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**Preserving Control: Understanding people's experiences before, during  
and after involuntary admission under the Mental Health Act 2001**

**A thesis submitted to the National University of Ireland, Galway for the degree of  
Doctor of Philosophy (Ph.D.)**

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## Abstract

**Aim:** To generate a grounded theory to understand people's experiences before, during and after involuntary admission and/or detention.

**Background:** The MHA (2001) provides a legal framework for the involuntary admission and treatment of people against their will. There is little research on people's *experiences* throughout the trajectory.

**Methods:** In-depth, semi-structured interviews were conducted with fifty people across three hospitals approximately three months after discharge. Interviews were analysed using constant comparative analysis, theoretical sampling and memo writing according to the Straussian Grounded Theory (Corbin & Strauss, 2008).

**Findings:** The core category was 'Preserving Control', which consists of three related categories: 'Losing Control', 'Regaining Control' and 'Maintaining Control'.

'Losing Control' describes the extent to which participants experienced a reduction in their autonomy and liberty owing to: (i) difficulties in regulating feelings and emotions; (ii) the involvement of professionals and or families and; (iii) the feelings of restrictiveness and coercion associated with being in hospital.

'Regaining Control' describes the way(s) that autonomy and liberty was restored to participants through: (i) fighting back against the system (ii) positive relationships with professionals; (ii) cognitively appraising what was happening to them or; (iii) conforming to the system.

'Maintaining Control' describes how participants were impacted personally and socially on discharge. Participants attempted to move on by: (i) preventing families and society from viewing them as 'mentally ill' or; (ii) by protecting their mental wellbeing.

**Conclusion:** The less extensive the loss of control, the more positive the experience was and the easier it was to regain and maintain control. Control may be optimised through more personal interactions and the provision of information and an explanation.

**Keywords:** Involuntary admission, detention, experiences, control, Mental Health Act, Grounded Theory.

## Publications

Smyth, S., Casey, D., Cooney, A., Higgins, A., **McGuinness, D.**, Bainbridge, E., Keys, M., Georgieva, I., Brosnan, L., Beecher, C., Hallahan, B., McDonald, C. & Murphy, K. (in press) A qualitative exploration of stakeholders' perspectives of involuntary admission under the Mental Health Act 2001 in the Republic of Ireland. *International Journal of Mental Health Nursing*.

Georgieva, I., Bainbridge, E., **McGuinness, D.**, Keys, M., Brosnan, L., Felzmann, H., Maguire, J., Murphy, K., Higgins, A., McDonald, C. & Hallahan, B. (2016) Opinions of key stakeholders concerning involuntary admission of patients under the Mental Health Act 2001. *Irish Journal of Psychological Medicine*.

Ranieri, V., Madigan, K., Roche, E., Bainbridge, E., **McGuinness, D.**, Tierney, K., Feeney, L., Hallahan, B., McDonald, C. & O'Donoghue, B. (2015) Caregivers' perceptions of coercion in psychiatric hospital admissions. *Psychiatry Research*, **228** (3), 380-385.

Bainbridge E., Hallahan, B., **McGuinness, D.**, Murphy, K., Higgins, A., & McDonald, C. (2014). A three month follow up study evaluating clinical change and attitudes towards involuntary admission in individuals detained under the MHA 2001. *Schizophrenia Research*, **153** (1), 162-163.

## Conference Presentations

**McGuinness, D.**, Higgins, A., Hallahan, B., Bainbridge, E., McDonald, C., Brosnan, L., Keys, M., Felzmann, H. & Murphy K. (2016) 'Preserving Control: Understanding peoples experiences before, during and after involuntary admission under the Irish Mental Health Act 2001'. *24<sup>th</sup> European Congress of Psychiatry Conference, Madrid, Spain 13<sup>th</sup> March*.

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# Chapter 1: Background and Introduction

## 1.1 Introduction

This thesis focuses on Irish people's experiences of being subject to an involuntary admission and/or detention under the Mental Health Act 2001 (MHA, 2001) (Department of Health & Children (DOH&C), 2001). Using interviews, it explores how people perceive, experience, adapt and are impacted by involuntary admission and/or detention.

Involuntary admission and/or detention can be a distressing or traumatic process for the person involved, and many people experience force and threat and face coercive practices such as seclusion, restraint, and forcible administration of intramuscular medications (Beveridge, 1998; Katsakou & Priebe, 2007; Raboch *et al.* 2010). Two thousand one hundred and sixty two people were detained in Irish acute psychiatric units in 2014 (Mental Health Commission (MHC), 2015). Involuntary admission deprives people of their liberty and impacts profoundly on autonomy.

The aim of this study is to generate a grounded theory to understand people's experience before, during and after being subject to an involuntary admission and/or detention under the MHA 2001. The thesis objectives are to:

1. produce a theoretical understanding of people's experiences of involuntary admission.
2. understand the psychological and social processes behind how people experience involuntary admission.
3. explore the processes that people use to adapt to involuntary admission.

This chapter provides the context for this research. It defines the terms used in the thesis and provides a history of mental health care in Ireland. It briefly outlines the history and origins of mental health legislation in Ireland and critiques the current MHA 2001. Following this, the international and national statistics in relation to involuntary detention are provided and some potential coercive practices used during the process of involuntary admission and detention are outlined. The legal obligations arising from the European Convention on Human Rights (ECHR) (Council of Europe, 1950) and the

United Nations Convention on the Rights of People with Disability (CRPD) (United Nations, 2006) are then summarised. Based on this, background information relating to people's experiences of involuntary admission under the MHA 2001 in Ireland as well as experiences in other jurisdictions are presented. This is followed by a rationale for this study before finally concluding the chapter with an outline of the thesis.

## **1.2 A Note on the Language Used in this Thesis**

There are a number of terms that are used interchangeably within the literature to describe the process of involuntary admission and detention such as “compulsory admission/treatment”, “sectioning”, and “civil commitment”. In this thesis the term “subject to an involuntary admission” will be used to describe the point at which the person is subject to the MHA 2001 and “detention” will be used to describe when the person is admitted involuntarily and treated in hospital against their will. While the term “patient” or “service user” is commonly used within the literature to describe people who were involuntarily admitted and/or detained, as well as those who are engaged with the Mental Health Services (MHS), in this thesis the term “people” will be used as not all participants continued to use the MHS after their being subject to an involuntary admission. The term “hospital” will be used to describe the psychiatric units or approved centres that people were admitted to, as this was the term most frequently used by participants. In addition, the term “mental distress” or “mental health problems” will be used instead of the term “mental illness” or “mental disorder”, as this is deemed to be a more accurate reflection of the way in which participants construed their problems before being subject to involuntary admission.

## **1.3 History of Mental Health Care in Ireland**

To set the thesis in the context of changes in policy on mental health care, this section explores some of the historical changes within an Irish context. It is reported by Kelly (2008) that in the 1700s and beginning of 1800s there was no specific provision for the care of “the insane” in Ireland and people were just confined in cells or wards in houses of industry or in prisons (Reuber, 1999). In the 1800s, local authorities built many district lunatic asylums for the confinement and institutional care of “the insane” (Reuber, 1999; Brennan, 2014b). Lay personnel provided care for people in these asylums under the direction of a lay superintendent (Mac Gabhann, 2014). As such, these asylums served to confine but not treat or therapeutically care for people. As far

back as the 1800s the Irish Inspector of Lunatic Asylums began to criticise the institutionalised care provided in these asylums. The reliance on coercive practices such as having people in solitary confinement (seclusion) for prolonged periods of time was seen as a significant barrier to progressive care and treatment (Rueber, 1999). During the latter half of the 1800s, doctors and attendants (keepers) provided medical observation and care whilst lay asylum superintendents began to be replaced by medical superintendents<sup>1</sup> (Brennan, 2014b; Mac Gabhann, 2014).

During the 1900s, these doctors began to specialise in psychiatry (psychiatrists) and began to treat people using medication. Later the role of “attendant” developed into the more specialised role of psychiatric nurse. At the same time there were developments in care and treatment including the establishment of internationally standardised diagnostic systems, such as the Diagnostic Statistical Manual (American Psychiatric Association, 1952), the development of drugs for the treatment of mental health problems – most notably the antipsychotic agents chlorpromazine and haloperidol (Lehmann & Ban, 1997) – and the use of Electro Convulsive Treatment (ECT) (Brennan, 2014b).

However, criticisms of the type of institutional care remained which included concerns in particular regarding the large number of people residing in mental hospitals. On foot of some of these criticisms, the Commission of Inquiry on Mental Illness (Department of Health (DOH), 1966) was set up (Brennan, 2014a; Mac Gabhann, 2014). This report called for a shift away from institutional care and the discharge of people once they had made a recovery from their mental health difficulties. It called for a significant decrease in the number of in-patient beds and the provision of community-based care, incorporating the provision of psychiatric units attached to general hospitals. However, the number of people in psychiatric hospitals remained high, reducing from 18,641 in 1965 to 13,984 up until 1981 (Walsh & Daly, 2004). During this period, it could be argued that there was little change in the quality of care in Ireland and the mainstay of treatment continued to be biomedical, focusing treatment on the administration of medicine with an overreliance on hospital based and paternalistic care (Amnesty International, 2003).

In 1984 the policy document “Planning for the Future” (DOH, 1984) identified similar difficulties to the Commission of Inquiry on Mental Illness report in 1966 and reiterated

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<sup>1</sup> Medical Superintendent – chief medical officer for a mental hospital

the need for the closure of large-scale institutions and for the development of mental health care in the community. Subsequent to this report and other policies such as the Quality and Fairness: A Health System For You (DOH&C, 2001), which aimed to improve the quality of MHS, an approximate 72% reduction in the number of people in Irish mental hospitals was noted between 1981 (13,984 people) and 2002 (3,891 people) (Walsh & Daly, 2004).

Further changes in care have been driven by important global health policy such as The World Health Report 2001 – Mental Health: New Understanding, New Hope (World Health Organisation (WHO), 2001). This report requested that policy be developed to allow, if possible, community treatment for people with mental health problems as well as the interfacing of mental health services and primary care. In 2006, the Irish Government Mental Health Policy “A Vision for Change: Report of the Expert Group on Mental Health Policy” (AVFC) (DOH&C, 2006) was published. The core concepts of this policy are recovery, person centeredness, participation, user and family involvement and the delivery of multidisciplinary community based services. It recommended a reshaping of mental health care by changing from the more dominant biomedical model of mental health care to a more recovery-based/user-centred approach to care. The aim of a recovery-based approach is to facilitate a sense of hope and self-determination to help individuals assimilate their experiences and to regain the ability to live a meaningful existence, often in the face of adversity (MHC, 2005; Higgins & McBennett, 2007; Kartalova-O’Doherty & Tedstone Doherty, 2010). The inclusion of people with mental health problems in the development of this strategy was important as it recognised the person’s voice in the modernisation of mental health care delivery. As such, AVFC provides the blueprint for how the MHS should be operating.

#### **1.4 History of Mental Health Legislation in Ireland**

In tandem with policy developments, there were also changes in legislation. In 1817, a select committee of the House of Lords was appointed to consider and report on the state of the Lunatic Poor in Ireland. On foot of this report, the Lunatic Act in Ireland (1821) was passed which provided for the establishment and maintenance of the Asylum System in Ireland (Kelly, 2008; Brennan 2014a). With the passing of the Dangerous Lunatics Act (1838), the judicial system had the power to confine those deemed insane to asylums (Reuber, 1999; Brennan, 2014a). In an attempt to quell

potential misuse and overcrowding, the Lunacy Act (1867) was passed. This allowed two magistrates to commit a person only on the basis of a certificate obtained from a dispensary medical officer (Kelly, 2008). In 1945, the Lunacy Acts were replaced by one Mental Treatment Act (MTA, 1945) (DOH, 1945). With the passing of the MTA 1945, the control of admission changed from a judicial to a medical process (Brennan, 2014b). This was the first time that family members could make an application to a medical practitioner for the involuntary admission of their relative. The MTA 1945 governed the involuntary admission and involuntary detention of people in Ireland for over 61 years. Some of the problems with the MTA 1945 were in relation to the fact that (1) addiction and intellectual disability were deemed reasons for detention, (2) people could be detained for six months, renewed up to 18 months with any formal review, (3) people could be subject to indefinite detention under the category classified as “person of unsound mind”, (4) many people were often unaware of their right to appeal their detention (Rooney *et al.* 1996), and (5) informed consent to treatment was not sought from people. Therefore, the MTA 1945 needed to be changed to ensure that rights of people were not violated unnecessarily and to ensure that people could not be detained for extended periods of time without a review.

There were many failed attempts to implement new Mental Health Legislation in the 1980s and 1990s (Kelly, 2008). The Health (Mental Services) Act 1981 was signed into law but never came to be implemented as its provisions had been overtaken by international law. Following years of advocating by several bodies including Amnesty International, the MHA 2001 was finally enacted in November 2006, thus reforming human rights deficits described with the MTA 1945.

### **1.5 The Mental Health Act 2001**

The MHA 2001 has been one of the most significant legislative changes to mental health in Ireland in that it considerably improved Ireland’s adherence to international human rights standards. The MHA 2001 led to the establishment of the MHC, an independent statutory body with responsibility to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of

mental health services. The Act also brought changes to involuntary admission procedures.

The guiding principle of the MHA 2001 relates to intervention on the basis of the person's "best interests" (welfare approach) which Keys (2014, p. 205) states is based on the need for the person "to be treated for their own good or that of others". Compared to the MTA 1945, the criteria for involuntary admission were narrowed. They stipulated that a person can only be admitted on the basis of a mental illness, severe dementia or significant intellectual disability, and that there must be a serious risk of immediate and serious harm to self or others. Thus, people with solely addiction problems could not be involuntarily admitted under the MHA 2001, unlike the MTA 1945. Consequently, the MHA 2001 defined "mental disorder" as a mental illness, severe dementia or significant intellectual disability, which also requires that:

*(a) because of the illness, disability or dementia, there is a serious likelihood of the person concerned causing immediate and serious harm to himself or herself or to other persons,*

*OR*

*(b) (i) because of the severity of the illness, disability or dementia, the judgement of the person concerned is so impaired that failure to admit the person to an approved centre would be likely to lead to a serious deterioration in his or her condition or would prevent the administration of appropriate treatment that could be given only by such admission,*

*AND*

*(ii) the reception, detention and treatment of the person concerned in an approved centre would be likely to benefit or alleviate the condition of that person to a material extent.*

*OR*

*(a) (as above) and (b) (as above)*

(MHA, 2001)

The MHA 2001 also entitled people to the right to independent legal advice, a second independent review by a Consultant Psychiatrist (CP), and gave the right to a mental health tribunal within 21 days of admission (Kelly, 2007). If a person remained a detained person after 21 days secondary to their detention being upheld at a mental

health tribunal, further reviews of their detention occur at 21 days, three months, six months and annually after this.

In relation to the detention, the severity of mental illness, the level of impaired judgment, the risk of serious deterioration, the potential prevention of appropriate treatment if the admission is not made, and the likelihood of benefit from the admission all have to be considered prior to detention of a person under the MHA 2001. In addition to addiction, the MHA 2001 excludes the admittance of people on the sole basis of a personality disorder or “social deviance”. It also made provisions to protect the person’s statutory entitlement to information this involves being informed of the legal basis of detention, and persons right to appeal (this information should be conveyed in a way that the person is able to understand it). Furthermore, the MHA 2001 provides certain safeguards around consent to treatment.

Under the MHA 2001, a person can become subject to involuntary admission in a variety of settings such as the person’s home, a public space, or a Garda (Police) Station. In the community, the process of involuntary admission starts with an application (typically a relative) (Form 1),<sup>2</sup> to a registered medical practitioner (typically a General Practitioner (GP) for a recommendation for the involuntary admission of a person. Of note there are three other types of applicants, Authorised Officer (AO) (Form 2)<sup>3</sup>, Police (Form 3)<sup>4</sup> and a member of the public (Form 4)<sup>5</sup>. The applicant must have observed the person within 48 hours of making the application. This in turn leads to an assessment being made by a registered medical practitioner within 24 hours to determine if a recommendation for involuntary admission should be made (Form 5)<sup>6</sup>. On foot of the recommendation the applicant should arrange for the removal of the person to hospital. If the application is made by the Gardaí, they “remove” the person to hospital. Under the MHA 2001, if it is not feasible for the applicants to “remove” the person, the registered medical practitioner should contact the clinical director of the unit to organise this. On a practical basis, nurse management

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<sup>2</sup> Form 1 – Application to (a registered medical practitioner) by a spouse or civil partner or relative for a recommendation for involuntary admission of an adult to an approved centre.

<sup>3</sup> Form 2 – Application to (a registered medical practitioner) by an Authorised Officer for a recommendation for involuntary admission of an adult to an approved centre.

<sup>4</sup>Form 3 – Application to (a registered medical practitioner) by a member of the Garda Síochána for a recommendation for involuntary admission of an adult to an approved centre.

<sup>5</sup>Form 4 – Application to (a registered medical practitioner) by a member of the public for a recommendation for involuntary admission of an adult to an approved centre.

<sup>6</sup>Form 5 – Recommendation (by a registered medical practitioner) for involuntary admission of an adult to an approved centre.

will organise an Assisted Admission Team (AAT), consisting of psychiatric nurses or in some cases the National Assisted Admission Team (NAAT). In situations where the person is thought to be at risk of harm to self or to others, the clinical director can request the assistance of the Gardaí in the removal of the person to hospital. The Gardaí can enter the person's house with force to remove the person to hospital.

In hospital, the MHA 2001 also provides a system that can allow voluntary people to be subject to involuntary admission. This can occur where a voluntary person requests to leave the hospital and it is deemed by clinical staff that due to a significant risk to themselves and/or others secondary to their mental "illness", that they require detention under the MHA 2001. In this instance, a voluntary person can be "held" under Section 23(1)<sup>7</sup> for a period of 24 hours. During this time, an assessment for detention is made by their treating CP and where their view is that the person requires detention a second independent CP reviews the person.

In both instances, if the treating CP believes that the person fulfils criteria for detention under the MHA 2001, an admission order, a Form 6<sup>8</sup> or a Form 13<sup>9</sup>, is completed. This order can remain in place for up to 21 days, at which point a renewal order (Form 7)<sup>10</sup> can be made for up three month, which can be subsequently extended for up to six months and again extended for up to a further 12 months (consequent on the results of mental health tribunals). When an admission order is complete, a Notification Form<sup>11</sup> must be given to the person within 24 hours outlining the proposed treatment and giving information about their rights. These include the provision of a solicitor who will represent people at a mental health tribunal and an independent psychiatrist who will complete an assessment and furnish a report to their mental health tribunal. Under the MHA 2001, a mental health tribunal reviews the person's detention within 21 days and either affirms or revokes (permitting the voluntary admission or discharge of the person) the order. The tribunal board consists of a barrister or solicitor (chair), an independent consultant psychiatrist, and a layperson, The treating CP is interviewed at the tribunal by the person's legal representative (solicitor) and the tribunal board and both the person detained and/or solicitor and the CP give their view regarding the

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<sup>7</sup>MHA 2001 Section 23(1) – Power to Prevent a Voluntary Patient (Adult) from Leaving an Approved Centre.

<sup>8</sup> Form 6 – Admission Order.

<sup>9</sup> Form 13 – Certificate and Admission Order to Detain a Voluntary Patient.

<sup>10</sup> Form 7 – Certificate and Renewal Order by Responsible Consultant Psychiatrist.

<sup>11</sup> Notification Form – Patient Notification of Making an Admission Order or a Certificate and Renewal Order Mental Health Act 2001.

involuntary admission and detention of the person. At any stage, prior to the mental health tribunal, the treating CP can revoke the admission order (Form 14<sup>12</sup>). The admitted person may still request a mental health tribunal even if their order is revoked. In addition, an appeals process to the Circuit Court can be enacted at the persons request if they do not agree with a tribunal affirming an admission order. In 2014, there was 145 appeals nationally, 26 of which proceeded to full hearing (MHC, 2015).

In contrast to mental health legislation in other jurisdictions, the MHA 2001 allows for admission and treatment in “approved centres” alone (“approved centre” is the designate term for an acute psychiatric unit in the MHA 2001). However, in other territories such as Australia, Israel, New Zealand, Ontario (Canada), Scotland, England and Wales, Taiwan and Sweden, psychiatric treatment can also be mandated in the community setting as well in the form of a Community Treatment Order (Monahan, 2011).

## **1.6 Critique of the Mental Health Act 2001**

Despite there being considerable improvement in Ireland’s mental health legislation since the enactment of the MHA 2001, concern has also been expressed that international human rights standards have not sufficiently been addressed and ameliorated with the MHA 2001. For example, Amnesty International Ireland have questioned whether having separate mental health law can actually contribute to causing significant prejudice and discrimination in terms of promoting segregation and reinforcing stigma towards people with mental health difficulties (Amnesty International, 2011). At present, it is argued that there are no provisions to reduce stigma against people with mental health difficulties. Ontario in Canada have their mental health law incorporated into relevant existing legislation in a way that may be seen as contributing to community integration for those with mental health difficulties.

According to Section 4 of the MHA 2001, the best interests of the person, continues to be the guiding principle of Irish Mental Health legislation. Consequently the ‘best interests’ principle is the main consideration followed in instances where high court rulings challenge the MHA 2001. ‘Autonomy’ and ‘self-determination’ are considered

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<sup>12</sup> Form 14 – Revocation of an Involuntary Admission or Renewal Order.

to be core concepts of modern mental health care, yet Craven's in his opinion article (2009) states that there are clear and potent indications of a paternalistic approach emerging from the principle of 'best interests'. Thus, the 'best interests' principle is that it may potentially enable the vestiges of paternalistic and custodial approach to remain, with the result that there is potential for diminished regard for the person's basic human right to liberty and autonomy. Consequently, it could be argued that the MHA 2001 is more a welfare-based than a human rights-based approach which can be perceived as a major deficiency based on international norms.

A more specific criticism is that the MHA 2001 in its current form is that it is not aligned with some of the core concepts detailed in AVFC, principally those of recovery, person centeredness, participation, user and family involvement and the delivery of multidisciplinary community based services. Amnesty International Ireland stated that the MHA 2001 should be amended in light of these core concepts. For example, the emphasis on recovery as proposed by AVFC is not present in the MHA 2001, and neither is the emphasis on the delivery of multidisciplinary community based services. Incorporating these core concepts into the MHA 2001 may enable effective implementation of AVFC objectives, thereby enhancing the provision of more robust community mental health teams.

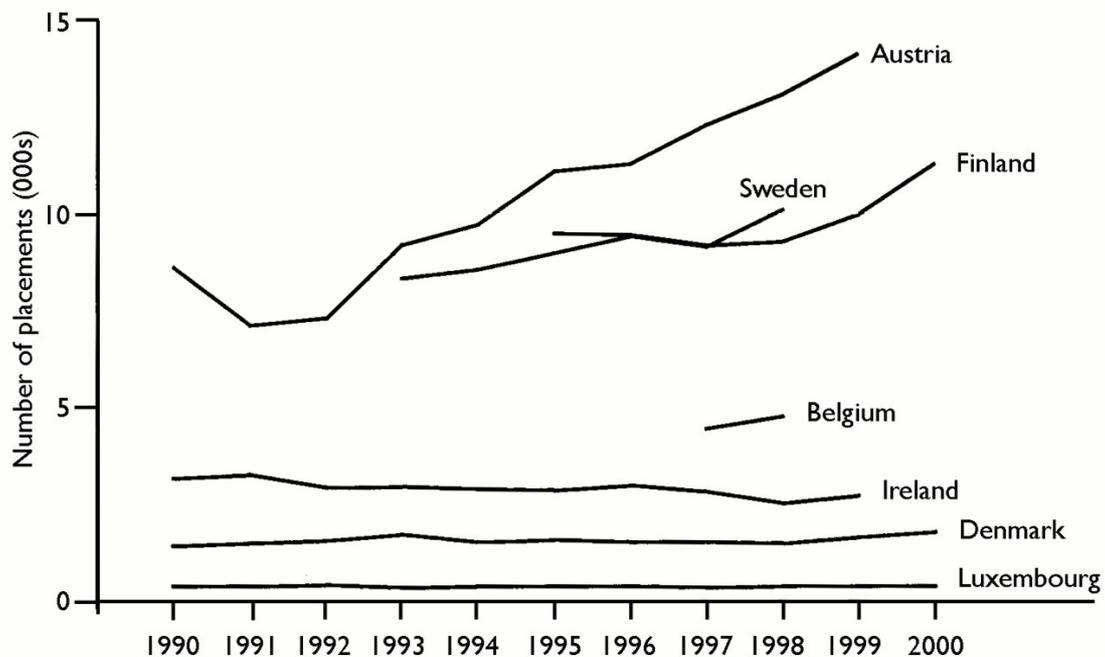
Similar to the MTA 1945, family members remain the most common applicant group (MHC, 2016), despite the provisions in the MHA 2001 for authorised officers to act in this role. It is of concern that family members still initiate the majority of involuntary admissions, despite the detrimental impact to the relationship between the person and family member (O'Donoghue *et al.* 2010).

