

EXPLORING SEVERE MENTAL HEALTH PROBLEMS AND INVOLUNTARY ADMISSION TO
PSYCHIATRIC HOSPITAL

By

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Overview

Volume I

Volume I consists of three chapters. The first chapter is a systematic review exploring the factors associated with coercion in those who are involuntarily admitted to hospital. Those with psychosis, aggression and poor global functioning were some of the factors associated with a higher likelihood of experiencing coercion. The second chapter outlines an empirical research study exploring the experience of being detained under Section 136 of the Mental Health Act (1983, 2007) using Critical Incident Technique (Flanagan 1954, Butterfield, Borgen Maglio & Edmunson, 2009). Semi-structured interviews were used to explore experiences of being detained, specifically identifying critical incidents which affected how the individual coped. A number of helpful, unhelpful and wish-list items were identified. The importance of meaningful human relationships was found to underpin many of the critical incidents. The third and final chapter is a public domain briefing document which provides a concise and accessible summary of both the systematic review and the empirical research study.

Volume II

Volume II consists of five chapters, each containing a Clinical Practice Report (CPR). The first report outlines the details of a 14 year old girl with anxiety formulated using cognitive-behavioural and systemic models. The second report presents a service evaluation of a dialectical behaviour therapy group provided by a CAMHS service, from both staff and young people's perspectives. The third report outlines the case study of a 72 year old woman with a fear of falling, formulated using a cognitive-behavioural approach. The fourth report documents a single case experimental design, evaluating the efficacy of a cognitive-behavioural therapy for psychosis with a 32 year old female experiencing distressing auditory hallucinations. The fifth chapter is the abstract of an oral presentation made outlining the use of cognitive analytic therapy to formulate the difficulties of a 32 year old male with avoidant personality traits.

All names and identifying features have been removed to ensure confidentiality.

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Chapter One

What does the literature tell us about what factors are associated with coercion in those who are involuntarily admitted to psychiatric hospital?

Abstract

Background

The Mental Health Act (1983, 2007) provides legislation for the care of those experiencing significant mental illness, with increasing numbers of people being involuntarily admitted to psychiatric hospital. The use of involuntary admission is often in conflict with the belief that an individual's autonomy and liberty should be protected, meaning that the process can often be experienced as coercive. Whilst there is some information available about the prevalence of involuntary hospital admission, there is significantly less known about the factors which might be associated with experiencing this process as coercive.

Aim

This review looked to explore what factors are associated with the experience of coercion during involuntary psychiatric hospital admission.

Method

A systematic search of four databases was conducted, focusing on the experience of coercion and involuntary admission. A total of 244 studies were evaluated against inclusion and exclusion criteria, with 11 being included for review here.

Results

This review identified that factors such as experiencing psychosis or poorer global functioning, episodes of aggression or self-harm and having particular personality traits were associated with the experience of coercion during the involuntary admission process. Organisational and cultural factors were also identified in association with coercion.

Conclusion

Factors which affect the experience of coercion during involuntary admission are complex, perhaps reflecting the nature of the difficulties for which people need help. The development of international legislation on involuntary detention would help to facilitate a consistent approach to involuntary admission, creating a rich environment for potential future research. Future research would benefit from exploring cultural factors and the views of difficulties such as psychosis held by clinicians involved in the admission process. Furthermore, developing the understanding of those with complex mental health difficulties in staff groups may assist in viewing the individual in a holistic manner rather than solely their presenting difficulties.

Introduction

The Mental Health Act

The Mental Health Act (1983), as amended by the Mental Health Act (2007), provides legislation for the care and treatment of those with severe mental health problems in the United Kingdom. The act outlines that those with a 'suspected disorder or disability of the mind' can be compulsorily detained within psychiatric hospital for the purposes of treatment, which has been recommended following an assessment by approved clinicians. It stipulates that the health and safety of the individual or that of another person must be at risk in order to be admitted to hospital on a compulsory basis. The ability to utilise involuntary admission is one which is unique to the field of psychiatry, with the use of coercive measures being legally sanctioned under limited conditions (Riecher-Rossler & Rossler; 1993 Salize, Dreßing & Peitz, 2002).

Definition of Coercion

The concept of coercion within psychiatric care is defined in a somewhat unhelpfully flexible manner throughout the available literature, ranging from the idea of the use of crude force such as physical intervention, to influences on autonomy and choice through interpersonal factors such as power or social status (O'Brien & Golding, 2003). Medical and bioethics literature adopts a broad view of coercion. Lakeman (2000) cites coercion as the use of objective interventions such as physical force or bodily harm, whilst Engelhardt (1996) refers to coercion as the use of social influence or power to initiate action or change without restricting this definition to solely physical force. Coercion has also been defined to involve implied or threatened action meaning the exclusion from being considered as an active participant in the admission process (Iverson, Hoyer, Sexton & Kristian, 2009; Newton-

Howes & Mullen, 2011). Curtis & Diamond (1997) take a similar view, extending the nature of coercion to include the way in which services are designed and delivered, meaning processes such as involuntary admission within the mental health system can also be included in the definition of coercion (O'Brien & Golding, 2003, Curtis & Diamond, 1997).

The definition of coercion therefore involves, but is not solely limited to, objective intervention or constraints applied to an individual. Coercion may also involve the implied or actual use of subjectively experienced processes, such as social status or power to exclude or minimise choice and autonomy (O'Brien & Golding, 2003, Lakeman, 2000). These coercive processes are delivered by an individual such as a nurse or doctor, as part of a wider team, or facilitated through the way in which an organisation is constructed.

Whilst definitions of coercion within the literature can be unhelpfully flexible, what is inherently similar to both objectively imposed constraint, subjectively experienced coercion, is the consequent removal or limitation of choice for the individual. This is something previously conceptualised as "perceived coercion", an internal subjective state marking the experience of being coerced through a lack of consent (Newton-Howes & Mullen, 2011).

The importance of adopting the current literature's broad definition of coercion is therefore highlighted when considering that both objective constraints and subjective experiences result in the limitation of choice and the perception of being coerced (Newton-Howes & Mullen, 2011, O'Brien & Golding, 2003).

As such, this review looks to adopt a similar stance to previous research by arguing for adopting this broad definition of coercion which includes objective constraint and subjectively experienced coercion (Newton-Howes & Mullen, 2011; O'Brien & Golding,

2003). Whilst it has its limitations in being less specific, acknowledging the perception of coercion for the individual, through whichever means this may be administered, allows this review to focus on identifying the factors which are associated with the distressing experience. Similarly, this position of allowing for differences in how coercion may be categorised in order to understand who may be more at risk of this experience of limited or removal of choice, whether objective constraint or subjectively interpersonal process, is something previously adopted by authors in this area (Newton-Howes & Mullen, 2011; O'Brien & Golding, 2003, Curtis & Diamond, 1997,). The nature of coercion in the psychiatric healthcare system is complex and multi-faceted, and as such, authors have often adopted a definition which reflects this intricacy (Newton-Howes & Mullen, 2011; O'Brien & Golding, 2003, Curtis & Diamond, 1997, Lakeman, 2000).

Rates of Detention

At the end of the 2014/2015 reporting period a total of 19,656 people had been admitted to a psychiatric hospital on an involuntary basis using the Mental Health Act (1983, 2007) (Health & Social Care Information Centre, 2015). This reflects a 6.7% increase in the use of involuntary detentions since the previous reporting year, and a concerning 20% increase since 2011. However, previous research shows that those who are involuntarily admitted to hospital are more likely to view their admission as unjustified and report less satisfaction with treatment, resulting in poorer levels of social functioning and a higher risk of rehospitalisation (Kallert, Glockner & Schutzwahl, 2008, Katsakaou & Priebe, 2007, Jaeger, et al, 2013).

Involuntary admission, ethics and consequences

Progressing with the decision to involuntarily admit an individual with a mental health problem can therefore often involve choices being made about treatment guided largely by legislation, rather than shared agreement between patient and clinician. The use of the Mental Health Act (1983, 2007) is arguably a key pillar in the foundations of safe and effective care for those with severe mental health issues. However, every decision taken using this involuntary approach to treatment has a significant impact on a distressed and often vulnerable individual. The choice to involuntarily admit somebody to hospital that is experiencing a severe mental health problem is a difficult one, ideally requiring awareness, and an integration of the individual's perspective on their difficulties. However, the admitting clinician's reasons for an involuntary admission may not necessarily be shared by the individual experiencing the difficulties (Kallert et al, 2007). This in turn creates conflict with the idea of autonomy, one of the most pertinent ethical principles which safeguard a patient's liberty (Beauchamp, 2011). Negotiating the complex factors involved in the relationship between clinician and potential patient during psychiatric admission is therefore one part of managing this conflict (Newton-Hownes & Mullen, 2011).

Interestingly, the current literature is unclear as to whether the potential benefit from an involuntary admission on an individual's mental health outweighs the drawbacks of imposing treatment on an individual (Beauchamp, 2011, Kallert, 2007). Specific areas such as quality of life and satisfaction with future treatment are however affected, due to feelings of restriction and loss of involvement in on-going care (Kallert, 2008; Fiorillo, et al, 2011, Katsakou & Priebe, 2007).)

How an individual experiences their care within the first week of admission is also a relevant indicator for the long term outcomes for treatment for those who are involuntarily admitted (Priebe et al, 2011). The expectation that the individual may later reflect back on the experience and agree with the decision to involuntarily admit has been found to be inaccurate, and benefits achieved by the involuntary admission process itself may be limited due to a sense of being dehumanised (Gardener, Lidz, Hoge, Manahan & Eisenberg et al, 1999, Van den Hooff & Goossensen, 2014, Wertheimer, 1993, Katsakou & Priebe, 2007). Despite this, research has found that the public view coercion as justifiable when preventing the individual from any potential future harm to themselves, or to others (Pescosolido, Mahan, Stueve & Kikuzawa, 1999). Moreover, involuntary admission has also been shown to have an impact on wider support networks such as the family with family members feeling unheard and reporting damage to relationship they had with the individual who was admitted (Hallam, 2007). It is difficult therefore to begin to draw any type of consensus about the benefits and costs of involuntary admission, given the varied findings reported in the literature about the potential benefits and limitations that have been identified.

Literature around coercion

The currently available literature suggests that therefore that an experience of involuntary admission can frequently involve a restriction or withdrawal of autonomy and involvement in decision making (Katsakou & Priebe, 2007). A previous review of ways to improve the quality of care found that when those who were involuntarily admitted to psychiatric hospital felt they were considered as part of their care, and that professionals were genuinely interested in their wellbeing, they found it easier to accept compulsory admission and care and consequently perceived the process as less coercive (Van den Hooff &

Goossensen, 2014). Staff who were able to consider the need for objective admission and safeguarding whilst also subjectively viewing the person as a human with feelings and needs were found to contribute to 'good coercive care' (Van den Hoff & Goossensen, 2014, Martinsen, 2011). It is clear therefore that the subjective experience of the relationship between the individual and admitting clinician can significantly affect whether that individual perceives the experience as coercive (Sheehan & Burns, 2011). There is however a concerning lack of clarity regarding the circumstances under which an individual may be subject to coercive measures due to a lack of cross-national harmonization of legal processes (Kallert, 2008).

Previous Review

Newton-Howes and Mullen (2011) reviewed empirical literature prior to 2009 to explore themes and correlates of coercion in those within psychiatric care. The review found no consistent evidence about who may be more likely to experience coercion. Biopsychosocial correlates such as gender, psychopathology and ethnicity showed mixed results, providing no clear picture. Thematic analysis of subjective experience demonstrated that, similar to previous research, those who reported perceived coercion often felt dehumanised and unheard.

In the context of the rising rates of involuntary admissions and increasing pressures on the National Health Service (NHS), developing a deeper understanding of the biopsychosocial correlates associated with coercion during hospital admission appears to be a timely question. Updating Newton-Howes and Mullen's (2011) review allows the development of understanding important research which has a clear clinical, socio-economical and public

health benefit in identifying and supporting those who are more likely to be involuntarily admitted to psychiatric hospital.

Questions and Aims

There is no current systematic synthesis of factors which might be likely to contribute to the individual perceiving their involuntary admission to psychiatric hospital as coercive. The current review looks to progress from the initial findings drawn within Newton-Howes and Mullen's (2011) review, using its initial findings as a context to conduct a systematic search of the most current literature available.

Evaluating the most recent evidence provides a means through which systems and clinicians may be able to understand who may be likely to perceive their admission as coercive. This has a number of clear benefits, most significantly through being able to use this synthesis of evidence to develop 'good coercive care' (Martinsen, 2011), and providing opportunities for healthcare providers to identify those at risk earlier on. This systematic review is therefore focused on the question:

'What does the literature tell us about what factors are associated with coercion in those who are involuntarily admitted to psychiatric hospital?'

Method

Scoping exercise

Prior to the literature search, a scoping exercise was conducted to ensure that the current review was not duplicating any recent reviews exploring coercion in those who are involuntarily admitted to hospital finding one previous review from Newton-Hones and

Mullen (2011). The paper was obtained and reviewed in detail. The most recent studies included in this review were dated as 2009. As the studies reviewed by Newton-Howes and Mullen (2011) were significantly outdated in the context of any current literature, the current review was conducted on literature from 2009. Searching for literature from 2009 allowed this review to collate the most current evidence, whilst avoiding the potential repetition of any findings drawn within the previous review (Newton-Howes & Mullen, 2011). The Newton-Howes and Mullen's (2011) review provided a context for the initial understanding of the concepts involved in this review, with the authors highlighting a paucity of understanding about the factors associated with coercion during involuntary admission. However, the authors in the previous review used only three terms to identify coercion within the literature, and neglected to include any search terms related to the context in which this coercion may occur. Only one term was used to help identify psychiatric literature, a limited approach risking neglecting a range of potential literature which may have been identified should more detailed and alternative search terms have been used.

Consequently, this review conducted a search using search terms adapted from those employed by Newton-Howes and Mullen (2011) by using a wider array of synonyms. This review also included additional terms related to involuntary hospital admission which were not included in the previous review's search strategy. The author of this review felt that using adapted search terms provided the most appropriate way to explore the unique factors associated with coercion during involuntary admission posed by this review's question, rather than wider literature on coercion in psychiatric care.

Relevant papers were identified through a systematic search method as outlined below. This involved searching electronic databases, and searching reference lists of papers identified as relevant to the review for any other potentially relevant papers.

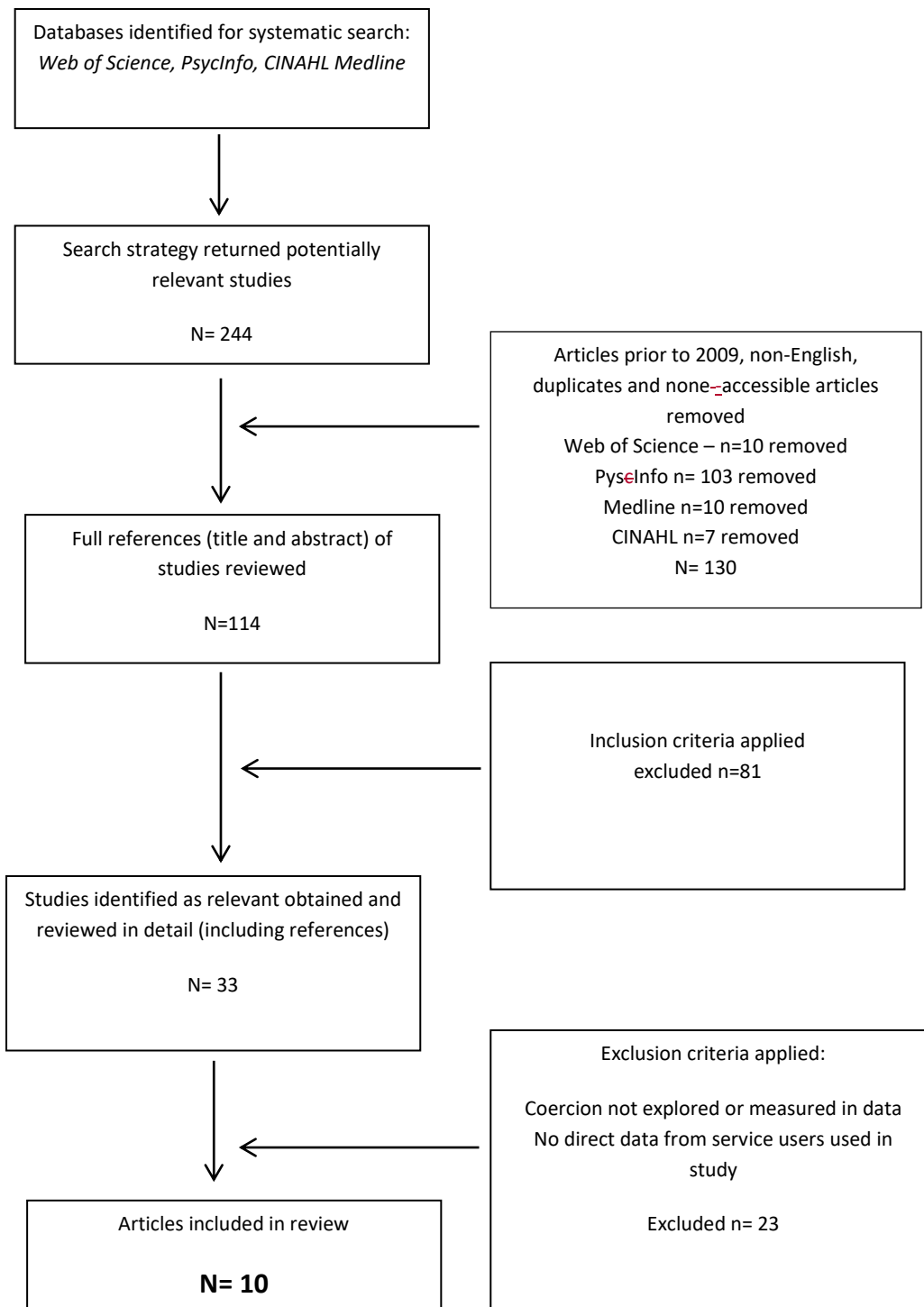
Search strategy

An electronic search of databases *PsycInfo (1967- September week 4 2015)*, *Ovid Medline (1946 – September week 4 2015)*, *CINAHL (1982 – September week 4 2015)* and *CINAHL (1982 – September week 4, 2015)* was conducted on the 23 of September 2015. This search used the following strategy:

1. Keyword search for coercion **or** Coercion **or** manipulating **or** persuasion **or** intimidation **or** force
2. Keyword search for mental health act **or** involuntary admission **or** formal admission **or** detention **or** section **or** voluntary admission
3. Keyword search for psychiatric hospital **or** inpatient settings **or** inpatient hospital **or** asylum **or** institution

Searches 1 and 2 and 3 were combined and resulted in 244 papers. Full references (titles and abstracts) were reviewed in order to establish initial suitability for inclusion. *Figure 1* outlines the systematic search strategy employed at each stage.

Figure 1: Literature search strategy



Inclusion / Exclusion Criteria

Following obtaining articles, references lists were reviewed for studies that may be potentially suitable for inclusion. This process did not reveal any potentially suitable papers further to that already identified by the systematic search. In total, 33 articles were obtained and reviewed in depth in accordance with the inclusion and exclusion criteria outlined in *Table 1*. Reviewing the articles in relation to the inclusion and exclusion criteria provided 10 suitable studies for inclusion in this review.

