel that this risk can be managed safely in the community. For many people, admission processes are their first encounter with mental health services, and for others they are a regular part of the treatment they receive. Voluntary admissions to psychiatric wards can vary in length between one night to multiple weeks (Mind, 2016).

The majority of UK inpatient psychiatric wards are used for both voluntary and involuntary patients; however, when on the ward, voluntary patients retain rights that are legally removed from those brought to hospital involuntarily. They retain the right to freedom of movement and can leave the ward should they wish (Mind, 2016), the right to refuse treatment and the right to request discharge. In this way, voluntary admission aims to promote patient choice and autonomy and to reduce potential violations of human rights that may occur through improper use of the Mental Health Act (2007). Guidance promotes use of voluntary admission where possible (Department of Health (DoH), 2015).

1.2.1. A brief history of institutional psychiatric care

Inpatient treatment of people with mental health diagnoses has a long and complex history. There are many more detailed histories of inpatient care available¹ but only a general understanding is needed for context here.

Institutional care for those of “unsound mind” has existed in the UK in various guises since the 13th century. Historically, these establishments were run by religious groups or the state, and served the purpose of removing “lunatics” or “idiots” from society. Understandings of madness included spiritual possession, witchcraft and early physiological theories; “treatment” included religious cures, confinement, restraint and tranquilisation (Cromby, Harper and Reavey, 2013).

In the mid-1800s medical physicians claimed jurisdiction over “care of the lunatic”; the creation of the British Journal of Psychiatry and the biological understanding of madness followed shortly after (Pietikäinen, 2015). Institution populations reached a peak in the 1900s (>100,000) but the increasing financial burden of institutions coupled with reports of abuse within them, led to a deinstitutionalisation movement mid-century (Pietikäinen, 2015). During this movement the NHS was formed and care in various community settings was advocated for. In 1959 the Mental Health Act was established to provide legal structure and guidance around the use of institutional care.

Although the role of institutions has changed through the years, the aims of psychiatric admission are still centred on safety, with legal emphasis placed on the treatment and monitoring of individuals to maintain their safety and the safety of their community. Today the NHS system understands “madness” through biopsychosocial theories, however historical and cultural understandings of madness still permeate society (Schnittker, 2013).

1.2.2. Current day inpatient psychiatric care

The current day use of institutional psychiatric treatment is governed by the Mental Health Act (MHA; revised in 1983 and 2007) and the Code of Practice (written in 2008, revised in 2015: DoH, 2015). The Care Quality Commission (CQC, 2017; pg. 10) defines the Act as:

¹ See Pietikäinen, 2015.

“a legal framework that provides authority for hospitals to detain and treat people who have a serious mental disorder and who are putting at risk their health or safety, or the safety of other people.... [it] includes safeguards for people’s rights when they are being detained or treated by professionals.”

The code states that practice should comply as much as possible with the Act but that practice must always be lawful under the Human Rights Act (HRA;1998). The HRA is the UK Law put in place to give further effect to rights guaranteed under the European Convention on Human Rights (European Court of Human Rights Council of Europe; 1998)².

The MHA is comprised of sections that outline frameworks for legal detainment. Various sections are used in different contexts to bring someone into hospital (e.g. sections 2 or 136) or to keep someone in hospital for further treatment (e.g. sections 3 or 5). For the MHA to be used, a clinician responsible for a patient’s care (“responsible” or “approved” clinician) and an impartial Approved Mental Health Professional (AMHP) must both agree that use of the Act is necessary and appropriate (MHA, 2007).

Voluntary admission was first introduced by the Mental Treatment Act in 1930. It gave patients the option to choose to accept the terms of inpatient treatment, rather than be detained against their will. Despite this Act providing opportunity for voluntary admissions, they did not become commonplace until outlined in the MHA in 1959, after which they quickly rose in popularity (Rogers, 1993). The MHA (2007) includes sections to legally detain people in hospital who were admitted voluntarily. These are known as “holding powers”; they allow staff to detain people for a period of either 6 hours (“nurses’ holding powers”) or 24

² The European Convention of Human Rights, upheld by the Human Rights Act (HRA) states that: “Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law: the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics or drug addicts or vagrants”.

hours (“doctors’ holding powers”) to assess for full MHA Sectioning (Section 5(2) and 5(4); MHA, 2007).

NHS Statistics showed that more men than women were detained under the Mental Health Act in 2016-2017 (NHS Digital, 2017), and that the highest proportion of people admitted were between 18 and 35 years of age. Reviews indicate that men are more highly represented in the younger age groups whereas women become more highly represented from around 40 years of age and older, being highly over-represented in the over 80 age group (likely due to different life expectancy) (Audini and Lelliott, 2002). Statistics also indicate that people from a Black and Minority Ethnic background are disproportionately represented under the Mental Health Act (CQC, 2017). Research indicates that this bias in use is linked to poorer support before admission and higher risk and more serious mental illness when presenting at admission (Gajwani, Parsons, Birchwood, and Singh, 2016). NHS England to not gather statistics which explore the intersection of gender and ethnicity however research indicates that ethnicity still predicts detention when gender difference is accounted for, which indicates that BME men and women are more likely to be detained than their white counterparts (Bhui et al., 2003). A recent review by Keown et al., (2016) also indicated that compulsory detention was highest in the most deprived areas of the UK.

No official statistics are kept on voluntary psychiatric admissions so it is difficult to monitor its use. Keown et al. (2016), described some patterns in voluntary admission in the UK, noting that voluntary admission is 50-100% more prevalent than Involuntary admission in many areas of the UK, and is most prevalent in urban areas outside London. In areas with larger populations of young adults (20-39), voluntary use was less and involuntary admission was more prevalent.

1.2.3. Aims and outcomes of psychiatric admission

Psychiatric admissions aim to offer a place of safety where a person can be monitored and mental distress can be treated (Mind, 2015). As such, success of admission and readiness for discharge is judged on reduced risk to self or others, improvement of psychiatric symptoms, and general functioning

(Katsoukou and Priebe, 2006; Kallert, Glöckner and Schützwohl, 2008; Qin and Nordentoft, 2005). In line with these aims, treatments available in current inpatient settings include the provision of a space, which reduces risk to self or others, physical health and mental health monitoring, and pharmacological intervention (Bowers et al., 2005). Additional support is provided from various members of a multidisciplinary team. Although this support can vary from hospital to hospital and ward to ward, it often includes psychological intervention, physiotherapy, occupational therapy, and arts therapies (National Institute for Health and Care Excellence (NICE), 2009; 2011; 2014).

Due to the variation in provision across hospital settings, it can be difficult to analyse the contribution that various factors make towards “successful inpatient treatment”. Despite this, research indicates that a positive therapeutic relationship³ is a key predictor of therapeutic efficacy in inpatient settings – mediating how diagnoses, medication, and multidisciplinary care are both given and received (Theodoridou, Schlatter, Ajdacic, Rössler, and Jäger, 2012). In a comparative outcomes study, Kallert et al’s. (2008) findings suggested that people admitted to hospital voluntarily are less likely to relapse, more likely to have shorter hospital stays and have lower rates of suicide in hospital than those admitted involuntarily.

1.2.4. Ethical considerations around voluntary psychiatric admission

Several ethical dilemmas arise when deciding whether to recommend a voluntary inpatient admission; key concerns are discussed below.

1.2.4.1. Deprivation of liberty (DoL) and informed consent

Ethical concerns surround the potential for voluntary inpatients to be unethically deprived of their liberty in infringement of their human rights. To give informed consent to hospitalisation, voluntary patients must be aware of their rights to leave the ward, to refuse medication and request discharge. If they are not informed of their rights, then they cannot give full consent to treatment. Furthermore, if patients are unaware of their rights, then the presence of locked

³ The therapeutic relationship refers to the relationship between a clinician and a patient whereby the clinician is engaged in supporting the patient to make a change. Over 15 scales have been developed to measure therapeutic relationship (MaCabe and Priebe, 2004).

doors and receipt of medication may be viewed as restraints, and patients may experience “de facto” DoL (CQC, 2017).

Additionally, to consent to a voluntary admission, a person must be deemed to have the capacity to consent. This means that they must be able to fully understand the nature of inpatient admission, weigh up the consequences of admission, retain information about the admission and clearly communicate their wishes (DoH, 2005). Without a proper assessment of capacity, or appropriate information given for a person to understand and weigh up the decision they are making, consent can be wrongly assumed where it is not fully given (CQC, 2017); this can also lead to unethical DoL.

1.2.4.2. Coercion

The use of coercion⁴ in mental health care raises complex ethical challenges (Hem, Gjersberg, Husum and Pederson, 2018). Coercive practice is embedded in psychiatric systems, in the use of restraints, DoL, and forced treatment on psychiatric wards. These practices are argued to be necessary to enable access to treatment when someone does not have capacity to choose it for themselves, and to protect staff and patients on psychiatric wards (Wilson, Rouse, Rae and Kar Ray, 2017). Other aspects of treatment procedures can include less conspicuous coercive pressures, such as persuasion, threat or reduced choice. Where coercive practice is applied in voluntary admission it can constitute an infringement of human rights. Ethical debate surrounds incidents where it could be perceived as ethical to coerce someone to engage in a treatment that might benefit them, and reduce their distress, the controversy surrounds whether or not in these cases coercive action is less harmful than no action (Wertheimer, 1993).

1.2.4.3. Ethical decision making and risk of harm

When advising voluntary admission, professionals are ethically bound to act in a patient’s “best interests” (General Medical Council, 2014; DoH, 2015). This means that the potential harm or risk to a person of not entering hospital is weighed against the potential risks posed by hospitalisation and treatment, and

⁴ Coercion can be defined as the practice of using force to persuade someone to do something.

the potential benefits of these treatments. Risks that people present with pre-admission often include risk of harm to self or others and threat to life through suicide or neglect. Risks associated with hospitalisation or treatment are less well recognised. However, psychiatric admissions are associated with feelings of shame, increased stress, and lower quality of life (Nyttingnes, Ruud and Rugkasa, 2016; Rusch et al., 2014). Treatment risks include life-limiting effects of psychiatric medication (Newcomer, 2007) and physical and emotional harm caused by restrictive practice (Bonner, Lowe, Rawcliffe and Wellman, 2002). Historical psychiatric admission can negatively affect job and visa applications (Mind, 2016). Despite the potential risks of hospitalisation, admissions are often the only available support offered by the NHS for people in crisis. Resultantly, the risks associated with admission and treatment are often perceived to be outweighed by the need to reduce the immediate risk of harm to self or other that a person may experience in crisis. Unfortunately, research indicates that hospitalisation does not always significantly reduce risk of harm to self, and treatment efficacy is widely debated (Goldacre, Seagroatt and Hawton, 2005; Rapley, Moncrieff and Dillon, 2011).

Traditionally, medicine has used a “paternalistic” decision making framework when considering hospitalisation and use of the MHA (Pelto-Piri, Engstrom and Engstrom, 2013). Paternalism assumes that professionals are in the position to make “the best” decisions for patients due to holding academic and clinical expertise in the area. The danger of the paternalistic position is that a professional’s idea of best interests may differ to that of the patient, and lead to experiences of the patient feeling coerced and disempowered (Kjellin, Andersson, Candefjord, Palmstierna, & Wallsten, 1997). There has been a shift in recent years towards promoting more reciprocal practice in health care which involves a shared dialogue between patient and professional through which expertise of both parties are considered equally. This trend is reflected in a systemic push in guidance towards collaborative care planning (NICE, 2011).

1.2.4.4. Accountability

The CQC produce best practice guidance which is informed by research and audit, and implements procedures which monitor ethical practice and hold services to account. Despite the presence of this guidance, reports indicate that

psychiatric care providers often do not meet expected standards and unethical practice is common (CQC, 2017; 2018).

The CQC (2017; 2018) raised concerns that on recent visits to psychiatric institutions they regularly found little to no evidence of accordance with the guidance on consent to treatment at admission. Insufficient information was given about patients' rights to appeal admission decisions. The CQC report also noted the rise in the use of locked doors on wards, and consequent increased risk of de facto DoL. Use of the MHA has risen over the past few years to the point that involuntary admissions now outnumber voluntary admissions (CQC, 2017, 2018); demand for beds is high and hospitals are stretched. In addition, recent CQC reports highlight gross inequalities within the use of the MHA, showing that young men from black ethnic minorities are up to four times as likely to be detained under the MHA as their white peers (CQC, 2017).

Historically when unethical practices have gone unchallenged, gross abuses of human rights have been permitted, resulting in harm to patients, and in the worst cases, death (Blofeld, Sallah, Sashidharan, Stone, & Struthers: 2003). In the context of austerity and cost savings in the NHS, the number of beds for psychiatric inpatients has been reducing year on year (NHS England, 2018). High pressure and limited resource leads to stressful working conditions that are more vulnerable to unethical practice; indeed deaths under the MHA have been numerous over the past few years (Ministry of Justice, 2017). These stretched conditions contribute to a risk of increasing prevalence of damaging or detrimental practice, which may negatively impact a person's experience of mental health admission rather than supporting them to reduce their psychological distress.

1.2.5. The role of psychologists in acute psychiatric care

NICE guidelines advocate psychological intervention across multiple services, settings, and presentation complexities (e.g. NICE, 2009; 2014; 2016). As such clinical psychologists are increasingly involved in acute and secondary care settings – engaging clients before, during, and post-admission. Research supporting psychological input in acute settings suggests that psychological input is delivered at multiple levels: directly to inpatients, indirectly through other

staff members and through consultation to teams to promote a reflexive environment, and strong therapeutic relationships. Evidence suggests that, despite limited resource, psychological input on wards can be effective in promoting recovery, making sense of crises, improving relationships and improving satisfaction with ward experience (Paterson et al., 2018, Wykes et al., 2018; Donaghay-Spire, McGowan, Griffiths and Barazzone 2016).

Since the revisions of the MHA (2007), it has been possible for psychologists and other mental health professions to act as a “responsible clinician” in the use of the MHA. Although very few non-medical practitioners have taken up this role, the revisions highlight a responsibility on all clinical staff to be aware of the legal frameworks used in inpatient admission, in order that they are able to recognise and be accountable for use of ethical practice in acute settings.

Additionally, many psychologists assess or provide psychological interventions for people who have recently been discharged from psychiatric wards. It is possible that some of this work will involve helping people to make sense of the recent period of crisis and the admission itself. Patients’ experiences of admissions may shape their understanding and expectations of future relationships with mental health professionals and consequently future psychological input (Reder and Fredman, 1996).

1.2.6. Section summary

Voluntary admissions have risen in popularity since their introduction in 1930 (Rogers, 1993). Admissions aim to give people access to multi-disciplinary support at times of acute distress and high risk. Voluntary admission gives a person the chance to choose to enter inpatient settings and as such aims to increase patient autonomy and involvement in decision making around their mental health treatment.

Ethical issues surrounding admissions to psychiatric wards raise concerns about potential negative consequences on patient experience, their therapeutic relationships, and recovery. It is important to understand whether voluntary admission does indeed promote autonomy in the way it hopes or whether the experience is impacted negatively by more debated practices. Without

understanding experience, it is difficult to fully acknowledge if admissions are in patients' "best interests" or not.

1.3. Experience of psychiatric admissions: A systematic literature review

1.3.1 Introduction and rationale

Historically, changes in mental health institutions have been prompted by accounts of experiences of services highlighting human rights abuses and harmful practice (Pietikäinen, 2015). Over the last few decades service user accounts and quality monitoring have continued to shape changes in mental health legislation and good practice guidance, by highlighting the impact that admission can have on recovery, mental health and relationships with mental health services (Gilbert, Rose and Slade, 2008; CQC, 2017; DoH, 2015).

At present voluntary psychiatric admission is often the only option available to adults experiencing acute levels of distress. Given the concerns raised in the sections above, it is important to understand patient experiences of voluntary admissions to illuminate how beneficial or effective they are. To gain a detailed picture of the current understanding of experience of voluntary admission, I conducted a systematic review of the literature in the area.

1.3.2. Outline of search methodology

A systematic review of literature exploring the experience of voluntary psychiatric admission was conducted four years ago in New Zealand (Prebble, Thom and Hudson, 2015). To effectively draw upon previous research, I explored the findings of the review and used the search terms to replicate and continue the search over the past four years. I replicated Prebble et al's. (2015), search terms ("Acute mental health services", "informal/voluntary" and "experience/perception"), and added the term "inpatient" to maximise findings. As this systematic review made up part of a larger piece of work, I did not have capacity to review all six databases; I chose to review the four biggest databases that are most relevant to psychology as a profession, excluding the medical and nursing databases (Included: Scopus, Science Direct, PsychINFO and Google Scholar. Omitted: MEDLINE and CINAHL PLUS). The search included research articles only, which contained specific analysis of voluntary

admission experience on non-specialist acute wards. Articles not in the English language and studies purely concerned with satisfaction ratings were excluded from the search; See full table of terms in Appendix A.

1.3.3. Review of the literature

48 papers were included in this review, 45 were also discussed in Prebble et al. (2015) work and three were published subsequently to the review. All relevant papers were read and grouped by research focus; research focuses were then grouped and regrouped into themes. Theme generation was both “bottom-up” and “top down” (Braun and Clarke 2006); themes were influenced by the data (content of searched articles), important themes in the wider literature and pre-identified gaps in the current literature (Prebble et al., 2015). Final themes shared similarities and differences with those discussed in Prebble et al. (2015) paper. Prebble et al. (2015) outline the following three themes: “Perception of coercion”, “Informed Consent” and “Knowledge of Rights”. A theme of “perceived coercion” was also recognised in this review; it was deemed that papers that considered rights and consent were well understood under a framework of “procedural justice and ethical concerns” alongside other similar considerations.

Four main themes are discussed below: perceived coercion, therapeutic relationship, procedural justice and ethical concerns, and lived experience. The themes are outlined and contextualised within relevant research in involuntary admission and psychiatric care. Research has explored the inpatient experience from numerous angles including admission procedures, life on wards, interactions with staff and experiences of discharge. Research ranges from qualitative analysis of experience to quantitative research designs and observational studies, though the majority of studies identified were quantitative. Research exploring admission procedures generally compared voluntary and involuntary experience.

1.3.3.1. Theme 1: Perceived coercion

Perhaps unsurprisingly, given the ethical dilemmas surrounding coercion, this theme dominated the existing literature. Of the 48 papers identified through the systematic search, 39 had some focus on perceived coercion.

Defining perceived coercion

The MacArthur group in the USA defined and operationalised the concept of perceived coercion in hospital admission (Hoge et al., 1993; Lidz et al., 1993; Gardener et al., 1993). They conducted interviews and focus groups with staff, patients, and patients' relatives, and analysed transcripts of admission processes (Hoge et al., 1993; Lidz et al., 1993). Their research explored participants' views on admission alternatives and preferences and their experiences of pressures and burdens involved in admission. The findings indicated that pressures could be divided into two categories; "positive pressures", including persuasion or inducement highlighting the benefits of admission, and "negative pressures", encompassing force or threats that highlight the negative impacts of not being admitted (Lidz et al., 1995). These definitions of positive and negative pressures are now well established and permeate the evidence base on coercion. Based on the findings of these initial studies the group developed and tested two well validated measures of coercion: the MacArthur Admission Experience Interview (MAEI), consisting of four scaled questions, and the MacArthur Admission Experience Survey (MAES), consisting of five true or false statements (Gardener et al., 1993). The interview and scale look at four dimensions of coercion: influence, choice, control, and freedom (Gardener et al., 1993). Seigal, Wallsten, Torsteinsdottir, and Lindstrom (1997) piloted and validated a Swedish version of this scale, which is often used in Nordic research (Nordic Admission Experience Survey/Interview; NAES/I). These scales are used in the majority of research exploring perceived coercion.

The group's findings also illuminated the differences between patient, staff, and relative's accounts of admission. Staff were more likely to focus on a paternalistic understanding of admission as a beneficial "last resort" and report less negative pressures; family wanted to help loved ones and would report higher negative pressures; and patients reported more negatively on pressures and raised a wish for alternative support (Hoge et al., 1993; 1998). Findings suggested that the power differential between staff and patients meant that "positive pressure" as defined by professionals, could be experienced negatively by patients. The research also clarified where or whom patients

experienced these pressures from. Findings indicated that professional pressure held the most power in decision-making at the time of admission but pressure applied by family members was experienced more forcefully in the long term (Lidz et al., 2000). Differences in perspectives and inconsistencies between patient, relative, and staff accounts have been replicated in studies in Ireland (Ranieri et al., 2015) and Sweden (Eriksson and Westrin, 1995). These findings highlighted the importance of gathering a multi-perspective account when evaluating the use of coercive practice.

Perceived coercion and legal status of admission

Almost all studies that explored perceived coercion included an analysis of the relationship between legal status and coercion but some studies aimed to look specifically at this relationship (Hoge et al., 1997; Rogers, 1993; Iverson et al., 2002; Kaltiala-Heino Laippala and Salokangas, 1997; McKenna, Simpson and Laidlaw 1999; Taborda, Baptista, Gomes, Nogueira and Chaves, 2004; Poulsen, 1999). Each of these studies explored the phenomena in a different country; consequently, differences in results may partially reflect differences between international legal systems (Riecher-Rössler, & Rössler, 1993; Zinkler and Priebe, 2002).

All seven studies found that perceived coercion was present in both voluntary and involuntarily admissions. Some studies indicated significantly higher coercion of those admitted involuntarily (Taborda et al., 2004; McKenna et al., 1999), whereas others found that admission status did not significantly predict coercion (Kaltiala-Heino et al., 1997; Iverson et al., 2002). Studies also found that those who were initially admitted voluntarily then sectioned during their stay were most likely to perceive high levels of coercion (Poulsen et al., 1999), and that psychiatric inpatients experienced significantly higher levels of coercion than non-psychiatric patients (Taborda et al., 2004). The studies indicated that as many as 44% of voluntary patients do not perceive their admission as voluntary (Rogers et al., 1993), and often experience the same amount of pressure (if not a different kind of pressure) to enter hospital as those who are involuntarily admitted (Hoge et al., 1997).

Predictive factors of perceived coercion

Some studies explored personal and physical factors that may impact perceived coercion (Katsakou et al., 2011; Fiorillo et al., 2012; Kjellin et al., 2004; Kjellin et al., 2006; Lidz, et al., 1998; O' Donoghue, Roche and Shannon, Lyne, Madigan and Feeney, 2014; Poulsen and Engberg, 2001; Anestis et al., 2013; Cascardi and Poythress, 1997; Bennet et al., 2003; McKenna, Simpson, Coverdale and Laidlaw, 2001; Lidz et al, 1995). Despite discrepancies found between different research findings, there were indications that demographic factors may affect perceived coercion. Although diagnosis itself did not predict perceived coercion (Katsakou et al, 2011), evidence suggests that the presence of “positive symptoms” (i.e. hallucinations, delusions or bizarre behaviours) was related to higher perceived coercion scores (Fiorillo et al., 2012; O' Donoghue et al., 2014; Poulsen and Engberg, 2001). Two studies indicated that females reported higher levels of perceived coercion than males (Anestis et al., 2013; Fiorillo et al., 2012), though differences in objective treatment between males and females could not be found (Fiorillo et al., 2012). Some researchers suggest that this discrepancy may reflect how different genders experience powerlessness in society more widely (Miedema and Stoppard, 1994; Rogers, 1993).

Higher perceived coercion scores were also related to multiple procedural elements of admission: locked doors (Kjellin et al., 2004), lack of procedural justice (Kjellin et al., 2006; O' Donoghue et al., 2014; Poulsen and Engberg, 2001; Cascardi and Poythress, 1997; McKenna et al., 2001; Lidz et al, 1995), increased negative pressures (Lidz, et al., 1998; O' Donoghue, et al., 2014), and exclusion from decision making (Katsakou et al., 2011; McKenna et al., 2001; Bennet et al., 2003).

Outcomes and satisfaction related to perceived coercion

Many authors explored the relationship between perceived coercion and outcomes of psychiatric admission (Bindman et al., 2005; Kallert et al., 2011; Kjellin and Wallsten, 2010; Nicholson, Ekenstam and Norwood, 1996; O'Donoghue et al., 2015; Sheehan and Burns, 2011; Svensson and Hansson, 1994; Sorgaard, 2007; Wallsten, Kjellin and Lindstrom, 2006; Bonsack and Borgeat, 2005). Findings that related perceived coercion and legal status to

psychiatric outcomes and satisfaction ratings were inconsistent and contradictory. These discrepancies may be related to methodological differences and to differences in populations and legal systems in contributing countries.

Outcome was most commonly measured using the Global Assessment of Functioning measure (GAF; Jones, Thornicroft, Coffey and Dunn, 1995; Wallsten et al., 2006; Nicholson et al., 1996; O'Donoghue et al., 2015; Kjellin and Wallsten, 2010). In some cases, treatment satisfaction (Sorgaard et al., 2007; Svensson and Hansson, 1994), subjective rating of improvement (Bonsack and Borgeat, 2005), future engagement in services (Bindman et al., 2005; O'Donoghue et al., 2015), or therapeutic relationship⁵ (Sheehan and Burns, 2011) were also measured as an outcome.

None of the studies found that perceived coercion or legal status significantly predicted outcome on the GAF measure (Wallsten et al., 2006; Nicholson et al., 1996; O'Donoghue et al., 2015; Kjellin and Wallsten, 2010) or predicted engagement with follow-up services (Bindman et al., 2005; O'Donoghue et al., 2015). However, there was some indication that subjective improvement was related to positive treatment from staff (Wallsten et al., 2006) and voluntary status (Bonsack and Borgeat, 2005), and that reduced coercion was related to higher satisfaction with treatment (Sorgaard et al., 2007; Svensson and Hansson, 1994). In a large study evaluating data from 11 European countries, Kallert et al., (2011) found evidence to suggest that being admitted voluntarily and feeling highly coerced was related to worse symptom outcomes than being admitted involuntarily and having a low experience of coercion, or being admitted involuntarily and experiencing high levels of coercion. This more detailed break-down of the relationship between legal status and coercion indicates the potential importance of reducing the experience of coercion in voluntarily admitted patients.

⁵ Therapeutic relationship will be discussed in detail as a separate theme below.

Experience of coercion

One study looked in more detail at how coercion was described and experienced by patients. Svindseth, Dahl and Hatling (2007), noted that patients often described coercive practice as humiliating. This was a word people referred to more often than speaking about pressure or coercion (words not often used by patients themselves; Hoge et al., 1993). Of the voluntary patients interviewed, 38% described feeling humiliated on admission to hospital. Humiliation was related to negative pressures and a feeling that hospital was not warranted. The experience of humiliation is addressed further in the wider literature. Nytingnes et al. (2016) consider why patients use such strong and evocative language when referencing coercion (i.e. humiliation and Nazism). They proposed that the cumulative effect of coercion combined with feelings of invalidation could erode self-confidence and increase experiences of being disrespected and misunderstood.