Since the enactment of the MHA 2001, there have been significant developments in international standards of human rights such as the 'least restrictive' environment and concept of advance directives. The MHA 2001, whilst recognising the principle of "least restrictive" setting, has no specific measures or alternatives identified to reduce involuntary admission. Mental health policy such as AVFC and mental health legislation are two complementary frameworks for building, improving and providing accessible, community-based, specialist services for people with mental health problems. Legislation can be an appropriate means to ensuring therapeutic and effective

means to mental health care; however, it is of concern that the MHA 2001 in its current form has not addressed some of the issues mentioned above.

### 1.7 Rates in Relation to Detention across Europe and Ireland

A variation in the rates of detention across Europe has been demonstrated (Riecher-Rössler & Rössler, 1993; Zinkler & Priebe, 2002; Salize & Dressing, 2004). Zinkler & Priebe's (2002) report noted in the 1990s that a 20-fold variation in detention rates was present between Finland (higher) than Italy, possibly attributable to the different legislative frameworks in operation and a society that perhaps had a more accepting attitude towards mental health problems. Similarly, in 2000 an 8-fold difference between Portugal (3%) and Luxembourg (26%) was noted in the number of people that were detained (Salize & Dressing, 2004).



**Figure 1: Frequency of involuntary placements during the 1990s in the smaller European Union member states adopted from Salize & Dressing (2004, p. 165).**

Zinkler & Priebe (2002) found that in some countries such as the Netherlands, England and Austria the rate of detention increased despite reforms to legislation. However, there may be several confounding factors for this including the reduced number of in-patient beds available or a greater number of total admissions.

Following the implementation of the MTA 1945 in Ireland, Brennan (2014b, pp. 15–16) states that “the proportion of people detained steadily decreased and voluntary admission became the predominant form of admission”. The number of people involuntarily detained decreased from 21,720 in 1956 to 4,321 in 2001 (Brennan, 2014b), with 17% of all admissions being detentions in 2001 (Walsh & Daly, 2002). Eight per cent of all admissions in 2008 were involuntary, in comparison to 12% in 2015 (Daly & Walsh, 2009; Daly & Craig, 2016). Between 2006 and 2015, the number of detentions under Form 6 increased from 1,398 to 1,755 whilst the number of detentions under Form 13 only reduced from 612 to 608.

Detention under the MHA 2001 effectively authorises medicine to be given without consent for up to three months. Keys (2007) argues that the fact that a person is suffering from a mental health problem does not in itself preclude that person from giving informed consent. The MHA 2001 provides that treatment can be given when it is the opinion of the treating psychiatrist that it is necessary to safeguard the life of the person, to alleviate the person’s health, condition or suffering, and by reason of the person’s mental disorder, the person is incapable of giving such consent. In instances where medications are still being administered to a person who is detained after three months, the person must then consent in writing or if the person is “unable” to provide consent, medication needs to be approved by the CP and one other psychiatrist.

When the MHA 2001 was enacted, it increased Ireland’s compliance with the ECHR and consequently provided better protection of people’s rights. However, certain parts of the MHA (2001) are arguably becoming out-dated due to progressions in international human rights standards such as the UN Convention on the Rights of People with Disabilities (CRPD) standards and the WHO Resource Book on Mental Health. According to Kelly (2011), the MHA 2001 is compliant with 48.2% of 175 standards regarding human rights in mental health legislation laid down by the WHO. One such area is failure of the MHA 2001 to provide for people who are detained but who do possess capacity to understand and consent to treatment.

As described previously, there are four possible applicants: (a) Form 1, (b) Form 2, (c) Form 3 and (d) Form 4. Relatives are the most common applicant, although the percentage of applications from relatives has declined marginally since the introduction

of the MHA 2001 from 69% to 53%, whilst Garda applicants (Form 3)<sup>13</sup> have increased from 16% to 20%, a member of the public (Form 4)<sup>14</sup> has increased from 5% to 15% and Authorised Officer (AO) (Form 2)<sup>15</sup> has increased from 7% to 12%. In Ireland, the MHC does not keep an official record of the number of people subject to involuntary admission who did not have an admission order completed and were admitted voluntarily or discharged.

Of note, only 9% of all detentions reviewed by mental health tribunals were revoked in 2015 (MHC, 2016). According to the MHC Annual Report 2015, 46% of people had their admission order or renewal order revoked by their CP prior to tribunal. There is no provision in the MHA 2001 for a tribunal to review the cases of those people subject to involuntary admission who did not have an order completed (were admitted voluntarily or discharged). In addition, people whose admission orders are revoked by a CP prior to tribunal must apply in writing to the MHC within 14 days of the revocation if they wish for their tribunal to proceed.

### **1.8 Coercive Practices during Detention**

As described previously, being subject to an involuntary admission describes the point at which the person is subjected to mental health legislation and detention is when the person is admitted and treated in hospital against their will. In Ireland and other parts of the world, the AAT, or in some cases the NAAT, have the power to remove the person who is subject to involuntary admission to hospital whilst the Gardaí have the power to enter the person's house with force. During this time, the person can experience (or perceive) force, threats, pressures and promises. At the hospital, the psychiatrist has extensive powers that allow for the detention and treatment of people deemed to have a mental disorder, whilst nursing staff have the power to restrain, seclude and forcibly administer medications. All of these coercive practices may impact negatively on the person and impinge on their human rights.

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<sup>13</sup> Application to (a registered medical practitioner) by a member of the Garda Síochána for a recommendation for involuntary admission of an adult to an approved centre.

<sup>14</sup> Form 4 – Application to (a registered medical practitioner) by a member of the public for a recommendation for involuntary admission of an adult to an approved centre.

<sup>15</sup> Form 2 – Application to (a registered medical practitioner) by an Authorised Officer for a recommendation for involuntary admission of an adult to an approved centre.

It is within this context that The World Health Report 2001 – Mental Health: New Understanding, New Hope highlighted the importance of the principle that as far as possible, every person with a mental health problem should have the right to be treated in the least restrictive environment with the least restrictive intrusive treatment.

Concerns across Europe about coercive practices during detention remain. Molodynski *et al.* (2014) found that coercive practices such as seclusion, restraint and the forcible administration of medication are common during involuntary detention. This is supported by a European study by Raboch *et al.* (2010) across ten European Countries who found that approximately 33% of all detained people have experienced coercive practices within the first four weeks of admission. They found that there was vast variation in the utilisation of such coercive practices, from 59% in some countries to 21% in others. Poland Italy and Greece had higher rates of coercive practices.

Coercive practices have been the subject of considerable critique deemed by some as a tool of state control rather than treatment and care (Szasz, 2003). Szasz (2003) argued that a person should not be deprived of their liberty unless they had committed a crime. He criticised the reliance in psychiatry on involuntary detention to protect society (Szasz, 2003) and viewed it as immoral (Szasz, 1977). He believed these coercive practices were a form of power wielding, were not therapeutic and subsequently lobbied for the abolition of detention for over two decades.

### **1.9 The Legal Obligations Arising from Conventions**

During the latter half of the 1900s, there was a stronger emphasis on the protection of human rights of people with mental health problems in Europe (Dressing & Salize, 2004). This has been driven by the requirement of the European Convention on Human Rights (ECHR) (Council of Europe, 1950), the increased recognition on the rights of the mentally ill (United Nations, 1991) as well as the case law of the European Court of Human Rights, especially the *Winterwerp v. the Netherlands* ECHR 4 (1979)<sup>16</sup>. There was an emphasis on reform and narrowing the criteria for involuntary admission across parts of Europe.

When the MHA 2001 was enacted, it increased Ireland's compliance with the ECHR and consequently provided better protection of people's rights. However, certain parts

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<sup>16</sup> *Winterwerp v. the Netherlands* ECHR 4 (1979) case relates to the criteria that need to be met in order for the deprivation of liberty of mentally disordered people to be lawful.

of the MHA (2001) are arguably becoming out-dated due to progressions in international human rights standards such as the UN Convention on the Rights of People with Disabilities (CRPD) standards and the WHO Resource Book on Mental Health, Human Rights and Legislation (Freeman, Pathare & World Health Organisation 2005). According to Kelly (2011), the MHA 2001 is compliant with 48.2% of 175 standards regarding human rights in mental health legislation laid down by the WHO. Areas of deficits of the MHA 2001 relate to the provisions for people who are detained but who do possess capacity to understand and consent to treatment, promoting economic and social rights, such as entitlement of housing, employment and specific services. Consequently, legislation again needs to be reformed in order to meet these standards.

According to Keys (2014, p. 207), the CRPD places mental health legislation within the area of disability law and requires a shift from a medical model to a more social and human rights model of disability. On 20 May 2007, Ireland signed the CRPD but has still not ratified it. Amnesty International Ireland has criticised the State's slow pace in the ratification of the CRPD (Amnesty International, 2011). Although 156 countries have ratified the CRPD, Ireland's reason for not doing so lies in its commitment to first pursue new capacity legislation to replace the current out-dated ward of court legislation. The CRPD and WHO Resource Book on Mental Health provided a framework to improve Ireland's compliance with human rights standards calling for a human rights-based approach instead of a welfare approach.

In a bid to be in line with the CRPD, Ireland's Assisted Decision-Making (Capacity) (ADM) Act was enacted in December 2015. This Act is aimed at addressing deficiencies that operate currently with regard to the failure to address the issues of capacity to understand and consent to treatment and to give the person the greatest level of autonomy. The ADM Act relates to people who require or may require assistance in exercising their decision-making capacity. It includes a presumption of capacity. The Act proposes three types of decision-making supports that should be implemented on a needs-led basis. These are: "assisted decision making" – where a person voluntarily chooses someone to assist with specific decisions based on their "will and preferences"; "co-decision making" – where the person chooses someone to jointly make decisions; and "decision-making representatives" – where the Circuit Court declares the person's

capacity is impaired and a person applies to the court to be made a decision-making representative. Incorporated within the ADM Act is the provision of Advanced Directives, which may be defined as a written document giving direction and guidance for healthcare decisions at a time of future incompetence.

The requirements of the CRPD (2006) – with which the Government must comply – along with the publication of the ADM Act 2015 have paved the way to improve Ireland’s compliance with human rights standards. International human rights conventions continue to oblige the State to provide legislation that meets the CRPD requirements. Existing measures within the MHA 2001 need to be updated or further measures need to be introduced to meet additional human rights standards. The Government plan is to revise the current Act rather than implement a new one. Consequently, legislation again needs to be reformed in order to meet these standards.

The Minister of State with responsibility for Mental Health asked for an initial review of the MHA (2001) by a steering group consisting of department officials and a member of the Health Service Executive (HSE) and the MHC. This review was completed in conjunction with public consultation and subsequent meetings with key stakeholders, professional representation bodies, and service user groups. It culminated in the publication of an Interim Report on the MHA (2001) (DOH, 2012). The Interim Report made recommendations to address current deficiencies and refine certain aspects of the MHA (2001). The Minister subsequently established an expert group, whose remit was to examine the interim report and make recommendations to update legislation. The MHA (2001) will be revised and amended in light of the 165 recommendations from the Expert Group. However, the Government has not given a specific time frame for the implementation of recommendations. The future of mental health legislation in Ireland is dependent upon political will to both ratify CRPD and to implement the recommendations of the expert group. If ratification and implementation occur, Ireland will then be more compliant with international best practice and will simultaneously ensure that vulnerable people who need care receive it when required (DOH, 2014). What is now required is the publication and passing of a Bill containing the proposed reform and change.

### **1.10 Rationale for the Study**

To date a number of descriptive qualitative studies: Hughes *et al.* (2009), Katsakou *et al.* (2010), Priebe *et al.* (2010), Sibitz *et al.* (2011) have captured people experiences of detention throughout hospital stay and have found a complex picture of both positive and negative experiences. However, understanding people's experiences of being subject to involuntary admission is relatively poorly developed across the trajectory. Little research to date has focused on coherently understanding people's experiences across the trajectory of involuntary admission and the processes influencing such experiences. A theoretical model for understanding how people perceive, experience and adapt to being subject to an involuntary admission is needed.

Katsakou & Priebe (2007) and Katsakou *et al.* (2012) have highlighted the importance of qualitative research to try to understand why people can form positive and negative views of their experiences. Therefore research is needed to understand the more nuanced aspects of experiences and how people are impacted in the longer term as well as how people adapt to being subject to an involuntary admission. If future studies are to advance the research field, they must be designed so that they understand not just people's experience but also to understand the various interplays that shape people's experiences. The present study aims to address this gap in the research field of involuntary admission, by understanding the processes that underpin people's experiences of being subject to an involuntary admission as well as the processes that people use to adapt to these experiences.

The aim of this study is to develop a theoretical understanding of people experience by generating a grounded theory to understand people's experiences before, during and after being subject to involuntary admission and/or detention. This study will develop a coherent understanding of people's experiences, as well as the processes that people use to adapt to involuntary admission. Understanding the basic social and psychological processes behind people's experiences may shed some insight into understanding how people's experience and adapt to involuntary admission as well as the dynamic interaction of these processes. This may assist moving beyond description and in developing a greater understanding of how people initially appraise their hospital treatment and might help in identifying those at risk of having a negative experience

and could assist in the development of new interventions to optimise a more positive experience.

This study will add to the qualitative research field on involuntary admission and detention in two key ways. Firstly, it will potentially identify processes that influence people's experiences of involuntary admission across the trajectory. Secondly, it will add to our understanding of the interplay of these processes as they influence each other, and in turn might influence personally meaningful outcomes that ultimately may influence people's experiences in a positive manner and in a way more people might benefit therapeutically from treatment.

### **1.11 The Mental Health Commission Project**

This Straussian Grounded Theory study formed part of the qualitative arm of a larger project funded by the MHC entitled: "A prospective evaluation of the operation and effects of the MHA 2001 from the viewpoint of service users and health professionals." The aim of this project was to comprehensively examine the operation of the MHA 2001 from the viewpoint of both service users and health professionals.

The researcher was involved in the initial recruitment of nearly 400 people subject to involuntary admission for the MHC project. In addition, the researcher led the qualitative arm of the MHC project, which involved undertaking a lead role in recruitment, data collection and analysis therein. The qualitative arm involved the researcher's Straussian ground theory study, which was generated through simultaneous data collection and analysis until a grounded theory emerged that encapsulated 50 participants' experiences of being subject to involuntary admission.

### **1.12 Outline of the Thesis**

This thesis is divided into nine chapters, including this background and introduction chapter. The next chapter reviews the literature on detention and treatment. The third chapter outlines the methodology and rationale for using Straussian Grounded Theory. Chapter 4 also describes the methods and procedures used for data collection and analysis as well as ethical approval. The substantive theory of preserving control that emerged from the data analysis is presented in Chapters 5, 6, and 7. Chapter 8 discusses

the theory of preserving control in relation to the existing theoretical literature. The final chapter outlines the limitations, contribution to knowledge, and recommendations for practice, legislation and research.

### **1.13 Summary of Chapter**

This chapter outlines the historical and changing context of mental health legislation and care in Ireland. It describes how Ireland's mental health legislation is moving from a paternalistic and welfare paradigm to a more human rights and social-based paradigm as result of international human rights standards and mental health policy. A rationale for the present study is then outlined highlighting the need for research to understand the processes behind people's experience of being subject to involuntary admission.

## **Chapter 2: Literature Review on Being Subject to Involuntary Admission and Detention**

### **2.1 Introduction**

This chapter begins by detailing the search strategy used to elicit relevant papers. The literature review is then divided into three sections: section one focuses on factors associated with being subject to an involuntary admission and detention; section two focuses on the outcomes of involuntary detention; and section three focuses on people's views of being involuntarily detained and treated. Evans (2013) states that Glaser supports the use of both the literature and what can be brought by other theories, but not until the data has had the opportunity to direct the researcher. This literature review is therefore a presentation of current research within the substantive area of involuntary admission and seeks to acknowledge the gap in the literature in terms of providing a rationale for the study.

### **2.2 Literature Search Strategy**

A comprehensive literature search was conducted. The electronic databases: Embase; PubMed; Scopus; PsychInfo and CINAHL were searched for papers. Replicating keywords applied by Seed (2014) to access papers pertinent to the substantive area, the keywords were drawn from four areas. The first area used keywords related to involuntary admission and detention such as 'involuntary', 'coer\*' <sup>17</sup>, 'forced', 'commitment', 'detention', 'compulsory' or 'control'. The second area used keywords related to the process of admission and treatment such as 'admission', 'admitted', 'treatment', 'assessment' or 'hospitali\*'. The third area used key words related to people's experiences such as 'experience\*', 'attitude\*', 'view\*', 'perception\*' or 'perspective\*'. The fourth area used keywords relevant to the field of study such as 'mental\*' or 'psych\*'. The keywords of the four areas were then combined with the Boolean term 'and'.

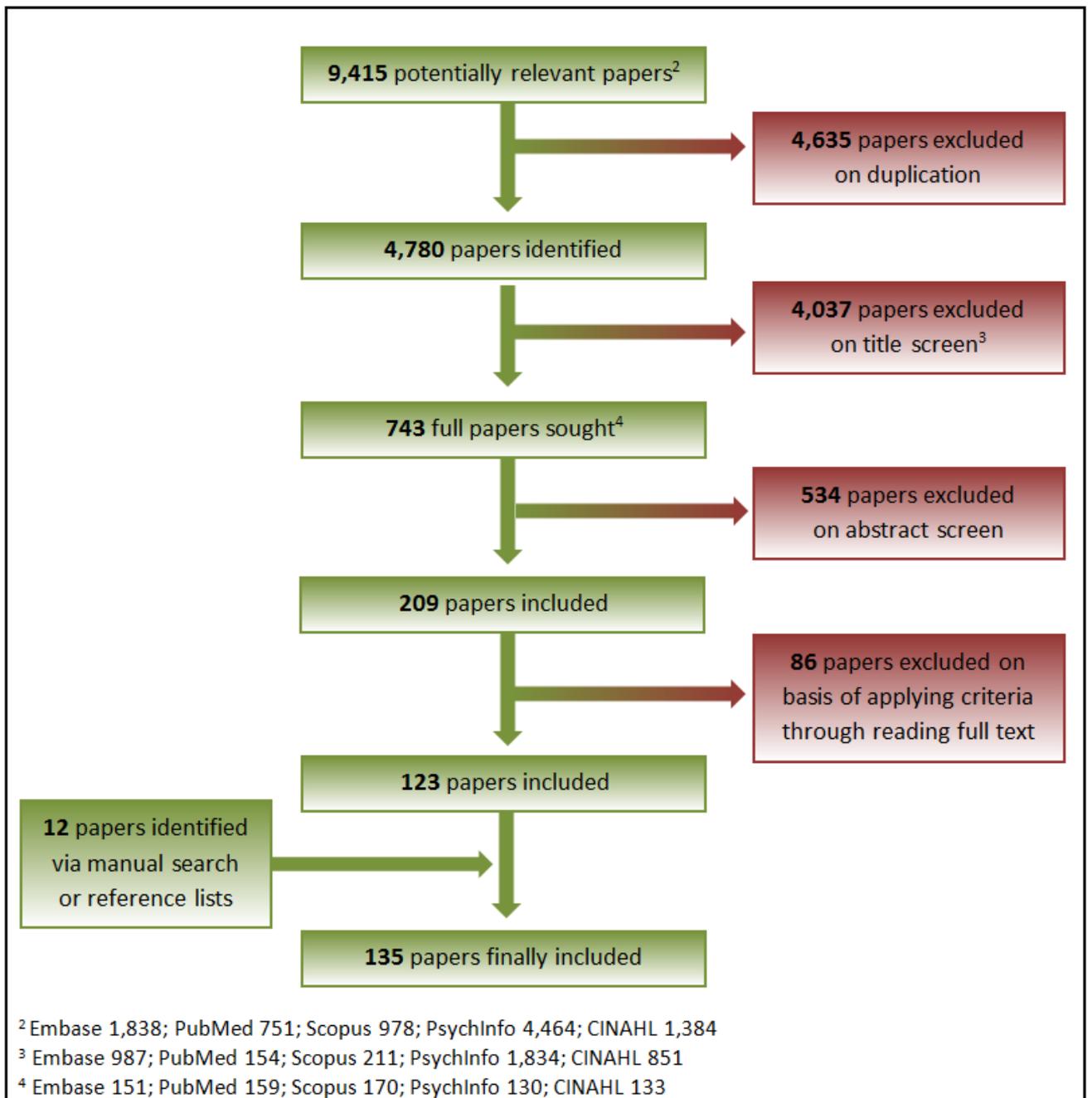
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<sup>17</sup> \* Refers to truncation, where one enters the root of a keyword and replaces the ending with an \* to find all derivatives of that word, for example, coer\* was entered to find words coercive or coercively or experience\* was entered to find the word experiences.

The three criteria used for including papers were that they: (1) included people subject to involuntary admission and/or involuntary detention in hospital; (2) were published in the English language; and (3) were peer-reviewed. The four exclusion criteria were that studies: (1) were carried out in intellectual disability settings or forensic settings only; (2) were confined to only one aspect of involuntary treatment (e.g. restraint, seclusion, involuntary medication, community treatment orders); (3) were an opinion article; and (4) were confined to adolescents only.

The titles of papers were reviewed in terms of their applicability to the substantive area. If the title was deemed relevant to the keywords, the abstracts were then read to assess the study's suitability according to the inclusion criteria.

To supplement the electronic search and to uncover further relevant papers, the reference lists within significant reviews and papers were searched and followed up on and added to the literature search. Seminal paper(s) that spanned 30 years were included. Information regarding detention statistics was obtained from the MHC and Health Research Board websites. Rich Site Summary (RSS) feeds were requested to ensure that the researcher was alerted to new research in the area. The university Intra Library Loan system was used to gain access to papers not available electronically. Some of these papers informed the background chapter and the discussion chapter.



**Figure 2.1: Flowchart outlining the identification of relevant studies**

An analysis of the literature identified three key areas to this review: factors influencing being subject to involuntary admission and/or detention; the outcomes of detention; and people’s experiences of detention and treatment.

## **2.3 Factors Influencing Being Subject to Involuntary Admission and/or Detention**

This section identifies the factors influencing being subject to involuntary admission and/or detention it is comprised of three subareas: clinical factors, demographic and social factors, and service related factors.

### **2.3.1 Clinical Factors Influencing Being Subject to Involuntary Admission and/or Detention**

A number of researchers have examined the diagnosis of people detained to acute psychiatric units (Riecher-Rössler & Rössler, 1993; Cougnard *et al.* 2004; Salize & Dressing 2004; Potkonjak & Karlovic 2008; Murray *et al.* 2009; Montemagni *et al.* 2011; Opsal *et al.* 2011; Dunne & Moloney 2012; Myklebust *et al.* 2012; Ng & Kelly, 2012; Douzenis *et al.* 2013; Lei-Yee Fok *et al.* 2014). There is strong international evidence across these studies that having a diagnosis of schizophrenia or psychotic disorder makes detention more likely.