Table 1: Inclusion & exclusion criteria applied to studies

Inclusion Criteria <i>Meets all of the following</i>	Exclusion Criteria <i>If meets one of the following</i>
Peer reviewed article published in English	Coercion explored in relation to longitudinal inpatient experience rather than admission
Study clearly identifies focus of research on 'coercion', 'perceived coercion' or 'coercive practice'	Missing or incomplete data on those involuntarily detained
Focus of data gathered in study related to admission process	Includes children or adolescents in sample
Study uses quantitative methodology	Unable to clearly define if sample had been subject to involuntary detentions
Published after 2009	Does not mention 'coercion', 'perceived-coercion' as variable of interest

Analysis of literature

Questions which were formulated to help answer the question posed by this review were systematically applied to each paper, and are summarised in *Table 2*.

<i>Table 2</i> <i>Summary of</i> <i>information</i> <i>taken from</i> <i>included</i> <i>papers</i>	1	2	3	4	5	6	7	8	9	10
Author	Al-Khalaji et al. (2014)	Anestis et al. (2012)	Bennewith et al. (2010)	Fiorillo et al. (2012)	Flammer et al. (2013)	Kalisova et al. (2014)	Myklebust et al. (2014)	Myklebust et al. (2012)	Raboch et al. (2010)	Norredam et al. (2010)
Date	2014	2012	2010	2011	2013	2014	2013	2011	2010	2010
Sample Size (n)	N=164	N=125	N=778	N=3093	N=576	N=2027	N=5538	N=1963	N=2030	N= approx.33,287
Sample country of recruitment	Australia	Australia	UK	EU-wide	Germany	EU-wide	Norway	Norway	EU-wide	Denmark
Any other information regarding sample	General hospital, limited mental health staff, participants identified via ED records	Inpatient unit integrated with acute unit as source of recruitment	Mental health trusts London recruitment	Participant recruited from inpatient hospitals	Data collected indirectly from database records	All who were involuntary admitted to inpatient hospital during specific time period	Analysis of hospital registry records	Analysis of hospital registry records	Inpatient hospitals across the EU	Refugees and immigrants compared with native population on 4:1 ratio

How is coercion defined in the literature? E,g, objective constraints, subjective experience	Defined under 'Section 10' of the Mental Health Act.	Defined under Mental Health Act legislation	Subjective ratings of coercion and records of objective intervention	Subjective experiences measured using McArthur and Cantril ladder scales	Objective interventions recorded as part of admission process	Objective interventions and subjective experiences using Cantril and McArthur scales	Involuntary admission process used as definition of coercion i.e. objective constraints	Involuntary admission process used as definition of coercion i.e. objective constraints	Objective interventions and subjective experience of psychological pressure	Admission recognized as objective coercion and other objective interventions
Objective coercive interventions identified?	Physical restraint, medication	None recorded	Restraint, seclusion and forced medication	No objective interventions recorded	Seclusion, mechanical restraint and involuntary medication	Seclusion, mechanical restraint	None other than admission process	None other than admission process	Seclusion, restraint and forced medication	Physical restraint and medication
Key findings:	2.% of people physically restrained, 39% sedated, 61% no	Gender, hostile-dominant personality traits more	No link between ethnicity and coercion. Higher rates of coercion reported in	Female and involuntary admission predicted higher rate of	Involuntary admission and aggression associated	Poorer global functioning, and positive symptoms of psychosis	Positive symptoms of psychosis	Positive symptoms of psychosis and emergency referrals,	Psychosis and more severe symptoms associated	Refugees more likely to be coerced

	intervention	associated with coercion	particular mental health trusts	coercion	with higher levels of coercion	associated with higher coercion		anxiety a protective factor against coercion	with coercion	
Sociodemographic variables associated with coercion	Median age of 35 more likely to be coerced	Female found to be more likely to be coerced	Patients who were not living in local area of hospital more likely to be coerced	Female and involuntary admission predicted higher rate of coercion	Involuntary admissions higher rate of coercion	No sociodemographic differences found	Males more likely to be coerced	No demographic information collected	No significant difference found	Refugee males, immigrant women and refugees overall more likely to be coerced compared with native Danes
Diagnosis variables associated with coercion?	35% self-harm or suicide	Hostile-dominant personality traits found to be associated with more experiences of coercion	No psychopathology explored	Positive symptoms of psychosis more likely to be coerced	Those with psychosis more likely to be coerced	Positive symptoms of psychosis and poorer global functioning likely to be coerced	Those with psychosis more likely to be coerced	Those with psychosis more likely to be coerced, and those with anxiety less likely to be coerced	Those with psychosis more likely to be coerced	Refugee men with psychosis and immigrant women with anxiety more likely to be coerced

Behavioural variables associated with coercion?	65% reported threats of self-harm or suicide	None explored	None explored	None explored	Aggressive behaviour 24 hours prior to admission more likely to experience coercion	Not explored	Not explored	Not explored	Aggressive individuals were more likely to be coerced	Not explored
Systemic variables associated with coercion?	None explored	Significant relationship found between presence of a h hostile-dominant personality styles and coercion compared with other personality styles	Two trusts had higher rates of coercion compared with other local hospital trusts when ethnicity was controlled for	No significant systemic variables found	None explored	Staff ratio was not a predictor of coercion	A deinstitutionalized system with a lack of available beds was associated with higher rates of coercion	Those who were subjected to emergency referrals were more likely to be coerced	Scores on coercive measures varied greatly according to country of recruitment	None reported

Recommendations for clinical practice	Increasing understanding regarding the large degree of variance in how self-harm is viewed	Interpersonal relationships important to be aware of with staff and how they react to service users	None detailed in paper	Strategies recommended to reduce coercion such as more understanding for staff of mental health difficulties	Earlier identification of aggression and reduced threshold for admission	Developing Europe-wide legislation and a reduced threshold of criteria needed to warrant involuntary admission	Increased number of beds	Reduced threshold of criteria needed to warrant involuntary admission	Developing Europe-wide legislation and a reduced threshold of criteria needed to warrant involuntary admission	Staff training in cultural understanding and equality skills
Recommendations for research	No specific recommendations for developing findings in future research made by authors	Experience of coercion & previous experiences of admission to be explored in more detail	More research into gender and coercion	More research into gender and coercion and increase in qualitative methods	None made	Increased research into strategies to manage positive symptoms of psychosis and staff training	No specific recommendations for developing findings in future research made by authors	Further exploration of existing findings	No specific recommendations for developing findings in future research made by authors	Increased qualitative research
Limitations acknowledged by authors?	Yes, acknowledged limitations in recruitment and methodology	Yes, discussed lack of previous experiences included in this study	Yes, discusses broad confidence intervals	Acknowledges issues in recruitment strategies and sources of bias	Discusses sources of bias in analysis	Acknowledged exclusion of participants over the age of 65	Yes, discusses lack of information included on those who had repeat admissions	Yes, acknowledges limitations in using a small set of variables	Yes, acknowledges limitations in methodology and bias in recruitment	Yes, acknowledges poor data set and many variables which were not controlled for

Results

Overview of papers

Five papers investigated coercion in relation to solely objective constraints or interventions. Al-Khafaji, Loy, and Kelly (2014) used a retrospective case methodology to explore factors associated with those who were more likely to be detained under Australian mental health legislation during admission. Similarly, Myklebust, Sørgaard, and Wynn (2014) and Myklebust, Sørgaard, Røtvold, and Wynn (2012) examined case registries in Norway to examine if there was any factors which might predict an individual being coerced through involuntary hospital admission. Flammer, Steinert, Eisele, Bergk and Uhlmann (2013) utilised a similar approach, using a multi-level analysis to identify characteristics which might predict being involuntarily admitted to German psychiatric hospitals. Norredam, Garcia-Lopez and Keiding et al (2010) used a retrospective cohort design to compare the risk of experiencing coercive constraints such as involuntary admission for refugees and immigrants with native Danish citizens.

Two papers explored perceived coercion only, with no objective interventions or constraints described within the study. Fiorillo, Giacco, De Rosa, Kallert and Katsakou et al (2012) conducted Europe-wide research exploring sociodemographic and clinical characteristics associated with those who had reported feeling coerced during hospital admission. Anestis, Daffern, Thomas, Podubinski and Hollander (2013) investigated the relationship between personality traits and the perception of coercive experiences.

The remaining three papers identified coercion in relation to both objective interventions and subjectively rated experiences of perceived coercion. Raboch, Kalisova and Nawka

(2010) assessed and compared the use of coercive measures across a number of countries, exploring the factors which were associated with a higher risk of coercion occurring. As part of the same programme, Kalisova, Raboch and Nawka et al, (2014) conducted a study exploring the degree to which both patient and ward related characteristics were associated with the experience of coercion. Finally, Bennewith, Amos, Lewis, Katsakou and Wykes et al (2010) looked at ethnicity in relation to the experience of coercion during involuntary hospital admission. All studies recruited from a broad range of countries across the world, with two samples being recruited from Australia; two from Norway, one from the United Kingdom and one from Denmark. Three papers also recruited participants from a number of countries across the European Union. The number of participants included in the studies ranged from one hundred and twenty five to approximately sixty thousand.

Quality of included papers

The quality of the studies included within this review was assessed using Fowkes and Fulton's (1991) quality tool for critically appraising the quality of published research. The tool includes guidelines in assessing the appropriateness of study design; representativeness of the included sample, quality of outcome measurements; and key considerations for validity of reported results. Using the appraisal tool, each paper was given a rating as to how much of a problem the study encountered in each area of quality review. Ratings were made on a basis of there being a major problem, minor problem, no problem or not applicable to the study. Fowkes & Fulton (1991) recommend assigning criterion as a major or minor problem based on their expected effect on the results. A major problem was therefore viewed as a methodological design error which posed a significant risk of

invalidating the results drawn from the study, such as unclear inclusion or exclusion criteria or unsatisfactory analysis. A minor problem was seen as an omission or methodological flaw which would have a detrimental effect upon the quality of the findings drawn, but not largely change the overall conclusions such as drop outs or limited sample size. Fowkes and Fulton's (1991) tool provided an appropriate framework for the methodologies employed by the studies, providing an accessible framework for summarising a broad range of factors. A table of the variables and the rating given for each study can be seen in Table 3.

Table 3 - Quality criteria appraisal tool systematically applied to included studies

Guideline	Al-Khalaji et al. (2014)	Anestis et al. (2012)	Bennewith et al. (2010)	Fiorillo et al. (2012)	Flammer et al. (2013)	Kalisova et al. (2014)	Myklebust et al. (2014)	Myklebust et al. (2012)	Raboch et al. (2010)	Norredam et al. (2010)
(1) <u>Study Design appropriate to objectives?</u> <i>Prevalence – Cross Sectional</i> <i>Prognosis – Cohort</i> <i>Treatment – Controlled Trial</i> <i>Cause – Cohort, case control, cross sectional</i>	0	0	0	0	0	0	0	0	0	0
<u>Study sample representative?</u> <i>(2a) Source of sample?</i>	0	0	0	0	+	+	+	0	0	0
	+	0	0	0	0	0	0	0	+	0

<i>(2b) Sampling method?</i>										
<i>(2c) Sample Size?</i>	0	0	0	0	0	0	0	0	0	0
<i>(2d) Entry Criteria / Exclusions?</i>	+	+	0	0	+	++	0	+	0	0
<i>(2e) non respondents?</i>	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
<u>Control group acceptable?</u> <i>(3a) Definition of controls</i>	NA	NA	NA	NA	NA	NA	NA	NA	NA	0
<i>(3b) Source of controls?</i>	NA	NA	NA	NA	NA	NA	NA	NA	NA	0
<i>(3c) Matching/Randomisation</i>	NA	NA	NA	NA	NA	NA	NA	NA	NA	0

<i>(3d) Comparable characteristics?</i>	NA	NA	NA	NA	NA	NA	NA	NA	NA	0
<u>Quality of measures and outcomes?</u> <i>(4a) Validity?</i>	0	0	0	+	0	0	0	+	0	0
<i>(4b) Reproducibility?</i>	0	0	0	+	0	+	0	+	+	0
<i>(4c)Blindness?</i>	++	++	++	++	0	+	0	0	0	0
<i>(4d) Quality control?</i>	0	0	0	0	0	+	+	0	0	+
<u>Completeness</u> <i>(5a) Compliance?</i>	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
<i>(5b) Drop outs?</i>	0	++	++	++	0	+	0	0	0	+

(5c) Deaths?	0	+	0	0	0	0	0	0	0	0	+
(5d) Missing data?	+	0	0	0	0	0	0	+	+	0	+
<u>Distorting Influences</u> (6a) Extraneous treatments?	+	+	+	+	0	0	0	0	+	0	+
(6b) Contamination?	0	0	+	0	0	0	0	0	0	0	0
(6c) Changes over time?	++	0	0	0	0	0	0	0	0	0	+
(6d) Confounding factors?	+	+	+	0	0	0	+	+	+	+	+
(6e) Distortion reduced by analysis?	+	+	0	0	0	0	0	0	0	0	+

Key: ++ = Major Problem + = Minor Problem 0 = No problem/satisfactory N/A = Not applicable to study

Methodological Quality of Included Studies

Appropriateness of study designs

The studies all had appropriate designs, the majority of which were cohort studies. Fiorillo et al (2012) adopted a cross sectional design to explore variables associated with coercion in those who were either involuntarily admitted or voluntarily admitted to psychiatric hospital. Inclusion and exclusion criteria were generally reported throughout the included studies, but a number of studies were vague about the specific characteristics of those potential participants that they excluded (Al-Khafaji et al, 2014; Anestis , et al, 2013, Myklebust et al, 2014). Reporting basic information such as participant characteristics is key not only within a wide range of research methodologies, but especially when considering the question posed by this review. Neglecting to include or acknowledge this information limits the depth of understanding that can be made between differing variables explored in the research, and also raises questions about the study's method of sampling.

Study's participants

The representativeness of study samples varied according to the study's inclusion and exclusion criteria, with some studies having excluded those with alcohol disorders or organic psychosis (Fiorillo et al, 2011, Myklebust et al, 2014). Fiorillo et al's (2011) study into sociodemographic variables associated with coercion had significant problems with the study sample's representativeness, excluding those with an eating disorder, forensic history, under the age of eighteen or over the age of sixty five. Similarly, Raboch et al (2010)

excluded potential participants from the study if they did not have an address within the catchment area of the hospital, significantly limiting the representativeness of their study.

Studies reported a range of sample sizes from (n) =125 through to (n) = 33,287, with some studies excluding data from subsequent or repeat admissions (Flammer et al, 2013). The exclusion of any further involuntary admissions risks neglecting potentially important associations between the cumulative effect of involuntarily admissions and perceived coercive experiences, given that involuntary admission has been shown to influence how the individual may view any future treatment (Priebe, Katsakou & Amons, 2008; Gardener, Lidz & Hoge et al, 1999). Whilst three studies reported large sample sizes from countries across the European Union, the replication of these studies could be problematic due to the complex methodology, design and funding required for the research.

Quality of outcome measures

Two papers had minor problems with the validity of outcome measures, using methods which were limited in their exploration or understanding of coercion with participants (Fiorillo, et al, 2012, Myklebust et al, 2012). The majority of those papers which included outcome measures on the individual's experience of coercion used the McArthur Admission Experience Scale (Gardner et al., 1993), a measure which explores the perception of lack of control, choice, influence and freedom during hospital admission. Other studies included adapted Cantril rating scales (Cantril, 1965) to rate participant's experience of coercion, providing a valid method of measuring perceived coercion within the studies (Bennewith, et al, 2010, Kalisova, et al, 2014).

Four studies included outcome data gathered from case registries or hospital records (Al-Khafaji et al 2014, Myklebust et al 2014, Myklebust, et al 2012, Norredam et al, 2010). All of the studies using hospital registry or records reported missing data, meaning that the outcomes measured were of potentially poorer quality. Two of the four studies made specific reference to missing data. Two studies reported that deaths were recorded in the participant sample meaning that participation in the research could not be completed (Al-Khafaji et al, 2014, Norredam et al, 2010).

Five of the studies included in the review were rated as having a significant problem with research team members blinding (Al-Khafaji et al, 2014, et al, 2013, Bennewith et al, 2010, Fiorillo et al, 2011).. Four studies were also rated as having significant problems with participants dropping out from the study, affecting the reliability and validity of concluded results (Anestis et al., 2013 Bennewith et al, 2010, Fiorillo et al, 2012, Kalisova et al, 2014).

Distorting Influences

Six studies which explored characteristics associated with the experience of coercion during involuntary admission did not satisfactorily control for extraneous treatments, such as other professional's interactions, medication or external influences on the individuals admission (Al-Khafaji et al 2014, Anestis et al, 2013, Bennewith et al, 2010, Fiorillo et al, 2011, Myklebust et al, Norredam, et al, 2010). Two studies were also rated as having a minor problem with data which may have been susceptible to changes such as changes in local or governmental policy, which may over time have affected the potential validity of results (Al-Khafaji et al 2014, Norredam, et al, 2010). Seven of the included studies were rated as having minor problems with confounding factors in the analysis of their data, meaning that

they did not satisfactorily control for variables which could have influenced results drawn from their data (Al-Khafaji et al, 2014, Anestis, et al, 2013, Bennewith et al, 2010, Myklebust et al, 2012, Myklebust et al, 2014, Raboch et al, 2014, Norredam et al, 2010).

Overall, the papers included within this review were of a varying degree of methodological quality. The omission of important data such as patient characteristics within some papers, and exclusion of variables such as repeat admissions in others, significantly limits the validity and reliability of the collective findings. However, the breadth of data collected from recruitment sites from a number of different countries provides a somewhat culturally-sensitive view of the variables involved with perceived coercion during involuntary admission.

Results

Definition of coercion

As discussed previously, the definition of coercion has been used somewhat flexibly throughout previous research (Newton-Howes & Mullen, 2011). The role of the individual's perception of a coercive act, whether this is accompanied by an external objective constraint or intervention or not, continues to be key to the definition throughout the current review.

Coercion was defined by studies in a wide range of ways throughout the reviewed literature. Five of the eleven studies included a definition of coercion which was centred around the involuntary admission experience itself (Al-Khafaji et al 2014, Anestis, Myklebust, et al, 2012, Myklebust et al, 2014, Norredam et al, 2010). The studies using this definition were

based both inside the European Union and Australia, perhaps suggesting that a number of countries view the external mental health legislation involved with involuntary admission as one type of objective constraint or intervention likely to result in being experienced as coercive by the individual. It is important to be mindful however, that each involuntary admission is understood socially in the context of the legislation of the country in which it is based. It is understandable therefore, that if the guidelines regarding involuntary admission vary according to social and cultural factors, then what a country may see as being perceived as coercive would be similarly varied. This presents a difficulty in generating a consensus about how the literature might define coercion in the context of mental health legislation.

Objective constraints and interventions associated with perceived coercion included the use of restraint, seclusion and forced or involuntary administration of medication (Bennewith et al, 2010, Raboch et al, 2014). The use of mechanical restraint was also cited as an objective coercive intervention in two studies (Kalisova et al, 2014, (Flammer et al, 2013). Cross cultural differences in how objective coercive interventions are defined are also highlighted here. For example, whilst restraint was identified as a coercive intervention still experienced routinely by participants across a number of recruitment sites, countries such as the United Kingdom have moved away from this, campaigning for a reduction in the use of restraint (Department of Health, 2014).