Summary

Coercive practices have been defined and understood broadly as positive and negative pressures resulting in previously unwanted admission or treatment. Research has found differences in perception of these pressures between professionals, families, and patients, identifying a gap in understanding of experience between staff and patients. Research indicates that voluntary admission does not remove experience of coercion, but that coercion can worsen symptom outcomes in voluntary patients. The experience of coercion may be more common in women than men, and in people experiencing positive symptoms of psychosis. It is linked to lowered satisfaction following hospitalisation and feelings of humiliation or shame.

1.3.3.2. Theme 2: Therapeutic relationship

Therapeutic relationship (TR) was mentioned explicitly in six papers (Gilbert et al., 2008; Roche et al., 2014; Sheehan and Burns, 2011; O'donoghue et al., 2015; Miedema and Stoppard, 1994; Koivisto, Janhonen and Vaisanen, 2004). As discussed in section 1.2.3. TR has been found to be a key predictor of many important aspects of psychiatric treatment including medication adherence (Weiss, et al., 2002), patient outcomes (Priebe and Gruyters, 1993; MaCabe and Priebe, 2004), and engagement with services (Lecomte et al., 2008).

Therefore, it is important to understand the evidence indicating factors that affect experiences of therapeutic relationships on wards. Despite the small amount of papers that mention TR, it has been included as a theme due to our knowledge of the impact of TR on outcomes, its relationship to the role of psychology, and its recognised importance in the wider literature.

Gilbert et al. (2008) conducted a qualitative exploration of inpatient experience and found that experience was understood in terms of interaction. Relationships of trust, exemplified by good communication, sensitivity to culture, and non-coercive practices, were key to a satisfactory experience of admission. This finding has led others to look at factors which may affect TR over the admission period (Roche et al., 2014; Sheehan and Burns, 2011). Sheehan and Burns (2011) found that positive TR was better predicted by low perceived coercion than by legal status. In a similar study in Ireland, Roche et al. (2014) found that negative pressures on admission and the presence of psychosis had the biggest negative effect on TR but did not find a significant correlation between TR and perceived coercion in general. High levels of procedural justice were also associated with better TR (Roche et al., 2014).

TR is known to affect future engagement in services (Reder and Fredman, 1996). O'Donoghue et al. (2015) looked to explore the relationship between coercive practice, procedural justice, and future engagement in services. Their results were inconclusive but indicated that where procedural justice was low, people would feel less inclined to engage voluntarily with mental health outpatient services and may be more likely to have a second admission within a year. Further studies looking more generally at the lived experience of admissions (to be discussed in more detail below), also recognised the importance of relationships on the ward (Miedema and Stoppard, 1994; Koivisto et al., 2004). They indicate that positive relationships between staff and patients on the ward would contribute to desirable experiences of "clarity" and "safety".

Wider literature on admission experience and TR

Several studies have further explored the impact of TR on admission experience and satisfaction (Wyder, Bland, Blythe, Matarasso and Crompton, 2015; Theodoridou et al., 2012; Smith et al., 2014). Wyder et al. (2015)

interviewed involuntarily admitted people who had been given a diagnosis of psychosis. They found that staff behaviours and attitudes shaped patients' experiences in hospital. Positive experiences were linked to examples where staff had listened to concerns, provided a space where patients could make sense of their experiences in their own language, and included patients in care planning.

Smith et al. (2014) followed up with service users after psychiatric admission and found that better TR (as well as reduced physical coercion and increased procedural justice) were associated with higher levels of treatment satisfaction. Smith et al. (2014) note that higher treatment satisfaction is associated with better quality of life (Blenkiron and Hammill, 2003) and reduced future hospitalisations (Priebe et al., 2009). Theodoridou et al., (2012) explored the relationship between TR and perceived coercion in an involuntarily admitted sample. They found that experiences of reduced autonomy and higher perceived coercion were significantly related to lower ratings of TR; this suggests that those voluntarily admitted who feel more highly coerced may be more likely to have negative TR experiences.

Summary

Positive TR is an important predictor of positive outcomes of mental health treatment. Positive TRs are characterised by trust, transparent communication, sensitivity and respect. Negative therapeutic experience can reduce patient outcomes, satisfaction with services, and future help-seeking. Research indicates that both coercive practices and low procedural justice can negatively affect therapeutic relationship.

1.3.3.3. Theme 3: Procedural justice and ethical concerns

Procedural justice is a concept created by researchers comprised of three factors: 1) a patient's perception that the decisions made around admission are "fair". 2) A patient's feeling of inclusion in decision making; that they can contribute ("voice") and have their contributions taken seriously ("validation"). 3) a patient's perception of professionals, namely that they display attributes seen as important to the job; "respect" and good will (good "motivation") towards the patient. The construct validity of the concept has not been explored at length;

research that looks at the impact of procedural justice explores it under various headings including: fairness, deception, information, voice, validation, respect and motivation (Lidz et al., 1995; McKenna et al., 2001).

Nine of the papers found looked specifically at procedural justice and the ethical questions raised by voluntary admission⁶. Five papers explored informed consent in admission procedures (Sugarman and Moss, 1994; Lomax et al., 2012; Perry Singh and White, 2017; Ashmore and Carver, 2017; Tuohimaki et al., 2001), three explored “de-facto” DoL (Poulsen, 2002; Perry et al., 2017; Haglund and Von Essen., 2005), and two looked more generally at ethical frameworks around decision making (Kjellin et al., 1993; 1997).

Informed consent

Informed consent is inherent to procedural justice and is reflected in aspects of fairness, voice, and validation. Research explored whether patients were fully informed of their rights when consenting to admission; data was collected through direct interviews (Sugarman and Moss, 1994; Lomax et al., 2012; Tuohimaki et al., 2001), observing medical records (Ashmore and Carver, 2017), and auditing written information provided to patients (Perry et al., 2017). Findings indicated that in the UK voluntary patients had mixed understandings of their rights (Sugarman and Moss, 1994; Lomax et al., 2012). They suggest that 55–65% of voluntary patients knew that they could refuse treatment and around 63% knew of their right to decide on discharge. These statistics are similar to those found in Finland as part of the ongoing Nordic paternalism and autonomy project (Tuohimaki et al., 2001).

Perry et al., (2017) audited the medical notes of a UK NHS trust and found that only 26% of notes on admissions included enough information to indicate that correct information was given at admission for informed consent. In addition, only 54% of records included statements indicating that a patient had the capacity to make that decision. Furthermore, a wider audit of 61 UK NHS trusts indicated that written information about admissions was often unclear,

⁶ Coercion is also an important ethical issue but has been considered as a separate theme due to the volume of papers concerning it.

inconsistent, and missing important details about rights to refuse treatment or request discharge (Ashmore and Carver, 2017).

Deprivation of Liberty

Deprivation of Liberty (DoL) could affect patient experience of all aspects of procedural justice. Papers that explored de-facto DoL looked particularly at capacity (Perry, et al., 2017; discussed above), and physical DoL (Haglund and Von Essen, 2005; Poulsen, 2002). Findings indicated that voluntarily admitted patients still experienced DoL in the form of restraint or omission of hospital leave and close monitoring or observation by staff (Poulsen, 2002). Poulsen also found that those who were most likely to experience DoL were those who were admitted voluntarily to hospital but later were legally detained through use of the Mental Health Act (“Sectioned”). Haglund and Von Essen, 2005) interviewed voluntarily admitted patients about locked doors on wards. Participants shared concerns that locked doors could lead to perceived or actual confinement, and could make people feel lower in mood or more frustrated. However, they also recognise a sense of security and safety related to the locking of doors thus highlighting the ongoing ethical dilemma posed in weighing up the benefits and costs of physical barriers that could lead to DoL.

Ethical frameworks around decision making

Paternalism has been identified as the dominant ethical framework in psychiatric decision making (See section 1.2.4.3.). Kjellin and colleagues (1993 and 1997) further explored how benefits and costs of DoL and coercion are weighed up and experienced by health professionals, patients, and their relatives They then explored how these processes affect psychiatric outcomes following admission (Kjellin et al., 1997). Findings showed that professionals, patients, and relatives all experienced both the benefits and costs of various elements of admission and treatment (Kjellin et al., 1993), however there were discrepancies between how costs and benefits were weighted. For example, although both patients and doctors recognised the costs and benefits of medication, doctors emphasised the benefits whereas patients emphasised the costs of side effects. This highlighted differences in evaluations of “best” decisions, and the downfalls of paternalistic decision making.

When outcomes were measured, no correlation was found between objective symptom measurements and ethical frameworks used by clinicians to make the decision to voluntarily admit a patient to hospital (i.e. paternalistic versus reciprocal frameworks). However, an association was found between self-reported improvement in mental health and an experience of feeling that patient autonomy was respected and reflected in joint decision making (Kjellin et al., 1997). This finding indicates that more reciprocal decision making may be helpful in psychiatric recovery.

Procedural justice, perceived coercion, outcomes and satisfaction

As discussed briefly above, multiple studies have found a negative correlation between procedural justice and perceived coercion (Hoge et al., 1998; Kjellin et al., 2006; O' Donoghue et al., 2014; Poulsen and Engberg, 2001; Cascardi and Poythress, 1997; McKenna et al., 2001; Lidz et al., 1995). The studies link poor procedural justice to the negative outcomes of perceived coercion described in section 1.3.3.1. McKenna et al. (2001) built on the work of Lidz et al. (1995) to analyse the varying impact of different factors of procedural justice on admission experience. They found that voluntary admission was related to higher levels of procedural justice than involuntary admission, and that this difference was accounted for through higher ratings of fairness, voice, validation, motivation, and respect. Low procedural justice has been linked to poor therapeutic relationships (Roche et al., 2014), decreased engagement with services, and increased likelihood of future admission (O'Donoghue et al., 2015).

Summary

Research indicates that voluntary patients often experience reduced procedural justice through poor communication which can lead to uninformed consent or de facto DoL. Low levels of procedural justice can negatively affect therapeutic relationship, patient outcomes, and satisfaction with admission. Research suggests that increased professional transparency and patient autonomy may be a way of decreasing procedural injustice and increasing satisfaction and subjective outcomes.

1.3.3.4. *Theme 4: Lived experience*

Despite early work on experience of admission and coercion highlighting the need for more qualitative studies of experience (Hoge et al., 1993), very few papers have been published which broadly study voluntary hospital experience from the perspective of patients. Although papers widely recognise that patients' perspectives are key to understanding experience, the majority of research explores questions about experience posed by academics and researchers. Three papers specifically looked to understand experience from the perspectives of service users and looked widely at what the phenomenon of inpatient experience might be like (Gilburt, et al., 2008; Miedema and Stoppard, 1994; Koivisto et al., 2004). These papers sought to raise the voices of service users and allow knowledge to be shaped by experiential understanding, hoping to generate ideas about how to make hospital admission most helpful to those undergoing it.

Each research paper recruited in a different country and focussed on different populations or elements of experience. Gilburt et al., (2008), recruited 19 people who had experienced an admission in the UK (London) and Miedema and Stoppard (1994), looked to understand the phenomenological experience of admission for 27 women in Canada; in both studies participants had experienced voluntary or involuntary admissions. Koivisto et al. (2004) explored the voluntary admission experience of 9 people who were recovering from psychosis in Finland. All three papers used methodologies which aimed to promote the voices of their participant's experiences. Gilburt et al. (2008) used an inductive approach to thematic analysis (Braun and Clarke, 2006), Miedema and Stoppard (1994) employed Kirby and McKenna's methodologies (1989), designed to promote social change and privilege the voices of those who are oppressed, and Koivisto et al. (2004) employed Giorgi's phenomenological methodology (1985), which allowed them to reflexively describe and interpret meaning from accounts of their participants' experiences.

There were shared and idiosyncratic themes across the three studies. All studies recognised the importance of relationships to experience. All discussed the importance of an experience of safety or "asylum" on the ward, and considered how "powerlessness", coercion, or mistrust can confound that

experience. Two of the studies also talked specifically about freedom, respect, and autonomy, and the positive effects these had on experience and relationships (Gilburt et al., 2008; Koivisto et al., 2004). Both Miedema and Stoppard (1994) and Koivisto et al. (2004) identified themes that recognised the need to acknowledge context, “real” experience, and social issues outside of hospital, when trying to understand admission experience. Additionally, for people seeking help towards recovery from psychosis, an aspect of “sense making” alongside staff was important (Koivisto et al., 2004).

Summary

Very few research papers look at how admission is broadly experienced from patients’ perspectives. Research indicates that experience is affected by a conflict between a hope for safety and asylum and a feeling of powerlessness. It also indicates the importance of the role of relationship, autonomy, respect, and context when trying to understand ward experience.

1.3.4. Summary of findings

Much of the literature base exploring voluntary admission looks to understand perceived coercion in hospital admissions, and more recently to recognise and understand the importance of procedural justice. Most studies look at both voluntary and involuntary admission and explore different factors which correlate with coercion scores. The literature suggests that despite the aims of voluntary admission to promote patient autonomy, voluntary admission can often be coercive or confusing. This negative experience can have an adverse impact on admission satisfaction and potentially on admission outcome. Literature has also highlighted the importance of procedural justice and informed consent and the detrimental impact of use of force and threats in the admission process. Research has also begun to highlight the detrimental effects that admission could have on therapeutic relationships, and the consequences this could have on long term outcome and engagement with services. Finally, research with a broader more phenomenological focus has studied the experience of different groups of patients in psychiatric settings. Though this is a small and heterogenous body of research, the findings indicate that admission experience is often conceptualised through conflict between a need for safety and experiences of powerlessness.

1.3.5. Limitations of the current literature base

There are several limitations of the current evidence base that need to be considered. Although much research aims to define and capture the experience of coercion, the dominance of quantitative studies in the area may be vulnerable to limitations, which reduce the nuance and validity of their findings. Hoge et al. (1993) acknowledged that it is likely that perceived coercion is under-reported due to fears or concerns about the consequences of reporting. Quantitative studies of both perceived coercion and procedural justice often use yes/no statements on short surveys and questionnaires, possibly leading them to miss nuance in experience (Gardener et al., 1993; Hoge et al., 1993; Gilbert et al., 2008). In this way the dominance of quantitative data in the field may have narrowed, rather than broadened, available knowledge on the experience of coercion and procedural justice (Gilbert et al., 2008; Hoge et al., 1993; Prebble et al., 2015).

Some researchers recognise the power held by staff to define patient experience (Hoge et al., 1993; Miedema and Stoppard, 1994; Koivisto et al., 2004). Research literature is often focussed on perceived coercion and procedural justice, which are both language constructs created by academics that are not used by patients to define their own experience (Hoge et al., 1993). In this way, the literature continues to be dominated by clinical, researcher, and academic views of experience rather than by patient voice (Gilbert et al., 2008; Koivisto et al., 2004; Wyder et al., 2015). Very few papers take a broad approach to understanding what the experience of the ward is like, and none look in depth at patient understanding and experience of voluntary admission itself. The literature base's somewhat narrower focus may mean that important understandings are missed. Furthermore, continued use of academic language and constructs may serve to increase the discrepancy between staff and patient views of admission experience (Hoge et al., 1998).

Those studies that do focus on broader more phenomenological understandings are also limited in their application to voluntary admission specifically. None of the three papers explicitly explore how people understand or experience a voluntary admission as opposed to a sectioned admission. Consequently, they

do not consider whether voluntary admission fulfils its aims of promoting a more reciprocal inpatient experience. Additionally, two of the discussed studies were conducted in different legal systems and with very specific samples (Miedema and Stoppard, 1994; Koivisto et al. 2004). As such, the findings discussed may have limited applicability to current experience of voluntary admissions in the UK.

Studies focussing on experience of psychiatric admission are often published in nursing journals. Authors of these articles recognise the nurse's role in connecting with a patient on a human level and providing care and understanding that connects with people's experiences. In contrast to this, psychological research has often privileged the views of psychological professionals and researchers. As psychologists have an increasing role in acute settings, it is important that the profession looks to generate research lending insight into how patients make sense of their own experiences.

1.4. Rationale and aims of the current study

Through this study I aim to build further understanding of what it is like to experience voluntary psychiatric admission. I hope to explore how the voluntary nature of the admission is conceptualised and experienced by those undergoing it. I hope to explore people's understandings of their own experience and in doing so privilege the voices of service users and their experiential knowledge of admission processes. In this way the study responds to calls in the existing literature for further qualitative data to add a depth to the existing knowledge base (Hoge et al., 1993; Prebble et al., 2015).

To best capture nuance and depth of experience I did not build research questions around research-derived constructs or existing interview schedules. I hoped instead to open new avenues of understanding and investigation, through posing broad questions for exploration.

The primary research question I am asking is:

- How do inpatients on acute psychiatric wards make sense of their experience of voluntary admission?

Secondary research questions are:

- What do inpatients on acute wards understand about the concept of “voluntary” in the context of their admission?
- How does this sense-making change over the course of the admission?

2.0 METHODOLOGY

2.1. Chapter Overview

In this chapter I outline the epistemological and ontological stance I took throughout this project. I describe and rationalise choices made around methodological design and consultation and consider ethical issues relevant to the study protocol.

2.2. Epistemology and Methodology

To contextualise this work, I briefly explain the epistemological and ontological stance from which I approached this study (Willig, 2013) and outline how this stance shaped methodological decisions made.

2.2.1. Epistemological stance

The primary research questions I aim to explore are concerned with phenomenological experience- i.e. what is the subjective experience of voluntary admission like? From a phenomenological epistemology I understand experience to be a person's "reality", and their understanding of this "reality" is the knowledge I seek. I am not purely concerned with describing participants' experience "as it is lived", (Moran, 2000; Giorgi, 1992), as I do not believe it is possible to capture another's experience in this way. Instead I have drawn on Heidegger's hermeneutic phenomenology (Moran, 2000) and understand that the accounts a person gives of their own experience are shaped by how they understand their experience in context. Heidegger introduced the concept of "Dasein" or "there being"; by which he suggested that human nature is to always be in context, and as such experience of reality must also be understood in this way (Larkin, Watts and Clifton, 2006). As such, I do not aim to access an innate "reality" but to understand unique subjective understanding of experience of phenomena, in this case voluntary admission.

2.2.2. Methodology

To gain a phenomenological understanding, a qualitative methodology was employed to allow richer and less reductive analysis of data (Willig, 2012). I employed methodology outlined in Smith's (1996) Interpretative Phenomenological Approach (Smith, Flowers and Larkin, 2009). Interpretative

Phenomenological Analysis (IPA) is an approach which lays out methodologies for applying hermeneutic phenomenological ideas through an ideographic framework to psychological research questions (Larkin and Thompson, 2012). This framework is increasingly adopted in health research (Biggerstaff and Thompson, 2008), as it provides a method to explore experiences of health conditions or services (Brocki and Wearden, 2006), and is dedicated to “giving voice” to the concerns of participants whilst making sense of these concerns from a psychological perspective (Larkin, Watts and Clifton, 2006).

IPA draws on a circular process of interpretation often adopted by hermeneutic phenomenologists (Moran, 2000). This circular process is referred to as the “hermeneutic loop/circle” and states that a text/ spoken word must be understood in its wider context and that a wider context is influenced by the texts and spoken words read (Moran, 2000). IPA privileges individual understandings of experience, and ensures to recognise ideographic themes in the data. The aim of this methodology therefore is not to be generalisable, but to add depth to knowledge of experience (Smith, Flowers and Larkin, 2009); as such IPA studies can be presented as case studies or case series (Smith, 1993).

2.2.3. Researcher in context

When making sense of phenomenological experience, both researcher and participant are positioned as conscious “meaning makers” (Smith, Flowers and Larkin, 2009). As such, interpretation of data is affected not only by participant understanding, but by researcher interpretation, and the cultural meaning-making systems which affect both persons (Pigeon and Henwood, 1997). Given that the knowledge obtained is affected by the cultural scripts available to the researcher, it is essential for the researcher to outline the contexts they speak from and to reflect on these continually throughout the interpretative process (Madill, Jordan and Shirley, 2000). When approaching this research, I recognised contexts which may affect how I make-sense of my own experience and how I understand the experiences of others; I have listed the most relevant here:

- I am a white female and was born in the UK.

- I have received higher academic education, have a professional background and would self-identify as “middle class”.
- I have worked on inpatient wards as a health professional; whilst working I heard many peoples’ stories of their experiences of admission.
- I believe it to be important to raise the voices of those with less power in society in attempt to level structural hierarchies.
- I have not experienced an admission to a psychiatric ward myself, nor have any close friends or family members of mine.
- I have never received a diagnosis of a “mental illness/disorder”
- I have never received treatment (with medication or otherwise) for a “mental illness/disorder”

2.3. Research Design

In this section I detail the consultation process I underwent before designing the project and the outcomes from this process. I describe the design, participant recruitment, sample details and procedures used for data collection and analysis.

2.3.1. Consultation Phase

I chose to consult with service users on methodological questions surrounding specificities of research design as the importance of empowerment and change in this study echoes key principles of service user involvement (Faulkner, 2004). It was important to me that people with lived experience of admission should be included in the planning of this study, in order to promote their voice throughout each stage of the research process (Larkin, Watts and Clifton, 2006). People with lived experience were employed at the level of “consultation” (Sweeney and Morgan, 2009; Hanley, 2000; 2004). Henceforth I shall refer to them as “consultants”⁷ as they requested to remain anonymous.

⁷ In the still young and growing field of participation research, the language used to describe those participating in research who have lived experience of mental health difficulties continues to evolve. Debate surrounds preferred terminology. Whilst some people thinking of themselves as “consumers” of services, others consider themselves unwitting users or “survivors” of services (Wallcroft and Nettle, 2009). I will use the term “consultants”, as this best describes the role played in research design.

2.3.1.1. Consultation Procedure

Consultants were invited to join a focus group to discuss the research project whilst it was in the design phase (Appendix B). Potential consultants were identified through liaison with a “people’s participation group” associated with the NHS trust in which the study was conducted. Consultants were paid for their time and additional travel costs to and from the consultation were covered. Payment was important in recognising the importance of consultant’s contribution and increasing involvement, in accordance with best practice guidelines (Wallcraft, Schrank and Amering, 2009; Faulkner, 2004). The group were consulted about recruitment and interview topics. Minutes were taken during the group which were summarised and disseminated to participants. This ensured that the process was dialogic and that consultant views were accurately included in design (Minogue, 2009).

2.3.1.2. Consultation Outcomes

Consultants provided specific feedback on questions brought for discussion. The main changes suggested in the focus group are summarised below, all were included in study design and output; See Appendix C; for full minutes.

Sample and recruitment:

Consultants were keen that representation should be maximised and suggested measures to facilitate participation. They suggested that recruitment should take place on the wards so the voices of those who are not followed up by outpatient services are not excluded. They suggested allowing people a few weeks after their admissions before inviting them to interview as this can be a difficult and chaotic time. They also shared concerns that they were an all-female group, and were keen that men’s voices not be missed.

Interviews:

Consent, choice and confidentiality were very important to the consultants when considering interview design. They were clear that the interview schedule should not be mandatory, and that participants should be clear that they do not have to discuss matters that they are not comfortable with. They felt that participants should be given a choice of interview venue to increase likelihood of participation. They requested that confidentiality be outlined on the

information sheet, consent form and reiterated at the beginning of the interview, and throughout where necessary. They suggested that participants be allowed to audio record the interview for themselves should they wish.

Impact:

The consultants were keen that other people would have more positive experiences of psychiatric services and admissions than they did. It was important to them that this research could effect change for the participating population. The consultants requested feedback to themselves and research participants which indicates how their contributions would lead to change alongside a push for publication of the research. They also requested that, should concerns be raised in interviews, participants should be provided with information about how to file an official complaint and aided with this process should they need.

2.3.2. Participants, Recruitment and Sample

Participants were recruited from both triage and long stay adult acute psychiatric wards, in a culturally diverse, economically-deprived inner-city borough. The triage ward is a mixed ward that admits people for stays between one and ten days; longer stay wards are single sex and admit people for between one day and several months.

2.3.2.1. Inclusion and Exclusion Criteria

To ensure that the sample participating in the research were best placed to answer the questions posed (Willig, 2013), the following inclusion and exclusion criteria were imposed:

- Participants were between 18 and 65 years of age; all participants were admitted to an adult acute ward, rather than a specialist unit.
- Participants were within two months of discharge from a voluntary psychiatric admission when interviewed. Interviewing participants close to discharge meant it was possible that participants accounts of their experience were influenced by the emotional distress that led up to their hospital admission. Despite this, the short time frame also makes it more likely that a persons' account of their experience is close to how they

lived their experience whilst they were on the ward. It is this lived experience that this research aims to capture.

- Participants must not have been placed under any section of the MHA at any point during the voluntary admission in question.
- Participants could speak English fluently. English did not have to be spoken as a first language.
- Participants were deemed as capacitous to consent and clinically stable enough to participate by staff and the researcher (i.e. participation in the study would not put the participant or researcher in undue risk).

2.3.2.2. *Recruitment*

Participant recruitment took place over several steps:

- 1) Potential participants were identified by ward staff and the local collaborator at the hospital.
- 2) Potential participants were approached by the local collaborator and/or clinical staff on the ward to gain consent for me to contact them to discuss the study. Participants who consented to be approached gave their contact details and were given the study information sheet.
- 3) I approached potential participants to discuss the study and gave opportunities to ask questions. Where possible I met with participants on the ward to increase likelihood of follow up. Where this wasn't possible I made contact over the phone following discharge. If they were interested in participation an appointment was made to meet for interview.
- 4) Participants were met for interview either at an NHS base or at the University of East London.

Of roughly 100 potential participants on the ward during the recruitment process, approximately thirty met inclusion criteria and were approached by the local collaborator, around 48% of those approached were interested in participation (see Appendix D). Fourteen people (10 Female, 4 Male) gave permission to be contacted for the study. Of those who agreed to participate I was unable to contact three (i.e. did not answer phones or phone numbers did not work), two people decided they did not wish to participate following

discharge, three people reported interest but were unable to find a time to meet or became uncontactable, and one man was unable to meet within the time frame required for analysis. Those who decided not to take part following discharge cited ongoing distress or complex social circumstances as the reason why they could not participate.

2.3.2.3. Sample

In total five people participated in the study. As the sample was small and demographically varied, presenting any specific demographic information may identify the participants. To preserve confidentiality, I will summarise sample demographics rather than present them in tabular form. All five participants were female, their ages ranged from 22- 64 years old. Two of the sample identified as White British, two as Black British and one as British Pakistani. All participants were interviewed within eight weeks of a voluntary admission to acute psychiatric hospital (range 2- 8 weeks). For two people the admission was their first psychiatric hospital admission and for one it was the first voluntary admission, two participants had experienced both voluntary and involuntary admissions in the past.