Riecher-Rössler & Rössler (1993) conducted a review of nine international research studies to identify and compare the diagnosis influencing detention. Across studies from the United Kingdom (UK), United States (US) and Germany comparing the diagnoses of those detained with those admitted voluntarily, it was found that having a diagnosis of schizophrenia makes detention more likely. In addition, six studies in this review found that personality disorder, addiction, diseases of old age, senile psychosis or mania amongst detained people also increased the incidence. It is of concern, however, that the researchers gave no detail about how systematic the literature search was or about the quality of the studies that were included. Nevertheless, the findings of the review are consistent with other more recent studies (Cougnard *et al.* 2004; Potkonjak & Karlovic, 2008; Murray *et al.* 2009; Ng & Kelly, 2012)

More recently, a retrospective study undertaken in London by Webber & Huxley (2004) that included a sample size of 300 found that having a diagnosis of Bipolar Affective Disorder significantly increased the risk of involuntary admission. However, caution needs to be exercised regarding the generalisability of these findings as this study was confined to a cohort of people who were involuntary admission solely under Section 4 of the UK MHA 1983, which involves emergency involuntary admission only.

As part of a European funded project, Salize & Dressing (2004) conducted an overview of the epidemiological data on detention across the European Union. Using an 80 item questionnaire, selected experts (psychiatrists) from each country completed information pertaining to their country by sourcing this information from national health reports and statistical bureaus. Across the countries Belgium, Finland, France, Ireland and the Netherlands, schizophrenia and other psychoses accounted for between 30–50% of all detentions. The epidemiological data revealed that there was large variance in the proportion of people with a diagnosis of dementia, affective disorder or substance misuse who were detained across these countries. However, Salize & Dressing (2004) noted that a limitation of this overview is that there was limited data available on diagnosis in some countries, which makes comparison difficult. In addition, the problem with relying on epidemiological data is that the recording of data may not be of a consistent standard.

Another prospective study on the factors influencing detention in first-admitted people with psychosis was undertaken in two French hospitals (Cougnaud *et al.* 2004). Comparing people who were detained (n=53) with those voluntarily admitted (n=33), it was found that having a diagnosis of schizophrenia influenced detention. Interestingly, people with first-admitted psychosis who had comorbid depressive or anxiety symptoms were less likely to be detained. The study was undertaken with a homogenous group in that all people had one overt psychosis symptom during the last month. A limitation of this study relates to the fact that it was confined to two French hospitals, so it is not known whether these results are applicable to other areas.

More recently, in Norway, a prospective study was conducted comparing voluntary and detained people across 20 hospitals, involving a sample of 3,326 (Hustoft *et al.* 2013). Using the Health of the Nation Outcome Scale (Wing *et al.* 1998, 1999) to measure psychiatric problems, a regression model found that higher scores for aggression, hallucinations and delusions were more common amongst people detained.

In Croatia, Potkonjak & Karlovic (2008) undertook a retrospective audit to identify the medical factors associated with detention (n=106), over a five-year period. Using medical records as a means of data collection, the audit found that the diagnosis of

schizophrenia was the most common diagnosis amongst females detained whilst drug dependence was the most common diagnosis amongst males, followed by schizophrenia. A key strength of this study was that the quality of data extraction was of a high standard as all data was collected from both the person's medical notes and from psychiatry expertise (the findings from the psychiatry expert that examines the person detained; this includes history data, mental status, description of the current illness, and diagnosis).

In Italy, Montemagni *et al.* (2011) conducted a prospective study to compare the factors predictive of detention amongst people with a diagnosis of schizophrenia. The sample consisted of 119 people (n=34, detained) and (n=85, voluntarily admitted). According to the regression model, excitement, impaired emotion perception and lesser insight were predictive of involuntary detention, as measured by Positive and Negative Syndrome Scale excitement component (Kay *et al.* 1987); Scale for the Assessment of Unawareness of Mental Disorder (Amador *et al.* 1994); and Comprehensive Affect Testing System (Froming *et al.* 2000–2006). A key strength of this study is that people were assessed clinically in the first 72 hours of admission, which is important as few studies have assessed people at a time so close to their admission. It is therefore more likely that the acuity of the distress that people were experiencing was captured.

Douzenis *et al.* (2013) conducted a prospective study to compare the factors associated with detention and voluntary admission amongst 79 people in Greece. The sample consisted of 79 people (n=40 detained) and (n=39 voluntary admitted). All participants were over the age of 60 – the mean age being 70 years of age. When the groups were compared, it was found that there were higher rates of delirium in those detained in comparison to a diagnosis of mood disorder among those voluntarily admitted. In addition, people detained displayed more aggressive behaviour, as measured by the Patient-Staff Conflict Checklist-Shift Report (Bowers *et al.* 2006). This study is important as there is a lack of studies investigating the factors associated with involuntary detention in those over 65 years of age.

Most of the studies that include diagnosis as a possible factor influencing detention fail to include secondary or comorbid diagnoses that may contribute to influencing detention (Potkonjak & Karlovic, 2008; Murray *et al.* 2009; Montemagni *et al.* 2011;

Ng & Kelly, 2012). However, a recent longitudinal London study by Lei-Yee Fok *et al.* (2014) examined the impact of comorbid personality disorder on detention in a cohort of people (n=11,924) with severe mental illness (schizophrenia, schizoaffective disorder). This study found that people who had a comorbid personality disorder with either schizophrenia, schizoaffective or bipolar disorder were twice as likely as those with a sole diagnosis to be detained.

Similarly, in Norway, a prospective study aimed to identify whether substance abuse in people with first episode psychosis influenced detention. Substance abuse was measured by the Clinical Rating Scale for Substance Abuse (Mueser *et al.* 2003). Amongst 103 people it was found that 72% of people who misused substances had experience of an detention at 2 year follow up, this was in comparison to 31% of non misusers (Opsal *et al.* 2011). This study is important as it investigates the influence of comorbid substance abuse as a factor in detention.

According to Irish data relating to involuntary detention published in the Health Research Board Annual Report, admissions for people with schizophrenia had the highest rate of detention at 20.2 per 100,000 followed by those with mania at 7.7, and depressive disorder at 4.8 (Daly & Craig, 2016).

In Ireland, substance misuse continues to be a factor for those subject to involuntary admission. Two Irish studies by Dunne & Moloney (2012) and Rafiq & O'Hanlon (2010) examined some of the clinical factors of those subject to involuntary admission under the MHA 2001. Dunne & Moloney (2012) undertook a retrospective case notes review to explore and to compare the factors influencing those who were not subsequently involuntarily detained versus those who were detained after being brought to an hospital with an application and recommendation for involuntary admission. The sample, which included 171 people and was conducted over a 22-month period, found that 32 (19%) were not subsequently detained and 139 (81%) were detained. When the two groups were compared, substance misuse related illness 12 (38%) versus 5 (4%) and personality disorder 3 (9%) versus 0 (0%) were the more common primary diagnoses in those not detained. Meanwhile, schizophreniform illness 6 (19%) versus 74 (53%) was more common in those detained. Of note, those who were not detained 35 (25%) were more likely to be using substances at the time of involuntary admission

than those who were detained 14 (44%). A limitation of this study pertains to the small number (n=32) in the group who were subsequently detained, which may affect the power to detect important clinical factors associated with those subsequently not detained. However, as the MHC does not collect data on those not subsequently detained, this study is important as it identifies some of the clinical factors associated with this cohort of people.

Consistent with Dunne & Moloney's (2012) findings, Rafiq & O'Hanlon's (2010) audit also found that substance misuse was a common factor in those subject to involuntary admission but who were not subsequently detained. This is despite the fact that substance misuse is excluded as a criterion for involuntary admission under the MHA 2001. In a sample of 41 people subject to involuntary admission but not subsequently detained, 12 (29%) had a diagnosis of mental and behavioural disorder due to psychoactive substance use. The limitations of this study are that it was confined to one acute psychiatric unit in Ireland and its small sample size.

An Irish audit comparing detention under the MTA 1945 and the MHA 2001 found no statistically significant difference in the diagnosis of people (Murray *et al.* 2009). In a sample of 175 people (n=91, MTA 1945) and (n=84, MHA 2001) it was found that psychotic and affective disorders accounted for 81.4% and 77.3% of people of admitted under the MTA 1945 and the MHA 2001. Indeed, Ramsay *et al.*'s (2013) review of Irish studies indicated that when comparing the diagnosis over a four-year period (2007–2010), people with a diagnosis of psychotic disorders, bipolar affective disorder/schizoaffective disorder continue to be the people most likely to be detained. This review is important as it investigated the prevalence of diagnoses over a 4-year period.

Risk of re-admission for those who had detentions is not uncommon. According to data available from the MHC a total of 37 Irish people had three or more detentions in 2014 (MHC, 2015). Cunningham (2012) investigated the epidemiological data of 121 people classified as having multiple detentions. Fifty-seven per cent of people had a diagnosis of schizophrenia, schizotypal or delusional disorder while 20% had a diagnosis of mania.

### **2.3.2 Demographic and Social Factors influencing Being Subject to Involuntary Admission and/ or Detention**

There have been fewer studies that have documented and investigated the influence of factors such as gender, marital status, age, and social supports on detention rates. Some researchers – including some of the researchers mentioned previously (Riecher-Rössler & Rössler, 1993; Salize & Dressing, 2004; Potkonjak & Karlovic 2008; Murray *et al.* 2009; Hustoft *et al.* 2013; Ramsay *et al.* 2013; Zhou *et al.* 2015) – have given attention to the gender, marital status, and occupational status, whilst others have investigated factors such as ethnicity (Singh *et al.* 2007) and deprivation (Bindman *et al.* 2002; Webber & Huxley 2004; Ng & Kelly; 2012)

In the international review of studies undertaken by Riecher-Rössler & Rössler (1993), researchers found that there was a higher detention rate amongst those who were male, those who were unmarried, those living alone and those of a higher age. In one of the studies, not owning a home was associated with detention and this effect was independent of diagnosis, pointing to the importance of this factor as a sociodemographic factor for detention as distinct from a clinical one.

Of note, people not owning a home tended to be younger, of male gender and of low occupational status. Not living in your own apartment or house was also a more recent finding associated with referral for detention in Norway (Hustoft *et al.* 2013). Living accommodation was determined through an admission registration form and the information was therefore not always completed, a limitation acknowledged by Hustoft *et al.* (2013). In addition, Riecher-Rössler & Rössler's (1993, p. 234) review indicated that “when compared with voluntarily admissions, involuntary admissions were more frequent in people of lower social class and among those who were unemployed”. This is consistent with the regression model computed by Cougnard *et al.* (2004), which found that being of male gender and having a diagnosis of schizophrenia were also independently predictive of detention.

Salize & Dressing's (2004) overview of epidemiological data found that in Belgium, France, Ireland, Luxembourg and the Netherlands, males were more likely than females to be detained. The finding that there is a higher incidence of detention amongst males is consistent with Riecher-Rössler & Rössler's (1993) and Hustoft *et al.*'s (2013)

findings. Salize & Dressing's (2004) overview is important in that they incorporate the findings from a wide number of European countries.

Hustoft *et al.* (2013) conducted a prospective study in Norway that aimed to identify the factors predictive of those subject to involuntary admission. They found that when compared, people involuntarily admitted were significantly older (involuntary,  $M=40.4$ ,  $S.D=16.8$ , voluntary,  $M=38.9$ ,  $S.D=14.5$ ,  $p=0.0005$ ), more often male, non-Norwegian, unmarried with lower levels of education, more often had a disability pension or received social benefits, and had lower level of social functioning. Consistent with previous findings, there was more frequent substance abuse amongst people detained. Functioning was assessed by the Global Assessment of Functioning Scale (American Psychiatric Association, 1994). A strength of this study lies with the fact that it investigated a multitude of factors that may influence detention and the fact that it used standardised instruments to assess potential factors.

According to the Irish epidemiological data available from the MHC Annual Reports, there is a consistently higher percentage of males than females who had been detained (MHC, 2012; MHC, 2013; MHC, 2014; MHC, 2015). The most recent rates indicate that 56% of those who were detained were males in comparison to 44% of females in 2014 (MHC, 2015).

As regards the age of people detained in Ireland, the epidemiological data available reports a higher percentage of people within the 25–34 and 35–44 age groups have been detained (MHC, 2013; MHC, 2014; MHC, 2015). The most recent statistics indicate that these age groups constituted 43% of all those detained – 22% in the 25–34 age group and 21% in the 35–44 age group. The lowest percentage (12%) was in the 18–24 and the (12%) 55–64 age groups (MHC, 2015). Indeed, an audit undertaken by Murray *et al.* (2009) found that there was no change in the demographic profile of people detained under the MTA 1945 or MHA 2001.

According to Cunningham (2012) (previously mentioned) who investigated the epidemiological data of 121 people classified as having multiple detentions. Fifty nine per cent were male who often lived in rural counties and 80% were between the ages of 22-64.

A recent prospective Chinese study compared the factors associated with voluntary and detained people in 16 hospitals in China (Zhou *et al.* 2015). Data was collected from 797 people one week after their discharge from hospital using interviews with the person and their family, in addition to information from the medical notes. A regression analysis found that male gender, diagnosis of schizophrenia and related disorders (consistent with previous findings) were associated with detention. In addition, having a history of hospitalisation and objective evidence of aggression in the week prior to admission (as measured by the Modified Overt Aggression Scale, Xie & Zheng, 2001) were also associated with detention. In contrast to other studies, this study also identified factors that were protective against involuntary admission. They included more years in education, higher insight scores (as measured by the Insight and Treatment Attitudes Questionnaire, McEvoy *et al.* 1989) and having accessed outpatient treatment prior to index admission. Strengths of this study pertain to the large sample size and the use of validated assessment scales to elicit data.

In Croatia, Potkonjak & Karlovic's (2008) retrospective study, which also explored the sociodemographic factors in detention, found that most people detained had secondary school education only, were living alone, were from urban areas, were unmarried, single or divorced, and did not work at the time of hospitalisation. Adding to the findings of some of the studies in Riecher-Rössler & Rössler's (1993) review, there was a higher rate of detention amongst of a higher age. This study found a statistically significant age difference between males and females who were detained. The mean age for a male detention, at 42 years of age, was higher in comparison to a mean age of 37 years for females. Caution needs to be exercised when interpreting these findings, however, as there was no comparison between those admitted voluntarily and those detained.

In other studies, socio-economic deprivation has been shown to be a factor that influences the variation in detention rates (Riecher *et al.* 1991; Bindman *et al.* 2002). In England, Bindman *et al.* (2002) studied 34 mental health sectors in eight health care trusts. In this retrospective study, the researchers investigated whether socio-economic deprivation as measured by the Mental Illness Needs Index influenced rates of detention. They found a significant association between detention and socio-economic

deprivation, even after controlling for other factors such as indicators of service quality. The strength of this study is that it is multi-centred and includes a large sample of people (N=1,507)

There are, however, some contradictory findings in relation to deprivation as a factor that influences detention. In a retrospective Irish study by Ng & Kelly (2012), which aimed to determine the clinical and demographic factors associated with detention, deprivation accounted for some of the variance in detention. However, this was confounded by diagnosis in multivariate analysis, diagnosis of schizophrenia was independently predictive of the rate of detention, accounting for 1/3 of the variance. The study, conducted in a deprived area of North Dublin City Centre, analysed data over a three-year period. A limitation of this study is that data was collected from case notes and therefore its accuracy may be questioned as quality procedures for data entry within medical records are usually not in place.

A systematic review of the literature has shown that ethnicity is a factor in detention (Singh *et al.* 2007). This review was conducted to determine whether there was a difference in detention rates within and between ethnic groups in the UK. Forty-nine studies met the inclusion criteria, and a meta-analysis on the results of 19 studies was undertaken. Comparing white, black and Asian people, the meta-analysis calculated the odds ratio for detention in black people to be 3.8 times higher than white people and 2.1 times higher in people from Asian backgrounds. This is a large systematic review but was confined to those detained under the UK MHA 1983.

More recently, a systematic review was conducted to investigate ethnic variations in detention amongst those experiencing a first-episode psychosis (Mann *et al.* 2014). Searching across three electronic databases, 7 studies were identified from a potential 1507. Three of the reviewed studies found that detention is more likely in black and minority ethnic groups. The quality of the studies was assessed using the Effective Public Health Project Quality Assessment Tool for Quantitative Studies 2009 and was additionally rated by two independent researchers. A limitation of the findings pertains to the moderate to poor quality of the studies. A key strength of the study pertains to the review of International studies.

There have been fewer studies that explore the social factors associated with being subject to involuntary admission. However, one such study investigated social exclusion as a factor associated with being subject to an emergency admission for assessment. A prospective London study, by Webber & Huxley (2004), reported social exclusion (as measured by an Index of social exclusion) as a factor influencing involuntary admission such that low social support in particular was independently associated with involuntary admission. The sample consisted of 300 people subject to Section 4 of the MHA 1983, (including those subsequently detained and those not). An index of social exclusion was developed that measured six dimensions: (1) housing, (2) education, (3) income, (4) employment, (5) social support, and (6) neighbourhood deprivation. Of note, using a retrospective case file analysis, the only dimension of this Index that influenced the likelihood of involuntary admission was social support. Contrary to Riecher-Rössler & Rössler's (1993) review, housing did not influence the likelihood of involuntary detention. Of further note, age and gender were not significant risk factors for Section 4 admissions. However, people of non-white British ethnicity had a marginally raised likelihood of admission under this section. A limitation of this study pertains to the lack of use of a psychometrically sound instrument to assess social exclusion.

In Ireland, Ramsay *et al.*'s (2013) review of 16 Irish research studies since the introduction of the MHA (2001) indicated that there was no difference in the gender, employment status, and nationality of involuntarily detained people since the introduction of the MHA (2001). However, the quality of this review may be questionable as only two electronic databases were used to search for papers.

### **2.3.3 Service and Legal Factors Influencing Being Subject to an Involuntary Admission and/or Detention**

People's diagnoses and demographics are not the only factors influencing the rates of involuntary admission and/or detention. The interplay of other non-clinical factors such as the functioning of the health service and changes in the legal requirements of mental health legislation might also influence the rates of involuntary admission and/or detention. Some researchers have investigated the influence of service factors such as the: functioning of the health services (the availability of home care) (Bindman *et al.*

2002; Quirk *et al.* 2003); the type of referral (whether Gardaí (Police) and whether it was the person's own GP) (Rafiq & O'Hanlon, 2010; Dunne & Moloney, 2012; Hustoft *et al.* 2013; Rotvold & Wynn, 2015); time of presentation for involuntary admission (inside or outside of office hours) (Rafiq & O'Hanlon, 2010; Dunne & Moloney, 2012; Hustoft *et al.* 2013; Rotvold & Wynn, 2015); and legal factors such as changes in the legal requirements of mental health legislation (Eytan *et al.* 2013).

In the UK, Bindman *et al.*'s (2002) retrospective study (previously mentioned), investigated service factors influencing detention across 34 mental health sectors. Using the service structure and function questionnaire (Johnson *et al.* 1997) to measure service factors, the ecological analysis found that some indicators of service quality influence detention (Bindman *et al.* 2002). According to the regression model, teams providing home visits after 10 pm assess fewer women for detention. In addition, teams that have an average delay of one day or more in obtaining an acute bed have higher rates of detention, whilst those with delays in obtaining hostel places averaging three months or more have lower rates. Of note, the validity and reliability of the questionnaire has not been investigated and therefore caution needs to be exercised when interpreting results on the basis of a measure that has not been validated.

In a UK Department of Health funded qualitative study, Quirk *et al.* (2003) used participant observation to determine the factors that influence of being subject to involuntary admission. The researcher shadowed mental health professionals during the course of mental health assessment with service users. In addition, interviews were conducted with seven key informants (professionals) to understand the decisional processes that led professionals to consider involuntary admission. A grounded theory approach to data sampling (theoretical sampling) and data analysis was used. Twenty assessments were observed, 11 for possible admission for assessment (Section 2), nine were for admission for treatment (Section 3) and one was for emergency admission and assessment (Section 4). Using observations and interviews, it was found that involuntary admission increased when staff had insufficient time to find alternatives to hospitalisation and when they felt unsupported by other professionals to do so. Other factors that could explain some variation in being subject to an involuntary admission were team level influences, local operational norms and ward-related factors. The team level influences included how services organised assessments – some services in outer

London had access to a 24-hour crisis team (consisting of a social worker, a community mental health nurse and a doctor). This team assisted in devising a plan that might avert being subject to involuntary admission. In contrast, other services in inner London had a duty community mental health team conduct assessments for involuntary admission during weekdays (consisting of a supervisor, a doctor, three case managers and two community mental health nurses). In the latter team, 20 people were involuntary admitted in a two-week period, whilst in the former team only eight people were involuntary admitted. The implication of resources and the support from the team impacted on variations of being subject to an involuntary admission. Variations in local operational norms included discussions with colleagues and peer support among staff, while ward-related factors included the perceptions of conditions in psychiatric hospitals such as the physical environment and the degree of people's disturbance. This study is important because it is one of the few studies that investigated staff's perceptions on the factors that they perceive influence being subject to an involuntary admission. In addition, it suggests that involuntary admissions could be prevented in some instances if alternatives to hospitalisation were available.

A retrospective study was conducted in one Irish psychiatric hospitals comparing people subject to an involuntary admission who were not subsequently detained pre and post introduction of the MHA 2001 (Rafiq & O'Hanlon, 2010). The sample consisted of 80 people, (n = 39, pre-MHA 2001) and (n = 41, post-MHA 2001). When the two groups were compared, 43.6% of people (pre-MHA 2001) were referred by a GP not known to the person in comparison to 63.4% of people (post-MHA 2001). In addition, 25.6% of the assessments (pre-MHA 2001) were conducted out of hours (after 5pm) in comparison to 34.1% (post-MHA 2001). Therefore, since the MHA 2001 was introduced people are more likely to be referred for involuntary admission outside of office hours by a GP not known to the person. It is of concern that that the method of data extraction was not documented so it is not known if this may affect the reliability of these results.

Dunne & Moloney's (2012) retrospective study compared some of factors associated with people who were detained versus those who were not after being subject to an involuntary admission. These factors included the time of presentation to the hospital, as well as who was involved in the application and recommendation process (whether

it was people's own GP, an on-call GP, or the Gardaí (Police). In a sample of 171 people (n = 139, detained) and (n = 32, not detained), 121 of these people presented outside of office hours. When the two groups were compared, people who were not subsequently detained were more likely to have their application made by the Gardaí, and a recommendation made by a GP not known to them. In addition, those not subsequently detained were more likely to be brought to hospital by the Gardaí. Again this study relied on case notes as a means of collecting data and it is of concern that the data extraction methods were not documented.

In Norway, Hustoft *et al.* (2013) conducted a prospective study (previously mentioned) to identify the predictors of detention by comparing 1,869 voluntary and 1,453 detained people. Using a regression analysis they found that contact with the police, referral by a physician unknown to the person, and contact with the health services within the previous 48 hours were predictors of detention. In addition, detained people had less contact with the MHS before admission and, consistent with Dunne & Moloney's (2012) findings, were more often admitted during the evening or at night.

Another Norwegian study, this time a retrospective study, was conducted by Rotvold & Wynn (2015) to determine the factors influencing involuntary admission (referred inside or outside of office hours and whether referred by the person's own GP). In addition, the researchers investigated the GP's subjective experience of referring people for involuntary admissions. Telephone interviews were conducted with a sample of 74 doctors. Thirty nine people were referred from an out-of-hours clinic. Fifty four people were referred by a GP not known to them. Thirty four of the GPs felt pressured by the health service, the family and the police to refer the person. Therefore, a GP known to the person is less likely to refer and GP's feel more pressured to refer for involuntary admission outside of office hours. It is of concern that the response rate was poor (148 doctors did not call back) and that there was no analysis of the difference between participants who did and did not respond. Given the high proportion of people who were referred outside of office hours by an unknown GP, this is clearly an area that warrants further research across studies.