Subjective experiences of coercion were recorded in five of the eleven included articles, being most commonly explored through the use of standardized assessment questionnaires or adapted subjective rating scales (Bennewith et al, 2010, Fiorillo 2012, Kalisova, et al, 2014, & Raboch et al, 2014). The use of adapted subjective rating scales such as Cantril's ladder

(Cantril, 1965), and other outcome measures such as McArthur's admission experience scale appear to provide a helpful way for studies to base their definitions within lived experience.

Demographic Factors

Studies reported a number of different demographic variables such as age, gender or residential status, with a varied consensus about which variables might be associated with higher levels of coercive experience. Raboch et al (2010) did not find any sociodemographic factors associated with the experience of coercion during involuntary admission. Myklebust et al, (2012) did not collect any sociodemographic data, a limitation which significantly reduced the quality of the conclusions drawn from their study population in comparison to other studies within this review.

There was some limited consensus in the literature suggesting that gender was a significant factor in understanding who might be more likely to encounter coercion during involuntary admission. There was however, no agreement about which gender might be more at risk. Fiorillo et al (2011) found that females were at a higher risk of experiencing coercion during an involuntary admission than their male counterparts. Similarly, in a comparison of immigrant and refugee population with Danish natives, Norredam et al (2010) found that immigrant women were more likely to experience coercion. In contrast to this, Myklebust, et al (2014) used a case registry analysis of two inpatient psychiatric hospitals and found that males were more likely to experience coercion than their female counterparts. This lack of agreement regarding which gender might be more likely to experience coercion during involuntary admission is something which mirrors previous review's findings (Newton-Howes & Mullen, 2011). This might reflect the complex differences that permeate each

study's country of recruitment, highlighting the ways in which gender is viewed differently in each country. If it can be considered that gender is largely culturally defined, it becomes difficult to draw a general conclusion about whether gender is a significant risk factor for experiencing coercion during involuntary admission. Thresholds for what may be considered significant mental health problems for men and women, and how the pathology of these difficulties are exhibited may also vary according to country. Considering this with the varied results described here, it is important to acknowledge that significant differences may exist in relation to gender and coercion, but that this is something which is difficult to conclude based solely on the results drawn from the studies included here.

Bennewith et al (2010) was the only paper to explore ethnicity in relation to coercion during involuntary admission. Having recruited participants from a range of psychiatric units throughout London, they found no significant relationship between participant ethnicity and reported experiences of coercion. There was however a significant association between the mental health trust that ran the hospital and perceptions of coercion from patients. Those hospitals which had higher levels of reported coercion also had higher rates of ethnic minority patients.

Whilst remembering the sample was limited in its generalizability due to its limited recruitment site, the data provide a helpful insight into another sociodemographic variable in relation to coercion. This might suggest that workplace values and sub-cultures may have had more of a significant role in understanding who might be likely to experience coercion rather than ethnicity alone. However due to the broad confidence interval reported in Bennewith et al's (2010) results, a relationship between ethnicity and coercion during involuntary admission cannot be certainly warrants more investigation.

Cultural Factors

In those who were involuntarily admitted to hospital, the residential status of the individual was reported by some studies to have an influence on whether or not that individual would experience coercion. In comparing non-native groups of immigrants, migrants, and native Danes Norredam et al (2010) found that there was a significant difference in the likelihood of being coerced during an involuntary admission depending on the residential circumstances of that individual. Refugee populations were found to be at a higher risk of being coerced than native Danes, with refugee men being particularly at higher risk. Immigrant women were also more likely to experience coercion during involuntary admission than other groups, including immigrant males or native populations. Bennewith et al (2010) reported similar results, finding that those who did not live within the catchment area of the hospital were significantly more likely to experience coercion during their involuntary admission. A possible explanation is perhaps those who are not viewed as integrated into a particular community or subculture might be viewed unfavourably by those who are involved in the involuntary admission process, leading to further coercion.

Psychopathology

The majority of papers included within this review reported data regarding clinical symptoms or diagnoses. Three papers found that those who scored more highly on symptom-based measures of their mental health were more likely to experience coercion than those who reported less severe symptoms (Raboch et al 2010; Kalisova et al, 2014, Fiorillo et al, 2011). A possible explanation of this is that those who are experiencing significantly poor mental health may be less likely to demonstrate capacity or insight to

engage in treatment, meaning that perhaps coercive measures are felt necessary to ensure that they receive treatment.

A prominent theme throughout the literature was that those who were experiencing psychosis were significantly more likely to report experiences of coercion during involuntary admission than those experiencing any other clinical disorder. Psychosis refers to a disorder in which the individual experiences a number of symptoms which can lead to a feeling of detachment from reality. Psychotic symptoms are broadly grouped into two areas; positive symptoms which relate to unusual experiences such as hearing voices that are not there or holding strong beliefs that others do not share, and negative symptoms such as difficulties with concentration, poor mood and motivation (British Psychological Society, 2014). Two studies identified that those with psychosis were significantly more likely to be subjected to coercion during involuntary admission if they were experiencing positive symptoms of psychosis (Fiorillo et al, 2012; Kalisova et al, 2014). Positive experiences of psychosis, such as delusional ideas, can have a significant effect upon the individual's ability to engage with the external reality of the situation, meaning that coercive measures may be necessary. Thus, those who report positive symptoms of psychosis may be more likely to be viewed as seriously unwell by staff and therefore a risk to themselves or others, a reason which has been previously reported to be a culturally acceptable reason for coercion (Pescosolido, Mahan, & Stueve et al, 1999).

In contrast to the general theme of papers discussing psychopathology as a risk factor for coercion, Myklebust et al (2012) reported that anxiety was a protective factor during involuntary admission. The findings reported that anxious patients who were admitted were significantly less likely to be coerced during involuntary hospital admission. This conclusion

should be treated with caution, due to concerns regarding the methodological quality of the research lacking exploration of further factors such as socio-economic status which may have provided a more detailed understanding of the findings. Whilst diagnostic categories are designed in such a way that they are meant to be standardized, ultimately the clinician's skill and experience in recognising individual symptoms of a mental illness has a large effect on the reliability of these categories. Factors such as cultural sensitivity and fidelity to the diagnostic guidelines can also limit the validity of assuming a category accurately represents the difficulties of the population being discussed.

Perhaps unsurprisingly given the severity of the difficulties discussed above, studies also found that poorer global functioning was associated with a higher likelihood of experiencing coercion during involuntary admission. Global functioning refers to the level of autonomous ability an individual holds in a range of areas of their life including social life, self-care, employment and activities of daily living. Kalisova et al (2014) found that those with higher level of impairment in daily functioning more frequently reported experiences of coercive interventions during involuntary admission. Similar results were found by Fiorillo et al (2011), who reported that those with worse global functioning reported higher levels of perceived coercion. Conversely, they found at follow-up that improvements in social functioning led to reduced levels of perceived coercion later on during their admission. These findings suggest a number of interesting possibilities, one of which might be that admitting staff view those who are unable to function independently as requiring more coercive control rather than supportive enablement. This data is however significantly limited without the important qualitative aspects which enable further understanding about the specific reasons for coercion. There may be a range of factors which might be associated

with poor functioning and coercion, such as self-neglect or poor self-care. There is however little detailed exploration of these specific aspects of impaired functioning which may lead to higher levels of coercion within the reviewed literature, meaning further exploration of functioning and coercion is needed in order to generate more generalizable conclusions.

Anestis et al (2013) was the only study exploring personality traits, reporting that those with a hostile-dominant personality were more likely to report perceived coercion than those with other personality traits. Those with hostile-dominant personality styles were more likely to perceive interventions as being coercive, and conversely meant that those who presented as challenging to professionals were responded to in different ways than those who do not. This might suggest the potential benefits of investing in the relationship during the admission process, both in helping those who find it difficult to initiate them, and helping staff to work with those patients who may evoke difficult feelings or responses in them.

When considering the role of behaviour during hospital admission, three papers reported data in relation to signs of aggression, self-harm or suicidal ideation. Al-Khafaji et al (2014) found that those who reported threats of harm to the self were significantly more likely to be coerced, perhaps highlighting staff concern about providing safe and appropriate care for the individual, leading them to become more controlling in their approach. Raboch et al (2010) and Flammer et al (2013) both found that patient aggression significantly increased the risk of that individual experiencing coercion during their involuntary admission. Specifically, Flammer et al (2013) found compared with those admitted voluntarily, having a report of aggressive behaviour 24 hours prior to involuntary admission was the best

predictor for the individual being subjected to all coercive measures identified, including seclusion, restraint or involuntary medication.

Interestingly a number of papers within this review only included a single involuntary admission as the focal point for data collection, disregarding any other potential admissions that participant might have had. This is of significant interest given the findings of Fiorillo et al (2011) and Flammer et al's (2013) findings that a prior involuntary admission was a risk factor for experiencing coercion during a subsequent admission. This may mean that repeat admissions are a significant factor in who might be subject to coercion during involuntary hospital admission, but this cannot be explored due to the lack of included data.

It appears therefore that having more complex needs, such as psychosis, particular personality traits or poorer overall functioning are factors more frequently associated with experiences of coercion within this literature. This might suggest that given the understandably challenging nature of these problems, difficulties with communication or understanding of their own needs may lead staff to engage in a more coercive approach to manage the behaviour.

Organisational Factors

As well as focusing on the individual variables which were associated with coercion during involuntary admission, a number of papers reported wider or organisational data as part of their study (Anestis et al, 2013, Bennewith et al, 2010, Kalisova et al 2014 & Myklebust et al, 2014).

The role of strategic planning throughout the institutions which provided the care underpinning involuntary admission was investigated as a factor in a number of articles. Myklebust et al (2014) found that that inpatients within a system based around a central psychiatric hospital which was supported by minimal local services were more likely to be involuntarily admitted and experience coercion than those who had locally available psychiatric beds. Exploring the provision of services, Myklebust et al (2014) found that those who received outpatient services and were then transferred to a central psychiatric hospital were more likely to be involuntarily admitted. In understanding this finding, one theory might be that the understanding and familiarity held within a relationship that the individual may have built with local outpatient services may be lost when the person is then transferred to a psychiatric hospital further away. The importance of relationships within the involuntary admission process is a theme which has continued to grow throughout the body of studies included within this review.

Similarly, Bennewith et al (2010) found that particular mental health trusts responsible for the hospital the individual was admitted to, were associated with higher reports of perceived coercion. This adds further credence to the importance of understanding the role of organisational and strategic planning in relation to coercion during involuntary admission. Interestingly, Kalisova, et al (2014) examined staffing levels in relation to coercion during involuntary admission, but found no significant relationship between the number of staff on shift at the hospital during the admission and coercion .This might suggest that the quantity of staff does not have a direct impact on coercion alone, but other factors may be more important in understanding coercion. This was the only study to explore staffing levels in relation to understanding coercion during involuntary admission.

There was also some limited evidence that the prevalence of coercive measures also varied according to the country in which the study was recruiting from, suggesting that coercive interventions could be influenced by cultural factors at an international level. Raboch et al (2010) and Kalisova et al (2014) found that rates of coercive intervention varied greatly across different countries. Specifically, Raboch et al (2010) reported that countries differed in the type of coercive intervention used; for instance, Bulgaria and Sweden used forced medication more than other countries. However when controlling for variance according to country, Fiorillo, et al (2011) found that sociodemographic predictors of coercion remained significant. One might expect to see variations across a number of countries in relation to coercive practice due to a number of factors such as the diverse range of mental health legislation that is used, understanding of mental health and involuntary admission policies. Therefore, in order to better understand the international differences in the use of coercive measures, further research would be necessary to consider how each country may provide a setting for the coercion to occur.

Organisational culture is therefore an important factor to consider when understanding the individual experiences of those who are subjected to involuntary admission to hospital. Considering the service provision of psychiatric inpatient beds is important, especially given the numbers of locally-available inpatient beds in comparison to larger central psychiatric hospitals. This is understandably likely to be influenced by the service context, including financial and strategic pressures. Similarly, understanding how individuals perceive the organisation which provides the involuntary admission service is also valuable to understand findings which suggest some mental health trusts have higher levels of perceived coercion.

Discussion

This review of ten studies exploring what factors are associated with coercion during involuntary admission has drawn out a number of significant themes, adding a depth to the previous review in this area (Newton-Howes & Mullen, 2011). Generally, papers identified by this review were of an observational nature, using a cohort design and included appropriate sample sizes. The quality of the papers was mostly satisfactory but varied greatly, from those covering a range of recruitment sites across the European Union to some which took data solely from hospital records. There was an omission of important characteristics within some studies and poor attempts to control for extraneous variables during analysis in others. The diverse methodologies and approach to conducting research may reflect the difficult task faced by mental health professionals in engaging a population which often has complex and multi-faceted needs requiring an idiosyncratic approach. Similarly, the varying definition of coercion throughout the available literature immediately poses a problem to researchers looking to standardize a method of measuring it. However, recognising that coercion is defined both objectively, socially and interpersonally is a commonality between this review and the previous review in the area (Newton-Howes & Mullen 2011). Papers also investigated a range of different factors with little consistency in the choice of variables they examined, perhaps unsurprisingly meaning a degree of variation in findings that were reported.

Research quality

A large proportion of the papers drew data only from a single involuntary admission, despite additional data being available to the researchers. This somewhat limits the generalisability

of the results drawn, as it becomes difficult to determine if the factors identified are associated with the unique experience of the specific admission being explored or a wider, more global sense of the involuntarily admission process which incorporates other admissions. Furthermore, a number of papers referenced a previous involuntary admission as a risk factor for further coercion during future admissions (Fiorillo et al, 2011, & Flammer et al, 2013). The data explored here are not sufficiently detailed to give meaningful context as to why this might be, but there could be a number of potential reasons. Those who have had previous experience of being involuntarily admitted often hold an unfavourable sense of the experience, perhaps meaning that they are less cooperative or engaged with mental health services (Kallert et al 2008; Katsakaou & Priebe, 2007, Jaeger, Piffne et al, 2013). Conversely, an admitting clinician whom has previous knowledge of an individual who they have involuntarily admitted before may perhaps be primed by this experience, and more likely to withdraw that person's autonomy and involvement in any future admissions.

Main Findings

In regard to psychopathology, psychosis appeared to be a significant factor which impacted on whether or not an individual would experience coercion during their involuntary admission. If we assume that this is due to the highly impairing nature of psychosis through unusual experiences, difficulties with social relationships and mood disturbance, then the need for more intensive support within an inpatient environment rather than in the community is understandable. However, previous literature has identified that those have experienced psychosis are much more likely to be stigmatised in society than those with other health difficulties (Birchwood et al, 2006). One suggestion is that that those who are

feeling detached from reality through unusual experiences may be harder to engage in mental healthcare especially admission to psychiatric hospital due to the stigma associated with their experiences. This may be due to a reduced capacity to understand a need for treatment, or feeling unable to understand or make sense of the process during a time when the individual's mental health is poor. Research has reported that positive symptoms of psychosis predicted poor medication adherence for those receiving treatment (Lecomte et al, 2008). Understanding this distressing experience for the individual may also provide insight into a context where admitting staff also feel concerned, perhaps frightened of an individual's reports of unusual experiences and rely on more coercive interventions to help manage feelings of uncertainty about how to help.

Similarly, those with poorer levels of global functioning were also found in some papers to have a higher likelihood of experiencing coercion. It is possible to imagine that those who are referred for an involuntary admission with poor global functioning perhaps are perceived as being unable to participate in the admission process. It is important however to make a distinction between poor global functioning, and the ability to contribute to a process which understandably can be difficult for the individual involved. Whilst understanding clinician's desire to safeguard an individual through an involuntary admission, providing the individual with a sense of autonomy through involvement in choices where appropriate in the process may provide benefits not only for their mental health but also their relationship with mental health services more generally. This ability to balance two perspectives, specifically, the need to admit, with the perspective of the person as a human with needs and wishes is defined as 'good coercive care' (Van den Hoff & Goossensen, 2014; Martinsen, 2011). This finding also mirrors previous research highlighting

the risk of clinicians being unaware of dehumanising those they admit (Katsakou & Priebe, 2007). This sense of valuing the individual as part of the decision has been found to translate into higher satisfaction with treatment, lowering the perception of coercion (Katsakou, Bowers, Amos, Morriss & Rose, 2010).

Aggression and self-harm

The display of aggressive behaviour, either prior to or during admission, was also associated with for coercion during involuntary admission. There was no exploration of this aggression in relation to type of mental health difficulty, a relationship which is arguably key in understanding the circumstances contributing to displays of aggression. These findings highlight the importance of exploring staff perceptions of patients, especially taking into account differently one individual may present in comparison to another, despite having similar mental health problems. Understandably, staff may be at the very least wary, and at the worst frightened of those individuals who are admitted with a documented history of aggression. It may however be beneficial to develop an understanding that those displaying higher levels of aggression may in fact also be those who perhaps might be feeling most scared or vulnerable, hence displaying this behaviourally. In turn, coercive interventions would be likely to worsen this experience and likely contribute to more aggression as a defensive act, in turn probably incurring more coercive intervention. Best practice guidance recommends the implementation of staff training in strategies to deal with aggression; outlining the importance of understanding the signs and possible causes for aggression, with the use of verbal de-escalation being prioritized over restrictive interventions which should only be a last resort (NICE, 2015).

Relationships

The significance of the relationship between the admitting clinician or team and the individual cannot therefore be underestimated. Although only one study explicitly explored relational styles in the context of coercion during involuntary admission (Anestis et al, 2013), the theme of valuing relationships was a present subtext throughout a majority of the papers. Findings from previous research into patient's views of inpatient admission can be largely traced back to the experience of their relationship with others; specifically their sense of being heard or listened to, meaning they felt respected as a human being (Kallert, 2008, Fiorillo et al, 2011, Katsakou & Priebe 2008, Van den Hoff & Goossensen, 2014). Those who view their relationship with the admitting clinician negatively are also more likely to report higher levels of coercive experience (Sheehan & Burns, 2011). This might also serve as context for other findings within this review suggesting that those who are viewed as external to a community or culture are more likely to be coerced (Norredam et al 2010; Bennewith et al, 2010). This may therefore provide some further understanding as to why those with more complex or severe mental health problems appear to be at a higher risk of being coerced. One viewpoint may be that those with severe mental health problems, such as psychosis, are more impaired by their difficulties and therefore find it more difficult to invest in the relationship with the admitting clinician. Conversely, the role of stigma and how the clinician views the individual's difficulties may influence the degree to which a therapeutic relationship can begin to form. It is, of course, more likely, that both of these viewpoints have some influence on the therapeutic relationship. A number of papers recommended that in order to understand these factors in more detail, future qualitative

research would be helpful to understand some of the interpersonal factors which mediate facilitation of good therapeutic alliance during the admission process.

Cultural factors

One might speculate that the role of cultural factors, such as language barriers or effective communication between patient and clinician, may exacerbate these difficulties in forming a therapeutic relationship. Although a smaller theme in comparison to others found in this review, cultural factors were found to be important in relation to coercion during involuntary admission. In one instance, refugee or immigrant status made the individual significantly more likely to experience coercion than their native counterparts. Considering this suggestion, it is certainly interesting that some studies omitted including participants who did not have addresses, perhaps demonstrating the sense of some individuals as 'outsiders' that is explicitly reported by Norredam et al's (2010). Clearly more research is needed to help us understand the relationship between residential status and a higher risk of coercion. Norredam et al (2010) consequently recommended that staff training should focus on understanding cultural factors in relation to coercion during involuntary admission.