2.3.3. Data collection

Data was collected through individual semi structured interviews to enable generation of rich, detailed, ideographic data (Oppenheim, 1992; Smith, Flowers and Larkin, 2009). Demographic information was gathered to contextualise individuals accounts (Madill et al., 2000). The interview schedule (see Appendix E) was devised between myself and my supervisor and addressed the issues raised by consultants to ensure relevance and decrease researcher bias (Chenail, 2009). The final schedule contained three broad questions:

- 1) How did you experience your recent admission to the ward?
- 2) How do you understand the “voluntary” aspect of the admission?
- 3) How has your understanding of your experience of the admission changed since you were admitted?

Prompts explored different aspects of admission, including admission process, ward stay and discharge. The interviews lasted for an average of 55 minutes (range 38- 74 minutes).

2.3.4. Data Analysis

Data was transcribed verbatim by the researcher from audio to typed format, and analysed following guidance outlined by Smith, Flowers and Larkin (2009). Smith et al. (2009) note that there is no set analytic method but that IPA gives a focus to analysis, prioritising sense making around experience (Reid, Flowers and Larkin, 2005). The analytic process typically involves “iterative and inductive cycles” whereby the researcher works between data, reflexive accounts and wider interpretations to create an account of their understanding of the participant’s experience (Larkin, Watts and Clifton, 2006). The analytic process was circular and included the following processes:

- I read and re-read the interview transcripts to familiarise myself with the data.
- I manually completed detailed and comprehensive note making and coding of the transcripts (Braun and Clarke, 1996). Focussing on each transcript one by one. To ensure context, language and interpretation were acknowledged I categorised my notes to include descriptive, contextual, conceptual and linguistic comments (Smith et al., 2009; Appendix F).
- I used the notes and themes alongside my reflective logs to begin to identify emerging themes and patterns in each transcript. I created maps for each interview outlining important themes and how they might interlink (Larkin et al., 2006). Analysing interviews separately in this way allows difference and depth in experience to be taken into account (Appendix G).
- I then looked across all five transcripts to consider similarities and differences, relations and interconnection between the emerging themes from each whilst continually referring to the raw data, so as not to remove it from the conversational context (Potter and Hepburn, 2005; Smith et al., 2009; Larkin et al., 2006). Themes were developed cross-sectionally in this way in order to bring breadth as well as depth to the experience and recognise similarities as well as difference (Appendix H).

- I collapsed emergent themes into overarching superordinate themes (Appendix I). This process was supported through the application of psychological understanding to coded data and themes, and peer discussion to ensure coherence and relevance of the themes generated (Smith, 2007).

2.3.5. Role of the researcher/ Reflexivity

Throughout the research I was aware of how my decisions on questioning and interpretation would shape the findings of the work. As such it was essential to be aware of the contexts, experiences, and assumptions that shaped these decisions (Madill et al., 2000). As an interviewer I endeavoured to remain reflexive, be led by participant responses rather than my own agenda, and probe appropriately in a way that allowed engagement with deeper experiential material (Smith, Flowers and Larkin, 2009). To help me to do this I kept a reflective diary (Elliot, Fischer and Rennie, 1999) which I updated immediately after the conclusion of each interview. I used the diary to reflect on thoughts about my engagement and relationship with participants, initial ideas I had around the content and process of the interview, and hypotheses about contexts and assumptions that may have been at play during in the interview (Appendix J).

During transcription I catalogued my own reflections alongside the transcribed data to allow for complete transparency (Smith et al., 2009) and to ensure that assumptions that might influence the analytic process were attended to (Willig, 2013). I considered why I used various prompts or questions during the interview and noted what assumptions might have been behind them.

Throughout analysis I ensured that I made notes of my assumptions and expectations of the data. I separated interpretative and descriptive comments to show if or when I diverged from the raw data, and ensured I repeatedly checked patterns and themes against both the raw data and reflexive accounts I had kept (Smith, Larkin and Flowers, 2009). In this way I ensured that data was contextualised and that I recognised my impact on the data and stayed as true as possible to participant experience (Potter and Hepburn, 2005).

2.4. Ethical Considerations

2.4.1. Ethical Approval

Approval was sought from the Health Research Authority (HRA) through the IRAS application system (See Appendices K, L and M). Approval was given by the HRA (IRAS no. 219410), following which local approval was sought and gained from the local NHS trust. Approval was given based on ethical concerns being addressed as discussed below.

2.4.2. Informed Consent

Participants were given information sheets and asked to sign consent forms (see Appendices N and O). Participants consented for interviews to be audio-recorded and for quotations to be used in write ups of the research. I went over the information sheet verbally to ensure that all aspects were understood. I gave information about the interview question areas, and the nature of the interview, as well as ensuring that participants understood their right to withdraw, or not answer any questions at any stage of the interview process. To reduce the possibility of coerced participation, participants always had a minimum of 48 hours with the information sheet apart from me, and time to ask questions before taking part. It was made explicit to all participants that taking part in the research would not impact the care they received in any way. If a participant had been deemed to lose capacity to consent during the interview process, the interview would have been stopped and their data would have been withdrawn from the study and destroyed.

2.4.3. Confidentiality and Data Handling

Participants' personal data was only available to myself and the local collaborator. Interview audio-files were only reviewed by myself. Anonymised transcripts were viewed only by myself and my research supervisor. Content of all interviews was kept confidentially and not shared with clinical staff.

Confidentiality was only to be broken in cases of risk (see below), this was consented to before participation began. Throughout the write up patients were referred to by pseudonyms and care was taken that demographic detail did not identify any participants.

Following consent participants were given a unique Participant ID, and their name was not stored alongside any demographic details, audio files or transcripts. Personal data and Audio files were stored on NHS and UEL servers. Data was collected and stored in line with UEL and NHS data protection guidelines and regulations. Personal data including audio-files will be destroyed following completion of the research project (within 6 months). Research data will be stored for five years after study completion in line with university policy.

2.4.4. Risks, Burdens and Benefits

The interview schedule was developed in line with guidance to allow space and time for participants to settle into the interview and build rapport with the interviewer, starting with more descriptive questions and building to deeper more searching prompts about emotional experience (Smith Flowers and Larkin, 2009). The interview schedule was informed by discussions with service user consultants and tested on colleagues in advance of interviewing. Participants were informed they could take breaks if they wished and were offered these periodically during interview. Participants were provided with debrief information and services they could access should they feel unsafe or wish to pursue talking support (Appendix P). Participants also consented for their care teams to be made aware of their participation in the study (Appendix Q). Consent was given for any information around risk or distress to be shared appropriately with care teams in line with safeguarding regulations. In this way provision could be made for future support if necessary.

2.5. Quality and Validity

Yardley has suggested ways in which the validity of qualitative research can be attested to and assessed (Yardley 2000; 2008). Numerous psychological research papers have used these guidelines since their creation to ensure high standards of qualitative research (Smith et al., 2009). The guidelines are outlined below alongside consideration as to how they were adhered to throughout this project.

Sensitivity to context: Reflexive accounts and comments throughout the study ensured due attention was paid to my own and participants' personal contexts. Findings were contextualised within the wider literature.

Commitment and Rigour: To ensure that data was rich in quality I practised interviewing colleagues before data collection to improve my skills in interview style and technique (Yardley, 2000). Continuous reflection and academic supervision were used to ensure rigour throughout the analytic process.

Transparency and Cohesion: I have recorded the decision-making processes and procedures involved in this project with transparency and cohesion to allow the reader to evaluate the methods used (Willig, 2013). Extracts from the analysis process and reflective logs have been included in the appendices to support further transparency (Smith, Flowers and Larkin, 2009; See Appendices M-R).

Impact and Importance: It was very important to the research consultants that the research findings make practical suggestions that can make an impact in psychiatric settings. As such these are included in the write up and will be disseminated appropriately at the hospital from which participants were recruited. In addition, I will seek publication in a peer reviewed journal.

3.0. RESULTS

3.1. Chapter Overview:

In this chapter I present the findings of the phenomenological analysis. A thematic map is presented illustrating the main themes that emerged from the data. The themes are outlined and illustrated with quotations from the transcripts.

3.2. Themes:

Three super-ordinate themes were identified during the analytic process, each containing sub-themes; see Figure 1: Thematic Map. Each theme is described below and illustrated with quotations from the raw data. Quotations are identified by pseudonym, transcript line location (i.e. Jackie, 42). In Table 1 below participants are identified as either being of white ethnicity (W), or as being of black or “minority ethnic” ethnicity (BME), and as either below or above 40 years of age to allow consideration to be given to the impact of ethnicity and age on accounts of experience (see Table X). Square brackets indicate that text has been removed [...], or replaced for anonymity [phrase].

Table 1: Participant characteristics

Participant No.	Pseudonym	Ethnicity	Age (yrs old)
1	Jackie	W	>40
2	Kiera	BME	<40
3	Susan	W	>40
4	Natasha	BME	<40
5	Ami	BME	<40

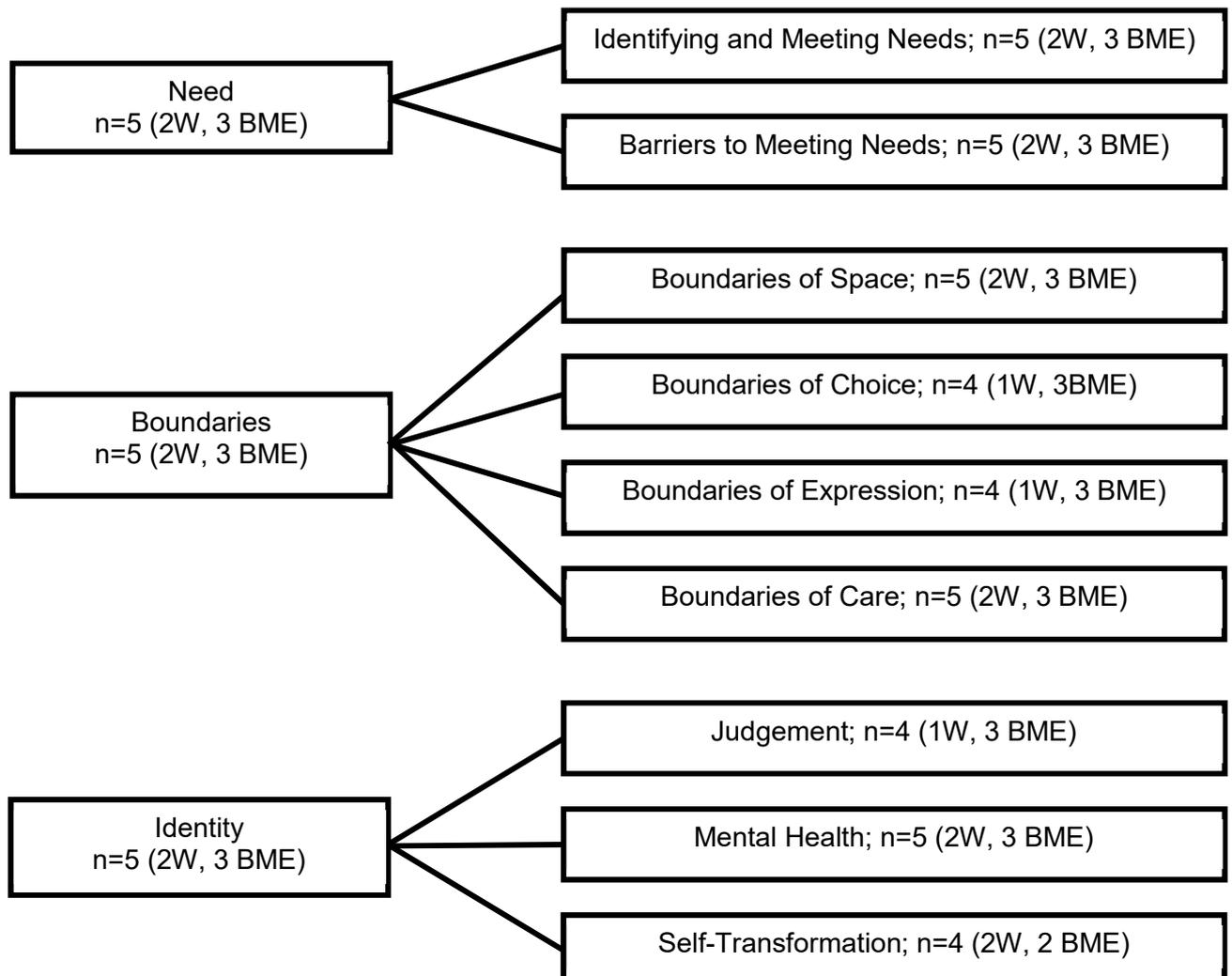
3.2.1. Theme 1: Need:

“Need” here is defined by the idea of the participants perceived “need for hospitalisation”, the theme is concerned with why participants understood that they entered hospital, and what they felt they needed to receive from hospital to meet these needs. Participants talked primarily about two needs. These were the need to be safe, having a safe space and being looked after or protected; and the need to be heard, validated, respected and included. Participants also discussed difficulties meeting these needs, relating to feelings of threat, fear or

powerlessness experienced when facing personal need and corresponding vulnerability.

Figure 1: Thematic Map

Map includes numbers of participants represented by each theme and subtheme, this is also classified by ethnicity, age left out as represented by ethnicity in this sample (i.e. all BME= <40, W= >40).



3.2.1.1. Identifying and Meeting Need

This subtheme is concerned with participants experiences of recognising their own needs and accounts of experiences of feeling their needs were met. The main needs identified by participants were the need for safety and for validation; they discuss of these needs were met through positive experiences of staff and boundaries of physical space.

At the point of admission many patients talked about feeling in danger or frightened and needing to feel safe. Susan told me about the desperate request she had made to emergency services which precipitated her admission to hospital and her relief on admission.

I was saying "look, I can't cope anymore, I need to go to hospital, I can't cope, I don't know what I'm doing love, I don't wanna make a cup of coffee please help me! [...] I was glad to get in there because it was a safe haven (Susan, 122)

She communicated a fear of being alone and feeling that she needed to be kept safe when she felt unable to look after herself. Other participants expressed fears of what they might do to themselves or others, and a concern that they should be kept somewhere safe.

I'm low sometimes I'll drink, depending, sometimes not, but you know I might do some really crazy stuff so it best that I'm in a room sometimes (Ami, 248)

I had said to the um, the health visitor that I don't think I'm safe, I don't think [daughter's] safe, [...] I think I can't cope and you know I, I think I might end both of our lives. (Kiera, 56)

Jackie talked about the continued role of hospital as a safe base throughout her stay on the ward from which she could explore the "outside" or "real" world. This extract illustrates the consistency she felt the ward provided, as a place to return to should she feel overwhelmed.

It was nice because you was actually, slowly but surely getting yourself better but also going out and doing everyday things which you would do but still coming back to your safe haven (Jackie, 139)

Participants discussed the nature of safe space in their experience; space was talked about as both a physical space away from others and as a mental space

away from the responsibilities, worries, or expectations of “reality”, where they could think or re-focus.

So it's like when I was there [on the ward] I didn't have [family] constantly calling me or always interrupting me, I was able to like be by myself and think (Natasha, 70)

I don't know what it is, 'cause when you're on the ward you're just on the ward [...] you ain't got to worry about too much at a time. (Ami, 88)

they was making sure that you was alright, whereas when you was at home you don't get that, you're main thing is... you're the mum, you're the wife, you've got to get on with it (Jackie, 177)

All participants described different troubles and pressures they experienced at home, but all reflect the need for a “pause” (Ami, 93) or time out from these realities. The real pressures discussed ranged from physical health problems of both self and dependants, long term mental health difficulties, social problems (homelessness), and relationship difficulties.

Participants also discussed needing to be looked after and supported by staff. Jackie described receiving psychological support on the ward which encouraged her to face situations which she struggles with in the community. She reflected on how support from staff helped her to learn how to manage and recognise her own ability to cope. She refers to the staff as a safety net, indicating a trust that their presence would support or “catch” her should she “fall”, or encounter difficulty.

It does learn you how to sort of relax, take deep breaths [...] it's showing you, yes, you can do it, but you also know that there's someone nearby if you do need it, yeah they're the safety net (Jackie, 270)

Some participants also described practical support provided for them both in hospital and post-discharge. Susan described the below support on the ward as evidence that “there are people out there who really care” (Susan, 73).

Even the nice nurse brought me in a chair so I could sit in the shower [...] He even draws my curtain for me, he come in my room and draw my curtain for me and brought me tea and toast [...] I felt like I was being waiting on, I felt happy (Susan, 50, 65, 105)

Both Susan, Natasha and Kiera all described support planned for them post-discharge to help them in the community.

then she [psychiatrist] was, then call a meeting with her and someone else and a social worker, and... to kind of think that how can we make the environment at, the home environment, more, um... um.. better you know. So it takes um some stress off of me (Kiera, 284)

Finally, participants discussed the need to be heard, respected and taken seriously. Kiera described admission as an experience of validation, understanding the need for hospital as a recognition of the extent of her difficulties.

I felt like the people around me didn't really take my mental health seriously, they just thought "she's really sad" [...] My parent and my, my siblings, they realised that, hold on a second here, somethings not really right, um and they said that you know, maybe she does need to be there because of how she's feeling, so that's a validation to them and everyone else in my community as well that this has impacted me (Kiera, 73)

Natasha talked about a similar experience, whereby she experienced her family's reaction to her hospitalisation as a sign that they cared for her and recognised her distress.

I'm not very close with my mum and like my sisters and stuff, so it's like the fact that they come all day to the hospital for me, that the way they was crying and the way they was it's like wow, they actually care (Natasha, 55)

Being heard allowed people to be included in decisions and feel respected. Jackie related conversations she had with staff surrounding admission, and treatment options. When doing so she relayed conversational extracts which I felt indicated the feeling she had had of both listening to the other and being heard herself. In the quote below she talks about the process of getting medication right as collaborative, using the word “we” to indicate she felt a part of the process. She said these conversations made her feel “like the adult I’m meant to be” rather than a child, which conjured up ideas about being respected and listened to.

because while you’re there then they’re levering it up for you [the medication], you know and then on the last week I found myself like brilliant, and they just kept asking like, and I said “no, I said there it’s muffles it’s not the voice” then we knew that the medication was working so they kept asking you “[...] how you feeling?”, I go, “I got muffles, not voices” (Jackie, 241)

Jackie goes on to reflect that increased expression throughout admission helped her meet her needs and problem solve with others, she discussed experiencing being heard as key to working towards recovery recognising that “if you talk more there is always a solution and you can get a bit of help” (Jackie, 228).

3.2.1.2. Barriers to Meeting Needs

This subtheme is concerned with participants accounts of difficulties in meeting their needs. “Barriers” refer to obstacles defined by participants in having their needs met, some obstacles were physical, some interactional and some were psychological.

Some participants talked about difficulty and personal, psychological pain associated with acknowledging their needs, recognising how this made them harder to meet. They discussed the conflict between facing difficulties, and trying to hide by “distract[ing] my mind” (Kiera, 180) or “just kind of block[ing] things from my memory” (Ami, 251). Kiera described the pain of coming “face to face” with her situation as feeling like “a train had hit [her]” (Kiera, 181). This

graphic metaphor implies how physical the sensation of pain was for Kiera to bear.

Four participants discussed how the chaos and complexity of other people on the ward made it more difficult for them to feel safe. They questioned whether this chaos might also prevent staff from noticing the distress they were feeling. Ami's repetition of "constant" and "tense" seems to echo the sense of pressure and "busy"ness she describes feeling on the ward.

it was daunting for me as well that being in place, because I didn't know what other conditions... people were gonna react, am I safe you know am I safe? (Kiera, 309)

But yeah the ward's very busy and they've got to deal with a lot of people all the time and it's constant, like constant, like new people [...] sometimes you've got people just in the way, you've got the nurses there, they might be trying to do something, um and then you got people, as soon as they see them they're just jumping on them [...] it's kind of, they seem tense innit, everyone seems a bit tense. (Ami, 60)

Susan, Kiera, Natasha and Ami all talked about things that had made it hard to feel heard and validated on the ward. Kiera referenced conversations that she was told would take place, where professionals would talk about her but not include her.

when I said, you know "when can I leave?", they'd say "oh, we have to, we have to have a discussion with a psychiatrist to, um you know, just ask when the, the best time for that is. (Kiera, 375)

Ami noted that language used by professionals often made it hard to understand them or feel included in conversation.

I don't understand the language when they're all talking to each other when they do that you know when they say "section code dadadada..." (Ami, 211)

She discussed how inconsistencies in staffing on the ward made it feel like important information was lost.

I spoke to a couple of doctors but every day you're there it's kind of a different doctor, so say on the third day I'm there, I spoke to a doctor, he'll say we're gonna put you upstairs, and then the next day the doctor was saying they're gonna kind of discharge you, so it's kind of confusing and it kind of left me in a, a kind of a way (Ami, 28)

She shared hopes for better communication and more inclusion in the service. She seemed frustrated that staff had not communicated better and been more inclusive, when she felt that to do so would be relatively "simple" and make a big difference.

I just wish that people could actually, work together to make things go smoother, when it, it includes the patients and the doctors. [...] we need to learn how to communicate to get things done ... simple (Ami, 259)

Kiera, Natasha and Ami all described a conflict between disclosing how they felt in order to receive the support they needed, and a fear of further confinement should staff know how they truly felt. Ami and Kiera reported that this meant their needs may have gone unmet where they could have received support if they'd felt safe enough to acknowledge it.

If you're honest, completely honest about how you feel then they'll keep you longer, and it's like you don't want to be there longer, you want to go home, and it's like, but then if you don't open up fully then you're not gonna get the right, the help you need. (Natasha, 136)

For Kiera, pressure to not disclose was also applied by her family:

I remember everyone saying to me is just, you know, "just tell everyone you're fine and then they'll let you go home", and I'm like "I don't think that's how it works, um, I'm not fine, that's why I'm here" (Kiera, 138)

Both Kiera and Ami suggested that their silence was compounded by feeling threatened on the ward. Both participants report using a “survival kind of instinct” (Kiera, 146) they had developed growing up, which involved being “quiet” and trying to appear “normal”. Both participants expressed that their attempts to keep themselves safe by keeping quiet may have masked the extent of the need they felt.

because I’m kind of quiet I don’t stress how deep my actually issues I’m going through is, so maybe it doesn’t seem to them that it’s as raw as it is (Ami, 321).

When I was growing up I wasn’t safe and I was, you know, I was abused as a child so, I was, it was so paramount to me to try and keep myself safe and at the same time try and keep everything normal [...] I think that’s why people feel like they’re not taking you seriously because I’m not screaming I’m not shouting like people seeing victims behaving like, (Kiera, 405)

Here the ward experience is likened to past experiences of abuse and danger, which really highlights the threatening nature of the experience. The presence of threats on the ward acted as a barrier to feeling safe or heard.

3.2.2. Theme 2: Boundaries

The theme ‘Boundaries’ picks up on recurrent and often paradoxical ideas around experiences of limits in various aspects of admission. Here “Boundaries” are both defined by a sense of containment and safety, and by the notion of limitation and entrapment. Participants described positives and negatives of limits on their freedom (both physically and more abstractly) and the care they received. Often boundaries cause an experience of conflict and frustration for participants resulting in feelings of confusion, mistrust, silencing and invalidation. In this way the theme of “boundaries” linked to the theme of “need”, as consequences of inconsistent or oppressive boundaries often meant that needs were not met.

3.2.2.1. *Boundaries of Space*

This subtheme relates to participants experiences of the physical space of the ward, its rules and its atmosphere. Space is also defined in terms participants experiences of boundaries on their movement within space. Finally, space is discussed as an abstract experience of “mental space”.

Participants talked about the physical space they inhabited on the ward, the boundaries around it, and the limits on their physical freedom. At times this space was referred to as containing and necessary for safety, or as a positive break from reality. However, there was also an experience of the space as tense or threatening and a fear of being confined to it. All participants talked about how the boundaries of the space related to their experience of being “voluntary”. The legal status changed their experience of the space, giving them more freedom to “do what you want to” (Natasha, 121).

when you go in voluntary you're not confined, you can go downstairs and have a coffee, you can go out walk around the grounds (Jackie, 51)

Jackie indicated that this physical freedom is mirrored in a mental freedom, giving her the experience of having “a bit more freedom in yourself” (Jackie, 449). Susan and Natasha also talked about a more abstract idea of space. They experienced that as well as the physical boundaries of space, being “voluntary” changed the boundaries of surveillance, meaning they were not “hassle[d]” (Susan, 177) and consequently had more “personal space”. This comes across quite graphically when Natasha indicates that people are not “on her”, giving the impression of having a physical weight taken off her back.

When you're voluntary [...] it's like the staff is not always on you, it's like you are, you are able to go out and come back in like (Natasha, 170)

Participants also acknowledged limits to these changed boundaries. They discussed rules that limited their freedom of movement on and off the ward, and the impact of being watched or monitored. Some participants experienced these rules as fair, necessary for safety or as an indication that staff cared:

we had to let them know where we was and what we was doing [...] that was ok because, how can I put it, you felt like they cared (Jackie, 311)

Some participants described monitoring or boundaries as more invasive, and although they recognised the need for safety, they shared frustrations with the restrictions in place, finding they reduced privacy, respect or freedom.

being like in that space and being restricted to certain things [...] like you can only charge your phone in the local room [...] it's just like, not being able to, you know like, you're used to like your vibe and like at home your things and everything and it's like I was there for two days and then it's like after the second... you it's like you've had enough. (Natasha, 140)

they'd just pass by, knock and look through the window and see that you're ok or whatever, and there are times that if you don't respond that they will come into your room, and they have a key so they can just basically come in the room whenever. Because for them I think it's more to do with, you know, we need to make sure this person's safe, [...] It was very, I feel like, I don't know what you call it, like fish-tank experience, like I'm here, and I feel like I am being, I have no privacy basically (Kiera, 266)

they search your clothes, when you go in there to see if you've got anything drugs [...] my mum said "how dare they go down the clothes that I brought you in" (Susan, 141)

At times these restrictions seemed to contradict the rights they had as voluntary patients, and lead to frustration or confusion.

people told me I could leave if I wanted to it's just I had to notify a staff where I'm going and when I'll be back that's it, but um that was not practical when I actually was, tried and so you know, even when I said, you know "when can I leave?", they'd say "oh, we have to, we have to have a discussion with a psychiatrist to, um you know, just ask when the,

the best time for that is.” So, although it was a voluntary admission, I don’t feel like anything else was voluntary. If that makes sense. (Kiera, 373).