Eytan *et al.*'s (2013) retrospective study investigated whether a change in a legal requirement of the mental health legislation in Sweden impacted on the rate of

detention. The change in the legislation provided that a psychiatrist alone (rather than a physician/hospital doctor) would be responsible for the signing of a person's detention. The audit compared the rate of detention four months prior to the implementation of this requirement to the four months after the requirement. Using a regression analysis, it was found that there was a reduction in the detention rate after the initiation of this requirement (OR = 0.745, 95% CI: 0.596–0.930). As such, if the legislation requires that a psychiatrist sign an detention, then the rate of detention is lower. A limitation of this study pertains to the fact that other factors may have influenced detention rates.

### **2.3.4 Research Quality**

Many of the studies reviewed were small-scale and did not pay sufficient attention to rigor. In most of the retrospective studies the mechanism for data extraction was not reported. There was a lack of standardised instruments to assess clinical factors and social factors and this made it difficult to make comparisons. In order to validate and further explore the service and legal related factors, future studies need to be conducted amongst larger sample sizes and in multi-centres.

### **2.3.5 Summary of the Clinical, Demographic, Social, Service and Legal Factors**

#### **Associated with Being Subject to Involuntary Admission and/or Detention**

Across studies a number of factors were associated with being subject to involuntary admission and/or detention including: diagnoses of schizophrenia or psychotic illness; comorbid personality disorder or substance abuse with severe mental illness; hallucinations; delusions; excitement (manic like symptoms); impaired emotion perception; aggressive behaviour and lesser insight. In addition, younger age, male gender, single marital status, not living in your own apartment or house, being of black origin, being socio-economic deprived, being unemployed and having lower levels of social functioning were some of the sociodemographic factors influencing involuntary detention.

Furthermore, factors related to the organisation of health service such as the availability of home visits after 10pm, access to acute beds and hostel places; involvement of the police; being referred by a GP not known to the person and being referred outside of

office hours and having a physician instead of a psychiatrist sign the detention all influenced the detention rate. It may be fair to say that there might yet be unidentified factors that influence the rate of detention; therefore, there is a need to examine other factors. Furthermore, to add value to the literature, they must be sensitive to the potential (and likely) existence of as yet unidentified factors beyond the factors referred to above.

## **2.4 Outcomes of Detention**

This section identifies the outcomes of involuntary detention; it is comprised of four subareas: clinical outcomes, service-related outcomes, people's perception of the necessity of detention and the factors associated with perceived necessity.

### **2.4.1 Clinical Outcomes of Detention**

Two systematic reviews have investigated the outcomes of detention on people (Katsakou & Priebe, 2006; Kallert *et al.* 2008). Across the studies included in Katsakou & Priebe's (2006) review it was found that most detained people improved clinically over time. Across the studies included in Kallert *et al.*'s (2008) review it was found that detained people had lower levels of functioning and higher suicide rates when compared with people who were voluntarily admitted. However, when the two groups were compared there was no difference in terms of general psychopathology between them, such that people in both groups showed clinical improvement within the same range.

Katsakou & Priebe (2006) systematically reviewed quantitative studies to examine people's clinical progress (functioning and symptoms). They systematically searched the literature across four databases and documented the inclusion and exclusion criteria used. They restricted studies to those published in English and those using a quantitative methodology (either prospective or retrospective). Eighteen studies met the inclusion criteria, with five of them originating in the USA, two in the UK, one in Australia, five in Canada, and five in Sweden. The sample sizes ranged from 16 to 138 participants. Of the 18 studies reviewed, nine were of low quality, six were of medium quality, and three were of high quality. While the studies were variable in their methodological

quality, size and rigor, across studies they found that most detained people improve clinically over time (some of the measures used to assess functioning and symptoms across studies included either the Global Assessment Scale (Endicott, 1976), Global Assessment of Functioning (American Psychiatric Association, 1994), Brief Psychiatric Rating Scale (Lukoff *et al.* 1986) or the Clinical Global Impression - Severity Scale (Guy, 1976). Comparison of the studies' findings on clinical outcome was difficult as they included different instruments that primarily assessed functioning.

Kallert *et al.*'s (2008) systematic review compared the difference in outcomes between people who were detained and those voluntarily admitted. They systematically searched the literature across only two databases and included studies published in both English and German. Outlining clear inclusion and exclusion criteria, forty-one studies were reviewed. Three researchers independently rated the methodological quality of studies according to six dimensions: (1) clarity of the inclusion and exclusion criteria; (2) attrition rate; (3) sample size at follow-up; (4) the definition of follow-up periods; (5) assessment instruments and (6) study design.

While the forty-one studies included were variable in their methodological quality, the review found that people detained had either comparable or lower levels of social functioning (as measured by Global Assessment Scale (Endicott, 1976), Clinical Global Impression-Severity Scale (Guy, 1976), or Global Assessment of Functioning (American Psychiatric Association, 1994) both at admission and discharge. It was found that whilst people detained showed no increased mortality, three studies in the review found that they did have higher incidence of suicide than those admitted voluntarily. However, there was not a statistically significant difference in psychopathology between the two groups as measured by Brief Psychiatric Rating Scale (Lukoff *et al.* 1986), or Positive and Negative Syndrome Scale (Kay *et al.* 1987), such that people in both groups improved in the same range. In addition, the review suggested that severe stress symptoms related to treatment experience were found amongst those who have had being detained, in one small Finnish study as measured by the Impact of Events Scale-Revised (Weiss & Marmar, 1996) and the Clinician Administered PTSD Scale (Foa *et al.* 1997). Furthermore, as regards insight, there were inconsistent findings regarding the difference in insight between the detained and voluntary people. The clinical outcomes assessed used standardised instruments.

More recently, Priebe *et al.* (2011) conducted a UK prospective study on people's clinical and social outcomes, assessing people within a week of detention and following up in 1, 3, 12 months after involuntary detention. Researchers also investigated the factors (socio-demographic, clinical factors, reason for admission and initial experiences of the person) associated with more or less favourable outcomes (clinical and social). The original sample consisted of 778 people, 396 of whom were re-interviewed one year after discharge. The researchers found that there was moderate improvement on symptom levels between baseline and 3 months, with scores on the Brief Psychiatric Rating Scale (Lukoff *et al.* 1986) decreasing from 54.5 (SD = 14.24) to 40.6 (SD = 12.72); however, there was no significant improvement in symptoms between the 3 months and 12 months follow-up. Global functioning also showed a moderate improvement between baseline and 1 year, such that scores on the Global Assessment of Functioning (American Psychiatric Association, 1994) improved from 33.56 (SD = 11.63) to 50.18 (SD = 16.43). In relation to objective social outcome (as measured by the Objective Social Outcomes Index, Priebe *et al.* 2008) there was a small but statistically significant decrease in functioning whilst there was a significant increase in subjective quality of life at 1 year (as measured by the Manchester Short Assessment of Quality of Life, Priebe *et al.* 1999).

Furthermore, the factors identified leading to less favourable symptom outcome were: people who were admitted due to risk to themselves and people who were on benefits. In addition, female gender and higher perceived coercion (as measured by the McArthur Perceived Coercion Scale, Gardner *et al.* 1993) predicted more positive objective social outcomes whilst higher initial satisfaction with treatment (as measured by Client's Assessment of Treatment Scale, Priebe *et al.* 1995) led to more favourable subjective quality of life. This study is important as it had a large sample size with a long follow-up period. In addition, psychometrically sound instruments were used to collect data and functioning was measured both objectively and subjectively – which few studies have done.

#### **2.4.2 Service-Related Outcomes of Detention**

A prospective study conducted by Jaeger *et al.* (2013) in Germany examined the effect

of detention on medication adherence, treatment engagement and feeling coerced to partake in treatment. It was found that people detained were more likely to show poorer adherence to medication. Across the studies included in Kallert *et al.*'s (2008) systematic review, it was found that people detained had a longer length of stay and their readmission risk and risk of involuntary readmission were at least equal or greater than for those people voluntarily admitted. Readmission risk amongst people who had being detained has been investigated by a number of researchers who found that people who were less satisfied and who adopted a sealing over recovery style were more likely to be readmitted (Priebe *et al.* 2009; O'Donoghue *et al.* 2011).

Jaeger *et al.*'s (2013) study included a sample of 374 people (diagnosed with schizophrenia or schizoaffective disorder), and the researchers compared the differences between voluntary (n = 290, voluntary) and detained people (n = 84, involuntary) over a two-year follow-up period. Medication adherence was both self-rated (by the Medication Adherence Rating Scale, Thompson *et al.* 2000) and assessed by clinical means (acquiring blood levels of antipsychotic medication at twelve and twenty four months). Researchers found that detention was associated with a lower self-rated medication adherence ( $p < 0.05$ ). However, adherence assessed by blood samples did not yield a significant difference between the two groups.

In addition, treatment engagement (out-patient treatment) and feelings of coercion to partake in treatment were both assessed at six, twelve, eighteen and twenty-four months by the compliance self-rating instrument (Jaeger *et al.* 2009). It was found that there was no difference in treatment engagement between the two groups, but people who were detained did feel more coerced to participate in treatment ( $p < 0.05$ ). A key strength of this study is that socio-demographic variables (number of past detentions) were controlled for. Jaeger *et al.* (2013) compared people who were interviewed at baseline and those who were re-interviewed at twenty four months, and reported that there was no difference in the characteristics of the sample. None of the interviewers were involved in the interviewees' care and there was a low attrition rate for a 2-year follow-up period (20%).

Of the studies included in Kallert *et al.*'s (2008) systematic review examining treatment adherence, length of stay, readmission risk and the difference in risk of readmission

between people who had an involuntary or voluntary admission, it was found that people detained had a longer length of stay than people who were voluntarily admitted. In addition the risk of further detention was at least equal or greater than for those who had been voluntarily admitted. Some studies from the UK, the USA and Israel found that there was a higher risk of further detentions if the person's first admission to hospital was involuntary. However, unlike Jaeger *et al.*'s (2013) finding, there was no difference in terms of treatment adherence between people detained and those voluntarily admitted. Of note, Kallert *et al.* (2008) states that the methodological quality of the studies included on service-related outcomes was not as high as it was for the studies included on clinical outcomes.

More recently, Priebe *et al.* (2009) and O'Donoghue *et al.* (2011) have investigated the risk of further detentions in a cohort of people who had a previous detention. In the UK, Priebe *et al.* (2009) conducted a prospective study investigating the rate of readmissions one year after detention. In addition, they investigated the factors that influenced readmission rates. Of an original sample of 778 people who had been detained, 396 were re-interviewed one year after discharge. They found that within a year, 15% of the original sample (778 people) were involuntarily readmitted and 11% were voluntarily readmitted. Researchers found that people who were initially dissatisfied with treatment, who were on benefits, and who lived with others were more likely to be readmitted. However, the findings were confounded by ethnicity in the multivariate analysis, as people who had a Black African or Black African-Caribbean origin were more likely to be detained within a year compared to their white counterparts, such that there was a rate ratio of 1.37 between people of black and white origins. It was surprising that no-one over 65 was included in the sample. A key strength of this study is that it reported the difference between people who did and did not partake. It was found that males and those people who were younger were more likely partake in the study.

A more recent Irish retrospective study investigated both the rate of readmissions and the factors that influenced readmission rates one-year after detention. (O'Donoghue *et al.* 2011). In a sample of 90 people, they found that 21% were involuntarily readmitted to a psychiatric unit and 22% were voluntarily readmitted. The researchers assessed recovery style as a factor associated with risk of involuntary readmission, using the

Recovery Style Questionnaire (Drayton *et al.* 1998). McGlashan (1987) identified two distinct recovery styles adopted by people who experienced a psychotic illness, 'integrating' or 'sealing over'. People who adopt an 'integrating' recovery style take a sense of responsibility for dealing with difficulties and try to make sense of their experience. People who adopted a 'sealing over' recovery style have negative views of the experience; they possess the traits of denial and avoidance, thus wanting to put the experience 'behind them' (Jackson & Iqbal, 2000). Interestingly, O'Donoghue *et al.* (2011) found an association between recovery style and readmission rates. People who adopted a 'sealing over' recovery style were at four times the risk of involuntary readmission than those who adopted an integrating style. Recovery style was not a factor previously measured in studies assessing the risk of readmission and thus it is interesting in terms of how it influences the risk of readmission. O'Donoghue *et al.* (2011) also found that that people's level of functioning, insight, procedural justice on admission, negative attitudes towards medication and view of involuntary detention as unjustified were not associated with involuntary readmission.

#### **2.4.3 People's Perception on the Necessity of Detention and the Factors associated with Perceived Necessity**

People's retrospective views on the perceived necessity of their detention have been assessed in studies included in Katsakou & Priebe's (2006) and Kallert *et al.*'s (2007) systematic reviews. In addition to these studies, many other researchers have investigated the topic (Priebe *et al.* 2009; Priebe *et al.* 2010; O'Donoghue *et al.* 2010; 2011; Katsakou *et al.* 2012). Furthermore, many of these studies have investigated the factors associated with the perceived necessity of their detention. Across the studies included in Kallert *et al.*'s (2008) systematic review, it was found that people detained were more likely than those voluntarily admitted to perceive their admission as not necessary. In addition, Kallert *et al.* (2008) found that people who achieved clinical improvement were more likely to perceive their admission as necessary. Across the studies included in Katsakou & Priebe's (2006) review, it was found that between 39% and 75% deemed their admission as necessary, whilst between 10% and 47% believed that it was not.

Seven studies were included in Katsakou & Priebe's (2006) systematic review on the extent to which people believed that their admission was necessary using single item

questions. Of the studies that assessed people's views within the first twenty-five days after admission, rates varied between studies from 39–58%, whilst the studies that assessed people's views between four months and three years after discharge found that 66% to 75% of people believed their admission was necessary. The research suggests that people's retrospective views of their detention improve as time progresses.

Katsakou & Priebe (2006) also reviewed the socio-demographic and clinical characteristics that predicted more favourable retrospective views. The review found that people who achieved more marked clinical improvement were more likely to have a positive retrospective view about the necessity of their detention. However, Katsakou & Priebe (2006) acknowledge that there was a lack of studies and that this limited the reporting of conclusive findings on predictors.

Four studies on people's views on the need of admission were included in Kallert *et al.*'s (2007) systematic review. They found that a statistically significant difference in the numbers of those voluntarily admitted than those detained who felt that admission was necessary, such that a greater number of people detained believed admission was not necessary.

In the UK, Priebe *et al.*'s (2009) large prospective study (previously mentioned) across 22 hospitals assessed people's view on whether they believed their detention was necessary or not. Interviewing people one year after their detention, it was found that of the 396 people interviewed, 40% of people considered their original detention necessary. Priebe *et al.* (2009) also found that positive judgements on the necessity of detention were associated amongst those who lived alone, had poor initial functioning and higher initial treatment satisfaction, as measured by clinical notes, Global Assessment of Functioning (American Psychiatric Association, 1994) and Client's Assessment of Treatment (Priebe *et al.* 1995). There was however an attrition rate of 49% at one year follow-up, which is of concern as it is not known if the views of those not followed up were the same or different, with those of male gender, who were younger and of black origin less likely to participate at one year follow-up.

In Ireland, O'Donoghue *et al.* (2010, 2011) undertook a retrospective study to determine the percentage of people who felt that their detention was necessary.

Assessing people (N = 81) close to discharge it was found that 72% of the participants viewed their involuntary detention as necessary (O'Donoghue *et al.* 2010).

They also used a logistic regression to determine if age, gender, marital status, diagnosis, whether it was people's first detention, length of detention, level of insight and use of physical coercive measures (restraint, seclusion, police being involved, assisted admission) were predictive of people's views of the necessity of detention. The regression found that two factors predicted perceived necessity: the level of insight (as measured by the Scale to Assess Unawareness of Mental Disorder) (Amador *et al.* 1994) and the length of time detained. There was a moderate association between insight and the view that detention was necessary, such that those with a greater level of insight were more likely to view their detention as justified and therefore are more likely to reflect positively on the necessity of detention. Participants who had a shorter stay were more likely to feel that their detention as justified. A strength of this study lies in the fact that it investigated a multitude of potential predictors that may influence subjective outcomes. O'Donoghue *et al.* (2010) suggests that given that participants were interviewed close to their discharge, it is conceivable that they may have been reluctant to give more negative views in case it interfered with their discharge and this may account for the high percentage of people who judged their admission as necessary.

O'Donoghue *et al.* (2011) reassessed people's view of the necessity of detention at one year follow-up. However, 12% of people changed their view with only 60% now reporting that their admission was necessary. At one year follow-up O'Donoghue *et al.* (2011) again found that insight was associated with a view that detention was necessary, as measured by the Birchwood Insight Scale (Birchwood *et al.* 1994). The strengths of the study include the fact that follow-up interviews were not carried out by researchers involved in the person's care. This study also reported on the difference between people who were and were not followed up and used standardised instruments to assess constructs.

Priebe *et al.* (2010) undertook a European retrospective study to determine the percentage of people who felt that their detention was necessary. People were assessed at one (n=1809), and three months (n=1613) across 11 European countries using an 11 point Likert-type scale to record people's responses to the question: "Today, do you find it right or wrong that you were admitted to hospital?". It was found that across

countries between 39% and 71% felt that the admission was necessary at one month, and this increased to between 46% and 86% after 3 months. In addition, Priebe *et al.* (2010) found that people from the UK, where views were most negative, had statistically significant less favourable views than those in Greece, Bulgaria, Spain, Germany, Italy, the Czech Republic and Slovakia. In contrast, people's views in Germany, Italy, Czech Republic and Slovakia were significantly more positive than in all other sites. A limitation of this study is that data was not available on the difference between people who were and were not followed up across study sites.

Priebe *et al.* (2010) used a regression analysis to determine the factors associated with perceived necessity. In the multivariate analysis it was found that males, those living with others and those without a diagnosis of schizophrenia were more likely to perceive their admission as necessary. The contradictory finding that living alone is associated with positive views in one study and negative views in another is inconsistent and needs further investigation. This study is significant in that it is the biggest ever study of people's views of detention over many countries.

A study by Katsakou *et al.* (2012) used grounded theory methods to analyse data on people's retrospective views on the necessity of their detention. Fifty-nine in-depth semi-structured interviews were conducted to explore people's views as to why they felt that their detention was necessary or not. Three groups were identified: those who thought admission was right, those who viewed it as wrong, or those who were ambivalent. Whilst there was commonality across the groups in terms of most feeling mentally unwell prior to admission and feeling out of control during admission, there was also variance in their opinion. Those who felt their admission was right (necessary) were more likely to say that hospitals offered a place to receive treatment, a place to avoid further harm and was a place of safety. Those who felt their admission was wrong (unnecessary) felt their problems could have been addressed using less coercive interventions. They viewed involuntary admission as an unjust infringement of their autonomy and that could cause a permanent threat to their autonomy. Those with ambivalent views of their admission felt they needed acute treatment but felt it might be managed in a less coercive community intervention or shorter voluntary stay. Service user researchers were involved in interviewing participants. This is an important study as it is one of the first qualitative studies known to be undertaken to

explore people's views on why they view their detention as necessary or unnecessary, as well as the fact that a large number of people were interviewed.

#### **2.4.4 Research Quality**

Across studies there was considerable variation in the times that assessments were carried out and, as a result, comparison is difficult. A limitation of some of the studies is that it is conceivable that memory bias may affect people's views, given that people were interviewed about their views sometimes up to a year or more after the detention. In addition, people's views of admission were assessed using a descriptive survey with a single item question related to the belief that admission was or was not necessary. Therefore, the lack of a standardised item question across studies made comparisons difficult.

#### **2.4.5 Summary of Clinical, Service-Related and Subjective Outcomes of Detention**

Across studies, a number of outcomes are associated with people detained including: lower levels of functioning and higher suicide rates, a moderate improvement on symptom level and functioning, and a decrease in social functioning. In addition, poorer adherence to medication, having a longer length of stay in hospital and having a greater readmission risk were some of the service-related outcomes associated with detention. Furthermore, people detained are more likely than those voluntarily admitted to perceive their admission as unnecessary; however, between 39% and 75% deemed their admission as necessary. The assumption that people report more positive views after longer periods of time is now questioned as O'Donoghue *et al.*'s (2011) study suggests people's perceptions of necessity of their admission is not stable over time and that other factors apart from time may influence people's perceptions. Indeed, there seems to be an initial increase in perception of necessity up to three months and then a decline, with 40% of people interviewed after one year considering their original detention necessary (Priebe *et al.* 2009). Notwithstanding, a substantial proportion of people view their admission ambivalently, or indeed negatively at post discharge follow-up (Katsakou *et al.* 2010). Researchers should then pay attention to specific, sub-outcomes

and not just more global outcomes, as this may well prove fruitful in understanding people's views.

## **2.5 People's Views of Detention**

This section explores people's views of detention and is comprised of two subareas: people's satisfaction with detention and treatment and the factors associated with treatment satisfaction; and people's experiences of detention and treatment.

### **2.5.1 People's Satisfaction with Detention and Treatment and the Factors associated with Treatment Satisfaction**

It has been consistently found that detained people express low levels of treatment satisfaction (Katsakou & Priebe 2006; Kallert *et al.* 2008; Strauss *et al.* 2013; Smith *et al.* 2014). Across studies, there is an association between lower levels of treatment satisfaction and higher levels of subsequent involuntary readmission in that lower treatment satisfaction is associated with higher levels of involuntary readmission (Kallert *et al.* 2008; Priebe *et al.* 2009; O'Donoghue *et al.* 2011; van der Post, 2014). Furthermore, some researchers have investigated the factors associated with treatment satisfaction (Kallert *et al.* 2008; Priebe *et al.* 2009; O'Donoghue *et al.* 2010; Katsakou *et al.* 2010; Priebe *et al.* 2010; Savill *et al.* 2012; Smith *et al.* 2014). People who are detained are more likely to experience higher levels of perceived coercion and objective coercion (seclusion, restraint, and forcible administration of intramuscular medications) during detention, and some of these practices have been associated with lower treatment satisfaction (Katsakou *et al.* 2010; Strauss *et al.* 2013; Smith *et al.* 2014).

In Katsakou & Priebe's (2006) systematic review, three studies were included that investigated satisfaction (two from Sweden and one from the USA) and eight studies were included that assessed whether people benefitted from hospitalisation. Using a single-item question to assess satisfaction, the researchers found that 46–73% of people reported to be satisfied with the treatment they received. Of the eight studies included in assessing the benefits of hospitalisation, it was found that 39–81% felt that they benefitted from hospitalisation; however, 6–33% felt harmed by their treatment. A

limitation of the studies included in the review was that there was no standardised instrument used to measure satisfaction; therefore, comparison across studies is problematic. While this study examines satisfaction at one and three months, there is some evidence that satisfaction may reduce over longer periods of time.

While between 46% and 73% of the people in these studies are satisfied (Katsakou & Priebe, 2006), across these reviewed studies there are large numbers who remained dissatisfied. In some cases, this number is as large as 54%. This clearly highlights the need to examine the reasons why some people did not view their detention and treatment as satisfactory.

In Kallert *et al.*'s (2008) review, five studies were included on satisfaction which used both standardised and non-standardised instruments to assess satisfaction. They found that when detained and voluntarily admitted people were compared, there were significantly lower levels of satisfaction amongst people in the detained group. On further comparison, people detained were more likely to report that the staff-patient relationship was unsatisfactory ( $p < .01$ ). The limitations of the studies included in the review pertain to the broad range of follow-up periods (varying from discharge to 15 months) and the lack of a consistent standardised instrument to assess satisfaction, both of which makes comparison difficult. Kallert *et al.*'s (2008) review concluded that there was no evidence to conclude that people detained showed a homogenous pattern of worse clinical outcomes. However, people detained expressed high level of treatment dissatisfaction with staff care – an area that could be therapeutically influenced. Therefore, by placing greater emphasis on the relationship between staff and patient treatment, satisfaction could be improved.