The need for understanding cultural factors within the mental health trust that provided the care for the individual was also highlighted. Although reported by only one study, a smaller theme in comparison with themes such as psychopathology and coercion, increased reports of perceived coercion were found in particular mental health trusts. It appears therefore that cultures of coercion may exist within particular mental health trusts, this reasons for which have not been explored within this review. These pressures might however be understood in the context of on-going service pressures and how clinicians view their role;

as receptive clinicians for those experiencing mental health problems, or as guardians for the trust's resources.

Organisational factors

When considering mental health trust resources, the way in which local beds were organised was reported to have an effect upon coercion during involuntary admission. Inevitably, each recruitment site employed its own legislation and policy in relation to involuntary admission, meaning it was important to interpret with caution. Considering the wide range of sites across the world, particularly the European Union, that were used in this study, the legislation used to define and operationalise mental health and involuntary admission varied. The development of cross-country legislation establishing a uniform approach to implementing involuntary admission across the European Union would facilitate much more generalizable perspectives on factors such as coercion (Kalisova et al, 2014, Raboch et al, 2010). This approach appears to hold significant promise, especially considering some of the unclear findings drawn from the current literature, such as those relating to gender. Investing in cross-European legislation would also help the development of higher quality, more ethically orientated services focused on the individual. In turn, this would also support the comprehensive exploration of factors such as culture and gender across multiple sites.

Limitations

Whilst presenting a number of interesting conclusions drawn from 10 recent studies into the area of coercion, there are a number of limitations which may have affected its findings.

Moher, Liberati, Tetzlaff & Altman (2009) outline the PRISMA statement, a guideline which

advocates a number of preferred items to report when conducting a systematic review. This review has followed many of these recommended items within the PRISMA checklist, but has not addressed some of the recommended checks such as collecting inter-rater reliability data. This is a significant limitation in terms of the PRISMA statement, and as such limits the degree to which the findings reported here are interpreted without bias.

One of the greatest challenges in reviewing studies regarding coercion is the identification of literature that accurately reports the concept of coercion, whether through objective constraints, subjective experience and interpersonal process, or a combination of both. Within some of the studies reviewed here, both objective constraints and subjective interpersonal experiences of coercion have been combined, meaning that there can be a lack of clarity when considering how specific coercive process such as objective constraint or implied pressure relate to individual characteristics. This is a limitation when trying to consider how different forms of coercion relate to different individual factors or characteristics.

Following from Newton-Howes and Mullen (2011), this review looked to develop the understanding of coercion within involuntary hospital admission in the current socio-economic, political and financial climate. To achieve this understanding, this review therefore included literature only since 2009, a decision taken to generate the most current literature since the previous review (Newton-Howes & Mullen, 2011). The search terms used in Newton-Howes & Mullen's (2011) review were not replicated; instead, adapted search terms were used, in order to achieve more comprehensive coverage. It must be acknowledged however that this may have had a significant effect on the literature that was reviewed, and consequently, the conclusions drawn here. It may be that replicating the

original search terms as used within the Newton-Howes and Mullen (2011) review may have resulted in a different body of literature.

Summary

In sum, there are a number of factors throughout the current literature that appear to be related to the experience of coercion during involuntary admission. These included psychosis, poorer global functioning, gender, aggression and hostile-dominant personality traits, as well as organisational and cultural factors such as where the individual lived and the sub-culture of the organisation providing care. This review has provided further clarity into the characteristics that might be associated with coercion during involuntary admission, something which was previously found to be unclear in previous reviews (Newton-Howes & Mullen, 2011). Furthermore, this information is likely to be of benefit to clinical staff involved in the process, helping them to understand the factors involved with perceived coercion during the involuntary admission process.

Research Implications

Conducting further research into understanding how admitting staff view those with such difficulties is important to understanding the context behind some of the findings that this review reported. The papers included within this review lack the depth to begin to assume any potential causal role for such perceptions, and therefore it is clearly an important factor to explore in more depth in future research. This would help clinical staff to understand in greater depth, what leads those with particularly complex needs to experience coercion during this admission process. The same could be suggested in relation to cultural factors, another significant theme drawn from the literature reviewed. Echoing a recommendation

from Norredam et al's (2010) study, qualitative analysis of some of the potential cultural themes that exist in relation to involuntary admission both in the community and within organisations may help to deepen understanding about who is more likely to experience coercion as a result of involuntary admission.

Clinical Implications

The conclusions made within this review generate numerous potential implications for clinical practice. Drawing upon the finding that those with psychosis are more likely to be coerced during involuntary admission, it may be that those with psychosis are at a greater risk of experiencing coercion. There appears to be a clear value in investing in further training around psychosis for those staff who are involved in the admission process.

Previous pilot studies of psychological formulations for staff working with those experiencing psychosis has found numerous beneficial effects such as reduced blame on the individual and more optimism for future interventions (Berry, Barrowclough & Wearden, 2009). This approach may also be seen as beneficial when considering findings that those with poorer global functioning or higher levels of aggression are more likely to be coerced during involuntary admission. For instance, developing a programme of shared understanding for admitting staff through formulation-led approaches to anger may help to minimise the need for coercive interventions from staff. Reduced levels of coercive interventions may then result in reduced rates of aggression during admission.

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Chapter Two

What are the critical incidents that affect how people cope with being detained under Section 136 of the Mental Health Act (1983, 2007)?

Abstract

Background

Section 136 of the Mental Health Act (1983, 2007) provides legislation for police officers to detain those who they suspect of being 'mentally disordered' in a public place for the purposes of a mental health assessment. Whilst the involuntary detention of an individual may be deemed necessary for safety purposes, those who are detained have previously reported feeling stigmatised by healthcare workers. Police also report feeling that they lack clear feedback about the experiences of those they detain about their experiences and would like more training. There is however a significant lack of research exploring the experience of those who have been detained, a paucity which leads the voices of those who are often most disengaged from mental health services to remain unheard.

Aims

The aim of the current study was therefore to understand individual perspectives on the process of being detained under Section 136, from those who had previously been detained; specifically exploring the factors which had either helped them cope with the experience or alternatively may have made it worse.

Method

Critical Incident Technique is a qualitative method used to explore the critical factors that contribute to, or detract from a specific experience. Participants were recruited from two NHS psychiatric hospitals and undertook a semi-structured interview to share their experience of being detained, with a specific focus on identifying critical incidents.

Participants were also asked to consider factors or knowledge that they wished they would have possessed at the time, named wish-list items. Interviews were then transcribed and analysed to generate categories of critical incidents and wish-list items.

Results

Analysis revealed rich data from a seldom heard group, with six categories of helpful critical incidents, seven categories of unhelpful critical incidents and five wish-list items being identified. The importance of authenticity within interpersonal relationships underpinned many categories, as well as the importance of challenging stigma and providing practical support.

Conclusions

The findings here reiterate the importance of investing in relationships with those that use mental health services, ensuring that the person is seen first and their difficulties second. Services would benefit from investing in communications skills training to enhance this, and future research could support this through identifying the help-seeking pathways that people take prior to being detained.

Introduction

Mental Health Legislation

When people become mentally unwell and present a risk to others or themselves it may be necessary to take action to protect both the person and others. This may well be relatively straightforward when the individual is already within a mental healthcare setting, but is often more difficult when the person is outside of this context, such as when in a public place. On such occasions, Section 136 of the Mental Health Act (1983, 2007) provides legislation for police officers to enforce the legal detention of any “mentally disordered” individual, with whom they come into contact with in a public place. Specifically, Section 136 of the Mental Health Act (1983, 2007) outlines that:

(1) “If a constable finds in a place to which the public have access a person who appears to him to be suffering from mental disorder and to be in immediate need of care or control, the constable may, if he thinks it necessary to do so in the interests of that person or for the protection of other persons, remove that person to a place of safety..”

(2) “A person removed to a place of safety under this section may be detained there for a period not exceeding 72 hours for the purpose of enabling him to be examined by a registered medical practitioner and to be interviewed by an approved mental health professional and of making any necessary arrangements for his treatment or care.”

(3) “A constable, an approved mental health professional or a person authorised by either of them for the purposes of this subsection may, before the end of the period of 72 hours

mentioned in subsection (2) above, take a person detained in a place of safety under that subsection to one or more other places of safety.”

(4)“A person taken to a place of a safety under subsection (3) above may be detained there for a purpose mentioned in subsection (2) above for a period ending no later than the end of the period of 72 hours mentioned in that subsection.”

The limited available literature focussing on the use of S136 of the Mental Health Act provides a concerning insight into the use of this act. Detainees report feeling criminalised by the police, often being placed in handcuffs or taken into police custody when experiencing significant emotional distress (Riley, Freeman, Laidlaw & Pugh, 2011). Whilst those detained under the act stated that they recognised the need for police involvement, many feel that professionals lacked appropriate understanding and/or training to appropriately manage the needs of an individual with a severe and/or pervasive mental health issue. Concerningly, previous reports have documented that healthcare professionals can sometimes be seen as the perpetrators of mental health stigma, rather than combatting it (Verhaeghe & Bracke, 2012; Chew-Graham, Rogers & Yassin, 2003). One possible explanation may be that those patients who do not comply with treatment can be viewed as deviant by healthcare professionals, resulting in becoming passive recipients of treatment (Playle & Keeley, 1997). Over time, such experiences of being regarded as deviant are theorised to begin to form schemas, i.e. expectations about future interactions with people, social roles, events and the self within the world (Augnostinos, Walker & Donague, 2006). The way that mental health difficulties are understood and managed by those supposed to provide support for them can therefore have significant implications for how the individual understands their own mental health in the future.

Similarly, the Police themselves have reported difficulties in the understanding and preparation needed in order to deal with the often complex needs of the individuals they are required to detain under the act. One current serving police officer with an interest in the needs of detainees' mental health likens the Police's role to one of a 'street psychiatrist', with officers having to recognise mental health issues with relatively minimal training (Brown, 2014). Recent research exploring police perceptions around the use of the Mental Health Act (1983, 2007) has indicated that officers would like more feedback from detainees about their experience, in order for them to modify their approach where necessary (Palmer, personal communication, 2014).

This therefore means that on occasions, those with severe mental health problems are receiving frontline services from those not specifically trained or equipped to deal with them. When an individual is detained under Section 136, the interaction that the individual has with the police is likely to have an effect on the individual's self-esteem and future perceptions about the police and healthcare services. Such experiences resulting in a loss of self-esteem have been reported to leave those concerned feeling robbed of future social opportunities (Corrigan, 2004). Experiences of subordination and a loss of belonging, such as those that might be encountered during a detention, have also been linked with feelings of shame, depression and social anxiety (Gilbert, 2000). Laugharne and Priebe (2006) suggest that those experiencing a power imbalance in their care, particularly when being forcefully detained, may be at higher risk of disengagement from support services leading to greater risk of mental health relapse and higher likelihood of repeat detentions. The need to understand the psychological impact of the use of Section 136 is therefore clearly important.

Stigma, shame and mental health

This suggests that those individuals who are detained under Section 136 are some of the people most likely to avoid making contact with, or use of, mental health services. With statistics estimating that around one in four individuals will experience some form of mental illness during their lifetime, the importance of increasing the availability and accessibility of good quality mental health services has been highlighted in recent legislation (Department of Health, 2014a; Department of Health, 2014b, The Health & Social Care Information Centre, 2009). A central principle of the legislative effort to improve access to mental health services is through establishing a 'parity of esteem' between mental and physical health (Department of Health, 2014a). By holding mental illness in equal regard with physical health problems, professionals hope that the public will feel more comfortable in seeking help for psychiatric issues. Mental illness has long been a taboo subject in societies; from being regarded as signs of the devil, through to being perceived as signs of madness and violence or danger, with many various invasive and what we would now regard as unethical treatments (Porter, 2002). Whilst there has been vast progression in how mental health illnesses are viewed during the 20th century, stigma still remains a persistent issue for those who experience such difficulties.

Previous literature has suggested that mental health illness is associated with high levels of stigma, ranking only second to conditions such as HIV or AIDS (Roeloffs et al, 2003). Recent research has reported that anywhere between 13% - 42% of people who reported symptoms of depression sought help by approaching their GP (Oliver, Pearson, Coe & Gunnell, 2005; Roness, Mykletun & Dahl, 2005). Considering that one in four people are

estimated to experience a mental health problem in their lifetime, a significant proportion of the population are at risk of experiencing the stigma associated with a mental health illness. This stigma can contribute to those suffering from severe mental health problems becoming more isolated and withdrawn from health services potentially leading to worsening mental health. This illustrates how the rate of Section 136 detentions could theoretically increase, given the risks associated with mental health stigma and accessing support services.

Public views of those with mental health problems as dangerous, and an individual view of one's own mental health difficulties as a sign of madness or incompetence, have been related to the reluctance to seek support (Corrigan, 2004). The role of cultural and societal norms, particularly in relation to mental health, have been well documented in psychological theory. Labelling Theory (Scheff, 1966) draws links between societal reactions and the emergence and maintenance of the concept of mental illness. Link, Cullen, Struening and Shrout (1989) empirically tested Scheff's (1966) assumptions, generating the Modified Labelling Theory, which argues that being part of a society facilitates an individual's creation of a set of beliefs about mental health illness, and can limit opportunities for social support (Link et al 1989). Considering this in the context of Section 136, when an individual is detained these preformed values and beliefs about mental health are likely to take on new significant meaning. This might also therefore contribute to individuals becoming more withdrawn from engaging with bodies such as the NHS or police, leading to greater risk of a relapse (of poor mental health) and consequent repeat detention.

Rationale for the current study

The limited literature currently available regarding Section 136 seems to show that those who are detained often feel criminalised by police, perpetuating feelings of mental health stigma which may then affect how the individual, and the wider society makes sense of their difficulties (Riley et al,2011). What is less clear however, is a detailed understanding of how those who are detained under Section 136 make sense of their experience. Similarly, the literature lacks detail regarding the complex factors, both internally and externally which may have a role to play in how the individual makes sense of the experience of being detained. Given the recent changes to mental healthcare, such as funding reforms and organisational restructuring within the NHS, conducting research which involves service users in the evaluation and improvement of those services is critical (Hunter, 2010).

Understanding the individual experience of being detained under Section 136 of the Mental Health Act (1983, 2007) therefore is of paramount importance for a number of reasons. Firstly, it provides an opportunity to understand the experience of being detained under Section 136 from those who are most knowledgeable about the experience- those who have been previously detained. An inductive exploration of the experience of being detained also provides numerous benefits for generating valuable understanding which can be translated into wider benefits, such as service delivery. For example, understanding the critical factors involved in the experience may enable services to improve their emergency care, crisis pathways and organisational relationships with those that are detained. Better understanding the relationship between services and those that use them may also facilitate the future exploration of care pathways to detention, highlighting potential opportunities

for earlier intervention. This translates into a wider benefit for public health, as care organisations who are better able to understand pathways to detention are in a better position to reduce the amount of missed opportunities to prevent an individual's mental health worsening. In turn, an action which promotes early intervention and reduce the use of expensive emergency care holds the potential for improving cost savings for the NHS. Finally, conducting research which explores the experience of Section 136 also directly combats stigma associated with being detained, by providing a format to facilitate the voices, experiences and opinions for those individuals who may perhaps have previously been unheard.

A qualitative approach to understanding the experience of Section 136 is therefore warranted, given the paucity of available literature to date (Borschmann et al, 2010). Critical Incident Technique (CIT, Flanagan, 1954; Butterfield, Borgen, Maglio & Edmunson 2009) is a framework which can be used to explore the experience of being detained, and due to its inductive nature has been cited as a useful methodology when a topic has been sparingly researched (Grove & Fisk, 1997). The CIT method has an a number of strengths, encompassing a range of experiential differences, identifying key turning points or factual events within a particular incident in the individual's own words (Woolsey, 1986). Within the CIT method, there is little preconceived perception of what will be important to the participant, meaning that the context is largely derived from that individual. As well as being a beneficial tool for understanding factors involved in individual experiences, a key strength of the CIT method is the ability to generate an effective framework for understanding critical incidents which promote or detract from the effectiveness of an event (Butterfield et al, 2009). CIT's ability to conceptualise the understanding of individual experience provides

an accessible way to disseminate research findings to wider stakeholders, in this case the police and crisis care services.

Aims of this study

The principle objective of the proposed research is to gain an insight and understanding of the process of being detained under Section 136 of the Mental Health Act (1983, 2007), from the individual perspectives of those who have been subject to detention. More specifically, through the use of CIT, this study will look to understand critical incidents, or factors, which helped those who were detained to cope with their experience; or similarly, critical incidents or factors which were detrimental or made the experience of detention worse. In association with this, this study also aims to explore the 'wish-lists' of those who have been detained, i.e. understanding what they would have ideally liked to have possessed at the time of the event in order to help them cope.

Methodology

Ethical Approval

Prior to the commencement of the study, approval for the research was given by an NHS Ethics Committee and by the local research and development departments for the trusts in which the research was conducted.

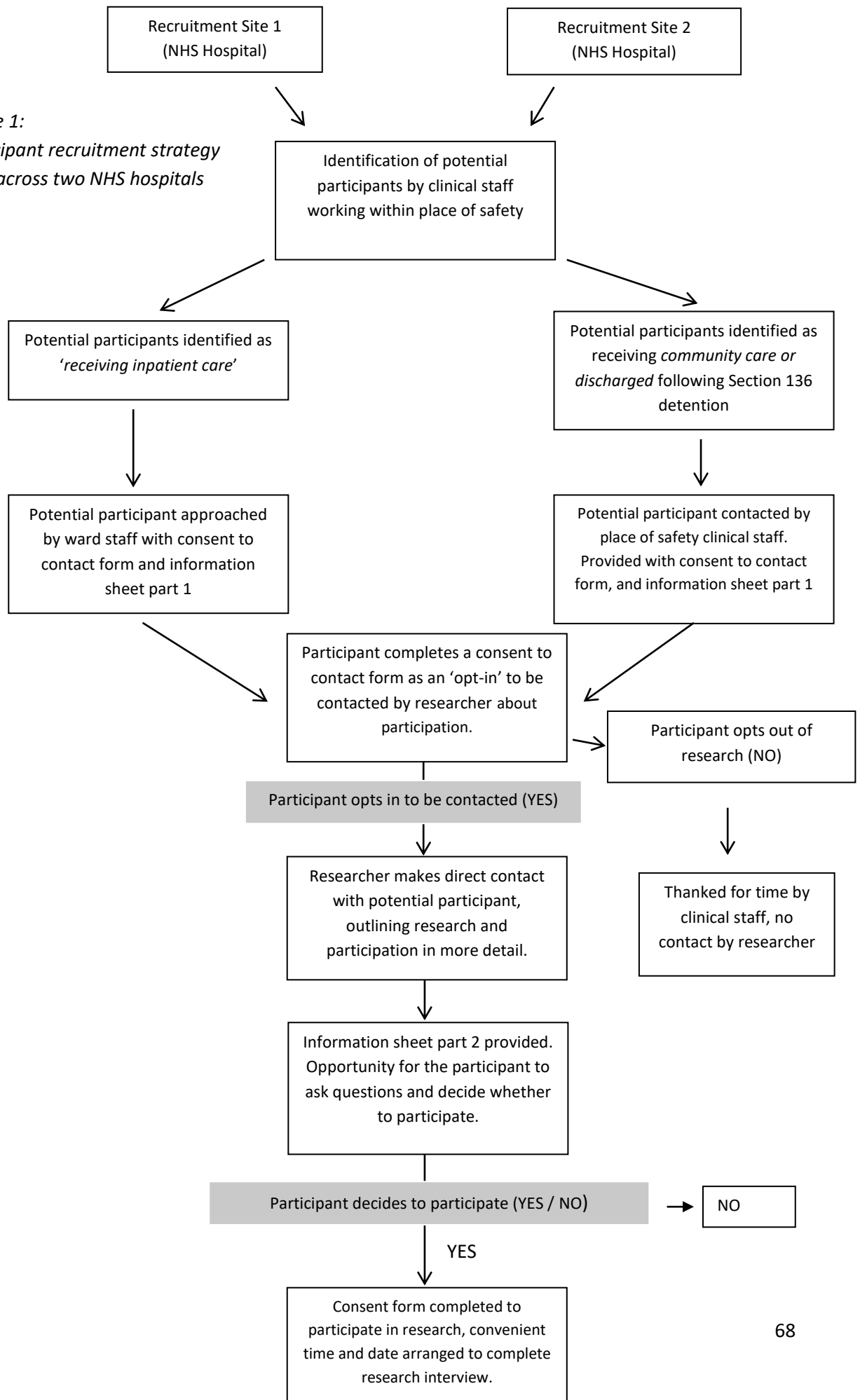
Approach: Critical Incident Technique

Originally developed for selecting and classifying air crew appropriate for particular roles within the U.S Royal Air Force, Critical Incident Technique (CIT) has since grown beyond its

original applications and has been used to support research within a wide variety of contexts including hospitality, nursing, industry and psychology (Flanagan, 1954, Butterfield et al, 2009). With its origins in industrial and organisational psychology, CIT is a qualitative method which relies on a set of procedures to collect, content analyse and classify human behaviour. It is a systematic, inductive set of procedures that can be used flexibly to collect observations of human behaviour (Flanagan, 1954). More recently, Butterfield et al, 2009) developed the model to include a number of credibility checks designed to increase the rigour and credibility of CIT, named Enhanced Critical Incident Technique (ECIT). Other than Butterfield et al's (2009) addition, there have been no other changes to the CIT methodology have been suggested since Flanagan's (1954) seminal article (Gremier, 2004).