Participant accounts suggest that a balance had to be kept in order to create containing boundaries that felt safe but were not oppressive.

3.2.2.2. *Boundaries of Choice*

The subtheme, “boundaries of choice” refers to the limits inherent in choice, it considers participants experiences of being offered choice and the boundaries of how true an experience of choice they really felt. Again boundaries were sometimes experienced through external opportunities of choice being given or not, and sometimes experienced in a more abstract or psychological way. In most cases participants discussed choice in respect to admission or discharge. Participants talked about having increased choice, often in relation to voluntary status but raised questions about the limits on, and difficulties inherent in that choice.

Jackie talked positively about her experience of choosing to come onto the ward; for her it stood out as being given choice in her life that she has rarely received. She relates experiences of boundaries on choice throughout her life which she associates with her status as a person with “mental health issues”. For Jackie, any choice seemed to be experienced as more choice than she may normally have.

when you have mental health issues, all your life you’ve got people making your choices for you [...] so it was a big difference because it was my choice whereas all my life other people made choices for me, like today me going in Morrisons was my choice. And I done it. You know and as soon as I went into the hospital I done it, so that’s two things I can put up that I’ve done, not other, other people telling me to do. (Jackie, 521)

For some participants choice at admission represented recognition of their needs and a sense of ownership or responsibility for their recovery.

I realised that I got to help myself, I thought if “I don’t get help...”, I thought “make a decision to sit in that hospital mate and get on with it!” (Susan, 284)

However, for many of the participants this was a difficult choice. Four participants talked about an internal conflict they fought when acknowledging their need for support and considering hospitalisation. For some participants this difficult choice was linked to the difficulties they had acknowledging their needs (see theme above). However, participants also talked about their fears of what the ward would be like and how these expectations made it difficult to admit themselves to hospital.

I didn’t want to, but it was like, my gut instinct was telling me I need to stay (Natasha, 29)

alright it was a bit frightening [...] I thought like they was all against me, they were gonna be nasty to me in the hospital, nick my money (Susan, 357)

when I first got there, I couldn’t go through the door, I got up like to the ward and then all the panic come in [...] ‘cause number one I didn’t want to go into the hospital at all, number two I knew I had to, you know what I mean I really knew I had to get some help (Jackie, 49, 124)

Jackie stated that by making the choice to go to hospital voluntarily “When you go in you’re not fighting” (Jackie, 449). When interpreting participants’ accounts of making the choice at admission, I wondered if perhaps the fight at admission was not an interpersonal fight with staff, but instead an intrapersonal conflict. For some overcoming this conflict and choosing hospital despite difficulties represented an achievement and sense of acceptance of their needs.

the fact that you’re able to make that choice as well, [...] it’s like you know and you’re willing and you’re finally like accepting the help. (Natasha, 162)

However, for Kiera, taking ownership of the choice to be admitted was associated with an experience of guilt for making the choice to leave her responsibilities at home:

it made me feel guiltier, in the sense that I'm voluntarily leaving both my kids (Kiera, 71)

There were also questions raised about the nature of the choice given. Some participants expressed that although they had a choice at admission, voluntary admission felt like the only choice available, either because the alternative was sectioning, or because of the despair they felt at their own situation. I questioned whether one can truly make a choice if they have no other options?

I've got a choice I can either be stuck there or voluntary... she said, "if I haven't heard from you in a couple of hours then we will have to sanction you" (Jackie, 119)

I phoned an ambulance for my own safety, I thought I was gonna die. (Susan, 120)

Choice was also limited by an experience of pressures to appease family members at admission:

I had my mum crying, my sons crying "please Mum go and get the help", and I said "yeah I will" but I kept putting it off, [...] I think that I'm not fair on my family- get through the door (Jackie, 504)

Finally, I wondered if some accounts highlighted a lack of choice through reduced capacity. Kiera and Natasha talked about feeling completely overwhelmed and exhausted at admission and struggling to engage in the decision-making process, being inclined to agree to suggestions made to them, as that was all they felt able to do.

I literally just wanted to sleep. It's just like, I really want to just get through the [admission] process so I can just really, just sleep. (Kiera, 538)

I was really hysterical as well, so it's like I didn't like, I wasn't really thinking much I was just like, ok if it's what I need it's what I need [...] when I spoke to my sister or I spoke to my friend, I just listened and "it's ok", normally I'd be like "no... but...", I wasn't myself if that makes sense (Natasha, 231)

The fact that participants suggest they did not feel fully themselves, might raise questions about whether they felt they had "capacity" to consent to admission or not.

Participants also shared different experiences of choice around discharge. Jackie experienced being included in decisions around discharge whereas other participants talked about the power held by professionals to make decisions around discharge, and a feeling of reduced choice.

but he [doctor] does ask you, do you think you're ready to go home? [...], if you don't feel ready they don't let you go but, you know if you do feel ready then you come straight back so you've got that choice (Jackie, 233)

I'm not too sure who was involved with it [...] they just writ up a housing letter and sent me on my way the same day, do you know what I mean, that's the same day they decided to discharge me, when really I've got other issues that kind of make me feel low (Ami, 34)

Ami seems disappointed that staff "just" wrote her a letter but missed what was "really" wrong. She suggests that had she been included in discharge decisions her "other issues" may have been heard. She described feeling "low" as a result of this exclusion; this word suggests a shrinking that could be interpreted as a feeling of reduced status or powerlessness.

Where choice was given it had the potential to increase acceptance of need and agency in recovery, however where boundaries on choice were experienced participants describe experiences of disappointment and disempowerment.

3.2.2.3. Boundaries of Expression

This subtheme relates to participants experiences of boundaries on their self-expression; this relates to both verbal expression and expression emotion. Boundaries experienced related to external powers, threat, and judgement and internal fears. Participants accounts explore what they experienced that they could and could not say, and to whom.

Participants alluded to a fear of what the consequences might be should they express their opinions of their true experiences on the ward. Susan and Kiera, told me about things they had witnessed that they were unhappy with.

they had to restrain him, and that was sad for me, and I thought “oh god, what they doing that little, that boy, he’s only young!” (Susan, 94)

Because I did feel like saying, “hang on if I’m voluntary here then I should be able to go out” (Kiera, 370)

In both cases participants expressed a sense of anger or sadness at injustice, but only “thought” rather than said what they felt when on the ward. Ami talked more explicitly about this experience as having to “bite her tongue”.

when I stress something that I care about it can seem really aggressive, that’s why I had to bite my tongue, also because it’s very intimidating when doctors and nurses are there that don’t really want to help you with things and immediately you’re scared [...] if patients are out of control then they like come and give them this sedation, like a really strong one so it just puts them like kind of to sleep, conked out for 70 hours and that, so that’s kind of fearful (Ami, 285)

For Ami, witnessing use of force on the wards, and the uncertainty about the threat this posed for her, reduced her freedom of expression. This silencing

meant that participants didn't challenge the things that they felt were not right, and increased mistrust between patients and staff. Where Ami uses the phrase "bite my tongue", she also indicates that keeping silence is causing her pain, perhaps referencing feeling uncomfortable not calling out perceived injustice, or perhaps referencing how keeping silent reduced her ability to communicate her own needs.

Jackie, alludes to this fear of expression discussing the differences between speaking to staff ("clinical people") and other patients ("normal people") on the ward. She noted that speaking as a group of inpatients she was less scared and could be more open, and in this way, she encouraged others to speak out.

When they're clinical peoples you seem to clam up more, whereas these were normal people like you, you all had different problems but you seemed to talk about them, and then when we did go into the meetings with the psychologist, we said more than we ever would because we felt a bit more confident because it was the same sort of group, and we even got a couple of the others that was sectioned actually speaking out because we had (Jackie, 68)

She describes professionals as "clinical peoples", indicating a sense of "otherness" she felt towards them. This otherness seems linked to an idea that they may not understand her, or a deeper mistrust and fear of how staff may use the information she gives them. She implies a sense of strength in unity when speaking as a group, indicating she needed strength in numbers of "normal" people, to match the strength of power of a "clinical person", and highlighting an experienced power divide between herself and staff.

Boundaries around what could be said to who were also reflected throughout the interviews in what was left unsaid. Both Susan and Ami said during their interviews that they "can't grumble... mustn't grumble" (Susan, 257), or "I ain't really got any complaints" (Ami, 176), however this contradicted the experience they shared with me. I reflected during each interview that participants had often omitted more negative details about ward experience, and alluded to rather than named things they saw. I wondered if their accounts were "honest, [but not] too

honest” (Natasha, 182) or if in a sense they were trying to “just do as [they’re] told” (Susan, 48). Ami, told me “I’d be scared to go back again, coz of [the interview]”. Although she laughed after saying this, there was a sense of concern about the power I held in my position, and the links I had to the hospital. Despite my attempts to reassure participants that I wanted to hear their honest experience, whether positive or negative, and assurances about confidentiality, I reflected that my status as “interviewer” or “academic” may have been associated with a level of power that allowed certain things to be said, or not to be said.

The boundaries on expression were born out of fear and threat but served to perpetuate mistrust. They caused a silencing which meant people felt unable to speak about unjust or unethical practice they witnessed and reduced the level of accountability on the ward.

3.2.2.4. Boundaries of care

This subtheme relates to participants experiences of “care” in a hospital setting; primarily care received from staff. Participants experiences of boundaries relate to the boundaries they felt existed in the care they received, both in the interactions they had with staff, the temporality of the hospital experience and the reach or effectiveness of treatment.

Participants talked about the paradoxical roles staff held in keeping them safe and being supportive, and administering restraint or forceful practice. This conflict is apparent in the themes above, where staff were seen as both supportive and threatening. This paradox is captured in the quote below where Susan talks about her doctor, simultaneously describing him as helpful, and as threatening.

he had ginger hair I used to call him all names, “ginger nut” and “ginger biscuit” and “you ginger bastard let me out,” but that man was so helpful (Susan, 420)

Participants also discussed the limits of the care that professionals could give and raised questions about the role of staff. Ami grappled with the fact that

caring jobs are indeed just “jobs” but that the role seems to demand a level of integrity in the care provided, and more is expected of staff than just going through the motions. She referred to them as becoming “desensitised” by the work and not as receptive and caring as she might have hoped.

you know sometimes some of the staff there don't want to be there, you know, you know that you can feel that so that's, that's very upsetting, coz, I don't know why, frustration or desensitised something so it's; like a lot of the people are just there for the pay cheque, which is hard to say but that's what a lot of people do things for anyway (Ami, 277)

Participants recognised the limits of the reach of care and support in both time and place. Susan and Kiera spoke about staff making them aware that hospital admissions are temporary. This brought up a conflict between wanting to be looked after, and feeling they could not rely on the care that will disappear, it seemed they felt discharge was out of their control

he said to me “right, you can't stay here forever [ppt name],” I said, “I know I can't [staff member]” (Susan, 463)

they said they usually don't keep people here for more than 10 days because, that can make them... what's the word that they used... um... it's not the word comfortable... attachment [...] I felt, there was just, there was different feelings. One of them was that, “Ok you will eventually be told to leave here, they're not going to keep you here for more than 10 days so that's good” but then the other, the other thing is that you felt like um, “how am I going to feel when I have to leave.” So, it's two different types of feelings that are the opposite of each other. (Kiera, 339)

Although she corrected herself, Kiera described a memory of being told not to get “too comfortable”. I wondered if this echoed the feeling she experienced being told she would have to leave. I wondered if she experienced that she could not get too comfortable on the ward, perhaps implying a sense that the staff wanted her to be un-comfortable, an experience that might have felt rejecting.

The concern about the temporality of support was reflected in others' accounts. Ami and Jackie recognised that post-discharge the same difficulties and fears they faced at admission were still waiting for them at home.

it's kind of like your life pauses for a minute, you know what I mean, so you can breathe, and then you have to get back to it once you're off
(Ami, 89, 182)

It was scary like coming back into this big wide world again you know I've got to face all these people (Jackie, 565)

Though Jackie felt more prepared to manage her fears, Ami expressed that she was still feeling deeply distressed and was unsure how to access further help. She was visiting her GP following the research interview in the hope of receiving further support.

Participants also recognised limits of the effects of treatment and hospitalisation. Susan shared a feeling of despair that nothing really makes problems go away altogether. This frustration was shared by Kiera who experienced emotional pain as impossible to remove through admission alone.

Interviewer: What do they do that's helpful? Susan: oh I don't know, there's no easy way out is there, no easy way out mate, I don't know
(Susan, 299)

when you're in the hospital there's none of that, they're actually sitting there just in pain and you know, you can't you can't give, like what do you give for the pain you know, like for example when I was having the kids -lots of pain- and you know they gave me an epidural so things won't.. and I'm going through this pain but what could someone give to me to... I really wish there was like an epidural effect for the mind (Kiera, 485)

Kiera compares physical and emotional treatments for pain, in doing so she highlights a paradox between wanting to understand both physical and mental health in the same way but recognising the inherent differences in the causes of the two types of pain. She acknowledges the limits of treatments available for emotional distress.

3.2.3. Theme 3: Identity

The final theme, “Identity”, refers to how participants experienced themselves during admission. Here identity is defined by people’s understandings and experiences of who they are and how they are perceived. Participants talked about judgement, both in terms of self-judgement and judgement from others; related to this, they talked in various guises about themselves in relation to “mental health crisis”. Finally, participants talked about changes in experience of the self over admission.

3.2.3.1. Judgement

In this subtheme “judgement” relates to how participants judged themselves or experienced being judged by others. These judgements related to their personality, ability, and moral character. All participants discussed an experience of negative judgement, both from self and others. It was evident that a voluntary admission to some was experienced as a failure of self, and an indication that they had not managed to cope alone. Kiera talked about how her admission was experienced as further confirmation of pre-existing feelings and thoughts that she was failing as a parent.

I started to think like, that’s when it went a bit more, like more when I felt like the children were more at risk at that time because I felt like I can’t do nothing for them now (Kiera, 88)

Ami and Susan talked about how being in hospital indicated that their lives had gone wrong. They seemed to place blame on themselves; alluding to an experience of responsibility for the difficulties that resulted in their hospitalisation and telling themselves it was them who needed to make a change.

I felt like, “well that’s shit, rock bottom again [...] when you’re on the ward you have to try to change your life bruv, because you can’t be, can’t be doing that all your life (Ami, 244)

I thought to myself well, just, just sort your life out, sort your life out you know (Susan, 183)

Feelings of shame, guilt or failure were exacerbated by judgement or perceived judgement from others. Kiera talked about her family’s reaction to her hospitalisation. She described how they questioned her on admission, seeming to blame her for going into hospital. She describes a feeling of guilt at leaving her children which was exacerbated by a sense of being judged for doing so by family and society.

You voluntarily going there, that has ummm the, the stigma to it, and I got told off as well, by some family members when I was there, that you know, “how can you do this?”, and “what about your kids”, and you know, “the social people are gonna come and take them away” and all of that [...] if you’re going to tell them that there’s anything wrong with you, your children might be taken away or, you know, you’re... you know, you might get in some problems when it comes to Social Services. For your children, tell everyone that you’re OK and everything is OK. But then again, if something happened to me or the children on a later date then who would, you know, then who would turn around and say “well, she should’ve sought help.” (Kiera, 540)

Natasha talked about her fears of judgement from others and concerns about what her family or friends might think. She noted that her friends had talked about suicidality and mental health as “selfish” (Natasha, 62) and indicated that at times she had felt embarrassed or guilty about admission. However, she experienced that her family did not react as she had feared; she described battling feelings of guilt or judgement in order to look after herself.

Um, so at first I don’t know I felt, in myself I was embarrassed like at first, it was more, because it’s like, “I’m here” and it’s like, “what will people

think?”, and what I did and everything, but then like at the same time it’s like, it’s how I felt, and it’s, I shouldn’t like care about how other people, it’s like how I thought myself and like just the fact that I’m getting the help now and I’m trying to do things for myself (Natasha, 77)

As well as fear of “social stigma” (Kiera, 533) related to admission, participants talked about an experience of judgement and assessment from staff on the ward. Kiera and Natasha referenced an experience of feeling they needed to prove their innocence and make their “case” (Natasha, 170) to be granted voluntary status. Ami talked about the experience of being “judged as a crazy person” on the ward, she said it’s “not easy”, (Ami, 134); she seemed to imply that by being on the ward you were open to judgement by staff and how you acted was important in being judged and treated more, or less, favourably:

I got judged as, I would say someone that’s just going through a stressful time, you know “she’s, she’s alright, it’s just a stressful time” so not so much for me, but you know there’s other people, you can see that they don’t really like that person innit, cause they’re annoying or they’re over the top or they’re too much you know (Ami, 153)

Judgement from self, family and staff on the wards increased a feeling of shame and identity of self as failure or self as bad.

3.2.3.2. Identity and Mental Health

In this subtheme, “identity and mental health”, refers to participants accounts of experiences of themselves in relation to their understandings of their own and others “mental health”. Participants often referred to diagnoses, understandings of mental health difficulties and expectations of mental health services when making sense of their experience, their sense of self and the sense of others around them. This was often linked to experiences of judgement (see above subtheme). In some instances, these understandings built a sense of connection, belonging and validation, whereas in others they were associated with “otherness”, difference and threat.

Some of the participants talked about sharing a sense of identity with others in the hospital. Feeling connection and friendship, or a sense of kinship that was accepting and allowed learning and support to take place through shared experience.

you're around the other people that's gone through similar stuff to you, so it's like they understand what you've been through and what you're going through and it's like nice to like hear other people stories, and like, how they dealing with things, and it's like you can benefit from each other.
(Natasha, 114)

out here, I don't have friends I just have my family but now I do. I have four new friends so it, it was nice to get to know people [...]it was the four musketeers always went together you know it was always look after each other (Jackie, 218, 310)

Jackie describes herself and others in hospital as the "four musketeers". The "Three Musketeers" motto is "all for one, and one for all". This indicated to me that her connection with others led to an experience of support and a sense of unity. Susan also talked about having friends and community within the "mental health" world. She seemed to identify as someone with "mental health problems" and found that she felt safer and better understood around others who shared this identity.

"I've got a lot of friends in the mental health and I still go about with my mental health people and they look after me." (Susan, 28)

Jackie and Susan described a sense of camaraderie with others on the ward. They experienced empathy for them and an urge to stand by them and offer support. In some ways providing this support seemed to give them a sense of role or purpose.

I looked at him and I said, sit down [patient's name] let's have a cup of coffee, so I put the table there and I made him a cup of coffee. He really

liked me, he said to me “thank you lady, thank you for helping me”
(Susan, 96)

Ami also recognised this sense of camaraderie between people on the ward, however she described feeling outside of it. She noticed a tension between staff and patients. She describes feeling like she needed to get away from both groups (patients and staff). She was concerned that by identifying closely with one group she would be putting herself in danger. For example if she joined closely with patients and there were disagreements between patients and staff she was concerned someone would be sedated, and she did not want to mixed up in this.

patient’s kind of split into a group and you know, this one’s going through problems and this one wants to help this one or something like that, it becomes like a unity and it’s almost like a division with the staff sometimes coz the tension [...] I just thought like “shit man, I need to get out of here” and also, you know what I mean, I don’t want no-one to get that sedation thing, so I kind of, that’s why I wasn’t involved (Ami, 300).

Keira also talked about staying separate from others on the ward, but described feeling different to them.

I did see a lot of things, I saw people falling apart [...] me being there was like Alice in Wonderland [...] I felt like I was really different to everyone else because I feel like I am still in touch with reality. (Kiera, 306)

She identified herself as “sane” and others as not, likening the experience of hospital to going ‘down the rabbit hole’. However, unlike Alice, she seemed less curious or frustrated by this ‘insanity’ and instead, experienced others as dangerous and scary.

This sense of difference to others on the ward was picked up by all participants. It was often attached to the “voluntary” status. The status led to an identification

of self as “less mad” and an insinuation that their experience of “mental health difficulties” may not have been as bad as others.

I know we've all got mental health problems but I think some are worse than others and some are more frightening than others (Jackie, 102)

if you're sectioned or something, it's like more secure, like there's more, like there's staff members, like you're constantly being watched and like security and stuff, while when you're voluntary and like, you've made your case and everything it's like the staff is not always on you (Natasha, 168)

For Jackie and Susan, voluntary status seemed to be understood as privilege and added to their previously mentioned sense of responsibility towards others:

When its voluntary you think “right, well I'm older, I, I should be showing an example” and it seemed that others did start following me and even the nurse said this (Jackie, 403)

Some of the differences between how people identify with others and relate to the concept of “mental health difficulties” may be linked to their understanding of “mental health problems” themselves. Some participants talked about their diagnoses as things outside of themselves that had a degree of power over them. In these cases, participants described the diagnosis as controlling which seemed to lead to a sense of self as helpless or unpredictable and of hospital as inevitable.

with depression it is hard and it's like it does get to a point where you feel like it's the end of the world. You just want to give up (Natasha, 90)

I know it's not the best of the place, hospital but like I said bipolar is worse than cancer [...] with bipolar you never know one day from another (Susan, 475)

I don't know when I'm gonna be up properly or when I'm gonna be down
(Jackie, 194)

The idea that people with mental health 'disorders' are powerless, or out of control was also apparent in participants' experiences and understandings of others on the ward.

I didn't know what other conditions... people were gonna react, am I safe you know am I safe? Because I don't know the other patients, I don't know what they're suffering from (Kiera, 310)

this specific one went off about three times you know, so it was... I know she couldn't help it, but she was aiming for us at the start (Jackie, 96)

Jackie talks about one woman on the ward "[going] off", this conjures a picture of unexploded mines, and a ward experience of tip toeing through a mine field never knowing when another inpatient might explode.

Some people held conflicting views on their distress, although Kiera talked about "suffer[ing] with depression" she also understood her difficulties as the result of trauma, which she suggested meant she was more "in touch with reality" (Kiera, 328) than had she been simply "mad". Ami talked about her own, and others', distress as resulting from life's difficulties and how people were able to manage them. This different understanding of distress was visible in her frustration with herself or others on the ward as it placed some responsibility for managing distress with the individual experiencing it.

... the reality of like people's lives, of seeing what trauma and stuff can do to people, [...] I got judged as I would say someone that's just going through a stressful time, you know "she's, she's alright, it's just a stressful time" so not so much for me, but you know there's other people, you can see that they don't really like that person innit, cause they're annoying or they're over the top or they're too much you know, they don't stop (Ami, 128, 153)

Differing relationships with and understandings of mental distress, diagnoses and disorder seemed to shape beliefs and consequential experiences, of both the self and the other on the ward.

3.2.3.3. Self-Transformation

In this subtheme “self- transformation” refers to participants experiences of a sense of change in their self or “identity” in relation to their experience of their hospital admission and stay. Most participants discussed elements of self-transformation during their interviews, referencing self-repair or a sense of change for themselves. Participants talked about building a sense of hope, taking a new direction or gaining a different perspective.

Jackie, Natasha and Ami all referred to a broken sense of self before admission; they talked about feeling fractured or “not themselves”:

I wasn't myself if that makes sense (Natasha, 236)

The fractured self was reflected in participants' accounts of admission which were often retold in a fractured manner, jumping back and forward in time. Jackie suggested that when she first entered hospital she did not feel “human”, but regained this humanity over her stay:

When you go in you, you're not yourself you know, you you're a tramp, I'm sorry, but you lose all interest in yourself [...] but as the week goes on by the second week you're feeling a bit more human (Jackie, 345)

Participants described being “put back” together during the hospital stay and an experience of feeling more solid. They talked about regaining a sense of purpose or wish to live,

whereas when its voluntary it sort of gives you that little bit more purpose, you know I can cope with this 'cause it's slowly, gradually putting you back (Jackie, 259)

so it's like, even though being in there for them two days even it was like, I didn't want to do it at first, I'm happy in myself that I done it, cause if I didn't then I really don't know if I would be here now (Natasha, 150)

Participants talked about gaining a new or different perspective on life or themselves over their stay on the ward. Some said that witnessing others suffering added a new perspective to their own situation, for some this gave them a sense of hope, resolve or gratitude.

I just sitting there and I thought to myself well, there, my old dad used to say "there's always someone worse off than yourself" and that was it [...] it's just it's an eye opener, you look around at them poor devils [...] it was sad you know what I mean, I just thought well you got to get on with it (Susan, 187)

there's some people that've been there for six months and shit like that and it's like woah man, there's some serious, serious... that's serious you know what I mean, that's a long time to be on the ward, so um you kind of just feel, kind of grateful in a sense, [...] it made me realise it's not really where I want to be, stuff like that (Ami, 128, 142)

Natasha talked about gaining a new perspective on herself through the actions of her family and seeing herself differently in their eyes.

if I did actually proceed in ending my life, like what, would've been happening to them, it just made me think the bigger picture and it made me open my eyes (Natasha, 57)

Jackie and Susan also talked about changes in their self-confidence and self-belief that occurred during their ward experience. Susan talked about interactions at the hospital with staff and other inpatients helping her recognise her own ability to cope.

I thought to meself, "I am gonna cope, I'm gonna do this thing", indoors don't matter about the stick, but I thought like, even [friend?] with the one

arm, she said [participants name] “be brave, be positive”, and I said “yeh, I will, I will be positive” and the next minute I came home and got a cab outside (Susan, 54)

Jackie talked in detail about the changes she experienced in herself. She talked about gaining confidence through facing her fears in small steps with support and reassurance from friends and staff, and she recognised the impact this had on her confidence in her own ability. Her changes in self were illustrated through her descriptions of art she created over her stay in hospital.

as you're feeling more better in yourself and more... your paintings are changing and you can see that, as I said, the last one I done was like a country scene with a cottage and that, and it, you know, was a vast difference to when, to the first one and then going up and they got better and better as you was feeling better and more confident in yourself (Jackie, 370)

Participant experiences of the ward indicated that voluntary admission held potential for positive experiences of change, repair, and belonging. However, their accounts also highlighted the potentially negative impact on identity that ward experience might have through social and self- judgement and beliefs about mental distress.

3.3. Chapter Summary

The data showed that patient experience of voluntary admission included experience of needs for safety and validation upon entering the hospital. These needs were met through support and inclusion in decisions. Where needs were not met, this related to chaos on the wards, difficulties acknowledging problems, feeling threatened or invalidated by staff and witnessing use of force on the ward. Boundaries were implicit in experiences of freedom and care, leading to conflicting feelings of both security and powerlessness. Experiences of identity on the ward were linked to judgement, beliefs about, and relationships with, mental distress diagnoses and disorder, and experiences of self-transformation.