In the UK, Katsakou *et al.* (2010) undertook a prospective study measuring detained people's satisfaction with treatment at different timescales: one week after admission, one month after admission, three months after admission and one year after admission. A sample of 778 people was recruited across 67 acute units. The means scores on the Client's Assessment of Treatment Scale (Priebe *et al.* 1995) (on a scale ranging from 0–10), found that there was a significant improvement in satisfaction from admission (5.5) to follow-up: at one month (5.8), at three months (6.03), and at one year (5.8). People were most satisfied at three months. Researchers also examined coercion

(perceived and documented), socio-demographic, clinical factors and clinical improvement as potential factors that may be associated with treatment satisfaction. They found that those who perceived less coercion, as measured by the MacArthur Perceived Coercion Scale (Gardner *et al.* 1993) and the Coercion Ladder (Hoyer *et al.* 2002), and those who demonstrated symptom improvement, as measured by Brief Psychiatric Rating Scale (Lukoff *et al.* 1986), were more satisfied overall. An important finding was that there was no association found between coercive measures documented in the medical notes (restraint, forced medication or seclusion) and satisfaction. It is conceivable that, given the attrition rate of 49% (396 interviewed at one year follow-up) over the course of the study, those who were more satisfied may have been more likely to participate in the study and as such this is a potential weakness/bias. A key strength of this study is that a valid and reliable instrument was used to assess satisfaction, which increased the methodological soundness of the findings.

In Amsterdam, van der Post *et al.* (2013) undertook a prospective study to investigate the association between opinions about prior psychiatric treatment, insight, service engagement and the risk of involuntary readmissions in a sample of 252 people subject to involuntary admission. Using the Verona Service Satisfaction Scale (Ruggeri *et al.* 2000), the Birchwood Insight Scale (Birchwood *et al.* 1994) and the Service Engagement Scale (Tait *et al.* 2003), it was found that people who were more satisfied with prior treatment were significantly less likely to be involuntary readmitted than people who were dissatisfied. This study is important as it focuses attention on satisfaction as an important outcome in reducing involuntary readmission. Key strengths of this study are the use of a standardised instrument to assess satisfaction, the large sample size and the substantial follow-up period (two years).

Savill *et al.* (2012) conducted a prospective study examining the types of symptoms that may influence people's appraisal of their hospital treatment. Researchers interviewed 2,105 people with a diagnosis of schizophrenia (n = 1530, detained), (n = 575, voluntary), within the first week following their hospitalisation. The Client's Assessment of Treatment Scale (Priebe *et al.* 1995) was used to measure appraisal, while the Brief Psychiatric Rating Scale (Lukoff *et al.* 1986) was used to measure symptoms. When those who were detained were compared with people who were

voluntarily admitted, it was found that more negative appraisals were apparent among the former, who also exhibited manic symptoms. This study is significant as it identifies the specific types of symptoms that influence initial negative views of treatment.

In the USA, Strauss *et al.* (2013) conducted a prospective study to identify whether objective coercion (prior/current detention, seclusion and restraint) or subjective coercion (perceived coercion) influenced satisfaction with care. Two hundred and forty people (15% detained and 85% voluntarily admitted) were interviewed when deemed psychiatrically stable, as close to planned discharge as possible. Satisfaction with care was assessed by the Perception of Care survey (Eisen *et al.* 2002), current involuntary admission status was obtained from notes, history of coercive treatment experience was assessed by adapted items from the service utilization section of the Duke Epidemiologic Catchment Area Study, (Blaser *et al.* 1985), and perceived coercion was assessed by the Admission Experience Survey (Gardner *et al.* 1993). It was found that both involuntary admission and perceived coercion were associated with lower satisfaction scores, which is consistent with Katsakou *et al.*'s. (2010) study. However, a drawback of the study may be in the conceivable fact that interviewing people close to their discharge may affect the reliability of findings, given the fact that they may not wish to say anything that might jeopardise their discharge.

More recently in Ireland, Smith *et al.* (2014) conducted a prospective study to measure satisfaction, using the Client Satisfaction Questionnaire (Attkisson & Greenfield, 2004) one week prior to discharge. The study compared 129 people that were voluntary admitted ( $n = 73$ ) with those detained ( $n = 56$ ) across three mental health services. The scale categorised four levels of satisfaction 'poor' (score 8–13), 'fair' (score 14–19), 'good' (score 20–25) and 'excellent' (score 26–32). It was found that whilst satisfaction within the voluntary cohort was excellent (CSQ-8 mean score = 26), which is consistent with other studies, people detained were less satisfied (CSQ-8 mean score = 22) ( $p = <0.001$ ). Using a logistic regression, they also found that those people with lower levels of procedural justice (as measured by the Mac Arthur Admission Experience interview, Gardner *et al.* 1993) were less satisfied. However, the therapeutic relationship (as measured by the working alliance inventory, Horvath & Greenberg, 1989), improved insight (as measured by the Birchwood Insight Scale, Birchwood *et al.* 1994) and functioning (as measured by Global Assessment of Functioning, American Psychiatric

Association, 1994) were associated with greater levels of satisfaction (as measured by the Client Satisfaction Questionnaire Attkisson & Greenfield, 2004). In contrast to Katsakou *et al.*'s (2010) findings, Smith *et al.* (2014) found that those who experienced objective coercion (seclusion) as opposed to perceived coercion were less satisfied. What is important about this study is that it investigated a multitude of potential predictors that may influence satisfaction and it is one of the first conducted in Ireland that used a standardised instrument to measure satisfaction.

### **2.5.2 People's Experiences of Detention and Treatment**

Two reviews have investigated people's experiences of detention and treatment (Katsakou & Priebe, 2007; van den Hoof & Goossensen, 2014). The studies reviewed used either in-depth semi-structured interviews, a narrative method or questionnaires and found a mix of both negative and positive experiences. These studies are significant as they focus on subjective evaluations of experiences rather than more objective measures.

Katsakou & Priebe (2007) undertook a review of studies that explored people's experiences of the detention and treatment. Across four databases and having personal correspondence with service user researchers while using specified inclusion and exclusion criteria, this review identified five qualitative studies out of a possible 188 papers that met the inclusion criteria. Of the five papers selected, two originated in Sweden and three in the UK. The researchers synthesized the themes of these studies and found that they focused on three key areas: (1) 'perception of autonomy and of participation in decision for treatment'; (2) 'the feeling of whether or not they were being cared for, listened to or respected'; and (3) the resulting effect this has on their 'sense of identity'. Implicit within these themes were examples of both positive and negative experiences.

The studies reviewed used one of three methodologies: a phenomenological hermeneutic method; a grounded theory or grounded theory approach; and content analysis, thematic analysis and narrative analysis. Not only did they include peer-reviewed studies, but also an unpublished report (access from service user researchers). The sample sizes varied from 4 to 18 participants, and none of the interviewees were

involved in the person's care. Only two of the studies documented how many people agreed to participate in the studies and this ranged from 28% to 58%. In four of the five studies, there was a lack of reporting of the steps involved in data analysis, which makes the quality of the studies difficult to determine. Furthermore, Katsakou & Priebe (2007) state that a limitation of this review's findings was the inability to elicit whether the negative and positive aspects of people's experience were pervasive – relating specifically to each person or being held by certain client groups.

More recently, van den Hoof & Goossensen (2014) undertook a review of 22 qualitative and quantitative studies published on detention from an 'inside' (respondents experience) and 'outside' perspective (description from an external point of view of the behaviour and the situation) of the person. Researchers systematically searched the literature across five electronic databases. Out of a possible 1,216 papers, 22 were selected using inclusion and exclusion criteria. The guidelines of Preferred Reporting Items for Systematic reviews and Meta-Analyses (Liberati *et al.* 2009), were used for the reporting of the review. Semi-structured interviews, questionnaires or a combination of both were used as methods of eliciting experiences. Across the inside and outside perspectives, the researchers synthesis of themes mainly centred on issues concerned with 'not being listened to or listened to'. Similar to Katsakou & Priebe's (2006) review, there was a mix of negative and positive experiences.

Studies reviewed under the inside perspective were themed as either 'powerless' or 'humiliation'. Implicit within the theme of 'powerless' was the feelings of not being understood or listened to, not receiving sufficient information, not being involved in decisions, being ignored, and feeling helpless and out of control during hospitalisation. Implicit within the theme of 'humiliation' was the feeling of not being treated as a human being, being dependent on health care professionals, feeling like an inferior, and not being involved in decisions, which engendered feelings of disrespect and helplessness. The positive experiences included being 'guarded' and 'seen' which included being protected, cared for, and respected.

Studies reviewed under the outsider's perspective consisted of themes that focused on the experience during the process of people's admission such as 'pressure', 'loss of autonomy' and 'procedural justice'. Pressure consists of both negative and positive

pressures; across these studies, the dimensions of negative pressure included the experience of threats, giving orders, deception and experience of force, while the dimensions of positive pressure include the experience of persuasion rather than force, promises and inducements.

The dimensions of loss of autonomy include the experience of loss of liberty, limited possibilities of moving, and being dominated by others. The dimensions of procedural justice include the experience of fairness, that people's opinions are heard and taken on board, and that they themselves can participate in the admission decision. Implicit within this was effective interpersonal communication during the involuntary admission process. A key strength of this review is that it included qualitative and quantitative methodologies involving different aspects of the involuntary detention experience, such as the admission process. This review is at risk of publication bias in view of the fact that it limited its search to articles published in English.

Seed (2014) undertook a meta-synthesis of qualitative studies on people's experience of detention, using a methodology developed by Noblit & Hare (1988). The meta-synthesis revealed seven themes; four of these dealt with 'Sanctuary', 'Loss', 'I left terrified' and 'Fluctuating emotions', while the remaining three themes (consisting of both internal and external factors) comprised 'A continuum of person-centred practice', 'You're disempowering me' and 'Intra-psychic coping' which were seen as mediators of the aforementioned themes. 'Sanctuary' describes the feelings of protection and perspective that came from detention. 'Loss' describes the feelings of being deprived of independence and the loss of identity that stemmed from detention. 'I felt terrified' describes the fear associated with (1) encounters with professionals during the process of their detention, and (2) being in hospital. 'Fluctuating emotions' describes the varying emotional reactions (i.e. anger) associated with coming to terms and dealing with detention. In addition, the external factors 'A continuum of person-centred practice', 'You're disempowering me' and the internal factor 'Intra-psychic coping' mediated the feelings mentioned above. 'A continuum of person-centred practice' describes both the positive and negative interactions participants had with professionals and how this contributed to a feeling of sanctuary or to a feeling of loss. Across the continuum, examples included collaboration versus non-collaboration, caring versus non-caring and being treated like a human being versus not being treated like a human

being. 'You're disempowering me' describes the power yielding practices that professionals exerted on people which contributed to the feeling of 'I felt terrified', examples of which included being forced to take medication and having to comply with rules of the hospital. 'Intra-psychic coping' describes the coping mechanisms that people employed to deal with their detention. Examples of these included 'fighting back', 'acceptance', 'developing a model patient role' and 'avoidance'.

The literature was searched across nine databases using inclusion and exclusion criteria. Fifteen studies were identified, and the quality of the studies was assessed by an appraisal tool developed by Walsh & Downe (2006). Although many studies varied on their methodological quality, a key strength of this study was the documentation of the steps involved in determining the quality of the studies included.

Using a meta-ethnography design, Wyder *et al.* (2013) employed the recovery perspective as a framework to synthesise the themes of qualitative studies on people's experience of detention. The themes of these studies were now centred on factors that enhance and hinder recovery during detention. Wyder *et al.* (2013) identified seven factors that have an impact on recovery during detention: 'Having input into own treatment'; 'Shared humanity'; 'Power imbalance/balance'; 'Freedom and control'; 'In/ability to incorporate the episode/experience'; 'Treatment factors' and 'Importance of relationships'. 'Having input into treatment' describes the extent to which people felt that they participated in their treatment. 'Shared humanity' describes the extent to which people felt that they were treated like a human being. 'Power imbalance/balance' describes how far people felt that they had information about their reasons for their detention, their rights and their treatment. 'Freedom and control' describes the extent to which people experienced a sense of autonomy and restriction. 'In/ability to incorporate the episode/experience' measures how far people were able to integrate their detention into their lives. 'Treatment factors' describes the extent to which people perceived their treatment as beneficial. Lastly the 'Importance of relationships' describes the extent to which people felt supported by staff or fellow patients.

Across studies, there was an expressed need for some semblance of control to be returned to people as soon as possible. Wyder *et al.* (2013) states that the concept of control can be seen as a gradual concept with many different layers and one which can

be enhanced by being treated respectfully, by being given choice, by being given information about hospital and treatment and by being informed of one's rights. A systematic search was conducted over five databases; however, across the seven studies reviewed, nobody over the age of 65 participated in the interviews.

More recent studies have been published that have not been included in the reviews mentioned (Chambers *et al.* 2014; Loft & Lavender, 2015; Seed *et al.* 2015). In the UK, Chambers *et al.* (2014) conducted a thematic analysis of people's experiences of how their dignity and respect was upheld or not during detention. Researchers interviewed 19 people using semi-structured interviews (12 male and 7 females) whilst they were under the care of the UK MHA 2007. Thematic analysis revealed five themes that impacted on people's feeling of not being respected: not being 'heard' by staff, a lack of involvement in decision-making regarding their care, a lack of information about their treatment plans (particularly medication), lack of access to more talking therapies and therapeutic engagement, and the physical setting and lack of daily activity to alleviate boredom. The people to be interviewed were selected by the manager of the ward and CP and, as a result, this may have introduced selection bias. Nobody over the age of 53 was interviewed. Trained service user researchers (who had their own experience of being detained) conducted the interviews, which increased the likelihood that participants would be willing to openly convey their experiences as opposed to having been interviewed by a professional involved in clinical care. In addition, a key strength of this study pertains to the fact that people were interviewed during their detention stay, which enabled the interviewer to capture the acuity of people's feelings at the time and decrease recall bias.

More recently, Loft & Lavender (2015) conducted a grounded theory on detention experiences of people with a diagnosis of psychosis in the UK. Seventeen participants, (eight service users, and nine psychiatrists) were interviewed. Using Glaser & Strauss' (1967) approach, the core category was identified as 'A disturbing journey to and from detention'. This consisted of five higher order categories: 'Deteriorating mental health of service user'; 'Professionals remove service user's liberty'; 'Managing mental health' (in hospital), 'Regaining liberty' and 'Recovery in the community'. 'Deteriorating mental health of service user' refers to service users' and psychiatrists' interpretation of the extent to which service users' mental wellbeing was affected and

factors associated with such deterioration. 'Professionals remove service user's liberty' refers to the point at which the service users experienced '*overpowering professional presence*' and '*powerless service users reactions*' associated with the activation of involuntary admission and the '*degree of transfer distress*'. 'Managing mental health' refers to the '*limited freedom and independence*' and '*limited cognitive stimulation*' (in hospital) and the associated impact on service users' mental wellbeing, which led service users to adhere to medication-focused treatment. 'Regaining liberty' refers to service users' relief and psychiatrists' concerns at the prospect of discharge. Lastly '*recovery in the community*' refers to services users '*experiential learning from admission*' the '*negative post-admission feelings*' and the '*experiencing of discrimination*'.

This grounded theory study was conducted in a homogenous sample of eight people with psychosis. Nobody over the age of 65 was interviewed and there was no mention of theoretical sampling being used. It is of concern that only 17 people were interviewed, given that the recommended number for a grounded theory study is between 20 and 30 (Creswell, 2013), and this may have impacted on the extent to which theoretical saturation was possible.

Seed *et al.* (2015) conducted a constructivist grounded theory on detention experiences of people with a diagnosis of anorexia nervosa. Semi-structured interviews were conducted with 12 people. The analysis revealed four categories: 'the battle', 'the bubble', 'stepping out of the bubble' and 'the anorexic self'. This study highlighted that people initially react by battling with professionals, progressing to a bubble, where people feel some relief from hospitalisation and where they alter their reactions to treatment. Across the trajectory of experience was the attempt to conceptualise or reconceptualise the self-termed 'anorexic self'. People were interviewed whilst they were detained, or discharged from the MHA 2007.

A key strength of this study is that a clear audit trail for the procedures of grounded theory was provided and constant comparative analysis and alterations of the interview schedule were apparent. This study was conducted amongst a homogenous sample (i.e. people diagnosed with anorexia nervosa). It is of concern, however, that there is no documentation of theoretical sampling in this grounded theory. A further limitation of

this study was the fact that only 12 interviews were conducted and Charmaz (2006) considers that 25 participants constitute a small grounded theory study. In addition, 8 of the 12 interviews were conducted over the telephone and the fact that some people were interviewed between one and 14 years after detention may introduce recall bias.

In Switzerland, Rusch *et al.* (2014) conducted a prospective study to determine the predictors of self-stigma and empowerment following detention. The study was conducted amongst 186 participants who had a recent detention across four hospitals. Researchers assessed shame and self-contempt using a 9-point Likert-type scale to record people's response to the following statements: 'I felt shame to receive involuntary psychiatric treatment' and 'I felt self-contempt to receive involuntary psychiatric treatment'. In addition, stigma-related stress was assessed by the stress-coping model of mental illness stigma (Rusch *et al.* 2009). Using multiple regressions, it was found that more self-stigma (as assessed by the Internalized Stigma of Mental Illness Inventory, Ritsher *et al.* 2003) was associated with higher levels of shame, self-contempt and stigma stress. In addition, empowerment (as assessed by the Empowerment Scale, Rogers *et al.* 1997) was associated with lower scores on self-contempt and stigma stress. Increased self-stigma and reduced empowerment were, in turn, associated with a poorer quality of life (as assessed by WHO Quality of Life Assessment Scale, WHOQOL Group, 1988) and poorer self-esteem (as assessed by self-esteem inventory, Rosenberg, 1965). These factors were predictive even when clinical (psychiatric symptoms) and socio-demographic variables (number of past detentions) were controlled for. Rusch's study is important given the lack of quantitative studies on the emotional and cognitive reactions to detention.

### **2.5.3 Summary of People's Satisfaction and Experiences of Detention**

Across studies, it is shown that satisfaction improves as time progresses, with people being most satisfied three months after detention. Ten factors were identified that were associated with treatment satisfaction. Treatment satisfaction post-discharge was associated with people who reported experiencing higher level of procedural justice, had a better therapeutic relationship, had improved insight and functioning, had shorter involuntary stays, had initial poorer social functioning and higher initial treatment satisfaction, and who experienced less coercion. Notwithstanding, a substantial

proportion of people view their admission ambivalently, or indeed negatively at post-discharge follow-up. Poorer treatment satisfaction post-discharge views have been found to be associated with having manic symptoms in the context of schizophrenia and having experienced seclusion. Furthermore, studies on people's experiences on detention and treatment show a complex picture of both positive and negative experiences. Experiences spanned from feelings of not being cared for to feelings of being cared for; there was mention of loss of autonomy and feeling devalued. On the other hand, some people mentioned that had respect for autonomy and acknowledged the treatment benefits associated with care. Associated with some of these experiences was a feeling of powerlessness. Across the studies, the importance of interpersonal communication and interaction was highlighted. In more recent studies, the effect on people's sense of identity and integrating the illness experience, feeling stigmatised have been identified as being important.

## **Chapter 3: Research Framework**

### **3.1 Introduction**

Grounded Theory was selected to guide study design and implementation. Creswell (2009) outlined three components of a research framework: (1) the research paradigm, (2) the research strategy, and (3) the data collection method. Using Creswell's (2009) components as a base for the research framework, this chapter will outline the research paradigms, research strategies and the data collection methods available in the context of Grounded Theory. The first section provides an overview of research paradigms and the most suitable paradigm to addressing the research question. The second section provides an overview of Grounded Theory. The third section provides an overview of central tenets of Grounded Theory. The final sections outline the data collection method, criteria for maintaining rigour, and ethical considerations pertinent to this research. The chapter begins by providing an outline of research paradigms, a rationale for the choice of paradigm, and then a rationale for the selection of the Grounded Theory as the methodology.

### **3.2 Research Paradigms**

When conducting research, the researcher is guided by philosophical assumptions, goals and purposes of a mode of inquiry known as a research paradigm (Dempsey & Dempsey, 2000). The following section will trace the development and provide an overview of the differences between positivism and constructionism.

#### **3.2.1 Positivism**

Positivism originated in the nineteenth century and was founded on the premise that social relations, behaviours and events can be studied scientifically and objectively by methods derived from the natural sciences. Within positivism, theory is established deductively through formal statistical control and prediction and the testing of hypotheses (Lincoln & Guba, 1985). The goal of the positivist approach is to discover truth through verification and replication of findings (Clark, 1998; Denzin & Lincoln, 2000). This paradigm emphasises that science could only be based on clearly defined hypothesis. The researcher using this paradigm strives for objectivity and uses

measurement to test hypotheses (Young, 2008). Relying on the hypothetico-deductive method, positivism focuses on efforts to verify a priori hypothesis. Replicated findings are considered 'true' and enhance theory verification evidence. Hesse (1980) states that the positivism paradigm is reductionist and deterministic.

### **3.2.2 Constructivism**

Constructivists hold that there are many instances where the positivist principles could not apply because people construct their own realities based upon their personal construction of the world. This view of science is referred to as the 'constructivism' paradigm, the premise of which is that meaning is not created independently of the mind, it is constructed (Crotty, 2003). The assumption of this paradigm is that knowledge is constructed through our interpretation and understanding and is located within the cultures we have been exposed to – as a result, knowledge is constantly changing. Narrative information (which is the product of the interaction between the researcher and the participant) is analysed for meaning. From this interaction process findings are created and, unlike the positivist paradigm, no emphasis is placed on generalisability or the researcher remaining objective. Proponents of constructivism tend to focus on the dynamic, holistic and individual aspects of phenomena and attempt to capture these in their entirety (Polit *et al.* 2001). Constructivists most often embrace naturalistic designs chiefly qualitative methods – given their stance on the centrality of intense research participant interaction and on the need to be immersed over longer periods of time in the participants' world. Naturalistic inquiry leads to qualitative research methods such as in depth face to face interviewing and participant observation.

Examples of two approaches to constructionism are: (1) Cognitive constructivism (Heap, 1995), i.e. the individual experience of constructivism and (2) social constructivism (Crotty, 1998). Constructionism or cognitive constructionism focuses on understanding the actions and meanings of individuals. The distinguishing feature between the two approaches is the high relevance that social constructivism places on culture. From a cognitive constructionism perspective, meaning is not passively received or discovered through the senses, but actively constructed by the cognisant person as they engage with the world in a dynamic manner (Ernest, 1995), and emphasis is placed on the role of the individual's mind and the individual cognitive mental

operations and judgments in the construction of a meaningful reality (Heap, 1995; Schwandt, 2003). Social constructivism differs to cognitive constructivism in that it places emphasis on the role of culture and also embedded within this is a more critical stance. Constructivists caution us to interpret constructionism broadly, in that there is no single truth but multiple representations of social phenomenon.

### **3.2.3 Rationale for Choice of Research Paradigm**

Attention was given to outlining each of the paradigms in an attempt to ascertain which one was best suited to answering the research question. The aim of the research was very specific and concerned understanding people's experience of being involuntarily admitted under the MHA (2001). There were two distinct research paradigms that were considered, namely: positivism and constructionism.

A weakness of the positivist paradigm is that it is concerned only with the tangible and quantifiable and their proponents assumed that natural science could be formulated to explain behaviour and the context in which the experience occurs. As the aim of this study was to conceptualise the experience of being involuntarily admitted and the processes behind people's experiences, the positivist paradigm was rejected because of its limitations in exploring human perceptions and the focus on context stripping (Schumacher & Gortner, 1992). The positivism paradigm would not allow the people's voice to be heard or permit concerns specific to the participant to emerge, nor would they enable or permit contextual understanding of the experience.