Critical Incident Technique (Flanagan, 1954; Butterfield et al, 2009) assumes that reality is measurable, allowing the researcher to (i) explore the general purpose of the activity, (ii) the criteria for what constitutes effective or ineffective performance of the activity, and (iii) explicit criteria for judging/evaluating observed behaviours as reaching the standard expected for the activity. Flanagan (1954) cites that CIT has five major components; (a) ascertaining the general aims of the activity to be studied, (b) making plans and setting specifications, (c) data collection, (d) data analysis, and (e) data interpretation and report on the findings.

Figure 1:
Participant recruitment strategy
used across two NHS hospitals



Participants were recruited via two main methods. Common to all participants was their detention under Section 136 of the Mental Health Act (1983, 2007), resulting in an assessment at a designated place of safety. The study recruited from two NHS psychiatric hospitals that provide a place of safety for those detained under Section 136. Participants were identified as being eligible for participation in accordance with the study inclusion and exclusion criteria detailed in Table 1. These criteria were shared with clinical staff at the place of safety in order to allow them to identify potential participants following their detention under Section 136.

Table 1: Inclusion and exclusion criteria for participation in study

Inclusion Criteria	Exclusion Criteria
Adults (aged 16 years or older) who have been detained under Section 136 of the Mental Health Act (1983, 2007)	Those who are under the age of 16 who have been detained under Section 136 of the Mental Health Act (1983, 2007).
Was taken to a place of safety as defined by the Mental Health Act (1983, 2007)	Those who were taken to a place of safety via a street triage team rather than via a detention under Section 136 of the Mental Health Act (1983, 2007)
Has capacity to consent to and participate in the study	Inability to speak and understand English fluently. This would restrict the degree to which the individual could engage with the interviews.
Participant is experiencing a settled period of mental health robust enough to engage in potential emotional demands of talking about experience	Adults with an identified learning disability
	Adults who are in a period of crisis with their mental health

Individuals who were discharged from hospital, or did not receive inpatient care as a result of their detention were informed about the research by the clinical team associated with the place of safety. If interested, they were provided with information sheet and contact details for the Chief Investigator, and were asked to complete a consent to contact form stating that they were happy to be contacted to discuss the nature of participating in the

research further with the research team. Those who were not detained were deemed to have capacity to make informed decisions at the time, as they had received a comprehensive assessment from two mental health professionals under the Mental Health Act (1984, 2007) who had made the decision not to detain them, demonstrating their capacity at the time of assessment. Posters were displayed within public areas in the place of safety to advertise the opportunity to participate in the research.

Alternatively, those who were detained and consequently received inpatient care were recruited from the ward in which they were being cared for. Nursing staff approached potential participants who fulfilled the inclusion criteria directly with an information sheet and consent-to-contact form with the Chief Investigator's details. This was done once their mental health was stable and they were deemed by the clinical team as having capacity to consent to involvement in the research study. Posters were also placed in all adult acute psychiatric wards advertising the opportunity to participate in the study.

Following the completion of consent to contact forms, clinical staff passed these to the Chief investigator, who made contact with the potential participant either in person or by telephone. The study was discussed in more detail and a second information sheet was provided either in person or by post if the potential participant indicated they were interested in taking part. All participants were given the opportunity to take the information sheets away, read them and ask questions about participation at a later date. Those who agreed to participate were then asked to read and sign an informed consent for the participating in the study. As the research was conducted as part of a wider study which also

explored pathways to detention under Section 136, only the appendices relevant to this study have been included.

Data collection procedure

A semi-structured interview lasting approximately 60 minutes was conducted in order to explore the individual's experiences of being detained under Section 136. The interview was based upon Critical Incident Technique (Flanagan, 1954; Butterfield et al, 2009), which is a qualitative methodology focused on individual experience of specific incidents (see below for more details). Flanagan (1954) outlines the importance of identifying critical incidents (CI's) within the interview exploring individual experience of a situation or event. A critical incident has been defined as any observable human activity that makes a significant contribution, either positively or negatively, to an activity or phenomenon (Grove & Fisk, 1997, Norman, Redfern, Tomalin & Oliver, 1991). Within the interview, the participant was asked to tell their story about being detained and questions around what helped or hindered the experience of being detained under Section 136 were asked in order to elicit any potential CI's from participants. Further to this, Butterfield, et al (2009) also recommend the use of wish-lists to identify factors such as knowledge, information or people that participants would think have helped them to cope at the time. Participants were asked to consider their own wish-list of what they thought might have helped them to cope with, or have made their experience of being detained under Section 136 better.

A total of fifteen interviews were conducted with participants at a time convenient for the individual; and when their mental health was deemed as stable, either by ward staff or represented by their discharge after detention under Section 136. A total of eight

participants (seven male, one female) were recruited from one site, with seven other participants being recruited from second site (six male, one female). The range of age of participants was 18 – 64, with the average age being 28 years old. At the end of the interview participants were thanked for their time and arrangements for travel reimbursements made.

Following the interview, participants were offered the opportunity to be contacted by telephone to review the interpretations made about the data by the researchers. This credibility check took place in person, or over the phone between 2-3 months after the interview. This time scale allowed reasonable time for any further interviews with other participants to be conducted, and initial analysis to be completed. A total of 7 participants agreed to take part in the additional credibility check interview. Participants were invited to provide feedback on the critical incidents that had been identified and whether they felt their perspective had been reflected accurately in the analysis. These second interviews helped to ensure that the analysis of the data accurately reflected participant's lived experiences and that they felt that their voices had been represented in a way in which they were happy with. This approach is one of many 'credibility checks' encouraged by Butterfield et al (2009) to increase the rigour of the CIT methodology, and are discussed in more detail below.

Materials

The semi-structured interview (provided in the appendices) was based upon the template outlined by Butterfield et al (2009). As part of the recommended 'credibility checks', the semi-structured questionnaire framed questions in such a way that maintained fidelity to

the CIT model (Flanagan, 1954), largely through using open ended questions which invited the individual to tell their story and identify specific helpful and unhelpful factors with examples. The provision of examples is an important way in which reliability and credibility is developed through the method (Butterfield et al, 2009).

Interviews were recorded using an audio recorder and transferred to a secure computer as soon as possible following the interview. Interviews were transcribed verbatim into a transcript for further analysis.

Analysis

When beginning the process of analysis within a CIT framework, clearly establishing the purpose of the data and its predicted use is of paramount importance (Butterfield et al, 2009). For the current study, identifying and understanding the critical factors involved in the process of being detained under Section 136 from the individual's perspective was used as the frame of reference (Butterfield et al, 2009).

Using this frame of reference, an initial analysis of three interviews was conducted to identify helpful critical incidents, unhelpful critical incidents and wish-list items. A thematic analysis was then conducted with the identified helpful and unhelpful CI's and wish-list items from the initial three transcripts, categorising them where appropriate into themes. This process of identifying CIs and wish-list items and placing them into thematic categories was then repeated with the remaining transcripts. Gradually identifying CIs or wish-list items, placing them within appropriate categories, refining a category or creating a new category where a CI or wish-list did not fit any current themes, was an important part of the process of analysis. An independent judge also received the initial three transcripts and was

asked to identify critical incidents and wish-list items. This was compared with the researcher's initial analysis to highlight any discrepancies, of which there were none. Where a study involves the reporting of perceptions rather than a direct observation of behaviour, Butterfield et al (2009) recommend integrating further credibility checks as part of the data analysis. Determining the point of saturation when no new categories have been created is one such check; alongside reporting participation rates and verifying the analysis of critical incidents, by providing 25 percent of CIs and wish-list items to an independent judge.

Results

Analysis of the transcripts resulted in six categories of helpful critical incidents; seven categories of unhelpful critical incidents and five wish-list items being identified. These initial categories were then subjected to some of the remaining credibility checks as recommended by Butterfield et al (2009). Participants undertook a second interview wherein the initial categories generated from the data was shared and discussed, as well as inviting any questions or additional information that participants felt may have been missed in the initial interview. Participants were also provided with the critical incidents and wish-list items identified within their transcript, and asked to provide feedback as to whether they felt that they had been placed in the correct categories. Where changes to categories or critical incidents were felt to be needed by participants, these were discussed and a mutual agreement was reached. Participants generally reported that they agreed with the categories of the study and the placement of their CI and wish-list items. A total of two changes to the wording of category names were suggested by participants, which were agreed and implemented by the researcher. Following this credibility check with

participants, the list of categories were finalised and operational definitions written. A random selection of 25% of CIs and wish-list items were also provided to an independent judge, who was asked to place them into one of the pre-existing categories headings (provided with operational definitions). The independent judge's placement of the CI and wish-list items within the categories was then compared with the original placement. Andersson and Nilsson (1964) recommend a match rate of at least 80%. In this study, the credibility check resulted in a 92% level of agreement between the researcher and independent judge.

In order to assist in assessing the strength of a category, the number of participants who identified critical incidents in relation to the category have been included as percentages named 'participation rates'. Reporting participation rates has been cited as an important factor in assessing the relative strength of a category (Butterfield et al, 2009). In addition, the number of incidents included in a category in relation to the total number of incidents (helpful, unhelpful or wish-list) has been included as a percentage, named 'incidence rates'. The final list of CIs, wish-list items and their operational definitions are detailed below. Where appropriate, the term 'staff' and 'professionals' has been used to refer to both NHS and police staff unless otherwise specified.

Helpful Critical Incidents

A number of factors which helped those who had been detained to cope with the experience were identified by participants. Helpful critical incidents varied in their nature and frequency depending on individual experience, but there were a number of significant categories which emerged from the analysis which are outlined in Table 2.

Table 2: Helpful critical incidents (CI's) identified by participants

<i>Name of Critical Incident</i>	<i>Definition</i>	<i>Participation Rate</i>	<i>Incidence Rate</i>
<i>Staff who provide emotional support</i>	A range of emotionally supportive actions such as providing reassurance, checking how the person was feeling, and creating a supportive and containing atmosphere.	66%	33%
<i>Helping to make the experience more tolerable</i>	The provision of support through concrete means such as food or sensitive physical contact helped to make the experience more tolerable.	66%	17%
<i>Professionals who develop meaningful relationships with service users</i>	Being able to connect with others interpersonally on a meaningful level. Problem-free narratives such as talking about the person's interests outside of mental health were often common.	66%	24%
<i>Knowing what to expect</i>	Having previous experience of being detained or previously knowing staff or police.	60%	14%
<i>Practices which challenge stigma</i>	Feeling able to talk openly about mental health problem without fear of judgement or shame with professionals and on occasions the use of self-disclosure of professionals for those who were detained to relate their experiences to. Discussing mental health in relation to public figures and celebrities also helped to challenge stigma.	33%	7%
<i>Good communication within and between services</i>	The use of effective communication, both verbal and non-verbal between the individual and staff/police, and professional communication. This translated into a sense of feeling heard.	33%	5%

One of the categories with the highest strength was 'staff who provide emotional support'. This category of critical incident appeared to be a fairly common experience for participants. This involved experiences where staff emotionally supported those who were detained through providing reassurance, being validating and checking out how the person was feeling. For example, one participant described the way in which staff at the place of safety treated them upon their arrival after being brought in by police:

"P: No, just being kind.

Researcher: Okay. How were they kind?

P: They was just kind to me. They spoke gentle to me, told me what was going on, and just telling me that they were there for me."

Another particularly powerful category of critical incident was the provision of tangible support for participants during being detained under Section 136. Identified as 'helping to make the experience more tolerable', participants often recalled that being provided with food or drink, or being empathically touched on the shoulder was something that made the experience easier to deal with. One participant recalled how she was advised by a healthcare support worker about the availability of food and drink during her detention at the place of safety:

"P: She even went out of her way, and she goes well sorry erm... lunch has gone, teatime has gone and all the rest of it, but I will see what I can do for you. And she came back erm, like 15 minutes later. She brought me tea, erm sorry a coffee, sandwiches and biscuits and erm... she was so helpful. So helpful."

As well as the emotional support that was provided by staff, participants reported that the detention process was helped by those 'professionals who develop meaningful relationships with those who use their services'. Both clinical staff at the place of safety and police officers were reported by some participants to have developed meaningful relationships with them through problem-free narratives, such as discussions about the individual's

interests, family or children, or discussing sporting interests such as football. One participant recalled a particular conversation he was having with the police officer who was accompanying him during his detention, whilst waiting for his assessment to begin:

"P: ...Just treated me like a human being and we talked about his wife and ... we talked about things.

Researcher: ah ok, so he shared some of his life?

P: Yeah, yeah, yeah. He was on about a curry or something (laughs)... she cooks with curry or..."

Those who had previously experienced being detained under Section 136, or had previous relationships with staff involved in the detention process cited this as a helpful factor in 'knowing what to expect' dealing with the experience. Knowing a healthcare professional from a previous period of treatment at the psychiatric hospital was something recalled as helpful by one participant:

"P:...erm, one of the erm...the healthcare assistants from <removed> where I was before erm, I think she must have recognised my name and she came in and just chatted to me for a bit.

Researcher: Okay, so someone you knew came to speak to you? How helpful was that?

P: Erm, that was quite helpful because she knew what I had gone through before. Erm... and she was, yeah. Yeah she was just chatty..."

Practices which challenge stigma were identified as a helpful critical incident, described by participants as being able to talk openly with staff about mental health problems was also something that helped to reduce the sense of stigma. Being able to relate their experiences to well-known public figures was also a way in which participants felt stigma was reduced about particular conceptions. For one participant, the difference between previous and current attitudes of staff was something identified as particularly helpful:

"P: But, I think they, I think it's... they have got a different way about them now. Because I think mental health is a bit more..."

Researcher: Can you tell me a bit..."

P: It's a bit more open now isn't it? You know what I mean? You know if you... it's not like, they throw you in a room in a padded cell is it."

A smaller number of participants recalled how helpful the experience was of being asked questions which were accurate, sensitively timed and had a clear purpose, as well as participants picking up on professional's non-verbal communication such as body language. A less common experience, the importance of good communication was highlighted not only within services, but also between services. Police who sought further support from statutory bodies or more experienced teams were identified within this category. The actions of a police officer liaising with local statutory services to provide the most appropriate support was noticed by one individual who was detained:

"...Researcher: Looking back?

P: A good thing was, the one, a few times they've actually put me in the police car then called the triage, is it? You know the triage, you know who I mean? Because then they can say like, you know what I mean..."

Connecting with those who are detained on a human level through emotional support and clear communication are common factors which participants felt helped them to cope with the understandably distressing process of being detained. In addition to this, the provision of tangible support and knowing what to expect were also practical ways in which participants felt that they could manage the process of being detained.

Unhelpful Critical Incidents

Whilst those who were detained identified factors which helped them to cope with the experience, there were also a number of unhelpful critical incidents identified by participants. These again varied according to people's experiences, but there were a number of experiences which were similar, leading to the formation of a number of categories which are outlined below in Table 3.

Table 3: Unhelpful critical incidents (CI's) identified by participants

Name of Critical Incident	Definition	Participation Rate	Incidence Rate
<i>Practices which make stigma Worse</i>	Stereotypical or judgemental ways in which staff spoke or acted towards those who were detained was felt to perpetuate the stigma associated with being detained or with mental health difficulties. This was also through the use of practices such as handcuffs, not listened to or being dismissed. The presence of stigma within wider society was also noticed.	66%	26%
<i>Feeling powerless</i>	Information not being shared, being prevented from gathering personal belongings or feeling not listened to by the police or clinicians involved in the admission process.	60%	26%
<i>Complications which make the process worse</i>	Factors associated with the circumstances and process of the detention, such as time delays, too many staff and seeing anxiety or worry on the faces of involved staff.	40%	9%
<i>Being misunderstood by others</i>	The sense genuine concerns not recognised by others, instead being misinterpreted as signs of mental illness, and therefore used by staff as justification for admission.	40%	15%
<i>Seeing police as enforcers</i>	A range of police related factors such as the police uniform and how the police were regarded as an institution. Examples of this included participants seeing police as there to police rather than support.	33%	9%
<i>Staff who use excessive physical restraint or force</i>	Those who were in positions of power and misused this ability, highlighted by examples of the use of restraint or handcuffs.	33%	8%
<i>Expecting the worst based on previous experience</i>	Those who had previously been admitted to psychiatric hospital found that these experiences prejudiced the process, or outcome, of their recent detention.	26%	7%

Practices which made stigma worse by perpetuating a sense of mental health problems as something bad or viewed negatively, was the most commonly reported unhelpful critical incident. This was reported by the majority of participants. Participants reported powerful stories of how practices such as being put in handcuffs or having their choices restricted could result in them feeling like criminals. One participant described his sense of how staff involved in the detention process had reacted to him during the initial phases of detention, informing him of his detention under Section 136:

"P: ...not helpful really because it was treating me like a criminal.

Researcher: Okay. So did it feel like you were treated like you were a criminal?

P: Only a tiny bit at first.

Researcher: What made you feel like that?

P: Just the way they went on, roughed me up and put the handcuffs on me."

Feeling powerless was another frequently reported category, with participants stating that information was not shared with the individual, or on a number of occasions they were prevented from accessing personal belongings such as clothes or a phone. One participant shared how he was prevented from re-entering his property upon being informed he was being taken to hospital for an assessment:

"P: No. No. They just said yeah erm... I went I just want to go up and get my stuff they said no, you can't go and get your stuff.

Researcher: What was that like?