4.0 DISCUSSION

4.1. Summary of Findings

This study aimed to explore how people understand their experience of voluntary admission and the concept of the “voluntary” nature of the experience. It also aimed to gain some further insight into how these understandings might change over time. Three main themes were generated from participant accounts of experiences of voluntary admissions: “Need”, “Boundaries” and “Identity”. Some of the subthemes generated are present in the existing literature base whereas some subthemes arose that are little acknowledged in current research.

4.2. Discussion of Key Findings

Participants accounts of their experiences of voluntary admission yielded rich findings covering broad themes. The themes were considered in the context of existing literature in the field and attention has been paid to those findings which are most novel or striking. Findings that drew attention were those that have been repeated throughout literature for a length of time and have not changed, and those which are relatively unexplored in the current research base.

4.2.1. Safety and Validation

Both themes of “Need” and of “Boundaries” grappled with the concepts of safety, validation and freedom which have been highlighted as core issues with both involuntary and voluntary experiences consistently over the past decades of research.

The findings from this study indicate that people experience psychiatric admissions through an understanding of acute and intense need for safety, space, support and validation; their experience relates to how those needs are met or not met. Needs were met through containment, provided by staff interactions and physical boundaries, inclusion and respect. Where needs were not met, this was related to exclusion from dialogue, and the presence of chaos, coercion, threat and fear on the ward.

The study found people needed to experience the ward as a safe space where they are kept safe from themselves and from others, and to protect others through their containment. Safety and validation were both needs identified in Gilbert et al. participants accounts of their inpatient experience 10 years ago (Gilbert et al., 2008). Participants accounts highlighted findings from previous research (Koivisto et al., 2004, Miedema and Stoppard, 1994), showing that for different people the need for safety might be met through being kept away from real life burdens, responsibilities and potentially hurtful situations, and the presence of staff fulfilling a role of “care-giver” or “protector”. For some being monitored by staff provided a sense of containment experienced as more helpful when done transparently through dialogue, i.e. “checking in”.

The current study highlighted barriers to meeting peoples need for safety. and validation. In this study witnessing the use of force or violence on the ward, presence of coercive practice, reduced communication, surveillance and restriction of movement, broke down trust between patients and staff. Mistrust reduced important disclosure, made it harder for people to bear the anxiety around their vulnerabilities and increased fear of confinement. For some participants this meant that they struggled to meet their need for safety, as the experience of threat meant they felt unable to ask for, or accept, protection. When dialogue and communication were reduced, people interpreted the presence of monitoring, coercive and restrictive practices as related to the presence of threat posed by themselves or others on the ward, leading to feelings of tension, invalidation or mistrust.

It is widely recognised in the literature that feelings of safety and of validation are compromised in the presence of coercion (Gilbert et al., 2008). Negative pressures of coercion (i.e. threats or force; Lidz, 1993) have been related to higher overall coercion scores, experiences of humiliation, poor therapeutic relationship and reduced procedural justice (Kjellin et al., 2006; O' Donoghue, Roche, Shannon, 2014; Poulsen and Engberg, 2001; Cascardi and Poythress, 1997; McKenna et al., 2001; Lidz et al, 1995; Roche et al., 2014; Svindseth et al., 2007; Lidz, et al., 1998; O' Donoghue, et al., 2014). Forceful acts of restraint can be traumatic for staff and patients both partaking in and witnessing these practices (Bonner et al., 2002; Rose, Perry Rae and Good,

2017), and can lead to increased tension and likelihood of violent behaviours that may result in use of such practices; thus perpetuating a vicious cycle of coercion (Koivisto et al., 2004; Rose, Evans, Laker and Wykes, 2015). An integrative review suggested that the presence of violent practices on the ward (i.e. restraint) can change the experience of power or control for patients, and lead to conditions whereby people on wards feel dehumanised and silenced (Cusack, Cusack, McAndrew, McKeown and Duxbury, 2018). Where people feel powerless and trust is broken a positive therapeutic relationship is hard to build and positive outcomes of admission are harder to achieve (MaCabe and Priebe, 2004; Laugharne and Priebe, 2006).

4.2.1.1. Safety, Adverse Experiences and Mental Health

Understanding participants adverse social experiences may help to contextualise and understand their experiences of mistrust on the wards. There is growing evidence that experiences of acute mental distress can be mediated by previous experiences of a wide range of adversities; including bullying, discrimination and childhood abuse or neglect to name a few (Johnstone and Boyle, 2018). Trauma and attachment informed understandings of mental health have evidenced that adverse events can mediate biological reactions to future events and shape the ways we react to the world (Van der Kolk, 2014). In these ways physical and psychological responses to earlier life adversity can shape responses to the world to be more primed to protect the self from threat, making trust harder. Some participants in this study spoke directly of childhood trauma or adverse life experiences, whereas others spoke out of contexts linked with increased adversity.

Participants ethnicity, age and gender may also help to situate their individual narratives and help to better understand their lived experiences (Burnham, 1993; Smith, Flowers and Larkin, 2009). Literature suggests that themes of coercion and powerlessness may have been emphasised due to the gender of the sample (Miedema and Stoppard, 1994; Fiorello et al., 2012). Research indicates that women report higher perceived coercion during psychiatric admission than men do, (Anestis et al., 2013; Fiorillo et al., 2012), this is linked to research which suggests that women's position in society can lead to feelings of powerlessness which may exacerbate difficulties in admission processes

(Meidema and Stoppard, 1994). Additionally, women experience higher rates of adverse experiences of sexual violence and aggression based on their gender including domestic violence and microaggressions, meaning they are perhaps more affected by experiences of threat and find it harder to feel safe (Reder and Fredman, 1996; Read, Foose, Moskovitz and Perry, 2014; Johnstone and Boyle, 2018).

It is also of note that the mistrust and fear described by those of 'Black or minority ethnic' ethnicity (BME) may be best understood in context of discrimination and resultant powerlessness this population experience in society and in institutions. Research suggests that people from "Black Minority, Ethnic" communities have more experiences of powerlessness within society and are exposed to higher rates of coercive practice and experiences of discrimination in hospital admissions (Keating and Robertson, 2004; CQC, 2017).

Additionally, recent research also indicates that younger adults (aged 20-39) are more likely to be compulsorily admitted (Keown et al., 2016). It is notable that those younger participants were also of BME ethnicity and as such may have been affected by the intersecting impact of the multiple contexts they spoke from (Seng, Lopez, Sperlich, Hamama, and Meldrum, 2012).

4.2.1.2. Therapeutic relationship and good enough care

For the sample in this study mistrust and invalidation were perpetuated through experiences of limitations on care received in hospital. The study found that limits on care in patient experience were understood in terms of human limitations located in staff, hospital limitations relating to reach of care, and treatment limitations relating to the effectiveness of treatment. Patients experienced frustration when staff were unavailable due to the busyness of the ward, or if they appeared uncaring or "desensitised". Uncaring interactions constituted a lack of interest or understanding in conversation or cases of limited contact. These experiences of staff heightened mistrust. Despite the frustration it caused them, some patients recognised the difficulties of nursing work, and the "humanity" of not being able to provide perfect care at all time. Participants also experienced a frustration at the limits of the reach and effectiveness of care. Participants experienced anger at discharge coming too

soon, before real change in situation had been experienced, conflicted with a want to be home and not kept in hospital too long. People also commonly experienced a sense of hopelessness that treatments offered (namely medications), could not completely remove emotional pain, or change social circumstance.

Frustrations at seemingly uncaring or unavailable staff, and conflict around hospital discharge, have been recognised as a part of inpatient experience by previous research (Miedema and Stoppard, 1994; Gilbert et al., 2008, Koivisto et al., 2004). Wider conflict about the differences between patient need and ability of staff, hospital or treatment to fulfil it, is a conflict integral to mental health provision. Roberts (2003) recognises the “impossible task” placed on hospital staff, by both patients and the staff themselves, to remove emotional distress. The reality of the limits of effectiveness of treatments, particularly medical treatments, on real life problems can be difficult to bear. These limitations are rarely discussed in inpatient settings (Menzies-Lyth, 1990), meaning the gap between expectation and reality may often go unspoken and leave patients feeling let down, or hopeless, and leave staff feeling guilty or ineffectual (Severinsson and Hummelvoll, 2001; Hummelvoll and Severinsson, 2001).

The difficult task of providing “good enough” care and building trust is made more difficult by the interaction between the limits on staff discussed above (both on ability to care and on hospital resource), and previous experiences of care relationships of people admitted to hospital (Johnstone and Boyle, 2018). As discussed above and in depth in literature around the therapeutic relationships, adverse experiences affect our biology and psychology in a way that affects future relationship building. This may go some way to explaining how some participants in this sample experienced care limitations as abandoning or neglectful, repeating patterns of care they have received in the past (Reder and Fredman, 1996; Van der Kolk, 2014).

4.2.2. Stigma and Identity

The concept of stigma and its relation to participants views of themselves and others was an important theme in this research. It is an area that has not been

discussed at length in previous literature relating to voluntary inpatient experience but is discussed more broadly in relation to mental illness and diagnosis. The findings of this study indicated that people's experiences of admission were shaped by their experiences of themselves. People experienced judgement of the self, exacerbated by an experience of feeling judged by others. They understood their experience of admission in relation to their understandings of, and relationship with, beliefs about "mental illness", and diagnoses. Understandings of the self often changed throughout admission, often characterised by stories or repair and reparation of a fractured or broken self.

4.2.2.1. Stigma and moral judgement

The findings showed that experiences of admission can be equated with judgement of the self as guilty, or as a failure. Experiences sometimes seem to be understood within a framework of morality, whereby admission seems to be equated with "badness"; assessments and monitoring by staff on the ward, are perceived as trials where one must try to prove their innocence. Identifying self as a failure during admission was linked to understandings of admission as evidence that one has failed to cope, or is in some way responsible for not managing without support. This identification led to experiences of shame and were linked to conflict at admission between wanting to seek support and fear of what hospitalisation might mean. Experiences of guilt or shame were exacerbated by negative views of hospitalisation from family or by reduced or incoherent communications from professionals.

Evidence suggests that feelings of guilt or shame are linked to a stigma around mental health difficulties, that stigma acts as a barrier to help seeking, and that it is perpetuated by personal beliefs, family and staff interactions and wider social networks (Xu et al., 2018; Link et al., 2001; Livingston and Boyd, 2010; Clement et al., 2015; Wood Byrne, Enach and Morrison, 2018). Conflict around negotiating the "stigma barrier" in order to seek help was evident in people's experiences in the findings of this study.

4.2.2.2. *Stigma, the medical model, and the sick role*

The study findings also showed that admission was understood within beliefs and understandings about mental health and diagnoses. These beliefs could positively shape experience and create experiences of belonging but could also create negative experiences of the self or others. Some people identified as a “someone who suffered from mental health problems”. This identification was often related to identification with a diagnosis which allowed people to see others in hospital as “like them” and as having “shared experiences”, adding to an experience of camaraderie and union. However, this same experience could lead to a perception of staff as “other” and perpetuate the staff, patient divide. Research suggests that “othering” and “groupness” serve to perpetuate feelings of stigma and shame (Corrigan, Bink, Fokuo and Schmidt, 2015) which breaks down trust in relationships (Verhaeghe and Bracke, 2011), and that diagnoses exacerbate this divide (Corrigan, 2007). Correspondingly, evidence suggests that dialogue between staff involving openness and self-disclosure, breaks down patient/ staff divides and increases experience of safety and trust (Laugharne, Priebe, McCabe, Garland and Clifford, 2012).

The findings indicated that people’s identification as “mentally ill” was often linked to diagnostic explanations of illness and an understanding that the illness is a thing that they “have” or that “happens to them”. This was related to experiences of reduced control over the self, and an understanding of self as unpredictable. This same understanding when applied to others understood to be “mentally ill”, led to understandings of others as dangerous and unpredictable, and subsequent experiences of mistrust, threat and tension on the ward. Conversely non-diagnostic understandings of distress (i.e. trauma or stress based causal understanding), were related to a sense of increased control over the self, and an understanding of others as having more control. However, these beliefs were more likely to be associated with feelings of responsibility and shame. These experiences can be understood within research that indicates that diagnosis-led biomedical causal understandings of distress increase both internalised stigma and stigma to others (Schomerus et al., 2012; Larkings and Brown, 2017). Although such understandings reduce blame on the self (or other), they simultaneously reduce sense of control over

self (or other), and increase the sense of self (or other) as unpredictable or dangerous (Haslam and Kvaale, 2015).

This changed sense of self in relation to a diagnosis has been understood through the sociological theory of “sick role”. This concept, defined by Parsons in the 50’s suggests that when to be ill means deviating from being able to contribute to society (Parsons 1951, 1975; Williams, 2005). As such the role has become “policed by the health care system”. He suggests that the role involves obligations and rights. The rights afforded are legitimised removal of responsibility, and an understanding that they cannot do things due to an assumption of legitimate incapacity. The obligations are to comply with systems in place for help-seeking and recovery. Although the original notion of the sick role has been contested on numerable points it can still lend helpful insight into participants experience (Williams, 2005).

The concept of voluntarily choosing to be hospitalised could be related to the notion of choosing a “non-contributing” role in society and as such failing in some sense to meet duties expected of you, this sense of guilt was present in some participants accounts of hospitalisation. A diagnosis legitimises this decision and taking it on board can perhaps make the choice of hospitalisation easier. However, the sick role brings with it an expectation that you will try to recover. Long-term illness and the permanent nature of many psychiatric diagnoses puts people in a bind whereby they cannot fully “recover” and lose their diagnosis but they cannot contribute and have their sense of agency or capacity removed by others perception. This bind seems to be present in many participants discussion of choice at admission and of their thoughts about their own identity, how much agency they have and how able others are to control themselves.

4.2.2.3. Women and the sick role

The context of gender may help situate the experiences of the sample in this study. Previous research has tried to understand the sick role within the concept of gender roles. In this study it was important that the safe space in hospital was experienced as restful and a space away from burdens or responsibilities outside of hospital. All participants were experiencing relationship or socio-

economic difficulties outside hospital which they linked to their distress, and needed hospital to provide an escape from this. The role of hospital as “asylum” for women from the outside world is recognised in Miedema and Stoppard’s research (1994). They found women’s needs for respite from roles and expectations which may cause distress, was a commonly cited reason for admission.

Women are more likely to go to hospital voluntarily than men, and in general more likely to seek help from physical and mental health services (Keown et al 2016, Nam et al., 2010). Early research suggested that there may be something about women’s roles in society that means it is easier for them to take up the sick role, or that they are more likely to take up the role due to the extent of inherent in the “female role” (Nathanson, 1975). The present study indicated that some participants associated their societal roles with their understanding of their illness or need for hospitalisation.

4.2.2.4. Mental illness and fractured identity

The study also found that experience of identity changes over admission, through reparation or transformation. Findings indicated that prior to admission people experience a lost or broken sense of self. Participants described the admission as having a role in putting the self back together again, and building self- belief and confidence. A sense of repaired self was associated with safety, validation and inclusion in dialogue. Ideas of broken self in mental distress link back to Kleinian psychodynamic ideas about the fractured or split unconscious self (Roth, 2001). Previous research has recognised how a lost sense of self can increase a sense of vulnerability and the need for safety (Koivisto et al., 2004) and validation (Barker, 2001), and how sense making in a patient’s own language can contribute to feelings of reparation (Wyder et al., 2015). The idea of the “broken psyche” has been wound through psychological understandings of distress and have their roots in psychoanalytic theory. These ideas are still inherent in the language surrounding madness, such as the diagnosis “schizophrenia” which means a literal splitting of self. Although contested these ideas go a long way in helping understand the phenomenological experience of unconscious brokenness described by participants when thinking about acute distress.

4.2.3. The voluntary status

Participants' understandings of the voluntary nature of their admission were interwoven throughout their accounts. Ideas about the voluntary nature of the experience affected how they could meet their needs, how boundaries were experienced and how they experienced and judged themselves on the ward. Understanding of the concept of voluntary admission has not been explored at length in previous literature and is worthy of further consideration.

4.2.3.1. Choice and conflict

The whole sample for this study were aware that they were voluntarily admitted to the ward and all understood this to mean that being on the ward was their "choice". Voluntary admission was understood as a decision to face or recognise need and accept support. For some this was a conflicting and difficult experience related to feelings of fear, guilt or shame. Overcoming conflict and choosing to face problems, facilitated the possibility of feeling pride for having made a difficult decision, for the purpose of keeping oneself safe. The notion of acceptance of help and recovery is explored at length in Acceptance Commitment therapy (ACT) and corresponding theory (Hayes, 2016). ACT theory suggests that where a person acts in line with their values, accepting the difficulties that may be associated with this, they are more likely to reach a state of psychological wellbeing. When applied to voluntary admission, participants are valuing their lives and their safety, and acting in line with this value, despite the fears or shame associated with admission.

4.2.3.2. Choice and expectations

The study also found that where freedoms and choice associated with the expectations of voluntary admission were not completely or consistently communicated or were acted upon inconsistently, boundaries were experienced very negatively. The study indicated that they were perhaps experienced more negatively within the voluntary context as the limitations went against the expectations patients had of their ward experience, and the rights they should have been granted on the ward. The Social-Cognitive Adjustment model used in much health research and clinical practice (i.e. Lepore, 2001) understands mental distress as arising from the difference between expectation and reality, and the difficulties involved in adjusting to loss in that reality.

For participants in this study the experienced mismatch led to an increased mistrust in staffs' ability and motivation to help them meet their needs, and a feeling of threat or fear associated with feeling coerced. Quantitative evidence suggests that voluntary legal status may mediate the effects of perceived coercion in leading to worse outcomes of hospital admission (Kallert et al., 2011). The findings of this study suggest that negative outcomes could be related to the decreased trust caused by the gap between given rights and expectations and experiences on the ward, and the impact this has on patients' abilities to meet their recovery needs.

4.2.3.3. Privilege and protection

The findings also indicate that the concept of "voluntary" was understood to affect boundaries of freedom, choice and expression. People recognised a sense of privilege in having the right to freedom of movement in comparison to their sectioned peers. For some this led to feeling included in decision making, as people felt included in initial decisions about admission, they began to feel an ownership of their stay and may have been more inclined to voice their desires around treatment or discharge. This continued sensation of agency was facilitated by transparency of information giving and a continued dialogue with staff.

The voluntary legal status also appeared to affect an experience of identity, allowing people to feel apart from or "other" to those on the ward who were sectioned. This was reflected in statements where they understood themselves to be less distressed, less vulnerable, less dangerous and in some respects "more human". In some instances, the notion of being other to or unlike those on section allowed for a sense of empowerment, and a feeling of gratefulness or privilege that contributed to experiences of hope or renewed perspective. In these ways othering may have served to protect their own identity. Additionally, for some it allowed a new perspective on their own difficulties, and lead to a more hopeful outlook for themselves in comparison to others.

Othering may have simultaneously added to the experience of the other as unknown, unpredictable or fearsome. The notion of patients as "other" or as

mistrusted was not present in research into general ward experience (Gilbert et al, 2008) but seems to relate specifically to understanding of legal status. In this way the concepts of “voluntary” and “sectioned” may serve as another vehicle for “groupness” or “otherness”, whereby assumptions of difference are made which precipitate fears or frustrations (Corrigan et al., 2015). This experience could again be linked back to Parsons, notion of a “sick role”. By identifying as “more well”, or “closer to recovery” participants were able to take up the “helper” role, providing them with “function” or purpose. At these times they were alleviated from the “sick role” and in turn felt a sense of agency or increased capacity which may have helped them to instigate change for themselves.

The understandings of the “voluntary” concept in admission, invited possibilities of experiencing freedom, empowerment, inclusion and even accomplishment. However, the notion also invited comparisons and an experience of difference on wards. This difference promoted “othering” which provided both experiences of gratitude, and experiences of fear. The voluntary experience also related to increased information and expectation from the ward, and experiences of distress related to discrepancy between expectations and reality.

4.3. Critical review

In order to better situate the discussion I considered the limitations of the research design I adopted and the impact of researcher contexts on the findings.

4.3.1. Limitations of the study

To ensure quality and validity of the findings of this research, I made efforts to fulfil Yardley’s criteria for assessing quality of qualitative research findings; see section 2.5 of the methodology for an account of the specific actions taken. Despite consideration given to these criteria throughout the work, obstacles arose that may have affected the findings of the study.

4.3.1.1. Small varied sample

Recruitment on the wards was a difficult task and there was a high drop-out rate between showing interest in the study and completing an interview. As a result the final sample size was 5. The small sample varied greatly across all

demographics. Although this variation broadened the experiences discussed, it made it very difficult to keep participants anonymous and in order to protect the confidentiality of participants many demographic details had to be excluded. This limited the extent to which ideographic detail could be presented in analysis which limited some of the depth and nuance of the report.

Changes in recruitment design may have helped to yield a larger sample size; the high drop-out rate may have related to the short time frame between discharge and potential interview. Many potential participants reported complex social situations which demanded much of their time and energy following discharge, making it more difficult to participate in the study. It is possible that sampling these people at a later date may have made it easier for them to participate. Future studies may take a single case or case series approach to the area to add further depth on knowledge to the field.

4.3.1.2. Gender representation

Whilst designing this research consultants recognised potential difficulties I may have in recruiting men to share their experiences. Despite interest from men during recruitment, none chose to complete their participation in the research. This means the findings from this study were derived from the accounts of five women's experiences of voluntary inpatient admission. Though this was opportunistic rather than purposive there are ways in which the sample may influence the themes generated. IPA generates ideographic phenomenological knowledge, and as such is not intended to be generalisable but to add depth to our knowledge of aspects of phenomenological experience; it can only tell us about the experiences of the contributing sample (Smith et al., 2009). Any generalisability will come through situating the findings in context of other research exploring experiences of other women and men alike.

This research indicated that it may be difficult to get a more mixed sample to engage in the research when opportunistically sampling from the acute ward population. This may be for a number of reasons: Firstly it might be of note that I (the researcher) am female. It is possible that men would have felt more comfortable talking to another man. Secondly, less men were identified during screening as meeting the inclusion criteria for the study. (i.e. being on the acute

ward, not being “clinically risky” and not having been under the mental health Act at any point during their stay). Statistics indicate that men are more likely to be admitted to hospital or detained in hospital using the mental health act than women are (Audini and Lelliott, 2002), and because of this the criteria of the study may have made recruitment of a mixed sample more difficult. Future research might look to purposively sample the male population in order to ensure the male experience can be explored in further depth.

4.3.1.3. Absence of discussion around ethnicity

The findings of this study did not include any explicit data on the impact of ethnicity on experience of admission. This is surprising given the mixed ethnicities in the sample, and the existing knowledge about the effects of staff’s cultural competence on admission experience, and the presence of discrimination reported within the mental health system (Gilburt et al., 2008; CQC, 2017). Although ethnicity is not explicitly mentioned it could be supposed, given existing research, that important factors influencing experience may have been excluded from people’s accounts.

It is possible that, being white, my ethnicity shaped my questions and prompts, or created a barrier to disclosure of experience related to ethnicity, and consequently somewhat limited the depth of findings the study produced (Gunaratnam, 2003). To promote inclusion of discussion of influence of ethnicity and of other areas of difference (i.e. sexuality or ability), the blurb given at the beginning of the interview could have been changed to invite comment on these areas, and prompts could more explicitly have pointed to experiences related to issues of difference.

4.3.1.4. Difference in quality of interview data yielded

Despite the use of an interview schedule there was natural variance in depth and length of interviews. Some interviews were shorter where interviewees expressed some worries about speaking openly or gave shorter answers and did not expand in depth despite prompts. In shorter interviews it was more difficult to acquire the depth and quality of data I had hoped for.

Despite practising interviewing technique, it is possible that having relatively little interviewer experience had some effect on the quality of interview data I gathered (Cleary, Mechanic and Weiss, 1981). Furthermore, contexts I spoke from likely influenced interviewees reactions to me. For example being white and working within academia may both have affected the relationship between myself and interviewees (Hoge et al., 1993). Further interview practice, and practice with someone from the sample population may have helped improve my interview style and relationship. In addition, I might have considered working alongside or training a peer interviewer as research indicates that this can yield richer interview data (Gilburt et al. 2008; Godfrey, 2004; Walsh and Boyle, 2009).

4.3.2. Researcher Reflections

The double hermeneutic at the heart of IPA recognises the impact of researcher context on interpretation of data and in turn recognises the impact of interpreted data on knowledge and understandings of the researcher (Smith, Flowers and Larkin, 2009). Below I have outlined how my experience influenced the research and how the process of doing the research influenced me.

4.3.2.1. Impact of researcher contexts on the procedure and findings

As stated in Section 2.2.3., I was aware of a number of contexts that influenced me as a researcher throughout the research process. Keeping reflective accounts throughout the work allowed me to notice when these contexts may have affected the research.

- Gender: I have already outlined how my gender may have affected recruitment bias. I also wondered when reflecting on analysis if my being female would have encouraged female participants to speak more openly about more typically female experiences, i.e. of motherhood. I too wondered if my gender may have helped them to feel they could identify with me in some ways and be more vulnerable and honest.
- Ethnicity: As mentioned above, I felt that my whiteness may have influenced the interview space and participants ideas about what they could or couldn't talk about. Also my lack of experience of racial

discrimination meant I was less primed to ask prompts about these experiences, and may have missed opportunities where racial discrimination was alluded to which I could have asked more about.

- Class: I was aware during interviews and the recruitment process that I was afforded a certain amount of power or respect through my affiliation with the university and academia. In addition I am often told my accent sounds “posh”, and can be linked to assumptions of privilege. One participant interviewed also worked in academia and was keen to tell me about her studies and work, others seemed to be somewhat intimidated by university settings and procedures. This may have affected participants abilities to identify with me or trust me.
- Expectations and experience: Working as a psychologist on inpatient wards I often spent most time speaking with those who were distressed and unhappy with their experience. In talking groups on the ward I had heard repeated themes of fear and frustration related to the ward environment and admission experience. I was aware that I was primed to respond to certain stories and some ideas were more familiar to me. Although I tried to come to the research with fresh eyes I am aware I may have found it harder to ask more questions and be curious about ideas that felt more familiar. I was also less primed to hear new stories and at times may have been less likely to pick up on opportunities for expanding some new ideas.

4.3.2.2. Impact of the research on the researcher

Reflection on my position throughout the work made me acutely aware of the power my position as an academic afforded me. I recognised the privilege I had of being the “right side” of the system, looking in rather than experiencing first hand. This I felt when hearing stories of practices I had witnessed on the wards; where I had been shocked or angry witnessing practices, my participants had been angry and scared, as the possibility existed that the practice would be applied to them also, whereas I had been protected and was exempt from that fear.