After outlining and distinguishing between each of the paradigms, constructivism was deemed to be the most suitable because of its capacity to gain an understanding of people's experience of being involuntarily admitted. In addition, the constructivism paradigm allows for the exploration of contextual factors that may be impacting or fundamental to understanding people's experience. The aim of this study was to develop a theoretical understanding of people's experience of being involuntarily admitted and denying the contextualised experiences diminishes the significance of symbolic, social, historical, and cultural aspects that play an important part of a person's experience. For this reason, it was a good fit for this study as it enabled an

understanding of the processes people use to adapt to the situation, their social interactions with professionals and people's perception of their 'social world'.

### **3.3. Rationale for Choice of Research Strategy**

The research strategy is a component of the research framework. There are two research strategies available to the research, namely quantitative and qualitative research. Within the quantitative strategy, the focus is usually on predication in areas where there is already a body of knowledge; Erzberger & Prein (1997) state that quantitative research is most useful when the aim is to test hypotheses or theories and generalise from data. Within the qualitative strategy, the focus is usually on description and on understanding the action and meanings of individuals. The goal of qualitative research is to provide a research methodology for understanding the complex world of lived experience from the point of view of those who live in it (Schwandt, 1994). Bryman (1998) suggests that it is counterproductive to argue regarding the strengths and weaknesses of research strategies. Qualitative and quantitative approaches are both valid to the advancement of knowledge when used appropriately. The aim of the study was to understand the experience of being subject to an involuntary admission and/or detained and, as such, the researcher was not so much interested in the causes of phenomenon as with understanding the phenomena itself. Experiences are complex, and some behaviours and events can be reduced for research outcomes while others cannot. Therefore, what is needed is a strategy that focuses on understanding the actions and meanings of participants and as such involves participants actively in this regard. Qualitative research offers the opportunity for participants to actively partake in a process that inquires and is interested in their experiences of being subject to an involuntary admission and/or detention. It gives participants the opportunity to tell their story in their own words and in their own time. A qualitative strategy was chosen to gain a richer perspective and understanding of these experiences.

### **3.4. Rationale for Choosing Grounded Theory**

Grounded Theory differs from other qualitative approaches in that its focus is on understanding the actions and meaning of participants and the processes involved in what is happening for participants rather than just a description of what is happening (Strauss & Corbin, 1998a; Corbin & Strauss, 2008). While description is possible in

Grounded Theory, its ultimate potential lies in its ability to develop and conceptualise an explanatory theory of what is going on for participants and how they go about resolving their main concern. Therefore, the difference lies in that the focus is not on providing a description of the data but developing the ideas that emerge from the data. In this way, Glaser (2001) states that the analyst conceptually transcends the data and develops ideas on a level of generality higher in conceptual abstraction than the material being analysed. Unlike other common methods of qualitative data analysis (content analysis and thematic analysis), which are descriptive in nature, Grounded Theory forms connections (categories and properties) that make linkages between each category in a way that the other data analysis does not. Grounded Theory is considered a suitable methodology where the focus is to explore social problems and situations to which people have to adapt (Corbin & Strauss, 2008), and exploration of how participants resolve particular problems in a particular area (Glaser, 2001).

Grounded Theory was an appropriate methodology in this case because of its emphasis on developing a theoretical understanding of the substantive area of involuntary admission. It enabled people's main concern to evolve from the data and shows how participants went about resolving their main concern. In addition, it contributed to understanding both the psychological and social processes that interplay in contributing to the people's experiences as well as the psychosocial reactions involved. By taking note of patterns and commonality in phenomena, it is possible to build up a body of knowledge.

### **3.5 Grounded Theory**

This section provides an overview of Grounded Theory including its philosophical underpinnings. It then describes the three versions of Grounded Theory, namely: Classic, Straussian and Constructivist Grounded Theory. Attention is then given to the decisional process that was involved in choosing the most suitable version of this approach in relation to this study, outlining four reasons for choosing the Straussian version (Strauss & Corbin, 1990; Strauss & Corbin, 1998a; Corbin & Strauss, 2008) over the classic approach.

### **3.5.1 History and Aims of Grounded Theory**

The aim of Grounded Theory is to generate theory from data using systematic and concurrent data collection and analysis (Glaser & Strauss, 1967; Strauss & Corbin, 1998a; Strauss & Corbin 1998b; Corbin & Strauss, 2008). Barney Glaser and Anselm Strauss founded Grounded Theory as a methodology in the 1960s, the origins of which developed as a result of Glaser and Strauss's research with dying patients which culminated in the publishing of the co-authored books *Awareness of Dying* (1965) and the *Discovery of Grounded Theory: Strategies for Qualitative Research* (1967). Grounded Theory has its roots in sociological research approaches. At the time there was concern about the lack of rigor in qualitative approaches. The drive at this time was to move away from just theory verification and to strengthen the focus on theory generation where the theory is generated and emerges from the data itself. Therefore, Glaser and Strauss endorsed a more systematic approach where the theory generation and verification occurred simultaneously. Consequently, the techniques of theoretical sampling and the constant comparative process were developed, both of which form the hallmark of Grounded Theory (Glaser & Strauss, 1967).

A formal theory or a substantive theory can be generated using Grounded Theory (Glaser & Strauss, 1967), each of which are mid-range theories in that they are considered on a continuum between working hypotheses or an inclusive grand theory (Glaser & Strauss, 1967). The emphasis on formal theory is a conceptual level of inquiry such as stigma, while the emphasis on substantive theory is on a substantive or empirical area of inquiry such as an aspect of patient care in nursing.

### **3.5.2 Philosophical Underpinnings**

Grounded Theory is thought by many to originate from symbolic interactionism, which was influenced by the thinking of Blumer (Heath & Cowley, 2004; Jeon, 2004; Stern 2007; Bryant, 2009). Symbolic interactionism focuses on how persons view their circumstances, and inherent within this are the symbols that people use to convey meanings (Baker *et al.* 1992). Blumer (1969) and Mead (1934) state that the basis of symbolic interactionism rests on the belief that people develop their view of self, context and others through social interaction. Blumer's (1969) assumptions for symbolic interactionism are: (1) that humans act towards things (persons, situations) on

the basis of meanings that those things have for them; (2) the meaning of those things is derived from social interactions with others; and (3) the individual modifies these meanings through an interpretative process.

According to Baker *et al.* (1992), human behaviour is a result of an interpretive process in which people assign meaning to the events and situations in which they encounter. Symbolic interactionists believe that the meaning of the event must be understood from the participant's perspective and behaviour must be understood at the symbolic and behavioural levels and examined in interaction (Chenitz, 1986).

Social interactions and the sociocultural environment in which they exist also influence interpretations of a situation (Benoliel, 1996). According to Hutchinson (1993), people make sense of their environment, and although their world may appear disordered or nonsensical to observers, she noted that people sharing common circumstances experience shared meanings and behaviours that constitute the substance of Grounded Theory. Charmaz (2006) states that research using a symbolic interaction theoretical perspective views the individuals as being active in their creation of understanding.

### **3.5.3 The Development of Grounded Theory**

This section describes three versions of Grounded Theory namely: Classical, Straussian and Constructivist Grounded Theory. Strauss' views differed from those of Glaser as regards how Grounded Theory should be developed. This resulted in the publishing of more editions of their book, the latest of which was edited in 2015. Strauss's diverging views related primarily to his belief that data analysis required a much more structured approach, while Glaser's remains true to the original focus on data analysis. While Glaser proposed two types of coding, substantive and theoretical, Strauss proposed three: open, axial and selective coding. Straussian Grounded Theory provides more explicit strategies to data analysis (Strauss & Corbin 1998a; 1990; Corbin & Strauss, 2008; Corbin & Strauss, 2015), which Glaser (1992, p. 5) condemns as leading to or being "forced, full, conceptual description". However, future editions (Strauss & Corbin, 1998a; Corbin & Strauss, 2008; Corbin & Strauss, 2015) suggest that the strategies they propose were to be used flexibly and were developed merely to assist in

the steps involved in data analysis. As a result, it is evident that Straussian Grounded Theory has continued to evolve.

The second difference in the Straussian over Classic Grounded Theory relates to whether verification is a principle of Grounded Theory or not. According to Strauss and Corbin (1990), induction, deduction and verification are central to Grounded Theory whereas Glaser (1992) claims that induction is the central principle of Grounded Theory. Glaser & Strauss (1967, p. 28) state that the “generation of theory through comparative analysis both subsumes and assumes verification and accurate descriptions, but only to the extent that the latter are in the services of theory generation”. Classic Grounded Theory’s emphasis is on induction and theory generation whereas some authors suggest that later editions of Straussian Grounded Theory (Strauss & Corbin, 1998a; Corbin & Strauss, 2008) favour deduction followed by validation and elaboration, whereas further editions do not refer to verification (Strauss & Corbin 1998a; Strauss & Corbin 1998b). Corbin & Strauss’s (2008) version of Grounded Theory developed in response to thinking that was aligned with more contemporary constructivist thinking. In this way, Corbin and Strauss’s version of Grounded Theory prompts the researcher to think beyond the data to the context to understand what is happening in the data, rather than Glaser’s belief that relies on theory that emerges solely from the data alone.

#### **3.5.4 Classic Grounded Theory**

Glaser’s approach to Grounded Theory emphasises the systematic generation of a theory from the data by means of comparative analysis (Glaser & Strauss, 1967; Glaser, 1998). Classic Grounded Theory is intended to be applicable to all types of data collection methods, although principally associated with being a qualitative method even though some have failed to recognise the maxim of ‘all is data’ – failing to recognise that data from questionnaires can also be used as a data collection tool.

Epistemologically, Classic Grounded Theory as put forward by Glaser is considered by Denzin & Lincoln (2000) and Charmaz (2000) to have its roots in the positivism paradigm. However Charmaz (2000) questions the feasibility of the positivist premise of neutral observer as espoused by Glaser within contemporary thinking. Classic

Grounded Theory emphasises the importance for the researcher to be cognisant of research objectivity – a concept that can be enhanced through the constant comparative process and having trust in ‘emergence’. Glaser was adamant not to make explicit an epistemology for Grounded Theory, as to do so would counter emergence, which is the central principle of Classic Grounded Theory. In this way, Glaser (1992) was critical of Strauss’s attempt to ‘force’ a theory into a theoretical framework, thereby violating the principle of the emergence of the theory. Furthermore, he proposed that Grounded Theory could be used from any perspective or epistemology and that this lay with the individual researcher.

### **3.5.5 Straussian Grounded Theory**

Strauss reformulated the original version of Grounded Theory and Glaser (1992) was critical of Strauss & Corbin’s (1990, 1998) version of the methodology. Strauss’s version differs from Glaser in terms of its epistemological basis. While Glaser & Strauss’s (1967) and Glaser’s (1978) approach propose that the researcher stays independent of research, Strauss (1987) and Strauss & Corbin (1990, 1998) placed more emphasis on looking beyond the data to the wider context and the impact of the researcher on the research process, locating the methodology within the constructivist paradigm. Glaser (1992) condemns Strauss’s approach for developing a theory that is a full conceptual description owing to its emphasis on using more techniques instead of relying on theoretical sampling and constant comparison. Strauss’s proposed an organising scheme to aid sorting and organising of emerging connections (Corbin & Strauss, 2008, pp. 89–90) called a coding paradigm which was also criticised by Glaser on the basis that it was forcing the data into predetermined frameworks. Another divergence relates to Strauss’s suggestion that a preliminary literature review can be completed to elicit a research problem; in this way, it differs from Classical Grounded Theory in that a literature review was not permitted on the basis that researchers should look for the problem within the data. Another divergence relates to the criteria to assess the rigour of the emerging theory. While Glaser assesses robustness in terms of fit, grab, work and modifiability, Strauss does not specify set criteria choosing frameworks used by others.

### **3.5.6 Constructivist Grounded Theory**

Charmaz (2000) pioneered a version of Grounded Theory called Constructivist Grounded Theory. Constructivist Grounded Theory evolved in response to Charmaz's (2003, 2006) rejection of the positivist paradigm that she perceived was a hallmark of Classic Grounded Theory. Glaser (2002), however, contended this version on the ground that constructivist data was just another type of data and was already covered by his maxim "all is data" (Glaser, 2002, p. 9). She developed Constructivist Grounded Theory to acknowledge the influence the researcher had on the research stating that the data and analysis are created and shared experiences and relationships with participants and other sources of data (Charmaz, 2006). Charmaz therefore is delineating Grounded Theory's association with quantitative research and aligning it to qualitative research (Charmaz 2003a, 2006). Unlike Glaserian and Straussian Grounded Theory that identifies a core category and/or a basic social process, Constructivist Grounded Theory as proposed by Charmaz takes on board the complexities of the human condition and the individuality of research participants subjective experiences.

### **3.6 Rationale for Choosing Straussian Grounded Theory**

The Straussian approach was particularly suitable for this study for four reasons that will be outlined. The decisional process was guided in many respects by the type of information sought to answer the research questions, the philosophical leanings of the researcher, and the analytical practices of the approach. The relative strengths of the Straussian approach are presented. Although there are commonalities across the Glaserian and Straussian approaches, there are also differences that need to be noted by the researcher to ensure that the approach taken: (1) addresses the aim of the research; (2) ensures compatibility to the researcher's style of working; and (3) remains cognisant of one's own research philosophy. The four issues that influenced the decision to use this approach were:

1. The Analytical Strategies;
2. Specific Aims of the Funded Project;
3. Sensitising;
4. The Coding Paradigm.

### ***The Analytical Strategies***

Strauss's approach to Grounded Theory differs to Glaser's in terms of coding structure with increased emphasis on the use of procedures to question and interrogate the data, thus applying structure to the data. Strauss & Corbin (1990, 1998) have proposed additional strategies for the coding process; these strategies such as the asking of questions and the making of comparisons are contrary to the Glaserian notion of 'emergence' and can in fact be seen as prohibitive to the emergence of the theory. The loose approach to analysis advocated by Glaser did heighten levels of anxieties regarding which approach to select, with data analysis lacking clarity in the early book (Glaser & Strauss, 1967). There was apprehension about the multiple skills required to use this approach, but uncertainty as to how to begin analysis without the use of detailed rules or procedures. The researcher was daunted about the prospect of entering into an approach that offered little in terms of analytical guidance. Strauss and Corbin's approach was aimed at making Grounded Theory more transparent to researchers and the detailed analytical strategies offered by Strauss and Corbin (Strauss & Corbin, 1998a; 1990) are relatively well developed; therefore, some semblance of comfort could be taken from choosing an approach that offered analytical guidance. Strauss and Corbin are thorough in addressing ways of developing ideas on how to forward one's thinking on an analysis. From the outset, this was seen as one of the biggest strengths of choosing this approach over Classic Grounded Theory, especially when one's analytical skills needed developing. However, Heath & Cowley (2004, p. 146) state that the intense questioning advocated by Strauss & Corbin (1990) extends far beyond the data to generate hundreds of codes, and it is possible that it is this proliferation of codes that necessitates consideration reduction and thus the extra level of axial coding.

The rigid coding structure for analysis advocated by Strauss has met with some criticisms suggesting that it is very restrictive and forces the data. Conversely, Glaser's approach to data analysis has been credited with its flexibility, which has long been considered the primary focus of Grounded Theory.

### ***Specific Aims of the Study***

The first exploration was consideration for the substantive area of the research. Predefining exact research questions in a Grounded Theory study is contradictory, as the focus of the research problem should emerge through the process and from the

participants. In addition, due to the requirements of preparing a research bid for the project, the literature review and the original interview guide were drafted before beginning the PhD, a notion contrary to the Glaserian approach. This study was funded by the MHC and is entitled a 'Prospective Evaluation of the Operation and Effects of the Mental Health Act 2001 from the viewpoint of service users and professionals'. Whilst Glaser focuses on letting the theory emerge, the project proposal had specific research aims concerning conceptualising service users' experience of involuntary admission. Meeting this aim demanded a method that could answer the research question. On reviewing the match of this approach to the study aims, the structure in the Straussian data analysis allowed the exploration of this very specific aim. In this instance, with the research question being defined, this focus eliminated the use of a classic approach and directed the researcher to a Straussian approach. Strauss's approach and style of Grounded Theory has more predefined aims, and though it is no less closed off than Glaser it was suitable in ascertaining an understanding of involuntary admission. As such, the substantive area was predefined.

### *Sensitising*

LeCompte & Preissle (2003) state that metatheoretical predispositions (conceptual assumptions) and our own personal (e.g. cultural) and professional (e.g. background experiences) assumptions influence our choices of study, selection of participants, our interpretations, and subsequent theories. The researcher has 11 years' experience working in the clinical environment as a community mental health nurse, a psychiatric nurse and assistant psychologist, and is therefore interested in people's perspectives and psychological theory. Situating the position of the researcher in the research as a health professional led to important choices in how the data was created and represented. Awareness of self in psychology is a key part and resonated with this research philosophy, as well as the need to be aware of one's own assumptions, values and biases. How a participant describes his or her experiences, and how a researcher interprets and analyses these experiences, are to a large extent based on one's self-understanding. Specific attention was given to choosing a methodological approach that would remain cognisant of how the researcher's experience of working with people who had been involuntarily admitted may sensitise, and how formative this may be in interpreting and explaining the analysis and the overall construction of a theory.

Credence must also be given to how the researcher views the world, as well as the fact that a preliminary literature review was completed on the area. Glaser supports the use of both the literature and what can be brought by other theories, but not until the data has had the opportunity to direct the researcher (Glaser, 2011). As such, choosing an approach that acknowledged some of the theoretical perspectives that informed the thinking style of the researcher and fed into the analysis was paramount. Straussian Grounded Theory allows for the recognition of the researcher's previous role and how one's theoretical perspectives may contribute to the developing theory. The researcher was more aligned to the Straussian hypothetico-deductivist approach than Glaser's inductive approach, as digging deeper than what is self-reported by the participant is critical in understanding the formation of people's experiences. Fundamentally, it elicits a certain amount of drawing from theoretical perspectives to understand the processes that might shape people's thinking. The researcher was cognisant of the professional interpretations of the psychological processes involved in the participants experience of involuntary admission. The Straussian approach allows for the sensitisation of one's theoretical perspectives and one's prior clinical experience, and in this sense it allowed the researcher to integrate and use self as a means of interpreting the data.

In contrast, Heath & Cowley (2004) have criticised the Straussian approach for putting more emphasis on deduction and verification, often leading researchers away from the data and following prior research and knowledge, which reduces the effectiveness of the research. Strauss & Corbin (1990) support the concept that the researcher brings the idea of the phenomena to be studied. Alternatively, Glaser would insist that it should come from the data and not be initiated by the researcher.

### ***Coding Paradigm***

The key texts of Glaserian and Straussian Grounded Theory outline different approaches taken to coding and theory construction. Evans (2013) states that axial coding is unique to Strauss and Corbin and, as an addition to the Glaserian approach, is defined as a 'set of procedures whereby data can be put back together in new ways after open coding by making connections between categories'. Strauss & Corbin (1990) designed a coding paradigm to guide the researcher in axial coding. According to Strauss & Corbin (1998), the coding paradigm offers a way to achieve an understanding

of a phenomenon, the conditions relating to it, interactions around the phenomenon and consequences. In addition, the coding paradigm provided an identified framework that allowed the researcher to explore contextual factors, as well as how other factors that may be involved in people's experience of involuntary admission.

However, Strauss and Corbin have been criticised for letting the coding framework override theory emergence. Kendall (1999) and Glaser (1992) state that use of the coding paradigm and axial coding is inconsistent to the purpose of Grounded Theory to generate a substantive theory and that the Straussian method allows an escape for those struggling with the conceptual difficulties. In contrast to the sole framework provided by Strauss, Glaser (1978, p. 72) provides 18 frameworks that he claims 'allow the grounded theorist to be both sensitive to and render explicit the subtleties of relationship within the data' allowing flexibility and 'discovery' of the theory rather than theory 'construction'.

The Coding Paradigm offers a very systematic way of exploring phenomenon. It was deemed particularly suitable for this study as it assists the researcher in developing insights to the phenomenon of involuntary admission and the processes involved in how people experience and adapt to it. This lens widens the scope of the order and is beneficial in providing perspective on the analysis and directing the researcher to see the processes behind the person's words. Strauss & Corbin (1998a, p. 183) argue that '...events that occur "out there" are not just interesting background material and denying the contextualised experiences diminishes the significance of symbolic, social, historical, and cultural aspects', as indeed these may play an important part of a person's experience of involuntary admission. For this reason, it was a good fit for the study as it enabled understanding of the processes people use to adopt to involuntary admission, their social interaction with professionals, and their perception of their 'social world'.

The coding paradigm was influential in the decision to choose a Straussian approach. The coding paradigm is aligned to the researchers' prior knowledge of Applied Behavioural Analysis and Antecedent, Behaviour, and Consequences of Behavioural and, as such, is in tune with a framework previously used to elicit the response of those

with behavioural problems. In this regard, it was user friendly and the researcher felt that nothing was left untapped.

### **3.7 Implementing Straussian Grounded Theory**

This section provides an overview of the central tenets of Grounded Theory: theoretical sensitivity, theoretical sampling, data analysis, constant comparison, memos and the integration of the theory. Two techniques are the hallmark of Grounded Theory: these are the constant comparative process and theoretical sampling. Constant comparison is an on-going process that commences when data collection starts. Theoretical sampling occurs in response to on-going constant comparison. Grounded Theory involves the simultaneous sampling and analysis of data.

#### **3.7.1 Theoretical Sensitivity**

Corbin & Strauss (2008, p. 32) state that theoretical sensitivity is about “...having insight, being tuned into, being able to pick up on relevant issues, events, and happenings in the data”. The researcher needs to be both internally and externally attuned to what influences data analysis – internally attuned as regards what is happening within their background and personal experience that influences data analysis, and externally attuned as regards what it is within the theoretical literature that influences data analysis. Theoretical sensitivity helps curb the potential bias from the researcher’s background experiences and diminishes the risk of compromising the study through premature closure in favour of the researcher’s pet theory (Schreiber, 2001, p. 60). Corbin & Strauss (2008) state that the researcher must keep in mind that findings are a product of data plus what the researcher brings to the analysis, and Schreiber (2001) cautions that it is when people are not attuned that they then run the risk that ‘pet theories’ or potential biases may dominate data analyses.

There are a number of means to which one can achieve theoretical sensitivity. Strauss & Corbin (1998a; 1990) and Corbin & Strauss (2008) recognise and place emphasis on the multiple sources that enhance theoretical sensitivity. These include personal and professional experience, the literature, and the analytical experience itself – these sources all play a part in allowing to ‘respond’ to what is emerging in the data.

Being theoretically sensitive involves being open to ‘theoretical possibilities’ and theories within the data (Schreiber, 2001), and allows for drawing on the literature in related areas in order to be open to think conceptually and to ask questions about what is happening in the data. Familiarity with relevant literature can enhance sensitivity to ‘subtle nuances’ in the data and sensitising concepts (Corbin & Strauss, 2008). Theoretical sensitivity requires a reading of the relevance of key pieces of theoretical literature and accurately sensing how this literature fits and holds relevance to the emerging analysis. Corbin & Strauss (2008) agree that the literature can produce sensitising concepts but also that every concept should earn its way into the theory.

In addition to being theoretically sensitive, there also needs to be cognisance of how one’s own preconceptions and biases may have influence on data analysis. Therefore, the researcher needs to know how to limit the impact that these have so that the concepts emerging in the data analysis are reflective of what is actually present in the data. In this event, the researcher needs to challenge and question any preconceptions they may hold (Schreiber, 2001). Strauss & Corbin (1990) offer practical strategies to promote one’s theoretical sensitivity, which include questioning, the ‘flip-flop technique’<sup>18</sup> and ‘waving the red flag’<sup>19</sup>. Indeed, the constant comparison process in itself can be used to challenge the literatures fit with the emerging concepts. According to Schreiber (2001), another strategy to challenge one’s ‘pet theories’ is to memo them, make them explicit and then set them aside for later comparison against the data.