P: Not very nice. Before....when the ambulance got there, I wanted to go and get my stuff and they said no, you can't get your phone, you can't even... we are taking you as you are. "

As well as individual factors, 'complications which make the process worse' was identified as a critical incident by some participants as something which detracted from the experience of being detained. When detained, participants reported that time delays were a particular

source of frustration. Waiting to be seen by an assessing clinician at the place of safety was something remembered vividly by one participant:

“Researcher: How is not waiting around a good thing?”

“P: Well when you’re stressed, I remember one time I went to bed about...I came in about 8 o’clock, I didn’t get to the ward until about three o’clock on the morning. That’s a massive ... 7 hours or longer, you know. When you’re tired and hungry, but luckily they had sandwiches, but when you’re tired I dunno, it doesn’t help...”

Participants reported that a negative perception of the police exacerbated by aspects such as the views of police as punitive rather than supportive contributed to this unhelpful critical incident. One participant shared his perception of how the police were regarded in his local community:

“P: ...You see the police, some people think they are community workers, but they’re not. They are there to protect public. And if there’s anyone that steps out of line, their job is to do you. And they, they are there to do you...”

A smaller proportion of participants felt that that their intentions or actions were misunderstood or not heard by staff during the detention process. Examples of this included not being listened to when they raised concerns or feeling as though staff had attributed their actions during the detention to symptoms of mental illness rather than legitimate concerns. A complaint described by one participant about a housing issue was felt to be ignored by police due to their perception of his mental health difficulties:

“P: The third time was when they brought me to the <removed>. I was actually just making a normal complaint, about where I was living and could they do something about it.

‘Researcher: Okay. So they didn’t take you seriously with that complaint?’

“P: No, they didn’t take me seriously.

Researcher: What else did they do which was not helpful or made the experience worse do you think?’

“P: They didn’t listen to me they... because nothing changed...”

Another experience which was reported by a small number of participants was ‘staff who use excessive physical restraint or force’. Examples of this included physical restraint by clinicians during admission, and the use of handcuffs by police during the initial phases of detention. The use of handcuffs on one participant by police upon arriving at a public place was something that was held in memory by that individual:

“P: Yeah, but that was with... They put handcuffs on to do that, then they did that after onto my shoulder. And I was screaming out in pain.

Researcher: So when you think about being put in handcuffs, what’s your thoughts about that?

P: Well it’s...its not... If you’re put in handcuffs, you’re put in handcuffs there. You’re not put in handcuffs behind your back. Why did they put me handcuffs behind my back?”

Previous experience was also identified as an unhelpful critical incident, albeit a category with significantly lower participation rates in comparison with the helpful category of knowing what to expect. For some, those who had experienced detention under Section 136 previously felt that this was a factor which was detrimental to their most recent detention. Participants reported feeling as though judgements or assumptions about their current state had been made based on their previous admission, leading to the process feeling prejudiced. One participant described a sense of how similar his experience in his recent detention had felt to previous contact with services:

“P: They didn’t do anything. They were very barbaric. They were very barbaric. It was like history was on repeat?

Researcher: Can you say a bit more?

P: It’s about 35 days to the year since, I think that’s it roughly...”

In summary, a number of factors which detracted from the experience of being detained under Section 136 were identified by participants, a number of which were underpinned by a sense of not being heard. In many ways, the unhelpful critical incidents identified by some

participants reflect the absence of the helpful critical factors that were identified by other participants who had also been through the process.

Wish-list Items

For participants, wish-list items reflected the factors, knowledge or experience they would have liked to better equip them to have dealt with the experience. As might be expected, participant's wish lists were often generated by their reflections on unhelpful critical incidents. On occasions, participants also identified wish-list items which were a continuation of helpful critical incidents that were previously identified. A table of wish-list items are detailed in Table 4.

Table 4: Wish-list items identified by participants

Name of Wish-list Item	Definition	Participation Rates	Incidence Rates
<i>Practical changes which make the experience more tolerable</i>	The desire to change practical elements about the detention process, such as a change in the transport that was used, and making the process faster with fewer staff.	53%	33%
<i>Changing attitudes towards mental health problems</i>	The wish for attitudes towards mental illness to change and in some cases specifically changing attitudes towards those who were detained. Examples included changing police officer's attitudes towards mental health, providing training to staff to help them better understand mental health issues, and helping them to see people as individuals rather than symptoms.	46%	28%
<i>Helping people to feel more empowered as part of the process</i>	To be more empowered during detention; including better access to advocacy services, reduced use of restraint and handcuffs during admission, and feeling more believed by professionals involved in the admission.	46%	25%
<i>Increasing the level of support in the community</i>	The provision of a higher level of support in the community, which they believed would lead to a lower potential need for detention.	13%	7%
<i>Encouraging a more diverse police force</i>	A more diverse police force to help cope with initially being detained, with both female and male police officers being requested so that people could relate to either gender.	13%	5%

In the context of the individual and contextual factors identified in this study, the most prominent wish-list item identified was to make 'practical changes which make the

experience more tolerable'. Practical changes proposed by participants included a change in transport used during the detention process and a more streamlined process. One participant recalled how she wished she would have been able to gather some belongings prior to arriving at hospital, in order to communicate with those people who were important to her:

"Researcher: When the police had brought you in, called the ambulance and brought you into the hospital, what would have been helpful to have?"

P: Yes it would have been. To go upstairs and fetch telephone numbers and that, it would have been very helpful yes.

P: Researcher: So, being allowed to communicate with people?"

P: Yeah, yeah it would have been nice to be able to communicate. To get telephone numbers and some clothes."

Helping people to feel more empowered as part of the process was something identified by participants as a wish-list item, and appears to be one way in which services can begin to address the unhelpful critical incidents of feeling powerless and seeing police as enforcers. Participants gave examples such as a reduced use of handcuffs and restraint, and more access to advocacy services as ways through which they could feel more empowered. The provision of an independent advocate for the individual was something deemed to be an important wish-list item by one individual:

"P: I would ask for a mental health care worker. But when you're like that, you don't think of anything. You see when you're vulnerable like that, you need somebody of authority on that, on the situation..."

A desire to address a sense of stigma was something reflected in the wish-list items identified by participants, with almost half of participants suggesting that changing attitudes towards mental health was something that would have helped them deal with the experience. This category does not solely refer to attitudes of staff but is inclusive of wider

societal attitudes to mental health. The ability to be sympathetic towards those who were being detained was one way in which a participant felt that staff could begin to demonstrate changing attitudes towards mental health:

"P: He could have dealt with it differently. He could have dealt with it differently. Probably more erm, what's the word I'm looking for... caring and understanding? Erm..."

Researcher: Okay. And how might he have shown he was more caring and understanding?

P: Being more sympathetic."

Participants also highlighted that they wanted a higher degree of support in the community, associating this with a lower need for detention in the first place. One participant felt that she did not feel supported enough in her local community and shared her sense of exasperation at how this could have avoided the involvement of the police:

"P: More support in the community.

Researcher: Okay. Can you give me an example of what that would look like?

P: Someone, someone just being there for me. That I didn't have to go through the police. It like I was crying out for help, but no one was helping me..."

Finally, a small minority of participants reported that they would like to see a more diverse police force, with both female and male police officers available to support the detention process. One participant talked about her desire to see both male and female police officers involved in the detention process, especially for her as a woman:

"P: And I think it is, it is important that women have their their... someone, they can have someone from either sex. It doesn't matter if it was say two men, or say two women. But it's important that they have someone there who they can relate to."

There were therefore a number of needs that participants identified in their wish-list items, which were often very specific depending on the individual's experience. Interestingly, some participants identified critical incidents such as emotional support as important wish-list items, suggesting the absence of these during their detention. Some participants did

however identify these as part of their experience of detention. This demonstrates the varied experiences and perceptions that those who have been detained under Section 136 shared during their participation in this study.

Discussion

This study aimed to explore and begin to understand the experiences of those who have been detained under Section 136 of the Mental Health Act (1983, 2007). In particular, the research hoped to understand the critical factors and incidents which may have helped or hindered the process of detention, by inviting participants to share their experience.

Through their story, critical incidents or factors which helped or hindered the experience of being detained were identified. In addition, participants were asked to consider a 'wish-list' of factors, knowledge or experience that they would have hoped to have had during the experience of being detained. Analysis of interviews revealed a rich breadth of factors; with seven categories of helpful critical incidents, six categories of unhelpful critical incidents and five categories of wish-list items.

The role of interpersonal factors appeared to be a consistent theme throughout the helpful critical incidents identified; with the value of emotional support being highlighted by participants. Given that the literature suggests that those who are experiencing mental health problems report feeling likely to be discriminated against and reluctant to seek support from healthcare professionals (Oliver, Pearson, Coe & Gunnell, 2005; Roness, Mykletun & Dahl, 2005), providing consistent emotional support during an understandably upsetting experience is important. Skills arguably involved in being emotionally supportive such as warmth, empathy and active listening have been identified as contributing to

building the platform through which a rapport can be developed (Papworth, Marrinan, Martin, Keegan & Chaddock, 2013). Moreover, the uses of empathic statements have been found to be associated with physiological changes such as increased electrodermal activity (Finset, Stensrud, Holt, Verhuel & Bensing, 2011). These findings suggest that investing in interpersonal skills training, such as communication skills for staff may help in the ways in which services are perceived by those that use them.

Previous literature also highlights the importance of the therapeutic relationship during the process of admission to psychiatric hospital, highlighting that a positive relationship between the individual and clinician may go some way to protect against feelings of being coerced (Sheehan & Burns, 2011). In this study, participants felt that they were able to develop real and meaningful human relationships with admitting clinicians and police based on information not solely related to their mental health difficulties. In a wider review of psychiatric care, Newton-Hones and Mullen (2011) found that participants' reports of coercion during involuntary admission were often accompanied by a sense of being dehumanised through a loss of normal human interaction. The importance of generating meaning about one's self is well documented in psychological theory. Modified Labelling Theory (Scheff et al, 1989) suggests that an individual's beliefs about mental health can have significant impact upon how they view themselves, reducing opportunities for social support. Considering this in the context of the findings here, one suggestion may be that investing in meaningful relationships through conversations about the individual and their interests helps to protect against some of the self-critical or shaming schemes that may be present, in turn providing a novel experience (Katsakou & Priebe, 2007). Investing time in the relationship forming between the individual and clinician may go some way to challenge

some of the assumptions that the individual may hold about their difficulties, and how they perceive mental health services.

The role of interpersonal factors within emotional support and developing relationships with those being detained under Section 136 appears therefore to hold a number of benefits for both the individual and the service. It is clear that the two critical incidents are somewhat correlated; staff who are emotionally supportive in their approach may also benefit from an improved relationship with that individual as a result of a more authentic and emotionally supportive relationship. This adds to previous literature suggesting complex interpersonal skills involved in emotional support, such as posture and eye contact form part of a process facilitates the identification of mental health difficulties (Giron et al, 1998). Furthermore, evidence suggests that a positive relationship between the individual and clinician may go some way to protect against feelings of being coerced (Sheehan & Burns, 2011), and previous interventions providing training in emotionally supportive approaches to wider healthcare professionals has reported favourable results (Wong et al., 2007). The longitudinal benefit of staff who are emotionally supportive and whether this makes a significant difference to the individual's future mental health care is however less clear. Future research may therefore benefit from exploring what longitudinal effect the experience of receiving emotional support from staff during the detention process has on how the individual understands their difficulties in the future.

In addition to interpersonal experiences, there were a number of contextual factors identified which participants reported as helpful in managing their experience of being detained, namely the provision of practical support and previous experience. Tangible support which made the experience more tolerable involved participant's having many of

their basic needs such as food, warmth and shelter met. The provision of food amongst other environmental factors has been linked with the level of satisfaction reported by those who are being cared for (Johansson, Oleni & Fridlund, 2002; Irurita, 1998). Whilst this provides a means through which staff can meet the practical needs of those who are detained, it also appears to represent a tangible way to communicate empathy and support between the individual and staff. The provision of tangible support may also serve as a method of facilitating the initial development of rapport between the individual and those involved in the detention process.

The ability to draw upon previous experiences of detention, or memories of interactions with the detention process, or admitting staff was a source of comfort for some participants. For many participants previous experiences helped to make the current detention more tolerable through being able to manage feelings of uncertainty which are often associated with the maintenance of anxiety (Beck, 1976, 2011; Wells, 2013; Dugas & Rochiband, 2007). The possession of information and knowing what to expect from hospital processes has been found to be a comforting factor, reducing feelings of vulnerability experienced by those admitted to hospital (Irurita, 1998). The importance of managing anxiety is one that spans disciplines, with examples such as those who had previously experienced anaesthesia requiring less information and feeling less anxious about an upcoming operation (Moerman, van Dam, Muller, & Oosting, 1996). This sense of helping to continue to make the experience more tolerable was something encouraged by participants and was their strongest wish-list item. Participants recommended the use of different transport and a reduction in contextual issues such as the time taken to be seen by a clinician.

Complications associated with the process including time delays and staffing levels were identified as unhelpful critical incidents, detracting from the individual's experience of being detained. Delays to accessing care are an issue which plagues many services within statutory healthcare services, often leading to feelings of discontent for those that use them (Murray, 2000). Although it is understandable that time delays may understandably cause a degree of frustration, this critical incident perhaps holds more significance in the context of the other findings reported here. For those detained who reported critical incidents of feeling powerless and stigma making the experience worse, enduring longer time delays are perhaps unlikely to combat these experiences. Recent NHS reforms have however significantly affected mental health services within the United Kingdom, posing a risk to patient care (Hunter, 2010). The challenge now presented to services is to facilitate factors such as that identified by participants in this wish-list item, with ever lessening resources to do so. This is perhaps reflected poignantly in participant's wishes for more community support, which would in turn mean a lower likelihood for detention in the future.

For some, however, contextual factors served as an unhelpful factor in making their experience of detention worse, with a small group of participants reporting that having being detained before made them feel vulnerable to prejudice. Similarly, the context in which the individual was meeting with clinicians was felt to skew the way in which their actions were interpreted, with some feeling as though their actions were attributed to symptoms of mental health problems rather than any other potentially reasonable cause. In an environment dominated by social interaction, individuals strive to generate causal explanations for experiences based on information available to them (Fiske & Taylor, 1991). The tendency to overestimate personal characteristics in preference of environmental

factors, commonly identified as the fundamental attribution error has been the subject of social sciences research for decades (Ross, 1977, Tetlock, 1985). The experience of contextual factors identified here, with both current and previous actions being attributed to internal characteristics of mental illness rather than a response to the environment, highlights the potency of this theory in this particular context (Ross, 1977).

These unhelpful contextual incidents not only highlight issues with the attributions made about participants behaviour, but may also serve to perpetuate the sense of a high level of stigma and feelings of powerlessness (Roeloffs et al, 2003). Factors involved in the process of detention, such as the visibility of the police at an individual's home or being transported via police cars or vans, added to the participants sense of stigma being made worse, through feeling as though they were being labelled as a criminal for having mental health problems (Corrigan, 2004). The issue of power was a prominent theme throughout a number of unhelpful critical incidents, with participants reporting feeling disempowered through a number of factors. It appears that, despite their intentions, these findings appear to mirror previous research documenting that those who are attempting to help those with mental health problems can sometimes be seen instead by individual's as perpetrators of stigma (Verhaeghe & Bracke, 2012; Chew-Graham et al, 2003).

The use of handcuffs and prevention of accessing practical support such as clothing is likely to only serve to confirm unhelpful perceptions of the police as enforcers and those being detained as passive and powerless recipients. Seeing professionals as enforcers or the excessive use of restraint is likely to contribute to worse emotional wellbeing, as well as potentially damaging the alliance formed between the individual and clinical team (Wynn, 2007, Kontio et al, 2010). It may be that clinicians provide the rationale that actions such as

using police transport or handcuffs may be in the best interests for the individual in order to protect their safety. The findings here suggest however that these experiences may in fact be highly shameful for the individual, exacerbating feelings of stigma during a time when the individual may feel particularly vulnerable. Addressing power imbalances in services and increasing a sense of empowerment held by those who are involved in psychiatric services has been highlighted as a key factor in both engagement and outcomes (Laugharne & Priebe, 2006). This was something echoed by participants, who identified a number of ways in which the use of advocacy services and reduced use of restraint and handcuffs could facilitate this.

Interestingly, there was a smaller minority of participants who reported that practices initiated by the staff helped to combat some of the stigma associated with mental health difficulties. In many ways, ways to combat stigma relates to many central mechanisms of emotional support and forming meaningful relationships with professionals, by facilitating the expression of difficult feelings and emotions in a space which felt safe enough to do. By doing so, professionals may be inadvertently addressing what Corrigan (2004) called public stigma, which are the wider cultural assumptions that those with mental health difficulties are dangerous or that such difficulties cannot be talked about. The presence of stigma as both a helpful and unhelpful critical incident therefore highlights the varied experience of participants in how they perceived staff, including police dealing with mental health difficulties and the stigma associated with it. One way of helping to reduce stigma during the process was suggested by a small minority of participants who felt that the experience would be made easier by a more diverse police force.

A potential explanation for the difference in their experiences may lie in one of the participant's wish-list items, by addressing the understanding that staff members held about mental health difficulties. Participants suggestions included providing more training to those involved in the process, such as police officers was identified as a way through which attitudes towards mental health could be changed. These wishes seemed to convey a desire for a more de-stigmatising, empathic approach from the police to dealing with those with mental health problems in crisis. Research would also support this idea, with studies suggesting that increasing mental health literacy on a public scale provides a way through which future emotional problems can be supported before they develop into significant mental health difficulties (Kelly, Jorm & Wright, 2007). Similarly, models of early intervention have been implemented with favourable research evidence for a range of significant mental health problems, particularly psychosis (Birchwood, Todd & Jackson, 1997, Jackson & Birchwood, 1996).

Considering this, the majority of the helpful critical incidents discussed thus far are arguably facilitated by the use of effective communication. Participants identified that both communication within the service involved in the detention process, and between services which were involved the process, helped to make the experience easier. Good communication skills have been identified as a key part of good quality care, increasing levels of satisfaction (Irurita, 1999).

Overall, a central theme of the importance of authentic human connection underpinned many of the experiences and critical incidents shared by participants in this study. This highlights the striking need to be able to develop relationships and communicate flexibly with an individual during a particularly distressing period, not only searching to recognise

symptoms of mental illness. The need for this human connection, to know and be known by others has previously been identified in psychological theory as the basis from which people are able to fulfil their potential. The 'Person-Centered Approach' (Rogers, 1959) emphasises the importance of an empathic environment, and a genuine and understanding approach from others in order to develop the actualising tendency (Patterson & Joseph, 2007).

Perhaps the absence of such an environment and relationship with another may, in combination with other complex factors such as stigma, have contributed to the individual's mental health difficulties, eventually leading to detention. What is clear however from this study, is that a range of services from the NHS to the police service can benefit from understanding the value of developing an authentic and meaningful connection with a person, rather than basing their interactions with an individual around the task of identifying and recognising symptoms of mental illness.

Strengths & Limitations

The current study has provided a unique insight into the experiences of those whose voices have not been heard enough in previous clinical research. Bringing the wider public into contact with those who are stigmatised is one way of beginning to combat mental health stigma, and disseminating research such as this is arguably one way which encourages this contact (Corrigan & Watson, 2002)..