I felt that at times participants were worried about the power I held. I recognised the trust they had to put in me to tell me their stories. I am incredibly grateful to the participants and consultants who participated in this study and was struck by their courage and their passion to make a change in the system. Being entrusted in this way was a great privilege and made me feel a responsibility to ensuring their experience was reflected accurately and discussed in detail.

Their passion moved me to want to make change, and in turn this also brought frustration. As the research process continued and I moved my attention back to wider literature to see how their stories fit, I was struck again and again by how often similar stories of fear or frustration had been catalogued, and how messages have been given time and time again but change has been little or none. It felt important to highlight both the repeated stories in the work but also bring in the new and ensure that the hope and passion about recovery and change in people's stories were not lost.

4.4. Implications Of The Findings

The findings add further support to pre-existing ideas about inpatient experience and contributing new ideas around stigma, identity and the concept of voluntary admission. Taking findings into account I recommend clinical implications that may improve voluntary inpatient experience and potential avenues for further academic exploration. It is of note that many of these changes, or versions of them, have been advocated for by multiple groups in various publications over the last few decades. It is of importance to consider why, when these findings have reoccurred often over the years, the changes are not made, and suggested improvements are still not in place.

4.4.1. Safety, coercion and trust

Findings indicate that patients chose admission, in the hope of fulfilling their needs of safety and protection from vulnerability. The presence of coercive practice in admissions continue to hinder patients' abilities to meet this need. Coercive practice has been understood to be a "necessary evil" of inpatient admission, however whilst it is an inherent part of the admission process it is a barrier to services meeting patients' needs (Wilson et al., 2017). Further consideration should be given to alternatives to coercive practice which shift the

balance of power in hospitals. Some suggestions which can reduce coercion (such as increased information sharing and collaboration), are discussed in depth below.

Increased freedoms in hospital may reduce tension and frustration on the wards which can further reduce violence and “extreme behaviour” (Nijman et al., 2011; Rose et al., 2017). Examples may be unlocked wards for voluntary patients, or access cards for these patients. Further research is warranted in alternatives to coercive practice that can promote the experience of safety for both staff and patients.

Alternatives to hospital environments may also be effective ways to increase safety and many psychological bodies advocate for their increased use (Cooke et al., 2014). Research indicates that safe houses and crisis houses are far more satisfying to service users and provide environments that feel safer, and staff that are more trusted (Sweeney et al., 2014). Furthermore, reviews indicate that they may be just as effective (both in terms of outcome and cost) as hospital admission (Mosher, 1999). Critics of this research often suggest that populations used for these studies are “less distressed” than hospital populations, and that for many the “risk” of a non-restrictive environment would be too high (Lloyd-Evans, Slade, Jagielska, & Johnson, 2009). The voluntary psychiatric population may often fit a “lower risk” or “high capacity” profile, however there are still not enough available alternatives for them to be offered.

Additionally, further thought needs to be given to reducing mistrust between inpatients and staff. Trust has been identified as a salient issue in mental health care (Laugharne and Priebe, 2006), essential for positive therapeutic relationship (Gilburt et al., 2008) and for alleviating anxieties around vulnerability (Brown, Calnan, Scrivene and Szmukler; 2009). Laugharne and Priebe (2006) noticed the importance of continuity of care in promoting trusting relationships in the health sector. This can be particularly difficult transitioning in and out of hospital, and stabilising staff shifts so patients have the chance to get to know staff may benefit trust in hospital settings (Menzies-Lyth, 1990; Laugharne and Priebe, 2006). Further to this, efforts must be taken to reduce discrimination in the use of the Mental Health Act and within mental health

institutions to help to rebuild relationships of trust between staff and inpatients of BME ethnicity (Macpherson, 1999; Keating, Robertson, McCulloch and Francis, 2003).

4.4.2. Real choice and available alternatives

The lack of alternatives to inpatient care outlined above limits the choice people can make when “choosing” voluntary admission. In this way the choice often feels coercive as there is no alternative. The importance of choice further goes to promote the need for crisis houses and research into hospital alternatives. In addition, some participants in this study described feeling overwhelmed at the point of admission that they felt unable to make a choice and just agreed for ease. Mental Capacity legislation have recently been further combined with the Mental Health Act (2001, revised 2016) procedures in Ireland in order to ensure that choices made are informed and willing. This could be a helpful reform to the system in UK in aiding real informed choice.

4.4.3. Informed consent and accountability

Increased availability of transparent information and informed choice for voluntary patients will decrease the discrepancy between their experience and their expectations. In turn knowledge of their rights will help them to hold staff responsible and feel safer and less powerless in their experience.

The BPS and CQC highlight how essential it is for patients to receive fully informed consent (CQC, 2017; Cooke et al., 2014). As such informed consent for voluntary admission should include information about the ward environment and protocols, sections and others on the ward. Information should be available about practices people might witness (i.e. restraint) and transparency about how, why and when these procedures might be used, and advantages and disadvantages of these. The charity “Mind” (2016) have produced a comprehensive document informing voluntary patients of their rights and the risks involved in admission, such a document could be well utilised by ward staff in helping patients give fully informed consent. Research is warranted to explore how this information can be communicated

Increasing information can increase accountability in practice whereby service users can speak out against practices they perceive to be unjust. Patients and clinicians should be supported to work towards a trusting position whereby they have a shared understanding of rights on the ward and actions are transparent and accounted for. They must both feel confident that expressing their views will not result in mistreatment or use of violence against them and that reporting unethical practice will result in changes in practice (Brown et al., 2009). Patel (2017), has gone some way in considering how this may be done, producing information and workshops for staff and service users to increase awareness of rights, best practice and accountability procedures on intensive psychiatric units. Increased knowledge of human rights and accountability on acute psychiatric wards and within voluntary admissions is also called for.

4.4.4. Validation and Inclusion; reciprocity over paternalism

Research suggests that increased transparent and coherent dialogue could be essential for reducing both the need for and fear of coercive practice and increasing experiences of validation (Koivisto et al., 2004, Gilbert et al., 2008; Rose et al., 2017). Experiences of validation and inclusion were related to increased empowerment, self-confidence and acceptance in voluntary inpatient experience in this sample. Clinicians can maximise the positive opportunities that could be provided by voluntary admission through entering into meaningful dialogue with patients about their experience, offering choices more regularly and care planning collaboratively (CQC, 2017). This involves a further step away from paternalism and move towards a reciprocal approach (Perkins and Repper, 1998; Cooke et al., 2014). The Open Dialogue approach (Seikkula, Alakare and Aaltonen, 2001), which is growing in popularity in some services, has dialogue and transparency at its heart and may be one way of promoting validation in admission (Anderson, 2002). Crisis houses and non-hospital alternatives could promote choice and reduce the power differential between staff and patients. Further research done in collaboration with service users with lived experience of the wards is likely to yield further richer ideas about how agency, choice and respect can be increased in a practical way (Walsh and Boyle, 2009).

4.4.5. Recognition and dialogue around the limits of care

The research indicated that the gap between expectations and hopes of hospital care or treatment, and the experienced limits of their realities could lead to hopelessness or disappointment in the system for patients on the wards. Psychologists are well positioned to open spaces for dialogue about these difficult paradoxes. Building non-judgemental and reflective relationships with staff and patients may allow for conversations to take place acknowledging the difficult emotions surrounding the limitations of care provision, in turn allowing the generation of more realistic hopes and building tolerance of uncertainty (Mason, 2015).

4.4.6. Reducing shame and stigma involved with admission

The findings also indicate that there may be a role for clinical staff in reducing stigma around mental health admission. Conversations between staff and patients that focus on patient understanding of their experience, rather than medical or theoretical understanding, may promote patient validation and recovery; allowing a patient's inner world to be heard, and giving them opportunities to re-structure and repair the "self" (Barker, 2001; Koivisto, Janhonen and Vaisanen, 2003; Koivisto et al., 2004). Additionally, psycho-education around psychosocial or continuum explanations for mental distress for patients and staff have been found to be effective in decreasing stigma (Malla, Joober and Garcia, 2015; Wiesjahn, Jung, Kremler, Reif and Lincoln, 2015; Carter, Read, Pyle and Morrison, 2018).

The findings also indicated that differing legal status' in hospital may provide an opportunity for "othering" and invite stigma towards others on the ward. Opportunities to have conversations that deconstruct legal status, allowing similarities between self and other to become more transparent, both between sectioned and voluntary patients and patients and staff, may serve to reduce self- stigma and shame during hospital admission (Weisjahn et al., 2015).

Little research exists that specifically looks to understand the effects and presence of stigma in hospital environments and around admission. The findings of this study indicated that guilt and shame related to stigma can greatly affect inpatient experience and may also affect understanding of legal

status in hospital. Further research in this area may look to understand this concept better and consequently lend further insight into how hospitals may adopt stigma reducing practices such as those suggested above.

4.4.7. A wider culture shift?

The current research stands alongside research from a decade ago and shows that little has changed following suggestions made then (Gilburt et al., 2008). As the above information shows, research has indicated ways of increasing safety and reducing coercion, stigma and shame, yet the system has changed very little. Understanding the wider socio-political culture may shed some light onto why change has been so difficult and slow.

Increasing space for staff to listen to and be with patients in order to build trust and provide best care is made significantly harder when staff feel under stress (Robertson, Wenzel, Thompson and Charles, 2017). The current climate in the NHS does not serve to promote space to think in this way, often staff themselves don't feel safe, and this limits their ability to promote trust and safety for their patients. Around 80% staff feel their teams are under-resourced and feel stretched (Turnbull, 2015). Research indicates that in recent years in the context of reductions in percentage funding of the NHS there has been an increase in staff stress, sickness and work place bullying in the NHS (Campbell, 2017, Oct 08; Carter et al., 2013; Greenwood, 2017, Sep 22; Johnson, 2015), and a corresponding decrease in staff productivity (Higginbottom, 2014). Past research indicates that the increased pressure on task and time that result from staff absence and lack of resource may result in reduced staff compassion and helping towards others (Darley and Bateson, 1973). Menzies-Lyth (1990) recognised that this reduced compassion and relationship building is also exacerbated by shift systems and rotating staff placements which make it even harder for staff to be with those they're working with.

Psychologists need to continue to remain aware the political systems we work within and the systemic pressures on staff which affect hospital relationships and can shut down routes to change. Helping people engage with political activity or wider change or providing space for teams to reflect can help promote spaces for changes to be implemented.

5.0 CONCLUSION

This study added further depth to existing understanding of the experience of psychiatric admission. It highlighted the importance of safety and validation in admission experience, and recognised how coercion and inconsistent boundaries, can lead to experiences of powerlessness and mistrust which act as barriers to meeting these needs. The study highlighted the role of stigma in perpetuating experiences of judgement and negative sense of self and other on psychiatric wards. It considered how the guilt and shame associated with stigma could interact with experiences of coercion to increase experiences of powerlessness and consequent mistrust.

Additionally, the study shed new light on how people understand the voluntary nature of voluntary admissions. Findings showed that having a “voluntary” admission was associated with increased freedom, choice and agency, which created the possibility of experiencing freedom, empowerment, inclusion and even accomplishment. Being “voluntary” also invited comparisons and promoted “othering” between patients on wards. This led to experiences of both gratitude and fear.

These findings highlight the need for increased dialogue and transparency around hospital procedures and environment and increased inclusion of patients in treatment and discharge decisions, to reduce experiences of coercion and mistrust on wards. Findings also advocate for use of policies or procedures that aim to reduce othering associated with mental illness or legal status, through increasing dialogue around patients’ understanding of these concepts. These changes may help to harness the opportunity given through voluntary admission for positive experiences of being helped and heard.

6.0. REFERENCES

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7.0. APPENDICES

Appendix A: Literature search comparison table

Figure 1: Search parameters for systematic literature search

	Prebble et al.	Current Study
Years	1993–2013	2014–2018
Databases	PsycINFO, MEDLINE, Scopus, CINAHL PLUS, Google Scholar and Science Direct	Scopus, Science Direct, PsychINFO, Google Scholar ⁸
Terms	Acute mental health services informal/voluntary experience/perception	Acute mental health services/inpatient ⁹ informal/voluntary experience/perception
Inclusion Criteria	Specific focus on inpatient experience Must have at least a separate analysis conducted for voluntary patients Articles not reviews	Specific focus on inpatient experience Must have at least a separate analysis conducted for voluntary patients Articles not reviews
Exclusion Criteria	Papers not in the English language Specialist services excluded Community care excluded Excluded quantitative satisfaction-only studies due to ill-defined focus	Papers not in the English language Specialist services excluded Community care excluded Excluded quantitative satisfaction only studies due to ill-defined focus
Relevant Papers found	46 (35 quant, 4 mixed, 6 qual, 1 obs)	2 (quant)

⁸ As this systematic review made up part of a larger piece of work, I did not have capacity to review all six databases within the time limits. As such I chose the biggest databases that are most relevant to psychology as a profession, excluding the medical and nursing databases (Medline and Cinahl plus).

⁹ The term “inpatient” was generated during an initial mind-map of search terms completed before the comparative review was found. It was included to try to reduce the likelihood of missing relevant papers.

Exploring Experience: Voluntary Admissions

What is this about?

I am looking to people with lived experience of voluntary admission to consult with me to **help to design a research project** exploring the experience of voluntary admission to acute wards in psychiatric hospitals.

Who could participate?

If.....

- ◆ You have personal lived experience of a voluntary admission to the wards. OR
- ◆ You have personal experience of caring for a friend or relative who has lived experience of voluntary admission to the wards. AND
- ◆ You would like to contribute to a research project through providing consultation at a focus group.

....Then I would love to hear from you.

No previous research experience is required!

The focus group will draw upon participants lived experience to consider optimum research design and interview questions, it will last up to 90 minutes. Consultants will be paid £10 plus travel expenses where receipts are provided.

Provisional meeting dates:

Friday 7th, Tuesday 11th or Wednesday 12th April

(Dates, times and venue TBC dependant on respondents availability)

If you are interested please contact me for more details:

Cat Iredale

Trainee Clinical Psychology Student at the University of East London

Email: u1525465@uel.ac.uk

Appendix C: Consultation minutes

Research Consultation Meeting Minutes

07/04/2017: 2pm-3:15pm

Introductions:

Facilitator: Cat Iredale: Trainee Clinical Psychologist, with previous experience working on acute mental health wards

The Consultants below requested not to be named in the research documents so are anonymised:

Consultant 1: (Carer) son has had multiple voluntary admissions

Consultant 2: Had negative experience of voluntary admission, which had become a sectioned admission

Consultant 3: Had multiple admissions in various hospitals over the past 10 years

Consultant 4: Had one experience of voluntary and sectioned admission, again a negative one

Consultant 5: (Carer) Has a son who has had multiple voluntary admissions

Agenda Item <i>Researcher questions</i>	Discussion Points	Outcomes and Actions
Items raised By Consultants <i>- What do you think about this area of research</i>	<ul style="list-style-type: none">- Will the number of admissions you have had change your experience of the admission?-Reach and Representation; whose voices are being heard? how do we capture those who are unhappy with the system as well as happy with it? Are these people likely to be hard to recruit? Everyone at the meeting was female, and this raised questions about how to engage and recruit male voices.	<ul style="list-style-type: none">- to be considered by the researcher throughout the process of the study during recruitment and post-analysis.- To be considered when discussing implications and ideas for future research.- Participants will be informed of complaints procedures and assisted to formalise any complaints disclosed during

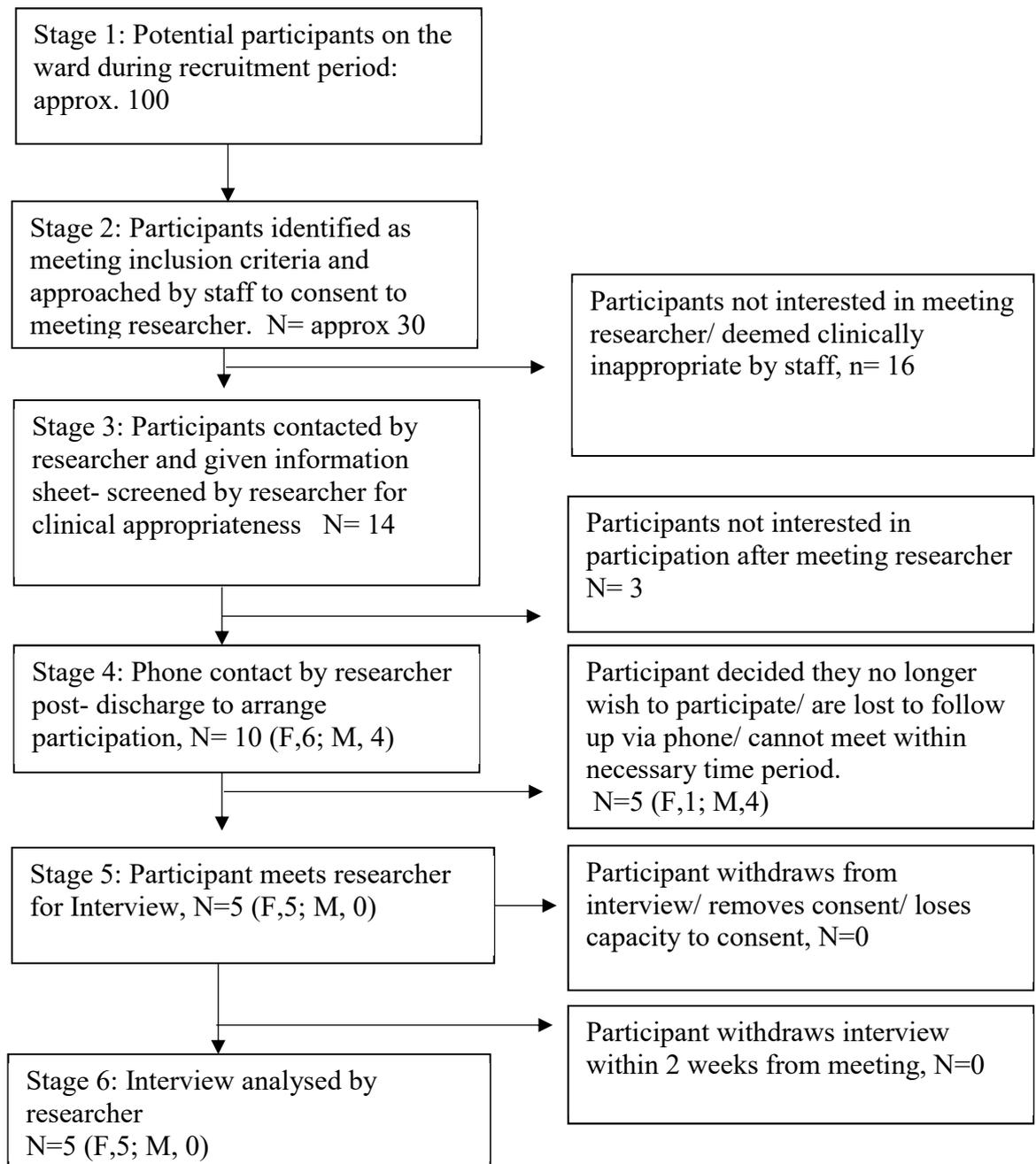
	<ul style="list-style-type: none"> - Medication: how is this used within the system, is it used coercively or threateningly? - Complaints procedures in hospitals can be complex and people may feel unwilling to raise complaints- how will negative experiences found in the study get back to hospital staff so they can make a change? 	<p>research if they wish to do so.</p>
<p>Research Question: <i>-What do you think about the aims and research questions</i></p>	<ul style="list-style-type: none"> - Agreed that it is important to understand experiences and have voices heard, however emphasised the need for this to effect change in services. 	<ul style="list-style-type: none"> - Emphasis will be put on dissemination of results in peer-reviewed journals and to the local trust to ensure any contribution or new information found in the research is used to the best possible effect.
<p>Recruitment <i>- What do you think about the pros and cons of recruiting on the ward?</i> <i>- Do you think 2 weeks or one month is an appropriate amount of time post discharge to ask people to interview?</i></p>	<p>Recruit from the ward:</p> <p>Pros- captive audience, interested, passionate, connected with ideas, people will have met you already before the interview. You may be able to talk to people who do not engage well with their community team if you recruit on the ward rather than through CMHT staff perhaps those with the most negative experience do not want to be in contact with their CMHT following discharge?</p> <p>Cons- people may not be well, may change story, haven't had time to reflect (more from sus), interviews themselves should not take place on wards. People may agree to take part on the</p>	<ul style="list-style-type: none"> - Aim to Identify participants on the ward and follow up post discharge for interview. - Apply for Ethical approval to recruit from CMHTs as well in case drop out from wards appears too high. - Interview within two months of leaving the ward rather than one to allow a week or two "settling period" post discharge.

	<p>ward but change their minds- may increase drop out. You may talk to someone who is on the ward informally but as discharge gets closer they are sectioned.</p> <p>Recruit from CMHT Pros- had time to reflect on experience including the experience of discharge Cons- Note that experience changes more and more the more distance you get from it. Problems of people being readmitted shortly after discharge.</p> <p>Timings: Post discharge, suggested the first week you are still “wobbly” and maybe even the second week, therefore would need longer time. Additionally, to be aware of the additional support people may be receiving at home (i.e. Home Treatment Team). Considered researcher position as outside of team and to not add to a feeling of invasiveness or coercion.</p>	
<p>Venue <i>-Where may be the best place to hold interviews?</i></p>	<ul style="list-style-type: none"> - Importance of a place that is separate to the hospital and to staff members for people to feel they can speak honestly - Good idea to use the university and have the range of venues -Let people choose where to meet if possible for some people the CMHT might be easier but some people may 	<p>- Participants will be given a choice of venue.</p>

	be put off by this and you might exclude certain views (i.e. those with negative relationships with the team).	
<p>Interview schedule <i>- What are your thoughts on the interview topics (i.e. voluntary admission experience) and intended time for interview (Approx. 60 mins)</i></p>	<p>- Offering control: the interviews topics are fine if people know that they don't have to do anything, making sure people know talking is on their terms is essential. People often have to answer numerous questions in hospital which can feel invasive so it is important not to replicate this.</p> <p>- An hour is a long time; it will be exhausting. Ensure people are offered breaks and asked if they want to stop, or come back another time- be flexible and work on others terms as much as possible.</p> <p>- Make sure you state all info about confidentiality clearly</p> <p>- Where audio recording is concerned ensure people know what you are doing with the audio recording, where it will be stored how it will be destroyed etc. Offer participants a copy of the audio recording.</p>	<p>- Participant choice and control will be stated on the information sheet and consent form as well as reiterated at the beginning of the interview.</p> <p>-Participants will be offered breaks and the chance to break the interview into two meetings.</p> <p>- Confidentiality will be outlines on the information sheet, consent form and reiterated at the beginning of the interview and again if the researcher is asked about disclosure.</p> <p>- Participants will be offered a copy of their audio-recording</p>
<p>Acknowledgments: <i>- I am very thankful for your input and would like to mention this in the paper where I can, how would you like this to be done?</i></p>	<p>- Would be happy to be acknowledged in the final paper but do not wish to be named.</p>	<p>- Names of consultants will be removed from all research documents</p>
<p>Follow up <i>Would you like to be kept informed about</i></p>	<p>- All agreed they would like to be informed about the study,</p>	<p>- Consultants will be updated when different study phases are</p>

<i>the progress and results from the study?</i>	preference for use of email for this purpose.	completed (i.e. recruitment, analysis and write up), and will be given a summary of results.
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Appendix D: Recruitment, participant flow diagram



Key: N= Total number, F= Number of female participant, M= Number of male participants.*

*Gender could only be identified past the point of consent for researcher contact due to consent.

Appendix E: Interview Schedule

Interview schedule

Question	Response
Name	Unlimited: Can give real/ fake name
Age	Age in Years
DoB	--/--/----
Gender/Sex	No specific options given
Ethnicity	No specific options given
Diagnosis	No specific options given
Reason for recent admission	No specific limit to length of answer
Other professionals involved in admission	Type of professional and how they were involved.
Length of recent admission	No. of Days
No. of previous admissions on MHA section	No. of admissions
No. of previous voluntary admissions	No. of admissions
No. of previous CTOs	No. of CTOs

Table 1: Demographic Data collected at the beginning of the interview (audio-recorded responses)

1) How did you experience your recent admission to the ward?

*Possible prompts: How/Why did you decide to be admitted to the ward? How did that feel at the time? What other choices were available to you? What influenced your decision? How would you best capture/sum up your experience of your recent voluntary admission? What are the important aspects of the experience you are taking away? **What is the/ are the lasting image/s or feeling/s that stay with you?** What was your experience of leaving the ward? Possible Prompts: How was the decision reached that you could be discharged? How did you feel when discussing leaving the ward/ when you left the ward/ after discharge?*

2) How do you understand the “voluntary” aspect of the admission?

How did being admitted voluntarily impact your experience of the admission?
Possible Prompts: If you have experienced an admission under section, how does this compare? How voluntary did the admission feel? What do you think voluntary admission should feel/be like? How did you understand being voluntarily admitted whilst staying on the ward? How did you understand your position on the ward in relation to your voluntary admission? How did you make sense of the voluntary aspect of the admission in respect to the treatment you received? In respect to your discharge?

3) How has your understanding of your experience of the admission changed since you were admitted?

Possible prompts: If it has changed, how has it changed? What do you think influenced the change in your understanding? If you would be admitted voluntarily again would your understanding of the experience be any different? Was your experience the same the whole time you were on the ward or did it change over time?