Corbin & Strauss (2008), Schreiber (2001) and Strauss & Corbin (1990) believe that there are personal values and professional knowledge and experience rooted within the researcher that also enhances analysis. According to Corbin & Strauss (2008, pp. 33–34), “...our backgrounds and past experiences provide the mental capacity to respond and receive the messages contained in the data” and they also “enable us to see connections between concepts.”

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<sup>18</sup> “Flip-flopping consists of turning a concept ‘inside out’ or ‘upside down’ to obtain a different perspective on a phrase or a word” (Corbin & Strauss, 2008, p.79).

<sup>19</sup> Waving the red flag is a tool to remind the researcher not to assume too much.

Being theoretically sensitive ensures rigour in the findings and, to paraphrase Corbin & Strauss (2008), every concept should deserve to be included in the theory.

### **3.7.2 Data Analysis**

Constant comparative analysis is the hallmark of Grounded Theory and involves comparing data to other data. The constant comparative technique is used to code and categorise data, which permits similarities and differences to emerge. Consequently data analysis drives further data collection (theoretical sampling). The purpose of constant comparative analysis is theory generation.

#### ***3.7.2.1 Open Coding***

Open coding is the initial coding conducted. It involves breaking down the raw data into manageable pieces, which helps in the process of beginning to think conceptually about the data. The process of conceptualisation is facilitated by questioning the data (Corbin & Strauss, 2008), and the questions asked are, ‘who?’, ‘what?’, ‘when?’, ‘where?’, ‘how?’ and ‘with what consequences?’. This questioning allows for the ‘opening up’ of the data and aids with the identification of emerging concepts while assisting in the development of initial categories.

Open codes are conceptual names (labels) assigned to a piece of raw data. These open codes are reflective of the concept that underpins that data and are used to capture the language and meaning used by participants. Corbin & Strauss (2008) recommend that open coding should be concentrated on coding for action and process. Strauss & Corbin (1998a, p.106) state that the open code should be reflective of ‘...context in which an event is located’ or the actual words of participants (in vivo codes).

In order to progress conceptualisation, emerging concepts are continually compared within and between existing concepts for their similarities and differences. To develop initial categories, similar concepts are linked together to form these categories. Through the use of comparative analysis, categories become saturated and developed in terms of their properties (characteristics) and dimensions (location of a property along a

continuum or range) (Strauss & Corbin 1990; Strauss & Corbin 1998a; Corbin & Strauss, 2008)

### ***3.7.2.2 Axial Coding***

Axial coding is about making connections between the categories developed during the process of open coding (Strauss & Corbin, 1990; Strauss & Corbin 1998a; Corbin & Strauss, 2008), the aim of which is to develop and relate properties and subcategories to their respective subcategories and categories. This is achieved by making comparisons through the constant comparison process, which allows relationships to be established regarding how subcategories relate to the category. As a result, subcategories, new categories or properties are further developed and elaborated on, thereby assisting with the theoretical development of categories.

In addition to this, hunches about how categories relate are also proposed. These hunches are then ‘checked out against the data’ (Corbin & Strauss, 2008, p. 199). By comparing newly coded data to previously coded data, the emergence of similarities and differences (evidence and counter evidence) now shapes the theoretical development of categories in terms of linking properties and dimensions to their categories.

Corbin & Strauss (2008, p. 89) state that the relationships between concepts can be complex and difficult to tease out in the data and they recommend ‘a conceptual analytical device’ that can be used called the Paradigm. This Paradigm can be used as a way to assist in discovering the complex connections between categories and to help elicit finer connections or subtleties in the data. Using a set of questions to establish links about what is going on in the data, the Paradigm enables the systematic thinking about the relationships between ‘context and process’ (Corbin & Strauss, 2008). The Paradigm consists of three components that look for evidence in terms of the following: (1) conditions that might have caused a phenomenon to develop (each of the main categories found in the data each represent a phenomenon), the context in which a phenomenon comes about; (2) the intervening conditions that may facilitate or constrain the development of a phenomenon, action strategies taken or not taken that might shape the phenomenon in some way; and (3) the consequences of the action taken

or not taken to manage a phenomenon. This involves applying a set of questions to data to look for evidence to explore what conditions, contexts and consequences impact a category.

Corbin & Strauss (2008) and Strauss & Corbin (1998a) recommend another analytical tool called the conditional/consequential matrix, which is used as a means of relating structure with process. Unlike the coding paradigm's more narrow focus on the phenomenon, the matrix assists in gaining and accomplishing a broader context in a bid to further contextualise the central phenomenon. The matrix is a further technique to question the complex interplay between macro and micro conditions (structure) and to assist in understanding the relations and interrelations to actions/interactions (process).

In addition, the matrix can be used to guide theoretical sampling decisions regarding where to look for contextual factors by thinking about the emerging concepts. The matrix can facilitate a different approach to this, thereby leading to more participants being selected and concepts being explored from different perspectives.

The centre of the matrix outlines the central phenomenon around which more circles revolve and widen which constitute a varying condition/consequences. The further out the circles, the more distant the condition/consequences are related to actions/interactions and vice versa. The matrix is adapted to each individual study (Strauss & Corbin 1998a; Corbin & Strauss, 2008), the aim of which is to outline the conditions that influence and are relevant to the central phenomenon.

### ***3.7.2.3 Selective Coding***

Selective coding is the final type of coding to be conducted – it is the process of integrating and refining the theory by interrelating categories into a larger theoretical scheme (Strauss & Corbin, 1990; Corbin & Strauss, 1998). The identification of the core category assists in the process of integrating the theory and, once established, the other categories are integrated around the core category (Strauss & Corbin, 1990; Strauss & Corbin 1998a; Corbin & Strauss, 2008). Strauss & Corbin (1998, p. 104) state that the “core category is that which appears to have the greatest explanatory relevance and highest potential for linking all of the other categories together”.

Selective coding helps properties and dimensions to become more fully developed, from which point the theory can be further refined. Analytical techniques have been proposed by Corbin & Strauss (2008) to help achieve integration and refinement in the theory. These are described below.

**Storyline:** The storyline is a tool that is used to aid theoretical development and, to some extent dissemination (Strauss & Corbin, 1998). Writing the storyline enables the systematic thinking and integration of interrelations between categories. Using the storyline assists in refining the developing theory; by using the existing categories and their linkages a theory of the data is formulated.

**Diagramming:** Diagramming visually depicts the relationships between categories and aids the integration of the theory. Diagramming provides a means to remove oneself from the subtleties of data to a form that enables working with concepts alone.

**Sorting of memos:** Sorting of memos establishes the relationship between generated categories and expands and gives ideas about how the categories might fit together. Memos tracing assists in the integration by understanding how old categories and new ones fit together looking for what Corbin and Strauss call the links in logic.

#### ***3.7.2.4 Refining the Theory***

The next phase involves refining the theory, which consists of reviewing the theoretical scheme for internal consistency and gaps in logic and validating and verifying the scheme against incoming data (Strauss & Corbin, 1998a) and, to paraphrase Scott (2004), relating salient phenomenon around the core category. As the constant comparative process progresses, the categories and properties will decrease. Refining the theory is the process whereby the categories are integrated and organised into a logical coherent theory. Refining the theory assists in ensuring theoretical saturation by checking that all data was available so that categories are fully developed, with theoretical sampling in instances where categories need further development (Strauss & Corbin, 1998a; Corbin & Strauss, 2008). The emergence of the core category helps in validating and thus refining the theory. Validating the theory involves techniques for working towards integration of the data and theory building (Strauss & Corbin 1998).

These techniques include the use of comparison to ensure the theory fits the raw data. Writing the theory is the ultimate step in constant comparative analysis

### ***3.7.2.5 Additional Analytical Strategies***

In addition to coding, analytical strategies are also available to stimulate thinking about the data. These include: (1) the asking of questions; and (2) theoretical comparisons (Strauss & Corbin 1998a; Corbin & Strauss, 2008).

The asking of questions is an analytical strategy that involves thinking about the range of possible answers, which helps assume the role of the other so that one can better understand the problem from the participants' perspective. As mentioned above, these questions include, according to Corbin & Strauss (2008, p. 69), concepts such as: 'what?', 'where?', 'when?', 'how?', 'who?', 'how much?' and 'with what consequences?' This in turn directs theoretical sampling. There are several different types of questions: (i) practical questions involve asking questions such as 'where to go?' and 'what to sample next?'; (ii) sensitising questions involve asking questions such as 'what does this mean?'; (iii) theoretical questions involve seeing process and variation such as 'what is going on here?'; (iv) structural questions involve asking questions that direct data collection; and (v) guiding questions specific to the study involve questions that guide data collection and analysis (Corbin & Strauss, 2008).

Theoretical comparison is an "analytic strategy used to stimulate thinking about properties and dimensions of categories" Corbin & Strauss (2008, p. 65) and can be conducted at the same time as constant comparison. The strength of this strategy lies in its ability to assist in both the development of the meaning of data if difficulties arise in the meaning of an incident. Theoretical comparison can be enhanced by being theoretically sensitive and using the literature and experiences as a means for making comparisons.

In addition to the main analytical strategies of asking questions and theoretical comparison as espoused by Strauss & Corbin (1998a) and Corbin & Strauss (2008), there are other analytical strategies that can be used interchangeably to assist and facilitate data analysis. These strategies can be used flexibly and some of these involve being alert to terms including: (1) according to Corbin & Strauss, (2008, p. 82);

“looking at language that is reflective of a particular culture or discourse” and (2) looking for words that indicate time is reflective of a change in perspective. According to Corbin & Strauss (2008, p. 82), time words are words such as ‘when’, ‘after’, ‘since’, ‘before’, ‘in case’, and ‘if’, and these are “relevant in identifying process and context”. In addition, the analytical strategy of ‘waving the red flag’ alerts the researcher to potential personal biases and assumptions by reminding the researcher not to assume too much.

### **3.7.3 Memoing and Diagramming**

Charmaz (2000, p. 517) states that memo writing can “help the researcher develop ideas about the data, to set an analytical course, to refine categories, to define relationships among various categories, and to gain a sense of confidence and competence in their ability to analyse data.” Diagrams assist in the visual representation of the relationships between concepts. Memos are used to record ideas about codes and their theoretical relationships as they emerge during coding, collecting and theoretical sampling. Additionally, they can include questions that the analyst would seek to answer during constant comparison. Strauss & Corbin (1998a) state that memos ‘ground’ the research, assisting in awareness of personal bias and assumption Strauss & Corbin (1998a, p. 218). Corbin & Strauss (2008) state that memos should not be thought of as being highly structured but should be flexible. Ultimately, diagramming and memoing facilitates the transition from working with raw data to working with concepts (Strauss & Corbin, 1998a; Corbin & Strauss, 2008).

### **3.7.4 Theoretical Sampling**

Theoretical sampling, unlike statistical sampling, “cannot be planned before embarking on a study” according to Corbin & Strauss (2008 p. 157). Corbin & Strauss go on to say that theoretical sampling is part of the comparative process whereby “sampling decisions arise from the questioning of the data and the need to focus data collection on answering unanswered questions in the data” (2008, p. 143). Sampling is therefore guided by concepts in a way that will inform the emerging theory. Participants provide the data that tell us about those concepts. According to Corbin & Strauss (2008, p. 144), “the purpose of theoretical sampling is to go to places, persons and situations that will

provide information about the concepts they want to learn more about” by deriving data that will inform the developing theory. Questioning already analysed data can also form the basis of theoretical sampling in that ‘incidents or events pointing to a concept may have been overlooked earlier because the significance of these events may not have been well understood by the researcher at the time’ (Corbin & Strauss, 2008, p.151).

#### ***3.7.4.1 Beginning Sampling***

According to Jeon (2004), grounded theorists’ initial sample is representative of purposive sampling. Theoretical sampling does not proceed until data analysis starts and as a result it is necessary to start with purposive sampling. Purposive sampling is, according to Streubert & Carpenter (1995, p. 43), a “method of selecting individuals based on their particular knowledge of the area with the purpose of sharing that knowledge”. Coyne (1997, p. 625) says that ‘the researcher must have some idea of where to sample, not necessarily what to sample for, or where it will lead’. Strauss & Corbin (1998) and Corbin & Strauss (2008) state that sampling decisions are deliberately made to start data collection. For example, the initial sample could be based on deciding on a site in which to study, or who the researcher thinks would be appropriate for the study, or in any way that leads to a broad perspective.

#### ***3.7.4.2 Later Sampling***

After purposive sampling, theoretical sampling can then proceed (Strauss & Corbin, 1998a). According to Corbin & Strauss (2008, p. 149), theoretical sampling begins after the first data sets are analysed and continues throughout the research process. Strauss and Corbin (1998a) suggest three types of theoretical sampling: Open Sampling; Relational and Variation sampling; and Discriminative Sampling.

***Open Sampling:*** Strauss & Corbin (1998) and Corbin & Strauss (2008) suggest the use of open sampling early in data gathering to ensure that researchers remain ‘open’. This facilitates the development of as many categories as possible and enhances discovery. The notion of being ‘open’ is especially pertinent to novice researchers, whose awareness may be less theoretically sensitive. Corbin & Strauss (2008, p.154) state that ‘When an analyst happens upon something new or different, he or she must stop and

ask, “What is this?” “What can it mean?” Strauss & Corbin (1990) and Strauss & Corbin (1998a) suggest three techniques of open sampling that can be used together or in isolation (sites, people and events are deliberately and maybe purposefully selected): (1) convenience or systematic sampling, i.e. through a list or database under the premise that variations in the situation will occur naturally; (2) fortuitous sampling, which according to Strauss & Corbin (1990, p.184) is where unexpected insights are incorporated into the analysis and is contingent on an ‘open and questioning mind’; and (3) backward sampling, i.e. going back to the data to reanalyse in light of theoretically relevant concepts.

***Relational and Variational Sampling:*** Sampling is directed systematically and purposefully towards uncovering and validating the relationships between categories. Its purpose is, according to Strauss & Corbin (1990, p.196), to explain how categories relate across “conditions, contexts, actions/interactions, and consequences”. The purpose of sampling in axial coding is, according to Strauss & Corbin (1990, p. 185), to “find as many differences as possible at the dimensional level of data” through investigating the relationships between categories and subcategories and finding variation and process between these. A more focused interview guide is developed in response to emerging concepts.

***Discriminative Sampling:*** Discriminative sampling is employed to validate statements about relationships, to fill in categories, and to form theory (Strauss & Corbin, 1990). It concerns itself with selecting sites or persons that maximise opportunities for comparative analysis (Strauss & Corbin, 1998a). Negative cases that do not express the categories at all may also be sampled to ensure saturation was reached.

### **3.8 Method of Data Generation**

This section will provide a description of the method of data generation most appropriate and compatible for this Straussian Grounded Theory – interviewing.

#### **3.8.1 Interviewing**

Interviews are one of the most common methods of data collection used in qualitative health research (Gill *et al.* 2008). Nathaniel (2008) identifies that in Grounded Theory one-to-one interviews are a very useful method of data collection and simply allow the

participant to tell their story. As a result, interviewing provides rich data that would be difficult to collect by other means of data collection (Burns & Grove, 1993; Creswell, 2009) and assist researchers in developing a deeper understanding and greater insights into social phenomena of which little is known (Silverman, 2000). The purpose of an interview is to explore people's experiences, attitudes, opinions and beliefs about phenomena and obtain some demographic and biological data (McCormack, 2000; Parahoo, 2014). There are three fundamental types of research interviews: unstructured, semi-structured and structured (Polit *et al.* 2001; Parahoo, 2014). Structured interviews usually have a set of predetermined questions asked in a particular order to each participant and require closed answers such as questionnaires; these are used mostly in quantitative research (Pontin, 2000; Parahoo, 2014). Unstructured interviews usually start with an open-ended question and allow the participant to tell their story in whatever order they wish. The participant has total control of the interview, meaning that this can be a time-consuming option and it is therefore used mostly when very little is known about a topic (May, 1991; Corbin & Morse, 2003). Semi-structured interviews fall somewhere in between and commence with an open-ended question allowing the participant the freedom to talk about their experience but with a predetermined framework of what information the researcher requires. Semi-structured interviews give the researcher some control of the data collected and is used when some information is known about a topic but a greater understanding is required (May, 1991; Britten, 1999). Unstructured and semi-structured interviews are both used in qualitative research (Polit *et al.* 2001; Parahoo, 2006).

Some authors believe unstructured interviews are the most appropriate method of data collection when using Grounded Theory (Corbin & Morse, 2003). However, the benefits of employing semi-structured interviews is that they provide flexibility for the researcher to pursue an area in more detail and prevent the participant from going off track (Gill *et al.* 2008). More specifically in Grounded Theory, the revision of interview questions as the theory emerges helps to develop categories.

The importance of having an experienced researcher proficient in interview skills, comfortable with periods of silence and engaging cannot be underestimated when gathering data (Polit *et al.* 2001; Williams, 2007; Corbin & Strauss, 2015). Corbin & Strauss (2015) recommend bringing a pencil and paper in addition to a recorder as participants sometimes offer the most interesting information at the end of the interview when the tape recorder has been switched off. Interviews should be transcribed

verbatim as soon as possible to protect against bias and ensure an accurate and permanent record is available (Gill *et al.* 2008).

### **3.9 Maintaining Rigour**

While Glaser (1978) assesses robustness in terms of fit, grab, work and modifiability, Strauss & Corbin (1990; 1998b) suggested the following criteria for judging emerging theory: fit, understanding, generality and control. Moreover, Corbin & Strauss (2008) claim that the findings should have: fit, applicability, concepts, contextualisation of concepts, logic, depth, variation, creativity, sensitivity and evidence of memos.

There is no universal criterion for evaluating rigour. Cooney (2011, p.18), cautions on how researchers can ‘...demonstrate that they have met these criteria in their studies’. There is still a question of how far researchers need to explain each aspect of their study as such criteria may not be equally applicable or important to a particular study. Authors such as Rolfe (2006) and Sandelowski & Barroso (2002) question the appropriateness of any predetermined criteria for judging qualitative research. Rolfe (2006, p. 304) states that instead of using predetermined criteria, researchers should recognise that each study is individual and unique, and the task of producing frameworks and predetermined criteria for accessing the quality of research studies is therefore futile. There is little consensus on a uniform framework to evaluate Grounded Theory. Strauss and Corbin do not specify a set of criteria, instead mostly citing others ideas on rigour; however, they do specify that the adequacy of a study’s research process and grounding of its findings should be considered (Strauss & Corbin 1998a).

Lincoln & Guba’s (1985) criteria for generating trustworthiness in qualitative research were selected. Bryman *et al.* (2008, p. 266) state that although Lincoln & Guba’s (1985) criteria are not the specific criteria for evaluating a Grounded Theory, they have the advantage of being parsimonious and are frequently referred to in the literature. They describe four criteria: credibility, transferability, dependability, and confirmability and these criteria are evaluated in the context of Straussian Grounded Theory studies and Strauss & Corbin’s 1998 standards of the adequacy of the research process and grounding of its findings.

### **3.9.1 Credibility**

According to Merriam (1998) credibility is an important factor in maintaining rigour and is about how congruent the findings are with reality. According to Corbin & Strauss (2008, pp. 301–302), “credibility indicates that the findings are trustworthy and believable in that they reflect participants’, researchers’ and readers’ experiences with a phenomenon, yet at the same time the explanation is only one of the ‘plausible’ interpretations possible from the data”.

Stern (1985) states that through the evaluation process (checking) of asking participants the question ‘is this how it is?’, participants are given the opportunity to refine or refute the theory. Validating the emerging theory is also what Cooney (2011, p. 17) states is already built into the Grounded Theory method through the inductive deductive cycle of theory generation. Within Grounded Theory, credibility can be enhanced by changes in the questions asked during data collection and by revising interview guides on the basis of emerging concepts and the appropriate use of theoretical sampling. Strauss & Corbin (1990) state that the usefulness of Grounded Theory’s findings can be seen as a matter of ‘understanding’ as well as direct application to the individual studied or a relevant practitioner in the field. Chiovitti & Piran (2003) suggest other ways of enhancing the credibility of a Grounded Theory study involves using in vivo codes and by making explicit any variation in meanings of words, concepts or relationships.

### **3.9.2 Transferability**

Transferability requires the researcher to provide sufficient data and context to enable the audience to judge whether the findings can be applied to other situations and contexts and to assess the theory’s capacity to offer a range of valuable possibilities for understanding such situations. The context of data collection should be described with regard to physical structure, general environment, approach to care delivery and service user choice and activity, to ensure the audience is able to judge similarities and differences across settings. In contrast, Morse & Singleton (2001) state that transferability is about the theory being transferable, thereby enabling the emerging theory to be bear relevance to people in similar situations.

### **3.9.3 Dependability**

Dependability refers to having sufficient details and documentation of the methods employed so that the research can be scrutinised and replicated. Dependability is ensured by the constant verification of categories and properties during the process of theory generation, ensuring the stability of the findings over time.

### **3.9.4 Confirmability**

Confirmability refers to ensuring that the study's findings are the result of the experiences of the participants rather than the preferences of the researcher, and this can be achieved through an audit trail of the raw data, memos, notes, data reduction and analysis. Lincoln & Guba (1999) state that the researcher should open up her or his inquiries to externals and provide an 'audit trail' with specific details of and justifications for decisions and actions taken during the process of inquiry. Confirmability is contributed to when the researcher uses and practises reflexivity, enhancing the objectivity and neutrality of findings. Mallory (2001) defines reflexivity as an evaluation of the effects of the research participant relationship on data collection and data analysis.

### **3.10 Ethical Considerations**

In Ireland, The Irish Council for Bioethics (2004) requires that all research involving human participants obtain ethical approval and a review by an ethics committee. The purpose of ethical approval is to protect the right of each participant and is especially important in healthcare research. In qualitative research in health care, it is widely accepted that participants may be viewed as a vulnerable group (Beauchamp & Childress, 1994). Indeed, the Nursing and Midwifery Council (NMC) (2007) identified people with mental health problems as potentially vulnerable. The following section describes the ethical considerations for conducting Grounded Theory research with a potentially vulnerable group.

*Primum non nocere* ('first to do no harm') provides the foundation of all healthcare ethics. According to Robertson (2009, p. 3), 'medical ethics has been subsumed under the umbrella of bioethics'. Since 1977, Beauchamp and Childress have written

extensively about the principles of biomedical ethics. Now in its 6<sup>th</sup> edition (Beauchamp & Childress, 2009), it is considered in codes of professional conduct and clinical guidelines around the world (Adams, 2011). Campbell *et al.* 2005 identify ‘psychiatry’ as needing a unique status within bioethics and state that there is little need to argue about the advantages of one ethical theory over another. Researchers are guided by ethical principles and their code of professional conduct (NMBI, 2014). The following ethical principles have been identified as important in healthcare research: (1) respect for persons/autonomy; (2) respect for justice and fairness; and (3) beneficence and non-maleficence (Radden, 2002; Polit & Beck, 2004; Beauchamp & Childress, 2008). Beauchamp & Childress (2009) expand these to the ethical principles of veracity, fidelity and confidentiality.