A variety of rich data was generated and analysed using a novel method which has not been employed in relation to this particular population previously, leading to a number of findings. There are however, a number of limitations with using such a method where other qualitative methods such as Interpretative Phenomenological Analysis exist as an

alternative. Whilst Critical Incident Technique provided a containing framework for participants to explore and discuss highly emotive experiences, this may have in turn limited the richness of exploring important factors such as trauma. There is a significant amount of literature exploring the traumatic effect of psychiatric hospital admission and consequent outcomes for patients, such as PTSD (McGorry et al, 1991; Beattie, Shannon, Kavanagh, & Mulholland, 2009, Morrison, Bowe, Larkin, & Nothard, 1999). There were no strong links to this trauma literature within the dataset from this study, but this may be due to the relatively 'concrete' nature of the interviewing methodology used in CIT.

The data from this study only represent a small sample from two recruitment sites in the UK, and as such the experiences of those who have been detained in other geographical areas may differ from those views included here. Similarly, the findings discussed here are representative only of those who were able to participate in the research, and as such there may be different experiences yet to be understood by others who have also been detained. Table 5 provides an accessible summary of these recommendations.

Clinical Recommendations

This study has found that problem-free discussion and getting to know the individual, not just asking about symptoms was felt to help participants cope with being detained.

Clinician's should therefore look to foster authentic relationships based on the individual rather than their diagnosis, as this authenticity appeared to underpin many of the helpful critical incidents reported by participants within this study. The provision of communications training may aid the development of these skills within staff groups. Staff should also be aware of any practices which might exacerbate a sense of stigma associated with mental health problems, and where possible look to minimise these. Examples of this

include avoiding the use of handcuffs and considering the type of transport used for those who are detained.

Services should also look to increase the sense of empowerment for those who are detained through the provision of advocacy. This would help those who are detained to feel more involved as part of the process, potentially facilitating communication between staff and those who are detained. The provision of practical support such as food and drink should be offered, something cited as helpful by participants who had experienced this within this study. Staff should also support those who are detained in meeting their basic needs by allowing them to collect some personal belongings before being taken to hospital.

Research Recommendations

The longitudinal effects of critical incidents identified within this study are not yet known, and as such future research would benefit from exploring the effects on longer term outcomes. Whilst this study has provided insight into the little understood factors which help or detract from an individual's ability to cope with being detained, there is a paucity of research exploring the pathways that lead to the incident of being detained under Section 136. Future research would benefit from exploring help-seeking pathways prior to being detained, which in turn would aid services understanding about where they may be able to provide earlier intervention for those with significant mental health problems. This research has also provided a platform for seldom heard voices to be disseminated to a wider audience. Further qualitative research exploring the experiences of those who have been detained under Section 136 is also needed.

Clinical Recommendations:

- Meaningful relationships should be fostered with service users; this study found that ‘problem free’ discussion and getting to know the individual, not just asking about symptoms, was helpful. This could be facilitated through communications training for staff.
- Staff should be aware of any practices which might perpetuate the stigma sometimes associated with mental health, and where appropriate minimise the use of these (use of handcuffs, considering method of transport)
- Services should look to ensure a sense of empowerment for those who are detained through available and accessible advocacy. Increasing involvement and choice in the detention process, where possible, would also help develop a sense of empowerment.
- The provision of practical support, should as food, drink and allowing those who are detained to gather personal belongings where appropriate should be encouraged to be routinely implemented.

Research Recommendations:

- Future research would benefit from exploring the longitudinal effects of helpful and unhelpful critical incidents identified in this study on the future treatment for those who have been detained
- Further research exploring the experiences of those who have been involuntary detained under Section 136 is warranted to contribute to a deeper understanding of the experience, and how this can be managed better by services
- The exploration of help-seeking pathways prior to detention for those who under Section 136 would also contribute to better understanding of how services may be able to intervene earlier to prevent crises of mental health.

Table 5 : Accessible summary of clinical and research recommendations

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Chapter Three

Public Domain Briefing Document

This document provides a brief and accessible overview of the thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Clinical Psychology at the University of Birmingham. Both the systematic review and empirical research paper are summarised here.

Public Briefing Document

What does the literature tell us about what factors are associated with coercion in those who are involuntarily admitted to psychiatric hospital?

Background

In modern medicine, choice over one's care is seen as the most pertinent ethical principle in order to preserve a patient's liberty (Beauchamp, 2011). Under the Mental Health Act (1983, 2007), those who are suspected to be experiencing a 'suspected disorder or disability of the mind' may be involuntarily admitted to psychiatric hospital. The current literature is unclear as to whether the benefits of imposing involuntary treatment on an individual through admission to hospital outweighs the risks posed by such a coercive measure. The definition of coercion within the literature has previously been successfully conceptualised as 'perceived coercion', the experience of feeling coerced that may not necessarily involve an external force such as restraint, but is often vague (Newton-Howes, Mullen, 2011). The factors associated with the experience of coercion during the involuntary admission process are however less clear, and are particularly important to understand given the increasing rates of admission to involuntary hospital.

Aims

The aim of this review was to systematically review the available literature to identify what factors were associated with experiencing coercion in those who were involuntarily admitted to hospital.

Method

A systematic search of four electronic databases was conducted, using keywords related to the question posed for the review. A total of 258 articles were returned, and reviewed according to a number of inclusion and exclusion criteria. This resulted in 11 suitable studies being included for this review. Fowkes & Fulton's (1991) critical appraisal tool was used to support the evaluation of the identified literature.

Results

The majority of literatures identified were cohort studies, with participants being identified across the world from a range of countries. The quality of the literature reviewed varied greatly but was largely satisfactory. Those who were experiencing a psychosis; were aggressive or self-harming, poorer global functioning or were not part of the local community were more likely to report experiences of coercion. Throughout many of the papers, the importance of relationships between the individual and clinician and/or service was highlighted, with hostile-dominant personality styles being found to be associated with increased coercion. There was also some evidence to suggest the culture of the organisation providing care was a factor in whether or not an individual report feeling coerced.

Conclusions

There were a number of factors identified in the literature which appeared to be related to the experience of coercion during involuntary admission. Investing in training for staff around complex mental health difficulties such as psychosis or managing difficult

relationships could help to lessen the experience of coercion for those who are involuntarily admitted to hospital. Exploring some of the findings outlined in this review in more depth would be warranted in future research, specifically exploring the role of organisational culture in coercion.

Public Domain Briefing Document

How do people make sense of their experience of being detained under Section 136 of the Mental Health Act (1983, 2007)?

Background

The Mental Health Act (1983, 2007) provides legislation for the care of those who are experiencing significant problems with mental health illness. Where people become seriously unwell and may present a risk to themselves or others, Section 136 of the Mental Health Act allows police to detain those suspected of being 'mentally disordered' for the purposes of mental health assessment at a place of safety, usually a local psychiatric hospital. Those who are detained have previously reported feeling criminalised by police (Riley, Freeman, Laidlaw & Pugh, 2011), and police officers being likened to 'street-psychiatrists' who have highlighted they would like more feedback about the experience. There is however, a significant lack of available research exploring the experience of being detained under Section 136.

Aims

The aim of the current study was to explore the individuals perspective upon being detained under Section 136 of the Mental Health Act (1983, 2007) from those who have been subject to detention. More specifically, the study looked to explore the factors which helped people cope with the experience, or made the experience worse.

Method

Service users who had been detained under Section 136 were invited to participate in a semi-structured interview. Critical Incident Technique (Flanagan 1954, Butterfield, Borgen,

Maglio & Amundson, 2009) was used to help participants share their story of being detained, whilst identifying critical incidents which helped or hindered the experience. Participants were also asked what they would have wished to have had at the time to help them cope, known as a wish-list.

Results

Fifteen participants completed interviews sharing their experience of being detained.

Analysis of transcripts of interviews resulted in a number of categories of helpful critical incidents, unhelpful critical incidents and wish-list items being identified.

Categories of helpful critical incidents identified included the importance of interpersonal relationships through 'staff who provide emotional support', 'professionals who develop meaningful relationships with service users' & 'practices which challenge stigma'. Practical support was also identified as helpful, with categories 'helping to make the experience more tolerable', 'knowing what to expect', 'good communication within and between services'.

'Practices which make stigma worse', 'feeling powerless' and 'being misunderstood by others' were categories of unhelpful critical incidents identified from participant experiences. 'Staff who excessively used physical restraint or force', 'complications which make the process worse', 'seeing police as enforcers' and 'expecting the worst based on previous experience' were also highlighted as unhelpful critical incidents.

Participants also identified a number of things that looking back, they felt would have helped them to cope with the experience of being detained at the time. 'Practical changes which make the experience more tolerable', 'helping people to feel more empowered', 'increasing the level of support in the community' and 'encouraging a more diverse police

force' were categories identified as wish-list items.

Conclusions

The experience of being detained under Section 136 can vary depending on individual experience. These findings suggest that forming human relationship through developing an understanding and empathic relationship with service users is an important part of good quality care during the detention process. In addition, being aware of the stigma associated with mental illness and being detained is also important; ensuring that staff develop non-stigmatising practices. Organisations may benefit from investing in communications training for staff, and look to create a culture through which the relationship between clinician and service user is valued highly. Future research would warranted in exploring the factors contributing to being detained under Section 136, identifying pathways of help seeking used prior to detention.

Clinical Recommendations:

- Meaningful relationships should be fostered with service users; this study found that 'problem free' discussion and getting to know the individual, not just asking about symptoms was helpful. This could be facilitated through communications training for staff.
- Staff should be aware of any practices which might perpetuate the stigma sometimes associated with mental health, and where appropriate minimise the use of these (use of handcuffs, considering method of transport)
- Services should look to ensure advocacy services are available and accessible.
- The provision of practical support, should as food, drink and allowing those who are detained to gather personal belongings where appropriate should be encouraged to be routinely implemented.

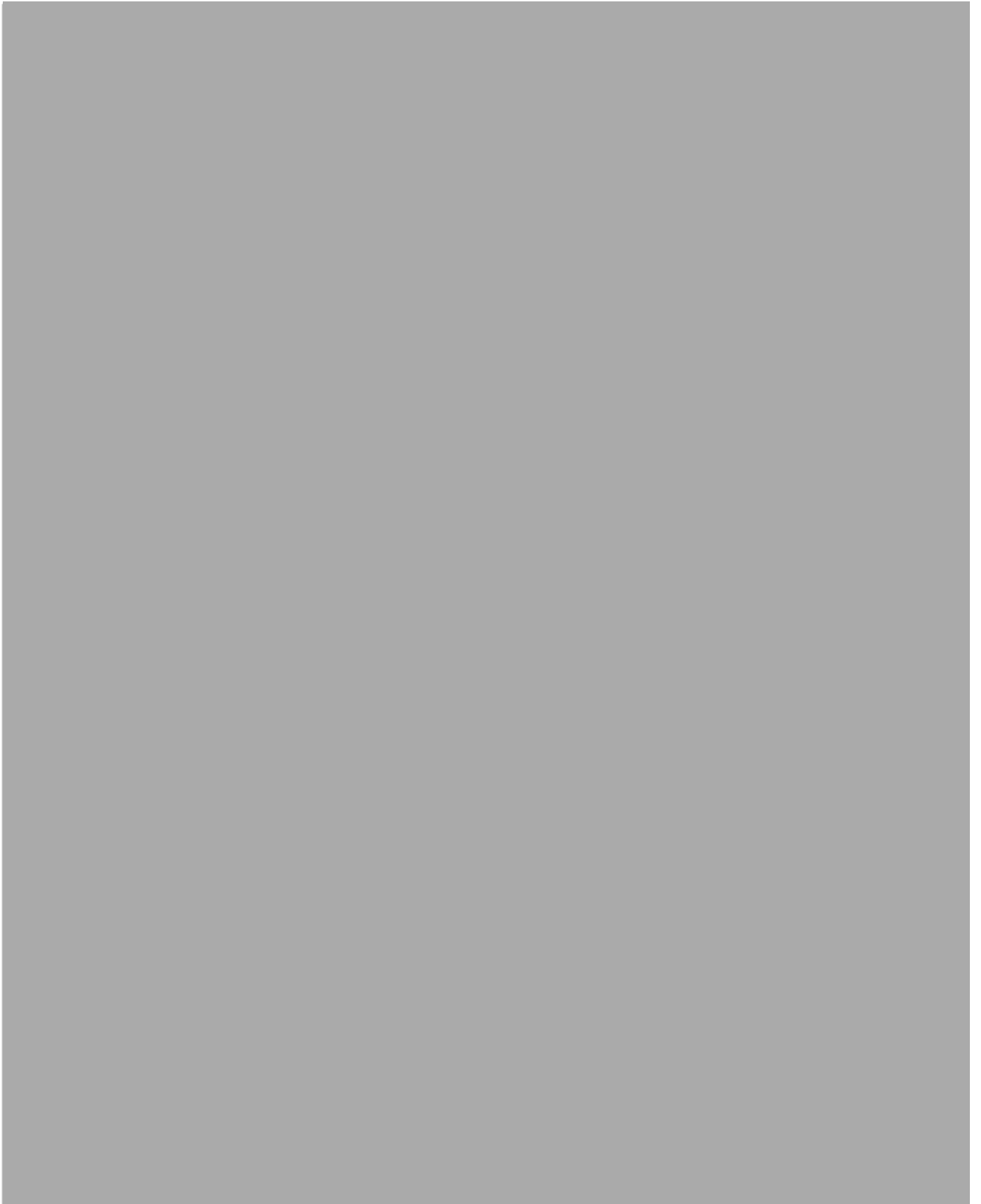
Research Recommendations:

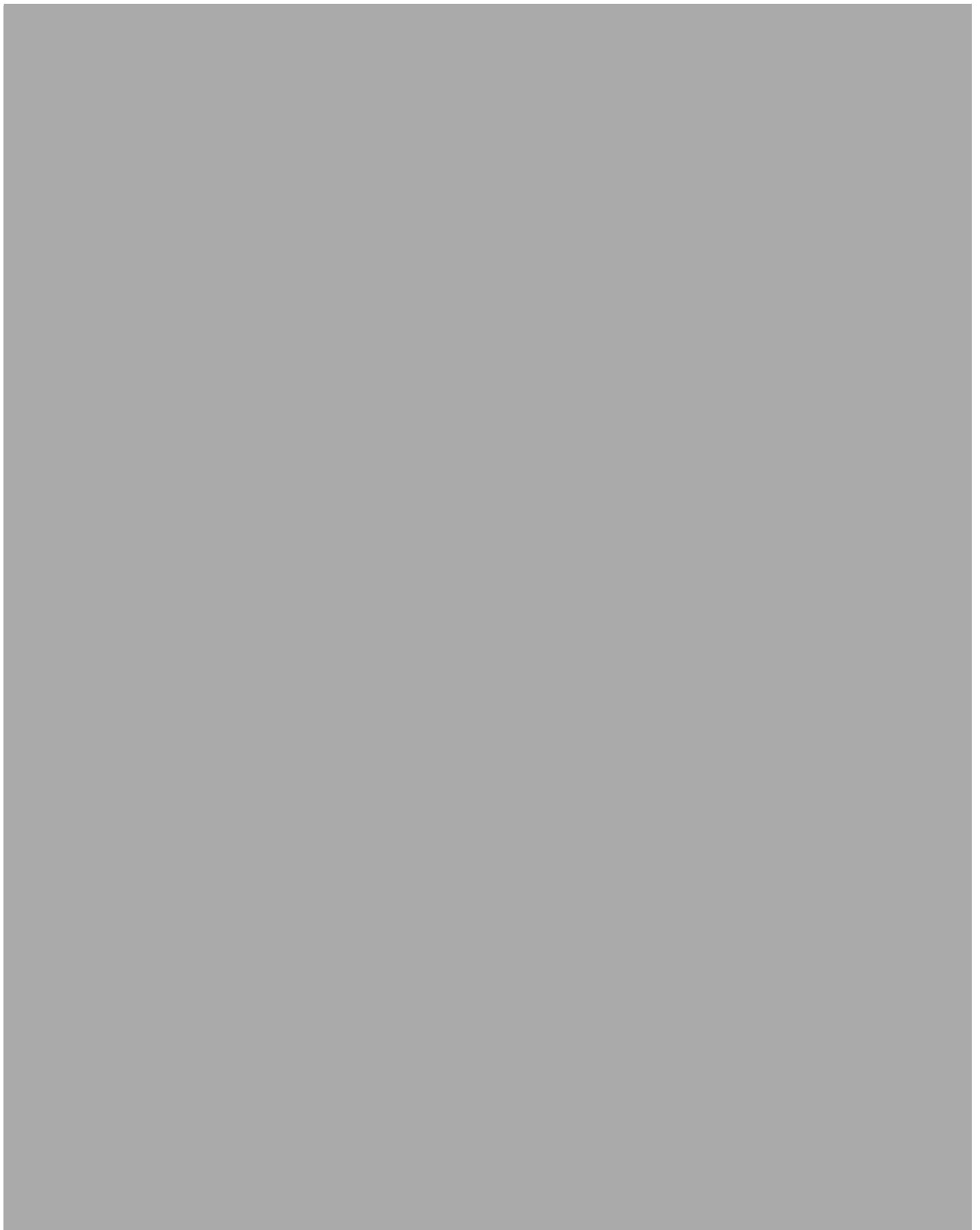
- Future research would benefit from exploring the longitudinal benefits of the emotional support & meaningful relationships which have been found to be helpful in this study, on future treatment for those who have been detained.
- Further research exploring the experiences of those who have been involuntary detained under Section 136 is warranted to contribute to a wider understanding of the experience and how this can be managed better by services
- The exploration of help-seeking pathways prior to detention for those who under Section 136 would also contribute to better understanding of how services may be able to intervene earlier to prevent crises of mental health.