Appendix F: Transcript extract with initial notes

	<p>but... today I found a bit too much, maybe because it's the Christmas shopping, I don't know I found it a bit too much so you know <u>yeh</u></p> <p>I: <i>so there was something about having the people there as well?</i></p> <p><u>Yeh</u>, because you know there's someone there that's <u>gonnabe</u> there. But today I done it on my own I felt quite proud coz I've <u>actually come</u> here and I done <u>morrison</u>s on my own, even though I only bought a loaf of bread I actually went into a packed store and got it</p> <p>I: <i>well done</i></p> <p>P: yes, yes this was my aim to sort of, [exhales... laughs] whether I'll get my own</p>	<p>"Trial" like practise or an experiment outside of a natural context like not real so <u>cant</u> really hurt as much?</p> <p><u>Removed from reality?</u></p> <p>Helped by staff and supported to do what was scary, had back up like "safe basing" or behavioural experiments <u>in graded exposure work</u></p> <p>Staging the trials from easier to more difficult, having time and support to do this <u>again like graded exposure to the fear- actually this links to being allowed on and off the ward again re exposure to fear on the ward, similar to exposure to fear off the ward.</u></p> <p>Experience today out of hospital felt quite intense, perhaps too much of a jump in comparison to what was happening before? Because there are more people around? Or because there is less support in the way of friends/staff?</p> <p>Having a person around looking out for you represents support and someone being there to look out for you.</p> <p>Another step towards progress and recovery?</p> <p>She is talking about an achievement, and does this in relation to her hospital stay.</p>
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	<p><i>busyness? Can you tell me a bit more about what helps with the peace?</i></p> <p>P: The peace is just you know you have, I don't know what it is, '<u>cause</u> when you're on the ward your just on the ward <u>init</u>, do you know, you <u>ain't</u> got to worry about too much at a time, <u>its</u> kind of like your life pauses for a minute you know what I mean so you can breathe and then you have to get back to it once your off, you know what I mean?</p> <p>I: <i>And being just on the ward?</i></p> <p><u>P:</u> I mean it doesn't matter it wouldn't matter what ward I was on because I've come to like pause, but you know some other people they bring the chaos from outside inside and that, its making things hard and that, you know people get fed up .</p>	<p>I'm trying to sort my head and <u>that-</u> does seeing this kind of thing make it harder to "sort your head", is it anti-productive? Is it harmful? Is it important to be away form it to get the peace she needs?</p> <p>you ain't got to worry about too much at a time, its kind of like your life pauses for a minute you know what I mean so you can breathe, experienced as a break from real life, an escape? A space away from worries/ troubles?</p>
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	<p>I: <i>Did you have any contact with the outside world when you were on the ward?</i></p> <p>P: Um <u>yeah</u> I did yeah</p> <p>I: <i>What did that look like? How did it affect your stay?</i></p> <p>P: To be honest with you, everyone outside, 'cause I come on for my own kind of issues, I don't really trust anyone, you know what I mean? I been done dirty <u>the passed</u> couple of years you know what I mean? its, you know, I talk to certain people from a distance, my sister was calling me and that, that's about the only person I was talking to while I was in hospital, just my sister</p> <p>I: <i>Is she someone you talk to a lot outside hospital? or was it different people?</i></p> <p>P: I don't really talk to her I was only really talking to her when I was</p>	<p>some other people they bring the chaos from outside inside- wants to experience the ward as peaceful but this can be difficult as others may be in a different place, bringing in "chaos"- <u>does this reflect experience having chaos to manage in the hospital- is this a physical or a mental outside -in or both?</u></p> <p>people get fed up – "people get fed up" with chaotic people? <u>Who are these people? Is "people" sometimes her? is it difficult not to "get fed up with people" on the ward sometimes?</u></p> <p>everyone outside,- almost like when she is in the ward she's protected? She's separated? In a bubble or something?</p> <p>I don't really trust anyone... I been done dirty the passed couple of years- find rusting/ being open with people very difficult- how would this have fit in with the rest of her experience? Fear of others anyway a bit higher? Less likely to let people know how she's doing?</p>
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	<p>in hospital, when I'm outside she calls me but I don't answer my phone to anyone, I'm surprised you got through! Yeah, it was kind of like, <u>honestly</u> I just, when I was in hospital, I honestly just really tried to use my time to try and get myself alright, do you know what I mean, enough to, to be here today to be honest.</p> <p>I: <i>How did you go about that?</i></p> <p>I just kind of slept, I <u>was able to</u> sleep able to eat, [breathes out] just breath, um met some, met some people. I get along with the staff do you know what I mean, I get along with the staff so... you know what I mean? I was alright.</p> <p>I: <i>Can you tell me, you say you met some people, what was that like meeting people on the ward?</i></p>	<p>Had some contact from her sister but this was still experienced as "at a distance" no-one she knew came into the hospital to see her? was there for her own stuff? Seeing it as an independent personal problem not one others should/could be involved with?</p> <p>Something a bit different in hospital- did talk to her sister, did answer the phone- (or did she call the ward so less choice?) didn't ask...</p> <p>Wanted to be alone and focus on herself and getting herself better, Try to get myself alright- <u>own responsibility to use hospital as effectively as possible, own responsibility to do the mending the supporting of herself?</u></p> <p>looking after herself physically and attending to basic needs- something possibly very difficult at the moment outside of hospital- no stable living place, drinking etc.</p> <p>met some people- as this part of getting better? How did effect experience?</p>
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<p>P: I'm, I mean, coz I get along with everyone, you know the patients are there, gonna say good morning gonna go for a cigarette gonna have a cigarette with them, you know that kind of thing, then there are other patients that kind of piss you off and you don't wanna talk to, you know what I mean, it's kind of the same with the workers there is some workers that you like, that you'll talk to coz you know they're alright and there's some that you'll avoid it's like that. Yeah.</p> <p>I: <i>How is doing that on the ward, having people on the ward to avoid and that you like, how does that affect your being on the ward?</i></p> <p>P: I'm kind of alright with being ignorant at the right time, so its didn't affect me, you know what I mean, if I don't get along with</p>	<p>Get along with staff so...- what does this so imply, so <u>im ok.</u> so what would happen if she didn't get along with staff? Is she lucky in this way or does it require effort and thought whilst on the ward?</p> <p>"the patients" a group of people- not separate humans, a group- and separate to her- does she identify as a patient or not?</p> <p>Some people you will say hello and have a cigarette with- these sound like normal day to day activities and a sense of routine/ normality within the ward? Some normal relating?</p> <p>Some people that are more difficult to be around- annoying, frustrating? Want to avoid these people- is this easy? Wanting to avoid people can make an experience <u>more tense/</u> less calm</p> <p>"the workers" almost another group, another separate group of people around who need to be negotiated?</p> <p>How does she figure out who to avoid- <u>past experience?</u> Observations on the ward?</p>
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<p>you know what I mean, that's a long time to be on the ward, so um you kind of just feel, kind of grateful in a sense, and um makes you realise stuff like that, and also cause I'm kind of observant, I kind of see two perspectives, I see like the patients side and the workers side as well, cos it's not easy doing that job <u>init.</u> you know what I mean? But it's not easy being judged as a crazy person as well [laughs] you know what I'm saying.</p> <p>I: <i>Can I talk about that reality and that gratefulness? Is that something you noticed in there or just after?</i></p> <p>P: Um I kind of, I kind of noticed when I was in there and um also when I'm out of there, do you know what I mean cause, yeah. You know, yeah, I noticed it because sometimes things can happen in life and that's</p>	<p>... the reality of like people's lives, of seeing what trauma and stuff can do to people- <u>its</u> shocking seeing others and hearig <u>peoples</u> stories in hospital- it gives a newer perspective on the hardest side of reality?</p> <p>People have some "serious stuff going on" things must have been bad for people to be on the ward for 6 months</p> <p>Feeling grateful? <u>A comparison made that at lest things aren't that bad? You are better off than some ppeople? A recognition of what you do have going for you? Perspective shift?</u></p> <p>Recognises the difficulties for everyone on the ward, feels like the staff have a "difficult job" and <u>have to</u> put up with a lot from patients but feels that patients have the weight of judgement on them which is also difficult</p> <p><u>Being in mental hospital= being judged?- does it feel this way that you are being judged/ assessed?</u></p>
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Appendix G: Transcript extract with emerging themes

<p>interest of medication prior to admission</p> <p>change drug admission - come out feeling better</p> <p>change in sense of self by improved</p>	<p>so, you know cause when I actually went in it was full blown, it was manic you know but now, you know it's very, very muffy but not actually hearing what they're saying so it's good.</p> <p>I: So if there's any kind of thing you're taking away from the admission or what's sticking with you or what's kind of a lasting feeling from this admission, how would you describe that?</p> <p>P: Um, you feel good in yourself when you actually come away with, it's not been like that before, you've come away still fried still I dunno</p> <p>I: So you feel good in yourself, can you tell me a bit more?</p>	<p>Initial experience as being "full blown" "manic" sounds intense like lots going on Concrete change as a result of admission, medication has muffled the experience again hints at an experience as in an inner world experience that is quite intense.</p> <p>What was it like before? Did it add to the fear? Hard to know as I didn't ask.</p> <p>Feeling better in self- this in comparison to the "bad place" at the start, to feel "good", there was something transformative about the experience.</p>
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<p>freedom / space to develop</p> <p>med feeling leads to more control</p> <p>ability to slow down the pace of change</p> <p>control of situation</p> <p>preparation for change, admission after medication</p>	<p>yeh, you feel good in yourself because it, I think what it is because you've sort of had that freedom where you can go out and have a coffee, you know and, and then you can go out for a couple of hours come back you know and then you go home for a night and go home for two days you go a half day with your medication one day, you stay over-night and come back the next day ready, well normally its about 10 o'clock you have to come back for but you're ready for that you know so it's, it sort of, it helps you to prepare yourself for going home, whereas if you're sanctioned you don't go home, so you know a lot of times you end up back there within a few</p>	<p>Difficult to access the experience here, very descriptive answer.</p> <p>Feel good because you've been free to do as you would wish/ as you need? Because you feel protected? She is again talking about the going and coming back the building up of self?</p> <p>A greater feeling of control? / inclusion? Being ready prepared, informed? Knowing what is expected of you and what you can expect of others?</p> <p>Assuming that the difference in discharge process here related to the admission type i.e. that the change in experience was due to voluntariness rather than just a different discharge approach.</p>
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<p>interest of Medication prior to admission</p> <p>change drug admission - come out feeling better</p> <p>change in sense of self by improved</p>	<p>so, you know cause when I actually went in it was full blown, it was manic you know but now, you know it's very, very muffy but not actually hearing what they're saying so it's good.</p> <p>I: So if there's any kind of thing you're taking away from the admission or what's sticking with you or what's kind of a lasting feeling from this admission, how would you describe that?</p> <p>P: Um, you feel good in yourself when you actually come away with, it's not been like that before, you've come away still fried still I dunno</p> <p>I: So you feel good in yourself, can you tell me a bit more?</p>	<p>Initial experience as being "full blown" "manic" sounds intense like lots going on Concrete change as a result of admission, medication has muffled the experience again hints at an experience as in an inner world experience that is quite intense.</p> <p>What was it like before? Did it add to the fear? Hard to know as I didn't ask.</p> <p>Feeling better in self- this in comparison to the "bad place" at the start, to feel "good", there was something transformative about the experience.</p>
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<p>Chose to try own ability to cope -</p> <p>self confidence purpose - sense of purpose / idiosyncrasy</p> <p>socialized largely / experience difficulties aspects of the housewife</p> <p>apex of learning / bits taught - self-developed part</p> <p>physical + mental space important.</p>	<p>hours because you're not coping, whereas when its voluntary it sort of gives you that little bit more purpose, you know I can cope with this cause its slowly, gradually <u>putting you back</u></p> <p>I: So what did that purpose, or something about learning about something about sorry?</p> <p>P: 'cause of the, no, 'cause of the, I told you that I often, I, I have panic attacks, so slowly it was learning me, you know 'cause you was shown how to do the breathing and, so you were slowly learning to do this, you know whereas when you're sanctioned you're so sort of closed in everything's, just it doesn't work you cant, whereas voluntary you're getting to</p>	<p>"purpose" existential type word- around identity/ meaning?</p> <p>Through building up her confidence and resilience grew, knowledge and belief in herself that she could cope, experienced this as being "put back"</p> <p>Put back- someone peicig you together again a bit passive someone else puts you back, but does it gently? Fixing type connotation, "restoring"</p> <p>made it lol re this before.</p> <p>I have "panic attacks" what do these look like- <u>Panic attacks are a symptom/diagnostic phrase but also have got a "lay understanding around them". How does this diagnostic/ symptomatic language effect her understanding of experience, she says I have, so there is something about her understanding of herself and something she has that is a general part of her life/ experience?</u></p> <p>She was taught in hospital ways of managing symptoms of anxiety through breathing, other people shared helpful knowledge with her. "they were learning me"- others empowered her?</p> <p>"closed in", you cant learn- <u>again the idea that your mind is closed as well as your body.</u></p>
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<p>feel excited/ empowered?</p> <p>Pride in achievement of overcome difficulty</p> <p>was difficult to overcome</p> <p>through gain real freedom</p> <p>support from others - dependent on support -</p>	<p>know "right, there's nothing to panic about, I can go out here, I can do this", you know. So it, it's, it's a big difference you know, like how come I'm so proud coz I brought that loaf, all on my own whereas normally I'd have to have someone with me, like my sister or something and if it gets too much they go and get what I want and I'll be standing outside, which isn't good so today I'll give myself a big tick coz even though I got a bit... I did some deep breathes and I thought all I want is this loaf and I done it and I stood in the queue so, yeh, it sort of, it, <u>it taught you, voluntary, because you was actually going in but you wasn't on your own you was going with someone</u></p>	<p>Something of the freedom to go out and try things taught a new understanding about herself.</p> <p>"I can do this"- <u>confident, empowered, enabled?</u></p> <p>Feeling of pride in herself- surprised herself done things she didn't think she was capable of through support and empowerment.</p> <p>Previously unhappy with how she needed to depend on others? <u>Something about requiring this support being "not good", about her being not good, and now she is learning new things she can start to think she is ok? Something in here about it not being ok to have panic attacks and need to rely on others- an appraisal or judgement being made here- where does this idea come from?</u></p> <p>Here is an example of using something she learnt in hospital to help her now she has been discharged.</p> <p>Experience of learning of being taught something useful</p> <p>Experience of being supported</p>
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<p>sense of accomplishment</p> <p>changed sense of self - idea of abilities</p> <p>others as a safety net</p> <p>it's interested in her.</p> <p>conversation used to consolidate growth through dialogue -</p>	<p>and you was slowly doing it. It does learn you how to sort of relax, take deep breaths you know it's nothing to argue, you you're gonna do it, so, so and I thought right if I've got to go into there, I got to go into morrison's, and my mum went [gasp], I said, no mum I can do it, she went really and I said I will, and as soon as I come out of morrison's I phone her and says I've done it, I've got it, you know so it was a big, yeh and I think it's because as I say, on voluntary you can go out for a couple of hours you know and you can go to the shop and you can walk back so you've actually done it, and then they've asked you when you did that, "how", you know, "how did it go?", and</p>	<p>Experience of doing something- active, accomplishing</p> <p>Experience of learning calm, or learning to overcome fears of overpowering your own problems</p> <p>Thoughts changing a new resolve</p> <p>Experience of changing understanding of herself, of changing others expectations of her as well, <u>a new narrative/idea about her own ability and needs</u></p> <p>Family becoming the people who are there- as they used to be, but in this case a bit different- just on the end of the phone (like with the friends earlier), <u>an experience of a safety net she can take away that's still there? And breathing is kind of her own in built safety net?</u></p> <p>It was big. This was a really important step- experience of progress- of movement in a positive direction?</p> <p>Conversation as a tool of consolidation, speaking about progress writing a new understanding. <u>Dialogue terms of support, checking in, knowing you, supporting you, but also changing the power again a little bit.</u></p>
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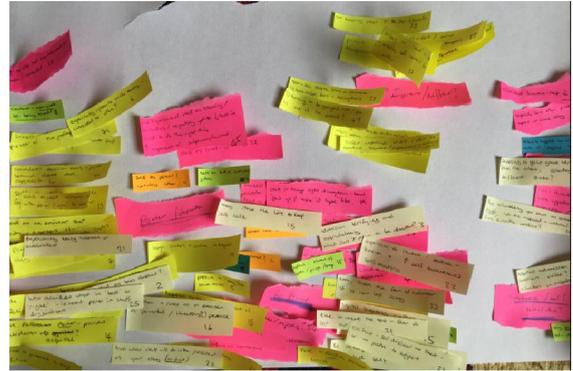
<p>Self reflected back a reflection space - shown to others.</p> <p>Contextual + supported</p>	<p>you said, I done it, I was fine, even though it was only a little shop, but you still done it or even down to the canteen, because you've got, all the nursing staff go there, all the staff so it gets quite packed but you actually, so really it is, it's <u>showing you</u>, yes you can do it, but you also know that there's someone nearby if you do need it, yeh <u>they're the safety net</u> yeh</p> <p>I: <i>OK and you've mentioned um once or twice the difference a bit between being sanctioned and um ... you said, there is nothing to panic about if you're voluntary. How is that different?</i></p> <p>P: Because when you're sanctioned you have to wait for someone to take you, you can</p>	<p>Conversation marked and pointed out little achievements, small steps were recognised through praise/ as progress. You still did it</p> <p>Chances to practise in all sorts of environments and get used to practising</p> <p>Being shown what you can do? How are you shown? Is this in the conversation and recognisiotn, the experience of being asked how it went seems really important in the learning.</p> <p>They're the safety net <u>Experience of being held, and having back up</u></p>
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<p>Other context for you - can remember</p> <p>Admits - friends</p>	<p>only go down and walk around the grounds and back up its only half hour it's not, and it's not really, and you're on your own you're solitary</p> <p>I: OK</p> <p>P: There's a difference 'cause it's one staff one person</p> <p>I: OK</p> <p>P: So <u>voluntary you're not like on your own</u>, as I said there was four of us and we always used to go together</p> <p>I: <i>How did those links form with the other ladies then?</i></p> <p>P: It, I don't know, we just seemed to click, yeh we was all sitting in the, the dining room one day and, and [friends name] said, "oh I'm [friends name]", so I said "hello I'm [participants name], how do you do [friends</p>	<p>Seems difficult to put her finger on what is different about being sectioned, you go down but you are with a staff member- feeling of not being trusted- does this make them feel more that she cant do it herself? Being solitary loses connection and discussion??</p> <p>Idea of commeraderie was a big featre in her experience, of togetherness belonging and support understanding?</p> <p>"dining room"- sounds more like a house than canteen or similar</p> <p>Again describes conversations, re-encating the to and fro, there seems to be something really important about talking in her experience</p>
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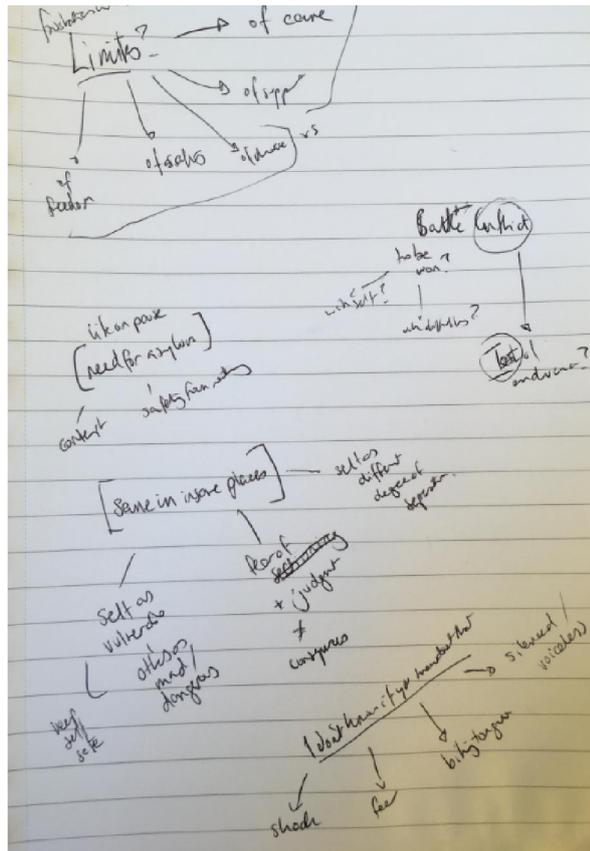
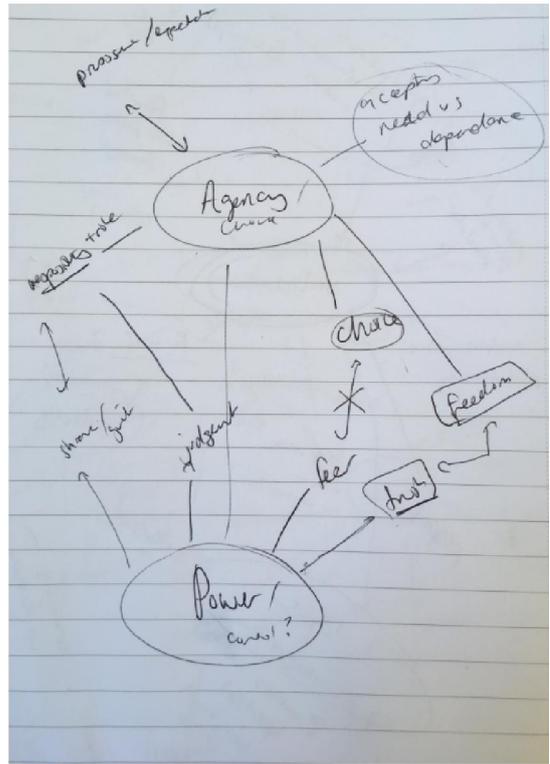
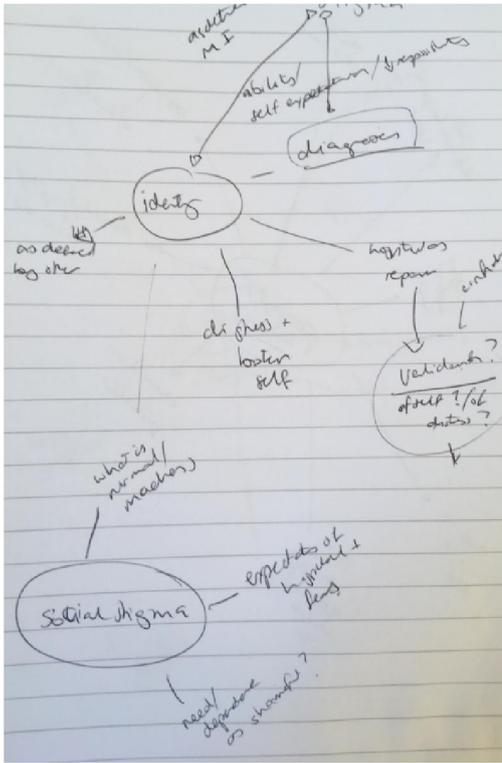
<p>experience of acceptance - group's ability</p> <p>Self ability in self as a friend</p> <p>avoiding bits in the hospital</p> <p>what is mental madness</p>	<p>name)", and then [second friends name], [third friends name], so we was all sort of, started talking and we just seemed to click, 'cause at first I was a bit, cause I'm not you know, and [friends name] said, we don't bite and it just made me <u>laugh</u>, you know and then that was it we done everything together, we go out together, we, 'cause on the grounds you sort of go down walk right the way round and they've got like a bench and it's under a gazebo and you can sit there watching the traffic and that like, "ahhh its <u>manic Dan</u>", like you know, and we'd have a laugh at some of the drivers as they were driving you know the way they was driving and that and it</p>	<p>They were all there already, an experience of them encouraging her to be friends with them to join them chat with them? Acceptance?</p> <p>Click? Get on?</p> <p>Im not? What is she not? Alluding to being shy? Not used to talking/ being asked to join in in this way?</p> <p>We don't bite- i.e. don't be afraid, did she seem nervous to them seem afraid?</p> <p>Laughter breaking the ice- allowing connection- <u>laughing not often thought about in hospital setting? making as well maybe different to previous experiences?</u></p> <p>Sit and watch the traffic- a connection to the outside, a semblance of life outside hospital just going and watching- <u>and allowing a different identitiv comparisons being made to "mad drivers" irony as they are ones in the "psychiatric hospital", labels and judgements. How do we decide what is "mad" or devia where are the points of out experience we base this on- what did the validation of these other women for her that shaped her experience?</u></p> <p><u>She uses the word Manic- last time she did this was discussing herself and her voices- she alludes to downs and it makes me wonder if she has been diagnosed with bipolar?</u></p>
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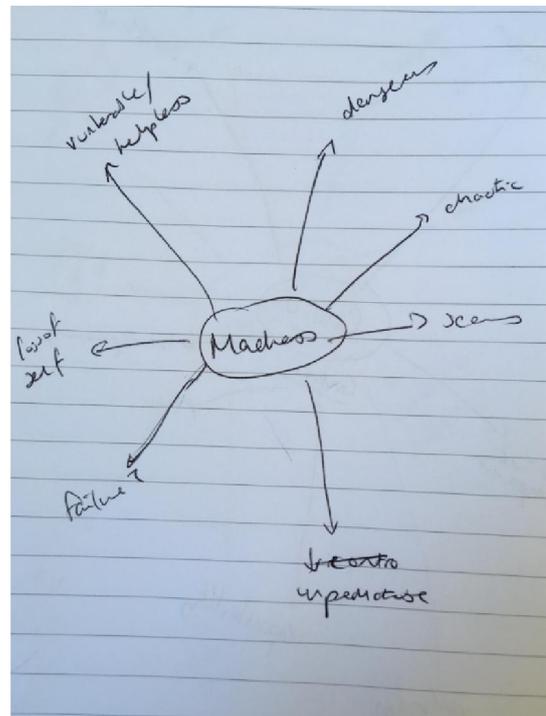
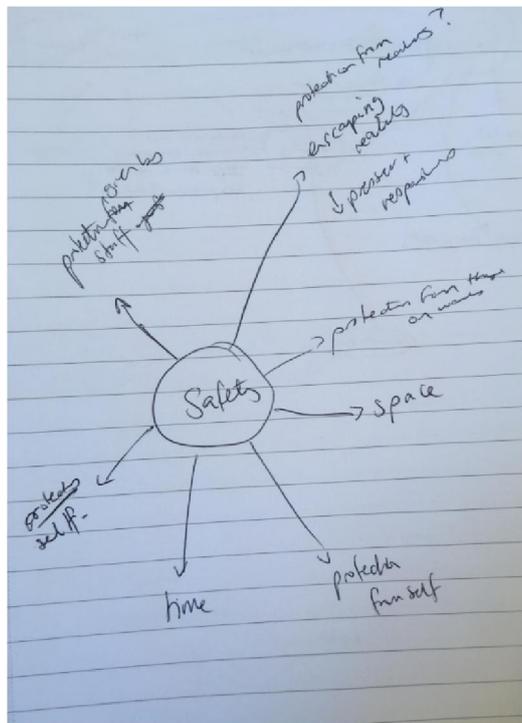
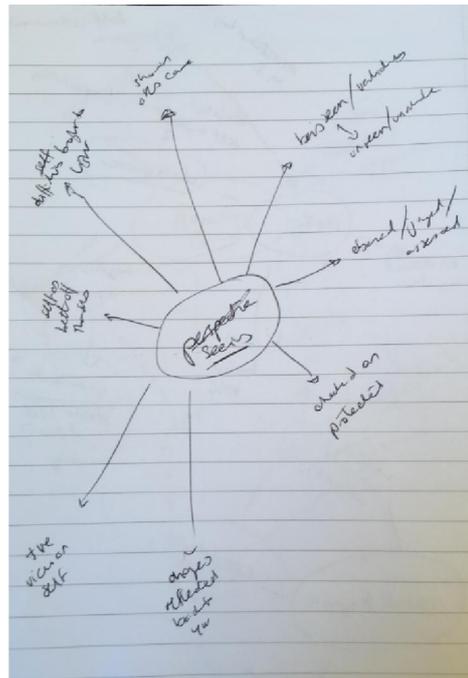
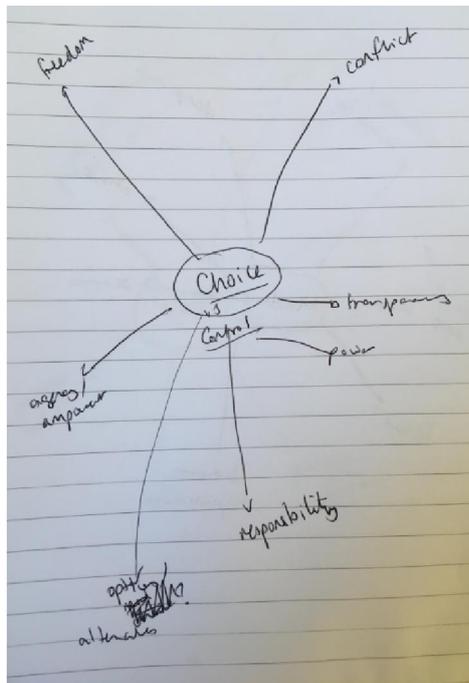
Appendix H: Mapping and Abstracting emerging themes

Emerging themes written alongside transcripts, transferred to post-its and grouped into emerging themes. Initial stages.