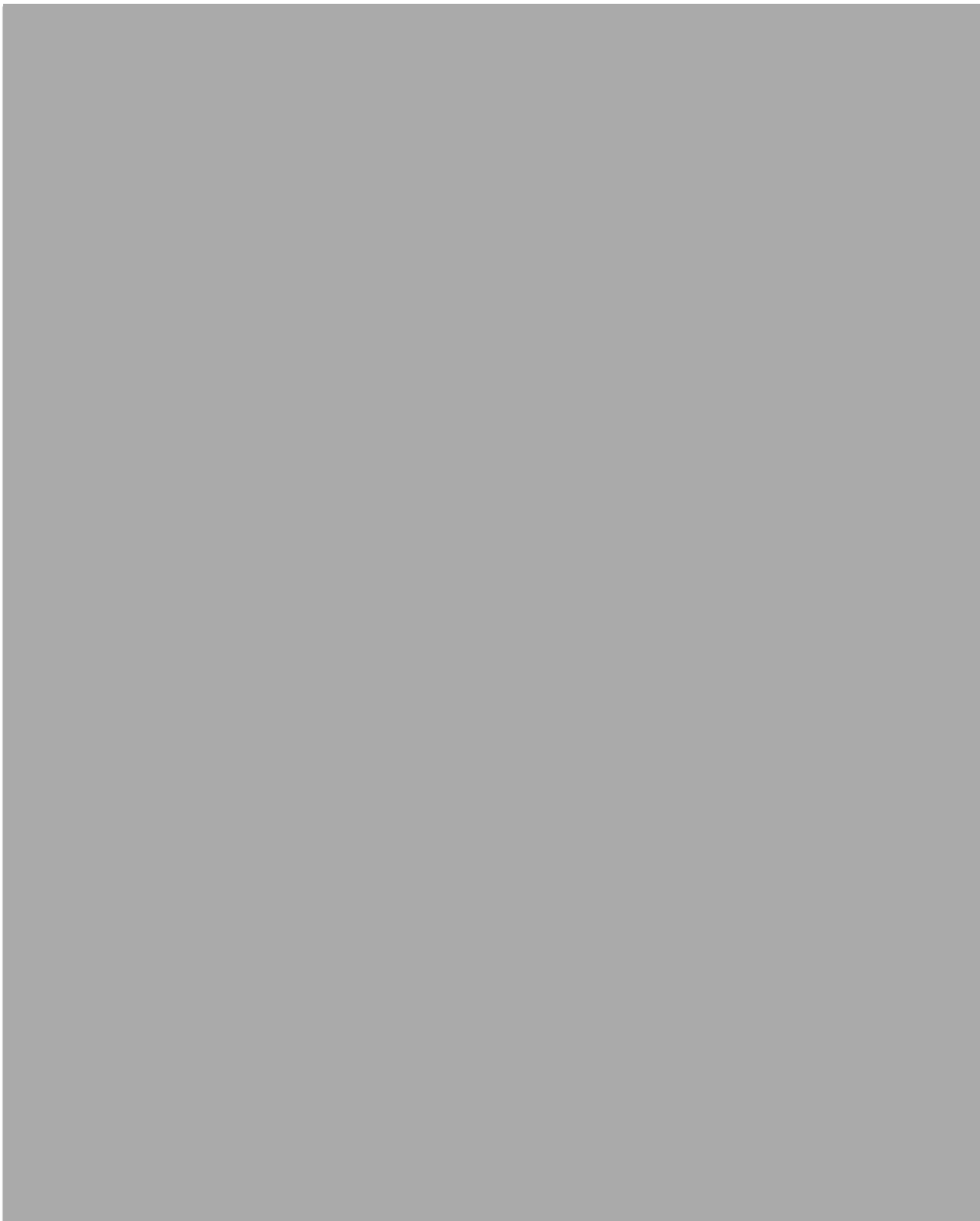
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Appendix A: Ethics committee approval letter









Appendix B: Example interview schedule

(v1, 17.03.15)

Sample Interview Guide: “Experience of Being Detained Under S136”

Participant #: _____ Date: _____

Interview Start Time: _____

1. Contextual Component

Pretext: As you know, I am investigating the experience of being detained under Section 136 of the Mental Health Act (1983, 2007). This is the first of two interviews, and its purpose is to collect information about your experience of being detained and what that was like.

- a. As a way of getting started, perhaps you could tell me a little bit about when you were detained, and the circumstances leading up to it?
- b. You volunteered to participate in this study because you wanted to share your experience of being detained under section 136. What did being detained under Section 136 mean to you?
- c. How has being detained under Section 136 affected your life?

(Probe, as needed: Are there any other impacts on your life?)

2. Critical Incident Component

Transition to Critical Incident questions:

- a. What helped you in dealing with the effect that being detained under Section 136 had upon you? (Probes: What was the incident/factor? How did it impact you? – e.g.: “Persistence is helping. How is it helping?” Can you give me a specific example where persistence helped? How did that help you to do well in handling the effects of being detained)

Helpful Factor & What It Means to Participant (What do you mean by...?)	Importance (How did it help? Tell me what it was about That you found so helpful)	Example (What led up to it? Incident, outcome of incident).

- b. Are there things that made the experience of being detained under Section 136 more difficult? (Alternative question: What kinds of things happened that made being detained more distressing?)

Hindering Factor & What It Means to Participant (What do you mean by...?)	Importance (How did it hinder? Tell me what it was about That you found so	Example (What led up to it? Incident, outcome of incident).

do you mean by...?)	unhelpful)	

c. Summarize what has been discussed up to this point with the participant as a transition to the next question:

We've talked about what helped you to cope with the experience of being detained under Section 136 (name them), and some things that you found unhelpful about the experience (name them). Are there other things that would of helped you at the time? (Alternative question: I wonder what else might have made the experience easier, but you didn't have at the time?)

Wish List Item & What it Means to Participant (What do you mean by...?)	Importance (How would it help? Tell me what it is about.... That would be so helpful.)	Example (How would this be helpful, in what circumstances?).

3. Demographics Component

i. Occupation

ii. Number of years in this occupation

iii. Occupation/job level

iv. Length of time in current job

v. Industry in which the person works

vi. Number of years in this industry

vii. Length of service in this company

viii. Age

ix. Sex

x. Income level (household)

xi. Country of birth

___ If not Canada, (a) length of time in Canada; and (b) 1st language

xii. Marital status

xiii. Family status/parental status

xiv. Education level

Interview End Time: _____

Length of interview: _____

Interviewer's Name: _____

Appendix C: Information Sheet (1)



University of Birmingham

Edgbaston

Birmingham

PATIENT INFORMATION SHEET (v5, 12.5.15)

PART 1

STUDY TITLE

How do people arrive at, and make sense of their experience of being detained under Section 136 of the Mental Health Act (1983, 2007)?

Before deciding whether you would like to participate you should carefully read the information provided in this leaflet and take time to ask questions. We think this should take about 10 minutes. Do not feel rushed or under pressure to make a quick decision.

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

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

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

What is the purpose of the study?

This study is being carried out to learn more about the individual experience of people who have been detained under a piece of legislation called Section 136 of the Mental Health Act (1983, 2007). This study is also hoping to understand what help people accessed prior to being detained and whether or not this was helpful to them.

It is hoped that by gaining some understanding of what it is like to be detained under Section 136, we can consider potential ways in which the detention process might be improved. Similarly, by exploring what help people sought for their mental health prior to being detained, we can think about where we might be able to better help people earlier in order to avoid detention under Section 136.

Why have I been invited?

You are being asked to take part in this study as you have recently been detained under Section 136 of the Mental Health Act (1983, 2007).

Do I have to take part?

It is up to you to decide to join the study. We will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time up to two weeks following your interviews (when data will be analysed), without giving a reason. This would not affect the standard of care you receive.

What will happen to me if I take part?

The study involves you attending for a meeting with the researcher which will last approximately 60 minutes, and your medical and/or mental health notes for the previous 12 months will be accessed with your permission. You will also be offered the opportunity to meet for one further interview if you wish to do so, exploring your experience of being detained in more detail. This further interview lasts approximately 60 minutes.

Expenses and Payments

You will be reimbursed for any travel expenses incurred as part of participating, for example bus or train travel. In addition you will receive £5.00 for each interview that you participate as a reimbursement for your time.

What will I have to do?

Interview one:

You will be asked to participate in an initial interview which lasts approximately 60 minutes, where a researcher will ask you questions about any help that you sought prior to being detained, for example from healthcare services, family and friends, religious groups, etc. They will ask you about anyone that you talked to, and also about what treatment or support (if any) was given. You will be asked questions about what appointments you were attended, or offered by services such as the NHS, charities or community support. Your medical and/or mental health notes will be accessed to help support your recollection. This interview may take place in hospital or at another place, for instance at home or a place you agree with the researcher that is convenient for you.

You will also be invited to participate in an additional interview, which will last approximately 60 minutes.

Interview two:

This second interview hopes to gain understanding about what is like to be detained under Section 136, and lasts approximately 60 minutes. During this interview you will meet with a researcher who will ask you questions about your experience of being detained under Section 136, and your thoughts and feelings about it. There are no right or wrong answers, and the researcher will be interested to hear your views and opinions about what the above experiences were like for you and any suggestions that you might have for how this could have been different.

The researcher will then ask to contact you approximately 4-6 weeks after your interview to share the initial results of the study with you. This will be over the telephone, or via email. The researcher will share the results of the study with you, and ask you if there is anything that you would change or amend. Your suggestions will be noted and contribute to the final analysis of the research. The purpose of this telephone meeting is to ensure that you are happy that the findings of the research accurately represent your views.

You can choose not to participate in the second, more detailed interview without having to give a reason. This will not affect your participation in the initial interview in any way. If you have indicated you are happy to participate in an additional interview, only a subset of 10 of those who agree to participate will be contacted to ask them to take part. The additional interview will take place in hospital, or a convenient time and place that you agree with the researcher. Those who are not required to take part but have agreed to do so will be contacted by letter to thank them for offering to participate.

What are the risks and disadvantages to participating in this study?

Discussing your experience of being detained under Section 136 and the help you accessed before this may understandably result in some emotional distress for some people. All researchers have had training in managing emotional distress and supporting those during participation in interviews. The researcher may recommend stopping the interview temporarily and taking a brief comfort break. You can withdraw or end the interview at any time. The researchers will also be able to support you in accessing further help should it be necessary.

What are the possible benefits of taking part?

There are no direct benefits to you as a result of participating in this study, however it is hoped that this research will help those who are detained under Section 136 in the future

What happens if there is a problem?

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

Will my participation in this study be kept confidential?

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

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



University of Birmingham

Edgbaston

Birmingham



PATIENT INFORMATION SHEET (v5, 12.5.15)

PART 2

STUDY TITLE

How do people arrive at, and make sense of their experience of being detained under Section 136 of the Mental Health Act (1983, 2007)?

What will happen if I don't want to carry on with the study?

You can decide to stop participation in any interview at any time and up until data is analysed two weeks following either interview. This will not affect your medical, social or legal rights in any way. If you have agreed to participate in the additional interview about your experience of being detained but change your mind, you can decide to no longer participate in this at any time before the interview is scheduled and can withdraw your consent for data to be used up until two weeks following the interview.

You will also be given an opportunity to review a transcript of the second interview prior to it being included in the research. You may also decide to withdraw all or part of your transcript. Unfortunately after this point you are unable to remove the transcript from the study as the data will have been analysed.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions on [REDACTED]. If you remain unhappy and wish to complain formally, you can do this by contacting <removed> Trust Customer Service Department. Details can be obtained by telephoning <removed>.

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against The University of Birmingham or the <removed> but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you.

Will my taking part in this study be kept confidential?

Your personal details will be kept in a locked filing cabinet and will be separate from any other data that could be traced back to you. Any paper records will be identifiable by a number only and not any personal details and will be kept in a locked filing cabinet. The second interview will be recorded using an encrypted data recorder and the voice files will be downloaded onto a password protected safe computer (either NHS or University) as soon as possible after the interview has taken place. The researchers will have primary access to the data, but The University of Birmingham and <removed> may also access the data for audit purposes.

During the second interview, recordings will be used to allow the research to transcribe the conversation into a word document using a secure NHS computer. Any information in the transcript of the interview recording which may identify you will be changed and false names will be used in order to protect your identity. Direct quotes may be used from the recordings in the write up of the research but they will be used in a way where you will not be identified. Data will be retained for 10 years after the research has finished by the University of Birmingham, and will be securely destroyed following this. Audio recordings will be deleted following award of the doctoral qualification (approximately 1 year following the interview).

Information discussed as part of the interview will be kept confidential, unless you discuss a risk to your own safety or the safety of somebody else. In this case information about the risk would be shared with appropriate professionals, such as your GP/Care-Coordinator or the Police. Where possible this would be discussed with you first.

Involvement of the General Practitioner/Care-Coordinator

With your permission, your GP and/or Care-Coordinator will be informed of your participation in the research. You will also be asked to provide consent for 12 months of medical and/or mental health notes to be accessed, in order to support your participation in the research. These notes will be reviewed by the research team only to identify what support you may have received or been offered for your mental health prior to your detention. This information will be used to support you during your participation in the interview.

What will happen to the results of the research study?

The results will be analysed by the researcher and will be presented in a written document. The researchers hope to publish the findings in a scientific journal, allowing for further research in this area. Research findings will also be shared with you if you wish, and will also be shared with service user groups involved in research. You can tell the researcher at the time of your interview whether you would like to receive a summary of the findings and he will send one to you once the study is completed. Results will also be shared with relevant services, so they may be able to improve the services they offer.

Are the police involved in this research?

No, the police have no direct involvement in the study. However, results of the study may be shared with the police so that they may be able to better understand the experience of being detained under Section 136 and possibly continue to improve the services they offer.

Who is organising and funding the research?

This study is being undertaken as part of an academic qualification (Doctorate in Clinical Psychology). The chief investigator (Thomas Goodall) works in the NHS as a trainee Clinical Psychologist, and is conducting this study with the support of <removed>. No payment is being received for this study.

Who has reviewed the study?

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

Further information and contact details:

To discuss the study: Thomas Goodall

Trainee Clinical Psychologist
School of Psychology

University of Birmingham

Edgbaston

Birmingham

[REDACTED]

Or

Elizabeth Newton (Supervisor)

School of Psychology

University of Birmingham

Edgbaston

Birmingham

[REDACTED]

Advice about whether to participate: Your GP or Care- Coordinator

Concerns or Complaints: <removed>

Research Title : “How do people arrive at, and make sense of their experience of being detained under Section 136 of the Mental Health Act (1983, 2007)?”

(v2, 17.03.15)

Name:

You have been informed about the opportunity of participating in this research as you have recently been detained by the police, under Section 136 of the Mental Health Act (1983, 2007). This research hopes to gain understanding about the experience of being detained under Section 136. We also want to find out who you sought help from and what happened prior to being detained by the police. By doing this, it is hoped that we might improve the process of being detained for those who might be in the future.

If you would like a researcher to contact you to discuss participating in the research further please provide your details below.

Returning this form does not mean that you are agreeing to take part now, rather that you agree to be contacted to find out more about the research and what participating involves. Signature:

Contact number: Email:

Contact number (alternative):

The best time(s) to contact me are: Mon Tue Wed Thursday Fri
(please circle) Morning/Afternoon/Evening

Appendix F: Informed consent form

CONSENT FORM B

(INTERVIEW TWO) (v5, 12.5.15) Participant Identification Number :

Research site:

Study: How do people arrive at and make sense of their experience of being detained under Section 136 of the Mental Health Act?

Chief Investigator: Thomas Goodall

Please initial box

1. I confirm that I have understood the information sheets dated (version v3) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I have completed Consent Form A, and have indicated that I wish to participate in one further interview for the above research. I understand that I am agreeing to participate in a further, more in depth interview about my experience of being detained under Section 136.
3. I understand that the information that I discuss within this is research confidential, unless I disclose any potential risks to my personal safety or the safety of others. In the disclosure of any risk to myself or others, I understand that this information may be necessary to share with appropriate agencies such as my GP or the Police.
4. I understand that the research interview will be audio-recorded on an encrypted data recorder and then analysed as part of the research.
5. I understand that direct quotes from my interview may be published in any write-up of the data, and used for training purposes, but that my name will not be attributed to any such quotes and that I will not be identifiable by my comments.
6. I understand that the data collected during this study will be looked at by the researcher and relevant others at the University of Birmingham to ensure that the analysis is a fair and reasonable representation of the data.
7. Parts of the data may also be made available to the NHS team responsible for me or my family member's care but only if any previously undisclosed issues of risk to me or my family member's safety should be disclosed. I also understand that the NHS research and development department may also have access to this data should they conduct an audit of the study.
8. I understand that following the research interview I will have a two-week period for reflection and to review my transcript. The researcher will then contact me at which point I may withdraw my interview entirely or in part, without giving any reason, without my own social care or legal rights being affected. I understand I will also be asked to provide feedback about the research findings, in order to ensure that the research is accurately representing my views.

.....
Name of participant

.....
Date

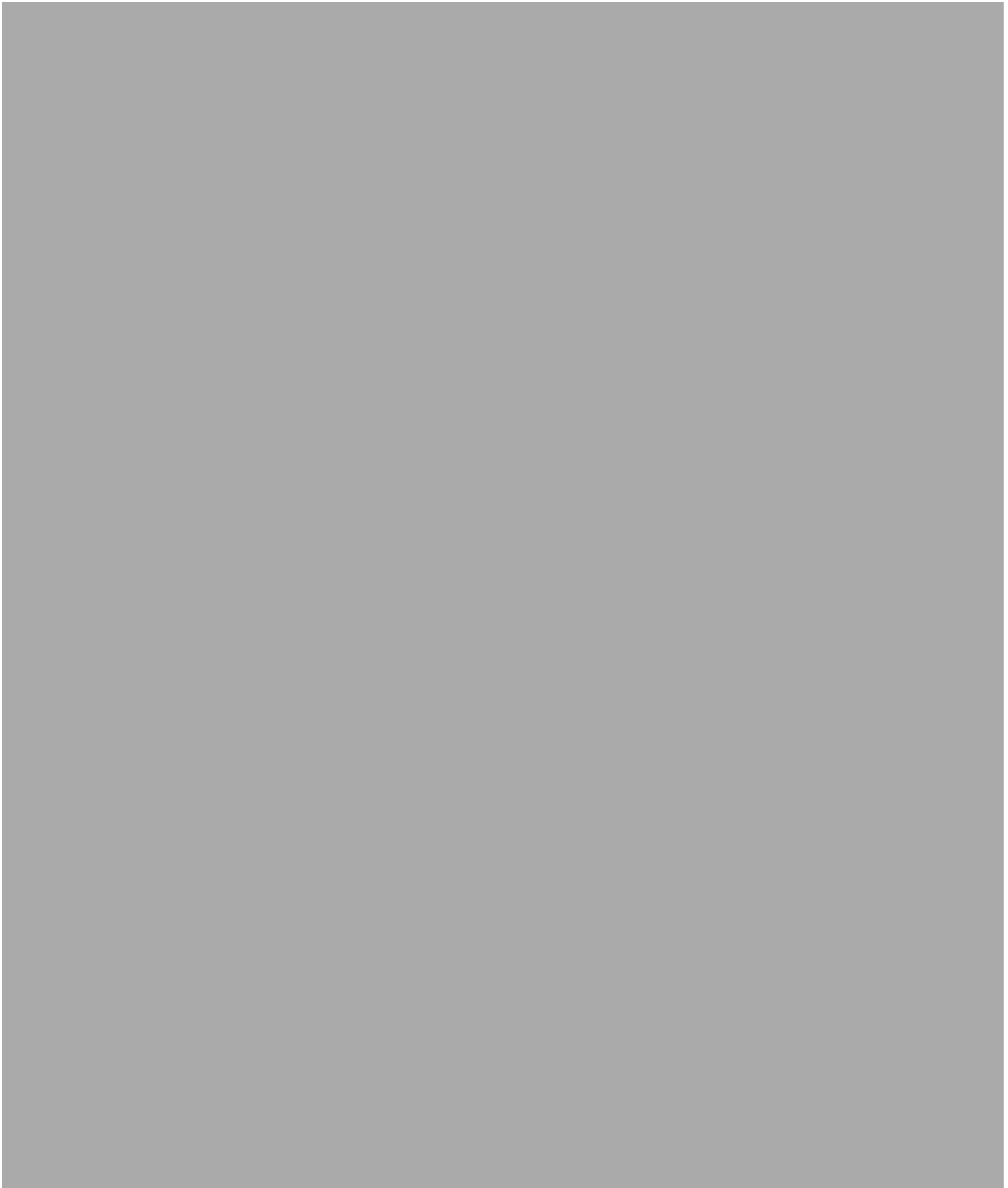
.....
Signature

.....
Name of researcher

.....
Date

.....
Signature

Appendix G: Letter to GP/care-coordinator





Were the police involved in bringing you into hospital?



Are you over the age of 16?



Would you be interested in helping researchers by:

- Telling them what this was like
- Telling them what help you sought prior to this happening
- Your views about what could be done differently in the future

If so, you could participate in research conducted by the University of Birmingham.

The research hopes to gain an understanding of the help people seek before they are detained under Section 136, and what it is actually like to be detained from the perspectives of those who have experienced it. Hearing the views of those who have experienced detention under Section 136 could improve services, and could contribute to improving the experience of detention for others in the future.

To find out more, please ask a member of staff for an information leaflet about how to participate.

****** You will be reimbursed for your time and any travel expenses associated with participating in the research. ******