Initial mapping to link and abstract emerging themes, variations collapsing/ subsuming themes that link. Later stage after further checking back to the data.





Appendix I: Final themes, and groupings

Need	Identifying and Meeting Need	Needing to protect self on the ward
		Change in support at home following admission
		Admission as a communication of need
		Admission Validating need
		Feeling supported and looked after
		Feeling heard
		Dialogue important for being heard
		Support from other patients
		Hospital as safe space
		Protection from self
		Transparency and inclusion lead to validation
		reduced responsibilities on the ward
	Hospital as escape from outside difficulties	
	Barriers to meeting needs	feeling unheard/ misunderstood/ ignored
		Sense of exclusion form decision making
		Context of powerlessness outside hospital
		Ward as Tense
		Mistrust between patients and staff
		Ward as threatening/ dangerous
		Fear of sectioning/ Confinement
Difficulties facing vulnerability		
Self-protection masking need for support		
Pressure from others to leave		
Boundaries	Boundaries of Space/Movement	Monitoring and rules as containing
		Monitoring and rules as invasive
		Freedom within limits
		Space from the ward gives safety from ward
		increase freedom= increased independence/ownership
		Increased freedom with voluntary status
		Freedom of movement linked to safety
	Boundaries of Choice	Hospital as the only option to stay alive/ safe
		Increased choice= increased responsibility/ ownership/ guilt
		Family pressures reduce choice
		limits on choice on ward

		inconstant inclusion reduces choice
		choice at admission = acceptance of difficulty
		Voluntary status= increased choice
		Inconsistencies in choice= mistrust
	Boundaries of Expression	Voiceless through fear of retribution
		Frustration and anger vs denial and compliance
		Powerless to complain
	Boundaries of Care	conflict in staff role protector vs perpetrator
		Frustration at reduced staff motivation
		Effects of hospital temporary
		Admission does not affect real life context
		dissatisfaction in limits of care
		dissatisfaction in effectiveness of treatment
Identity	Judgement	Judgement from others (feared and real)
		Being assessed/ judged
		Shame asking for help- Self as bad
		Guilt at admission
		Need to prove innocence
		self at fault- hospital= self as failure
		Voluntary =judged less harshly
	Mental Health	Sense of belonging and community
		self helpless against mental disorder/ disorder as powerful
		Self / other as dangerous
		negative beliefs about mental health
		voluntary= mental health less bad
	Self-Transformation	Taking ownership of change
		Loss of self at admission
		Self repair over ward stay
		Increased self-esteem/ self-confidence
		experience changes perspective
		New hope or purpose

Appendix J: Reflective Diary Extracts

Interview 1: “I thought the interview went well, it was a little repetitive on my part, I was aware of trying not to lead but wanted to pick up certain things to explore in more depth. I kept feeling that maybe I wasn’t quite getting to the “essense” or the “feeling” of what it was like, there were a few key points that maybe I should have explored more. Definitely got strong messages coming from the interview, thinking about all stages of the admission felt fairly natural, got into it quite quickly but did definitely feel that we got to a deeper meaning bit later thinking about the idea of being treated like an “adult”. Sometimes could maybe have asked questions about details. One or two side tracks but not bad, felt that they were needed for rapport building. I think it took me a long time to explicitly understand that she was comparing the Morrison’s trip to the hospital admission in some ways. But this was good as it made her spell it out for me. I could definitely have left longer silences. I found it hard not to give lots of encouragement, especially about her recent achievement which seemed really important to her....

...I was aware of applying some psych theory to my understanding of what she said when she was talking- I tried to get her to explore these things further but may have lead a little based on my knowledge of a few things. Namely attachment theory and the idea of “secure base” and exploration. Maybe also the idea of graded exposure. Was also definitely thinking about the frameworks of “autonomy” and “empowerment” when she was talking and this again may have led me a bit further away from the comment of her words, or her own understanding of experience....”

Interview 2: “More confused interview ... much harder to come back to experience and “phenomena” without leading etc. Lots of the chronology was quite difficult to follow....

... I kept noting similarities and differences and this may have informed/ lead my follow up questions a little bit. I wonder if I was first to use the word “confident”. I picked up on emotions as much as I could and tried to explore “good” and “scary”. It was hard to separate the experience from the experience of being bipolar- maybe actually to her they were one and the same and I kept missing that? Maybe I could have further explored how the two linked or what having bipolar was like, in hospital- i.e. “what did it mean to have bipolar in hospital?” ...lots of experiences of admissions. Some concern about blurs between experiences, and it was difficult to tell if she has had multiple voluntary admissions or not. Again there was some important comparisons made. Not sure if it safe to assume opposite experience to sectioning by default, which I may have done at times,. i.e. when asked “how is it different”, they say well it was like XXX on section- is it safe them to assume that not on section is not like that?...

...she said “it was brave of me to do”- i.e. go into hospital, after we had finished recording ...”

Interview 3: “Observations in the room: more nervous of me, more distrusting. Quite a negative view of the ward, getting through it not talking to anybody etc. Quite a lot of leading questions- wonder what avenues I may have cut off through follow up questions, Disclosed a lot re trauma, quite aware of finding this difficult to manage in the room, two heads re risk and clinical vs research. I wonder if my responses to disclosures weren’t researchy enough and if my difficulty wearing the two hats meant I missed times I could have further explored an experiential element but got caught up with making links/ summarising etc....

blame (though historic relationship with men bad- father as abuser)....

...How might she have positioned me? Similar age, she talked about how young staff were, I should maybe have explored this further...”

Interview 4: “Harder to talk at length and get lots of information, quite short interview. she was also clearly not very well lots of sniffing and sneezing so had a feeling of not wanting to keep her which may be why I didn’t prod and explore so much. Shorter answers needed much more prodding. She also arrived 30 mins later than id expected I had kind of given up waiting and because of this I did not spend as much time with her as id have liked..

why was she embarrassed about admission? What would happen if she was honest?

... conflicts of wanting help but being scared, lots of unknowns and implicit threats/ fears about what might happen/could happen I

She said “obviously” a lot like assuming I have a certain amount of knowledge about the system. As the interviewer I struggled to push her, felt that it was important that she trusted me..

Interview 5: “Kept referring to being “paranoid”, not wanting to tell things, taking along time, asked at the beginning do you want positive or negative feedback – I replied honest experience. She said at the end, I had worse stories than what I told you, she also referred to being worried about notes, and worried that this research will get back to those working on the ward...

After the recording: At the end she said that voluntary people seemed to want to be there, and needed to be there whereas sectioned people don’t want to be there and it makes them worse so it doesn’t make sense, a feeling that there should be more space of calm for those who are voluntary.

She was tearful at times and it was clear she still was not in a great place, and felt that people hadn’t realised the extent of her difficulties, I really wanted to help with that- gave lots of ideas at the end and recommended her talk to her GP.

Aware of the issue of race and who I represented as a white middle class female in education, I have not brought it up in particular, but wonder about it and whether it effects her experience of the wards (I imagine it does), but don’t know if she would have wanted to talk about it. My presence maybe shuts off certain avenues of conversation.”

Appendix K: SREC Approval


London - Central Research Ethics Committee
3rd Floor, Barlow House
4 Marshall Street
Manchester
M1 3DZ

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

27 September 2017

Miss Catherine Iredale
Trainee Clinical Psychologist
Camden and Islington NHS Trust
Doctoral Programme in Clinical Psychology, School of Psychology,
University of East London, Stratford Campus,
Water Lane, London
E15 4LZ

Dear Miss Iredale

Study title:

Exploring how people make sense of and understand their experiences of voluntary psychiatric admissions to Acute Wards in East London: An Interpretative Phenomenological analysis.

REC reference:
17LO1410

Protocol number:
N/A

IRAS project ID:
219410

Thank you for your email of 25th September 17, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further

information, or wish to make a request to postpone publication, please contact ira.studies@nhs.uk outlining the reasons for your request.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

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

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

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

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

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

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

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

Registration of Clinical Trials

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

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

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

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

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

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Approved documents

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

Document	Version	Date
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Indemnity Certificate]	1	11 May 2016
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [new]		11 August 2017
GP/consultant information sheets or letters [Letter to GP or Clinical Case Manager]	1	03 July 2017
Interview schedules or topic guides for participants [Interview Schedule]	1	03 July 2017
IRAS Application Form [IRAS_Form_02082017]		02 August 2017
IRAS Checklist: XML [Checklist_02082017]		02 August 2017
IRAS Checklist: XML [Checklist_25092017]		25 September 2017
Other [Service User Consultation_Meeting Minutes]	1	03 July 2017
Other [Participant Debrief Information]	1	03 July 2017
Other [Participant Information Sheet V2 Final copy]	V2	18 September 2017
Other [Consent Form V2 Tracked Changes]	V2	18 September 2017
Other [Consent Form V2 Final Copy]	V2	18 September 2017
Other [University of East London Data Policy]	V1	07 October 2015
Other [Letter of Response to Provisional Opinion]		25 September 2017
Participant information sheet (PIS) [Tracked]	2	18 September 2017
Research protocol or project proposal [Study Protocol]	1	03 July 2017
Summary CV for Chief Investigator (CI) [CV_Chief Investigator]	1	03 July 2017
Summary CV for student [Student_CV]	1	03 July 2017
Summary CV for supervisor (student research) [Supervisor CV]	1	03 July 2017
Summary CV for supervisor (student research) [Local Collaborator CV]	1	03 July 2017

Summary, synopsis or diagram (flowchart) of protocol in non technical language [Summary flow Chart]	1	03 July 2017
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Statement of compliance

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

After ethical review

Reporting requirements

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

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

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

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
<http://www.hra.nhs.uk/about-the-hragovernance/quality-assurance/>

HRA Training

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

17/LO/1410 Please quote this number on all correspondence

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

Yours sincerely



pp
Dr Andrew Hillson
Chair

Email: NRESCcommittee.London-Central@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: Dr Mark Finn, University of East London
Ms Karin Albanji, East London NHS Foundation Trust

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The document “After Ethical Review – guidance for sponsors and investigators”, issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, 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.

In addition to the guidance in the above, please note the following:

- HRA Approval applies for the duration of your REC favourable opinion, unless otherwise notified in writing by the HRA.
- Substantial amendments should be submitted directly to the Research Ethics Committee, as detailed in the After Ethical Review document. Non-substantial amendments should be submitted for review by the HRA using the form provided on the [HRA website](http://www.hra.nhs.uk), and emailed to ira.amendments@nhs.net.
- The HRA will categorise amendments (substantial and non-substantial) and issue confirmation of continued HRA Approval. Further details can be found on the [HRA website](http://www.hra.nhs.uk).

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at <http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-cc-review/>.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

Miss Catherine Iredale
Trainee Clinical Psychologist
Camden and Islington NHS Trust
Doctoral Programme in Clinical Psychology, School of
Psychology,
University of East London, Stratford Campus,
Water Lane, London
E16 4LZ

Email: iraapproval@nhs.net

27 September 2017

Dear Miss Iredale

Letter of HRA Approval

Study title: Exploring how people make sense of and understand their experiences of voluntary psychiatric admissions to Acute Wards in East London; An Interpretative Phenomenological analysis.

IRAS project ID: 219410
REC reference: 17/LO/1410
Sponsor: University of East London

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read Appendix B carefully**, in particular the following sections:

- **Participating NHS organisations in England** – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- **Confirmation of capacity and capability** - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- **Allocation of responsibilities and rights are agreed and documented** (4.1 of HRA assessment criteria) - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: <http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

Your IRAS project ID is 219410. Please quote this on all correspondence.

Yours sincerely

Kevin Ahmed
Assessor

Telephone: 0207 104 8171
Email: hra.approval@hhs.net

Copy to: *Dr Mark Finn, Sponsor Contact, University of East London*
Ms Karri Albani, R&D Contact, East London NHS Foundation Trust

Appendix A - List of Documents

The final document set assessed and approved by HRA Approval is listed below.

Document	Version	Date
Evidence of Sponsor Insurance or indemnity (non NHS Sponsors only) [Indemnity Certificate]	1	11 May 2016
Evidence of Sponsor Insurance or indemnity (non NHS Sponsors only) [new]		11 August 2017
GP/consultant information sheets or letters [Letter to GP or Clinical Case Manager]	1	03 July 2017
HRA Schedule of Events	1.0	27 September 2017
HRA Statement of Activities	1.0	27 September 2017
Interview schedules or topic guides for participants [Interview Schedule]	1	03 July 2017
IRAS Application Form [IRAS_Form_02082017]		02 August 2017
Other [Service User Consultation_Meeting Minutes]	1	03 July 2017
Other [Participant Debrief Information]	1	03 July 2017
Other [Participant Information Sheet V2 Final copy]	V2	18 September 2017
Other [Consent Form V2 Final Copy]	V2	18 September 2017
Other [University of East London Data Policy]		07 October 2015
Other [Letter of Response to Provisional Opinion]	V1	25 September 2017
Research protocol or project proposal [Study Protocol]	1	03 July 2017
Summary CV for Chief Investigator [CV_Chief Investigator]	1	03 July 2017
Summary CV for student [Student_CV]	1	03 July 2017
Summary CV for supervisor (student research) [Supervisor CV]	1	03 July 2017
Summary CV for supervisor (student research) [Local Collaborator CV]	1	03 July 2017
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Summary flow chart]	1	03 July 2017
17 LO 1410 FHO Z7 08 17		27 September 2017

Appendix B - Summary of HRA Assessment

This appendix provides assurance to you, the sponsor and the NHS in England that the study, as reviewed for HRA Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England to assist in assessing and arranging capacity and capability.

For information on how the sponsor should be working with participating NHS organisations in England, please refer to the *participating NHS organisations, capacity and capability and Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria) sections in this appendix.*

The following person is the sponsor contact for the purpose of addressing participating organisation questions relating to the study:

HRA assessment criteria			
Section	HRA Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	The sponsor has submitted the HRA Statement of Activities and intends for this to form the agreement between the sponsor and study sites. The sponsor is not requesting, and does not require any additional contracts with study sites.

Section	HRA Assessment Criteria	Compliant with Standards	Comments
4.2	Insurance/indemnity arrangements assessed	Yes	Where applicable, independent contractors (e.g. General Practitioners) should ensure that the professional indemnity provided by their medical defence organisation covers the activities expected of them for this research study
4.3	Financial arrangements assessed	Yes	No application for external funding has been made. No study funding will be provided to sites, as detailed at Schedule 1 of the Statement of Activities.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Yes	No comments
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.

All participating NHS organisations will undertake the same study activities. There is therefore only one study site 'type' involved in the research.

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. For further guidance on working with participating NHS organisations please see the HRA website.

If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England which are not provided in IRAS or on the HRA website, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net. The HRA will work with these organisations to achieve a consistent approach to information provision.

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken

Where arrangements are not already in place, network staff (or similar) undertaking any of the research activities listed in A18 of the IRAS form a Letter of Access based on standard DBS checks and occupational health clearance would be appropriate.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England to aid study set-up.

The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRIN Portfolio.

Confirmation of Capacity and Capability

This describes whether formal confirmation of capacity and capability is expected from participating NHS organisations in England.

NHS organisations in England that are participating in the study will be expected to formally confirm their capacity and capability to host this research.

- Following issue of this letter, participating NHS organisations in England may now confirm to the sponsor their capacity and capability to host this research, when ready to do so. How capacity and capability will be confirmed is detailed in the Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria) section of this appendix.
- The Assessing, Arranging, and Confirming document on the HRA website provides further information for the sponsor and NHS organisations on assessing, arranging and confirming capacity and capability.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and the minimum expectations for education, training and experience that PIs should meet (where applicable).

A Local Collaborator should be appointed at study sites.

GCP training is not a generic training expectation, in line with the [HRA statement on training expectations](#).

Appendix M: University Ethics Approval (UREC)



29th May 2018

Dear Catherine

Project Title:	Exploring how people make sense of and understand their experiences of voluntary psychiatric admissions to Acute Wards in East London; An Interpretative Phenomenological analysis
Researcher(s):	Catherine Iredale
Principal Investigator:	Catherine Iredale

I am writing to confirm that the application for the aforementioned NHS research study reference **17/LO/1410** has received UREC ethical approval and is sponsored by the University of East London.

The lapse date for ethical approval for this study is **29th May 2022**. If you require UREC approval beyond this date you must submit satisfactory evidence from the NHS confirming that your study has current NHS R&D ethical approval and provide a reason why UREC approval should be extended.

Please note as a condition of your sponsorship by the University of East London your research must be conducted in accordance with NHS regulations and any requirements specified as part of your NHS R&D ethical approval.

Please confirm that you will conduct your study in accordance with the consent given by the Trust Research Ethics Committee by emailing researchethics@uel.ac.uk.

Please ensure you retain this approval letter, as in the future you may be asked to provide proof of ethical approval.

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



Catherine Fieulleau
Research Integrity and Ethics Manager
For and on behalf of
Dr Lisa Mooney
University Research Ethics Committee (UREC)
Research Ethics
Email: researchethics@uel.ac.uk

Appendix N: Participant information sheet

Participant Information Sheet; 18/09/2017; V2

How do people make sense of their experience of voluntary admission on acute psychiatric wards?

We would like to invite you to participate in this study. Before deciding whether or not you would like to participate please take time to read the following information carefully.

What am I being asked to do?

You are being invited to take part in a research study exploring the lived experience of voluntary admissions on acute psychiatric wards. This study is being conducted to fulfil requirements to obtain a Doctorate in Clinical Psychology (DClin-Psy) at the University of East London. Once you have read the information sheet please ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

The purpose of the study is to explore how people make sense of voluntary admission and their experiences of the admission process, stay on the ward and discharge process. Previous research has focussed on specific aspects of the admission experience whereas we hope to gain a broader and richer understanding of what being on the ward voluntarily is like and what people's understanding of their experience is. I hope to gain this broader understanding by talking in depth with people who have experienced this first hand. I hope that this research will raise the profile an understanding around personal experience in this field and effect future service planning and delivery.

Why have I been asked to take part?

We are inviting you to take part in this study as you have first-hand experience of being on an acute psychiatric ward under a voluntary admission and you are either on the ward currently or have been within the last two months.

Do I have to take part?

No, you do not have to participate in this research and declining to take part will not affect the care you receive in any way. If you do decide to take part, you will be given this information sheet to keep and will be asked to sign a consent form when you meet before you participate.

Can I change my mind?

If you do decide to take part you are free to withdraw your contribution without giving a reason, if you do decide to withdraw at any point the care you receive will not be affected. If, after you have completed the interview, you decide you do not wish for your interview to be transcribed and analysed, you will have two weeks to withdraw your input. After two weeks your interview may already have been analysed and it will be impossible for the researcher to fully remove its influence from the analysis.

What will happen to me if I decide to take part?

The study will involve meeting with a researcher to complete a semi-structured interview, which should take around 60 minutes to complete. If you are currently on the ward, the interview will take place once you have been discharged from the ward. The questions you will be asked will be about your experience and understanding of your most recent voluntary psychiatric admission. The interviewer will ask you a short set of questions but will be interested to explore the aspects of your experience which were of importance to you. The questions were designed alongside people who have personal experience of staying voluntarily on inpatient wards. You will be under no obligation to answer any question you do not wish to.

The interview meetings will take place off the wards in a convenient NHS or University space for you to attend. We will be asking for your consent to audio-record the interview and you are also free to audio record the interview yourself. The audio- recording will only be listened to by the interviewer, no other member of the research team will have access to it.

Will my information be confidential?

All of your responses will be confidential and anonymous. They will be stored on a password protected computer and will be identifiable only by a number, not by your name. We will ask for your consent to include anonymised quotations in research publications and training.

If, at any point, you disclose an occurrence of harm or risk of harm to yourself or anyone else, the interview will be stopped and the interviewer will be obliged to breach confidentiality and refer the concern to an appropriate authority.

Your care team (GP or Care coordinator) will be notified of your participation in this study, with your consent. They will not have access to any information you give in the study and your interview will not be shared with the team. However, if you disclose information that raises concern for your safety or the safety of others we would let the staff relevant to your care know, following discussion with you to ensure you receive the most appropriate support.

What are the possible risks of taking part?

It is not expected that participation in the study has any risks. If you find any of the discussions or questions asked during the interview cause you distress, the interview will be stopped and you will be referred to an appropriate member of clinical staff for support. In addition you will be provided with the details of relevant services to contact for follow-up support.

What are the possible benefits of taking part?

Taking part in this research will not directly benefit the participant but we hope that the experiences offered by participants for this research will help to inform understanding of the effects of voluntary admission on individuals and inform service planning and delivery both during and following admission, to improve experience and outcome for future service users.

It will not be possible to reimburse any expenses incurred in taking part in the study.

What will happen to my information once the study is complete?

Once the study is complete, study information pertaining to you will be kept for up to five years, in accordance with University guidelines, as evidence of the research findings to support publications of the outcomes of the research. You will be provided with the outcomes of the study and summary of the research unless you state you do not wish to receive one.

Who has reviewed the study?

The study has been approved by the University of East London. Additionally, all research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given a favourable opinion. IRAS Ethics Code: 219410

Who do I contact if I wish to make a complaint?

If you are unhappy with the way you are treated by staff involved in the study or experience changes in your care which you perceive to be related to your participation in the study you are within your rights to complain to the relevant service. Details of the complaints procedures are available below:

XXXXXXXXXXXXXXXXXXXXX or
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

UEL: Dr Libby Watson:

020 8223 4220 / Dr Mark Finn:

How do I contact the research team?

If you would like further information about the research or have questions about taking part please contact the research team using the details below:

Researcher: **Cat Iredale**, Trainee Clinical Psychologist, at University of East London;

Email:

Cat will be visiting the hospital once a week but can receive messages of interest or queries through other members of staff.

Local Research Contact: **XXXXXXXXXXXX** **XXXXX** works at **XXXXXXXXXXXX** and can be contacted through clinical staff on the wards.

Research Supervisor: **Dr Libby Watson**, Clinical Psychologist;

If you have any question regarding your rights as a research participant or general guidance around participating in research please contact the team at INVOLVE: www.invo.org.uk

Appendix O: Participant consent form

CONSENT FORM: 18/09/2017; V2

How do people make sense of their experience of voluntary admission on acute psychiatric wards?

Name of researcher: Cat Iredale

Please initial boxes:

1. I confirm that I have read the information sheet dated 18/09/2017 for the above study. I have had the opportunity to consider the information and ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw from the study at any point up until two weeks after interview. I understand that withdrawal from this study will not affect the care I receive in any way.
3. I am willing for my meeting with the researcher to be audio-recorded and for anonymous quotations to be used in the results, write up, and research publications. I understand that I am also free to audio- record the interview if I wish to do so.
4. I understand that my personal information and audio-recording will only be available to the interviewer (Cat Iredale), and that the anonymised interview transcript will be kept confidential and will only be accessed by the research team (Cat Iredale and Libby Watson).
5. I am willing for my care team (GP or Care Coordinator) to be informed of my participation in this study. I understand that they **will not** have access to the information I give in interview.
6. I understand that if I become distressed or disclose information that raises concern about my safety or the safety of others, the interview will be stopped and I will be referred to an appropriate member of clinical staff or relevant authority.

7. I understand that my data will be stored securely and will be kept for up to five years after the study in order to publish the results.

8. I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from the University of East London, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

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

Name of participant

Date

Signature

9. I have explained the study to this participant and answered their questions honestly and fully.

Name of researcher

Date

Signature

Appendix P: Debrief information

Support Service Directory

Crisis Care Providers:

If you become distressed following this interview and are concerned that are no longer safe, please visit A&E at the below address to receive appropriate emergency support.

- XXX

Support services:

If you would like to talk to someone for emotional support following this interview there are a number of places you can contact for advice.

If you receive care and support from a local Mental Health team you can contact them on the relevant number below.

- XXXXXXXXXXXXXXXXXXXX
- XXXXXXXXXXXXXXXXXXXX

If you do not receive ongoing support from a specific mental health team you can contact your GP.

There are also a number of National helplines available for anyone to call should they want support or advice over the phone:

- **Samaritans: 116 123 (UK).** *For emotional support.*
- **Rethink: 0300 5000 927;** *Advice and information service*
- **Mind: 0300 123 3393;** info@mind.org.uk; Text: 86463. *For information about where to get help and advocacy.*

Complaints services:

If, following participation you wish to make a complaint about the research itself please contact Dr Libby Watson at the University of East London.

- **Dr Libby Watson:** l.a.watson@uel.ac.uk; **020 8223 4420**

If you wish to make a complaint, or give feedback on the care you received in hospital please contact the patient advice and Liaison service at XXXXXX:

- XXX

Appendix Q: Example Letter to GP/Staff member

[Address]

[Date]

Dear [GP/ Care Co-ordinator Name]

RE: Name: **DoB:** **Address:**

I am writing to inform you that [Participant Name] has given their consent to participate in a qualitative research study exploring how people make sense of their experience of voluntary admission to acute psychiatric wards. The research procedure requires that [Participant Name] engages in an interview asking questions about their most recent admission. For further information please see the Participant Information sheet attached.

If you have any further questions about the study please do not hesitate to contact me, or [local collaborator], the local collaborator for the study on the details given above.

Yours Sincerely,

Cat Iredale

Trainee Clinical Psychologist