Respect for persons/autonomy is achieved by understanding that participants have the right to make decisions independently and that they have the right to decide voluntarily to take part in the research without fear of any negative impact (McCormack, 2000). Respect for persons/autonomy is safeguarded through the seeking of written informed consent from participants before commencing research (Parahoo, 2007). Informed consent should not be viewed merely as an event, but as a process that precedes the signing of the consent form and continues for as long as it is relevant (Hall *et al.* 2012). There are four essential components of informed consent: (1) disclosure of information; (2) comprehension; (3) competency; and (4) voluntariness (Beauchamp & Childress, 2001). Participants must be informed of all aspects of the study, the process involved, potential risks and benefits and, most importantly, their right to withdraw consent at any stage throughout the process (Royal College of Nursing, 2004; Parahoo, 2014). *Information* should be unambiguous and given both verbally and in a clear written format, and time should be given to ensure the participant fully *understands* what is involved. Discussion may be helpful and ample opportunity to ask questions throughout the process is necessary (NMC, 2007). *Competency* relates to the participants’ capacity to understand the information given and their ability to comprehend the implications of consenting to take part in the study (Beauchamp & Childress, 2001). While competency may be an issue in mental health research, it also may not (Stanley, 1982; Davies, 2005) and it should not be assumed that because participants have mental health difficulties they are not capable of making an informed decision (Davies, 2008). In fact, some authors believe it is disrespectful of the participant not to allow them the opportunity to

self-determine (Polit & Hungler, 1997). The researcher should have the clinical experience to make a decision on capacity but further information may be sought from the treating consultant or key workers if there is any doubt about a participant's ability to consent (Koivisto *et al.* 2001). Each participant's capacity to consent should be assessed individually (Brabbins *et al.* 1996). Participants must consent *voluntarily*, without coercion, persuasion, inducement or fear of negative impact (McCormack 2000; NMC, 2007). They must be made aware that they can withdraw at any stage from the study without penalty (Parahoo, 2007). Sometimes unforeseen consequences or issues arise and in such instances process consent is recommended. Process consent is when the researcher renegotiates consent (Holloway & Wheeler, 2002). Process consent is generally accepted as the most appropriate form of consent due to the concerns with potential capacity in participants with mental health difficulties (Munhall, 1991). Thus, consent is not static but an ever evolving process that may require on-going discussion and negotiation throughout the study.

Respect for justness and fairness emphasises that participants should be treated fairly and equally, whether or not they agree to become involved in the research or indeed whether or not they opt out of the research. This principle deals with racism, sexism and all other potential aspects of discrimination. Beneficence and Non-maleficence is about doing good and above all not doing harm to the participants. Research should only be considered if it is envisaged it will add to the welfare of participants or the health of others (Parahoo, 1997; 2014). If the researcher at any stage feels the study is negatively impacting on the health or well-being of a participant, the researcher should terminate the interview. In terms of qualitative research, authors recognise that spending time with participants and giving them space to discuss their experiences can be helpful and cathartic (May, 1991; Hutchinson *et al.*, 1994). However, if the experiences they are recounting are traumatic, they could develop symptoms of distress (Gibson, 1996; Bonner *et al.* 2002). It is paramount therefore that the researcher has the experience to differentiate between normal emotional responses and disruptive distressing reactions (Corbin & Strauss, 2003). The researcher should have the skills to deal with normal emotional upset during the interview and giving the participant the space to work through these emotions (processing) should be helpful. However, if a participant becomes so distressed they are unable to move on in the interview, it is recommended the interview is ended temporarily (Corbin & Morse, 2003). The

interview can recommence if the participant feels composed enough to continue and the researcher deems it appropriate. The researcher should have planned procedures in place for participants who become so distressed they are unable to proceed with the interview, such as access to a counsellor, a key worker or family member. Ashton (2014) highlighted the difficulty of ‘blurring of roles’ while conducting semi-structured interviews with vulnerable people on sensitive issues. In qualitative research, the researcher must balance the need to be empathic and understanding with the importance of neutrality. Researchers need to recognise if they are moving out of the nurse researcher role into the nurse therapist role to ensure qualitative research is credible (Patton, 1990).

The potential of harm coming to the researcher by vicarious traumatisation if listening to disturbing experiences or aggression if participants become distraught or hostile has been well documented, and strong recommendations on the safeguarding of researchers from physical and emotional pain during qualitative research have been made (Dickson-Swift *et al.* 2006; Bloor *et al.* 2010). Procedures should be put in place to ensure the safety of the researcher, such as conducting interviews in safe environments, supervision, mentoring and counselling if required (Ashton, 2014).

Veracity/truth involves telling the truth at all time to participants. Researchers must endeavour to truthfully answer all questions about the study to participants. They must be fully informed of all aspects of the research and not deceived about the nature or purpose of the study. According to the NMC (2007), the principle of veracity is linked with respect for autonomy; however, the concept of trust (fidelity) also comes hand in glove with veracity, and participants must have a sense of trust in their researcher if they trust they are more likely to be honest in their answers and feel safe to discuss their experiences.

Respect to confidentiality emphasises the importance of guaranteeing the participants’ confidentiality. According to Polit & Hungler (1995, p.712) confidentiality is defined as “the protection of participants in a study such that their individual identities linked to the information they provide will never be publically divulged.” All identifying information will be removed and coded for analysis and any information not essential

to the study but potentially revealing should be deleted or modified (Polit & Beck, 2004).

### **3.11 Summary of Research Framework**

This chapter provided an overview research paradigms and designs culminating in providing a rationale for the paradigm and design ultimately used in this study. A description of Grounded Theory and its variations is provided while at the same time highlighting a rationale for using Straussian Grounded Theory. An outline of the principles of data collection and data analysis is then given, criteria for maintaining rigour were identified and finally, an overview of ethical considerations was outlined.

## **Chapter 4: Research Design**

### **4.1 Introduction**

This chapter describes the research design used in this Straussian Grounded study. It provides a detailed description of all phases of the research: access and recruitment of participants, consent, data sampling, data collection, and the process of data analysis. It explores the ethical issues in this study as well as describing the approach undertaken to maintain rigour. Firstly, the study context is outlined alongside a description of the study sites.

### **4.2 Description of Study Sites**

Three study sites (acute psychiatric admission) units were purposely selected. The study sites comprised adult mental health service catchment areas of the Irish national health system (Health Service Executive) and covered a population of around 290,000 people. The three mental health services that were chosen reflect a range of typical services as found throughout the country. They encompass both urban and rural settings, from well-resourced to poorly resourced mental health services according to per capita funding (MHC, 2005; 2008), a range of community-based care models, and include inpatient units attached to a tertiary referral academic hospital, a county hospital and a standalone psychiatric unit.

#### **4.2.1 Acute Psychiatric Admission Units**

##### *4.2.1.1 Physical Structure and General Environment*

Two of the units were located at the rear of the general hospitals and the other was a stand-alone building. On arrival at the unit for involuntary admission, people would generally be assessed in an office but in some instances participants could be escorted directly to a seclusion room. Two of the sites had a mixed male and female setting while the other site had a male and female unit. Bedrooms were single, four or six bedded rooms, and all beds had a surrounding curtain to facilitate privacy. Two of the three units needed some refurbishment; the fourth unit was bright. There were issues with privacy in one of the units.

Two of the units had a seclusion room, within which were mattresses, while the third unit had access to a seclusion facility, which gave more room to move around. One seclusion room had CCTV which was incapable of recording. There was a toilet immediately outside the seclusion room door, which people had to request access to. Shower facilities were outside of the seclusion room.

The bed capacity varied from 15–43. These admission units were first opened in either the 1930s or in the 1970s to facilitate the move away from providing acute psychiatric care in large psychiatric hospitals. The unit doors were primarily locked on all three sites and all units were located on the ground floor. There was access to a fenced garden in one of the sites while the other two areas did not have access to a garden. There was access to a smoking gazebo in one unit and a smoking room in the other two. Each person had access to a wardrobe. Lavatory and showers were lockable in all but one ward, and in two units the toilets and bathrooms were poorly maintained.

People attended a large dining room for meals unless on observations, in which case they either received meals on a trolley at their bed area or within an area on the unit where nurses observed. There was a sitting room on all units where there was access to TVs. There was an ECT room in two of the sites.

The Mental Health Tribunals were held in a room outside the ward but in the same building. There was an occupational therapy section in each of the units, one of which included a multisensory room and access to two other rooms.

#### *4.2.1.2 Approach to Care Delivery*

Some of the people were able to retain control of their personal belongings. On admission, an inventory of people's property was documented in a property book. In one of the units some of the service users were dressed in night clothes. Each person had access to nurses and doctors, and in some instances throughout the hospital stay people had access to other members of the multidisciplinary team including occupational therapists, psychologists and social workers. However, in one unit access

to some of the allied professionals was limited. There were individual care plans in two of the three units, while the third unit had no individual care plan for some people.

People had access to appropriate recreational activities such as TVs. One unit had a DVD player, pool table, table tennis and library books and there was limited access to internet on this unit. In another unit there was a room with gym equipment, which some people could attend under staff supervision. People, if allowed, could see visitors in a large sitting room, quiet room or at the bed areas. Visiting times were generally open.

There was access to an appropriate range of therapeutic activities, provided participants had access to their day clothes. A pharmacist was available to speak with people on aspects of medication in one of the units. There was a well-equipped occupational therapy area with three rooms available in one of the units, some units had input from occupational therapists or nurses. In another unit there was a Clinical Nurse Specialist for recovery-orientated programmes.

People were permitted to retain their mobile phones unless clinically indicated. Information about an advocacy group and an advocate was displayed in all units. The Guide to Mental Health Act was available to participants on completion of Form 6 or 13, while a patient information booklet was available to all people on admission which outlined housekeeping and visiting arrangements. In one of the units, the information booklet gave details of all the multidisciplinary team members. There was access to Cognitive Behavioural Therapist in one of the sites. Meanwhile, access to social work and clinical psychology was limited in another.

#### *4.2.1.3 People's Choice and Activity*

The acute psychiatric admission unit is primarily treatment-focused (medication and nursing support) and provides a service for those with acute mental health difficulties, severe mental illness and depression. Some participants were restrained and forcibly given medication intramuscularly during their hospitalisation, most typically in the early stage. Some people were not allowed to attend occupational therapy initially unless they were in their day clothes and their involuntary admission had ended. All people were allocated a primary nurse. Activities were provided but some people had

little interest in attending them. Detained service users were not allowed leave the unit unless accompanied by a nurse or if they were granted approved leave.

### **4.3 Access and Recruitment**

Information in relation to people who were subject to involuntary admission was sought from the three psychiatric inpatient units in the region that accept people subject to the involuntary admitted.

#### **4.3.1 Access and Recruitment of Participants**

On foot of ethical approval, the researcher arranged and met with the management and clinical staff (nursing and medical) of the study sites to explain the nature of the study. In particular, this meeting highlighted the important role that clinical staff (nursing and medical) would have in acting as gatekeepers as well as in terms of how people might be recruited. Time was given to inform and discuss clinical staff's role in acting as gatekeepers and careful consideration was given to discussing any potential concerns that staff might have in informing and supporting people in their potential recruitment. Due regard was given to the acuity of mental distress that some people might be experiencing, as well as difficulties people may have in understanding and retaining information, particularly in the early stages of hospitalisation. The process of 'assent' was explained to staff, i.e. people who may not be fully capable of providing written consent were considered to assent to the study if they verbally agreed to partake initially. However, it was explained to staff that all people would later be sought to provide informed consent.

All staff were reassured that the researcher would be guided by staff's clinical judgment as regards determining people's level of mental distress and the timing and suitability of recruiting people for the study. For example, it was acknowledged that people may be prescribed relatively high doses of neuroleptic and/or benzodiazepine medication which may affect people's levels of alertness, which in turn might question the appropriateness of recruiting and assenting/consenting people at this particular time. It was felt by the researcher that being guided by staff's clinical judgement was significant validation of their important role as gatekeepers. In particular, it was felt by the

researcher that it acknowledged staff's clinical judgement in determining what might be either potentially beneficial/harmful and potentially therapeutic/untherapeutic in terms of the people that they were supporting and caring for during a period of hospitalisation. In addition, it meant that people were assisted and supported in ensuring that they got the opportunity to partake in a study to make their voice heard. There was consensus that the ethical principle of first doing no harm was the overriding guiding principle. Similarly, clinical staff acknowledged the potential benefit and therapeutic value of having an independent researcher giving people the opportunity to have a discussion regarding their being subject to involuntary admission and the validating effect this may potentially have in terms of providing a means to listening to people's experiences. The researcher acknowledged the extra time implication this had on already busy clinical staff in terms of facilitating the researcher and the informing of people. However, clinical staff were overwhelmingly enthusiastic in support of the study with particular reference to the potential benefit this study may have for people subject to involuntary admission.

A range of strategies was employed to inform and recruit people who had been subject to involuntary admission during their hospitalisation. A poster was displayed in a prominent area of the units (**Appendix 1**) informing people of the study, giving brief details of the study and giving contact details of the researcher. In addition, nurses informed people of the study and gave those who were potentially interested an information leaflet detailing the study (**Appendix 2**).

The researcher contacted the nursing staff in the acute units on a daily basis by telephone (Monday–Friday), usually at 07.00 or 22.30 to ascertain the initials of people who had been subject to involuntary admission. These times were chosen by the researcher as it was his opinion that these were typically the 'least busy' times in terms of direct clinical care and a time that staff might have more time to discuss potential recruitment.

On contacting the nurses, the nursing staff informed the researcher who was interested in talking to the researcher about the study. A mutually suitable time was organised for meeting with the person to inform people of the study. The researcher travelled to the

units as frequently as was required to recruit people who were interested in participating.

Of those persons who had not been informed of the study, the researcher asked the nursing staff their opinion about the appropriateness of the timing of information given the potential acuity of the people's mental distress. In addition, the researcher was aware that a small percentage of people may present a risk of harm (albeit low) to others (violence) and that speaking to a researcher may inflame any potential situation(s). If it was the opinion of nursing staff that this was not the most suitable time, the researcher informed the nurses that he would log the initials and ask the nurse on further occasions regarding the appropriateness of informing and/or recruiting the person. The researcher would then, on further phone contact and/or travelling to the site, enquire again about their suitability for recruiting until such time as the acuity of the person's mental distress and/or capability in understanding and retaining information had abated. The researcher travelled to the sites as frequently as was required and felt this was beneficial in developing a working relationship with nursing staff. This in turn enhanced their willingness to inform and assist in the potential recruitment of people, making sure that each person subject to the MHA 2001 had an opportunity to have their voice heard regarding their experiences.

#### **4.4. Consent to Partake in the Study**

Nurses asked people whether they might be interested in talking to the researcher about the study. The researcher met with all potentially interested people in the units at this stage, agreeing a mutually suitable time. As people were often involuntarily admitted due to acute and severe mental illness, the researcher needed to be cognisant, depending on the phase of recovery, of the possibility that some people may not be fully competent to understand the details of the study whilst in hospital. If people were too unwell objectively as determined by the nursing staff to understand and retain information, people were informed of the details of the study at a later stage in hospital when they were more likely to understand. The researcher was aware that some people may have difficulties in understanding or retaining some details of the study. As people were or had been subject to involuntary admission, perhaps due to acute and or more longstanding mental health difficulties, they may not have been fully capable of

providing written informed consent in relation to the study at that time and, in particular, may not have been willing to sign a consent form. In such situations and given the low risk associated with participation, the person could 'assent' to partaking in the study if they verbally agreed to do so. However, all people were later offered the opportunity to choose to participate in the study and were required to provide written informed consent. Any assenting people that refused at this time to provide such written informed consent would have all data acquired in relation to them destroyed.

If potential participants agreed to meet the researcher, the details of the study were communicated via the information sheet for service users (**Appendix 3**) and via verbal explanation. Potential participants were told that they could discuss the information with a service user advocate or a family member. This information sheet included details regarding agreeing to be contacted about possibly partaking in a qualitative interview three months after their involuntary admission has ended and the request to consent to access medical notes to determine sociodemographic and clinical information as well as quantitative assessments such as insight scores to determine selection for interview. At this stage the researcher explained the information repeatedly if necessary or if requested so as to ensure that information was accessible before then asking the person to recall details of study as a means of concept checking. The researcher asked if they felt they required any additional or specific assistance (in supporting them in understanding and making a decision in whether to partake in the study or not (including having an advocate present)).

It was the researcher's experience, however, that potential participants were all competent at the time in providing consent to participation. Potential participants were really very open to discussing their experiences, which the researcher thought may not be the case prior to the commencement of the study. Most people were in fact very eager to register their interest in study participation. Many were angry regarding the manner in which they were detained and brought into hospital and this may have been a factor in their willingness to engage in a study that explored their views of their involuntary admission experience. Although this stage was about informing potential participants about the study, in actuality many people recounted their experiences at this stage. In some instances, the researcher felt that this was a missed opportunity to 'collect and record quotes' at a critical point when participants were very emotionally

laden. Invariably, the researcher spent as much time as was needed (in many over one hour) listening to people's experiences at this very emotionally laden stage. While it was frustrating that the researcher could not use these experiences as part of data collection, it did provide a useful insight into people's experiences which subsequently impacted the style of interviewing and questioning the researcher then used in the semi-structured interview guides.

Any potentially interested participants were then given the information sheet which detailed the study and included the contact details of the researcher and were informed that they were free to ask questions about the study at any time. Potential participants were asked if they were willing to participate. If they were, they were asked if they consented to their medical notes being accessed by the researcher. One participant did not wish to have their medical notes assessed at any stage. It was the researcher's experience that having consent to access medical notes as a separate consent section afforded the person more control in the situation. In addition, it was felt by the researcher that this contributed to the person's experience that they would be taken at face value and not be seen as just the experience of someone who had a 'mental illness'.

In addition, any potentially interested participants' contact details were sought and they were advised that they could discuss the study with their primary nurse, an advocate and or a family member. They were informed that they would be contacted again following their discharge from hospital (after three months of the ending of their involuntary admission and/or detention) and asked if they still wished to participate. They were informed that they could again ask further questions, seek clarification, have an advocate and/or a family member involved. In addition, they were informed that they were free to withdraw from the study at this stage if they so wished. A three-month timeframe was chosen in order to allow the service users a period of recovery time.

#### **4.4.1 Informed Consent to Partake in Straussian Grounded Theory Study**

The ongoing process of informed consent ensured that potential participants understood information given and were given adequate opportunities to discuss and contemplate

their participation. Consent was viewed as an ongoing process<sup>20</sup>. Information was provided in a format and manner that might be comprehensible and was thought to be cognisant of wide range of people and different backgrounds.

The researcher contacted potential participants once more (three months after the ending of the involuntary admission and/or detention) to again explain the study and ascertain whether they still wished to be involved in recounting their experiences in a tape recorded interview or not at this stage. The researcher contacted eligible participants by phone to remind them of the study and to again determine their willingness to be interviewed. In some instances, people did not have a phone or their mobile number was no longer active, which was frequently the case and was extremely frustrating at times. Therefore, in order to ensure that all potential participants were given the opportunity to be interviewed if they so wished, Community Psychiatric Nurses (CPNs) were very obliging in assisting and ascertaining their willingness to participate. If they agreed to participate, a date, time and a venue for the interview was negotiated in advance.

As previously stated, the details of the study were communicated via the information sheet for service users (**Appendix 3**) and via verbal explanation whilst the person was in hospital. On contacting the potential participant three months after the ending of the involuntary admission, the person was again reminded of their speaking to the researcher and their willingness to be contacted at this point regarding the study. It was the researchers' experience that most people remembered the researcher and remembered the details of the study. However, if interested, a verbal explanation of what the interview would entail was again provided. The researcher spent time answering any questions that people had and checked their understanding of the study. It was reiterated to people that they were free to withdraw from the study at this point and that any data pertaining to them already collected would be destroyed. Any questions were again answered

Again, it was the researcher's experience that some people were eager to talk about their experiences at this stage. While it was important to listen to what they had to say

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<sup>20</sup> Process consent is when the researcher renegotiates consent (Holloway & Wheeler, 2002).

at this point, it was emphasised that they would have an opportunity to recount their experiences on meeting the researcher if partaking in the interview. The researcher highlighted to potential participants that it might be useful to note their experiences ahead of the interview so that they got the opportunity to discuss these very important points on the agreed day.

In addition, potential participants were informed that they could have a service user advocate and/or a family accompany them to the interview with the researcher if they so wished. The contact details of the researcher was again provided should people have any further questions that they wished to ask after the telephone conversation had ended.

On the proposed day of interview, all potentially interested participants met with the researcher and details of the study were again provided via the information sheet and a verbal explanation. The researcher spent time with potential participants answering any remaining questions that they had. The researcher checked that the participant had a clear understanding of the study by again providing the information sheet and verbally checking their understanding of what it entailed. Prior to the commencement of the interview, the researcher answered any questions, informed the participant that they were free not to participate and then requested the participant to sign the consent form for interviewing and audio-recording (**Appendix 4**). Participants were assured that they were and had the right to withdraw at any time without penalty and that they may decline to answer any of the questions during the interview. One participant declined to have the interview audio-recorded.

People eligible to participate in the Straussian Grounded Theory Study were those who:

- (i) had experienced any activation of the MHA 2001 in any of the three sites between 01/05/2011 and 01/07/2013 for whom three months had passed since the ending of their involuntary admission/and or detention.
- (ii) agreed to be contacted about participating in an interview.
- (iii) were adults (over 18 years of age).
- (iv) had the capacity to consent to interview after three months of the ending of their involuntary admission/and or detention.

People excluded were those who:

- (i) were cognitively impaired due to intellectual disability or dementia and were not able to understand questions or respond.
- (ii) were currently inpatient.
- (iii) were children (under 18 years of age).
- (iv) did not feel well enough to partake in an interview and were at risk of further distress.

#### **4.5 Sampling and Theoretical Sampling in this Study**

Strauss & Corbin (1998) and Corbin & Strauss (2008) state that initial sampling decisions are deliberately made to start data collection through purposive sampling. At the beginning (Phase 1, Stage 1), a purposive sample was selected and this was based on the inclusion and exclusion criteria. After that and as preliminary data analysis progressed, decisions were then taken about theoretical sampling. Sampling decisions arose from questioning the data and the need to focus data collection on answering questions arising from the constant comparative process. This involved the inclusion of particular participants and the collection of particular data in a way that informed the emerging theory. Sampling was then progressed by using three types of theoretical sampling: open sampling, relational and variational sampling, and discriminate sampling (Strauss & Corbin, 1998a).

*Open Sampling* was used in Phase 1, Stage 2 and was used to sample participants on the basis of potentially different experiences. Sampling at this stage consisted of interviewing a complete range of views and experiences: (1) participants from different units; (2) a broad age distribution; (3) participants from both urban and rural backgrounds; (4) participants with short and longer hospitalisations; (5) participants with different diagnoses including schizophrenia and bipolar affective disorder; (6) participants who were admitted directly from the community and participants originally voluntarily admitted and subsequently subject to involuntary admission and/or detention; and (7) sampling by revisiting the previously collected and analysed data to further explore tentative concepts in light of their emergence in data analysis.

***Relational and Variational Sampling*** consisted of gathering data that ‘maximised’ or ‘minimised’ differences in the emerging concepts from the constant comparative process. Data was collected to allow for the greatest exploration of such concepts and categories. This was done to increase the likelihood of obtaining ‘new data’ in subsequent data collection in a way that would build on previous data analysis. For example, concepts such as: ‘grappling to make sense’, ‘fighting the system’ and ‘anger’ emerged early in the study. Thus, further interviews looked for instances of these concepts and the processes that influenced or hindered them. Consequently, the researcher, being cognisant of pursuing any emerging concepts in further interviews, focused on instances that enabled greater exploration of these concepts or any other concepts that subsequently emerged.

As part of relational and variational sampling, other concepts unrelated to those were further explored in data collection with later participants. Participants were selected using information from prior quantitative assessments, such an example was when concepts emerged around ‘insight’. Consequently, participants with significant changes on insight scores (as measured by the Scale for the Assessment of Insight in Psychosis (SAI-E) between Time Point 1 (at admission) and Time Point 2 (three months after the ending of their involuntary and/or detention) were selected and interviewed. This led to five more participants being sampled. Not alone were participants selected, but also theoretical sampling guided the questions used within interviews (Elliot & Lazenbatt, 2005), each interview and subsequent analysis provided direction for additional questions for the next interviews. The next step of relational and variational sampling was to focus data collection in a way that assisted in the development and refinement of theoretical categories that were not well developed in the emergent data analysis. After the first 36 interviews had been completed, a more focused interview guide was developed which concentrated on elaborating categories generated from earlier data analysis. Questions were asked in subsequent interviews that were reflective of the on-going data analysis. For example, concepts around ‘The Need for Others to be More Direct’ and ‘Safety’ were explored in more depth in the revised interview guide. The concept of ‘safety’ needed further exploration in later interviews, so it was necessary to explore why more people felt unsafe in the hospital. ‘Not Wanting Help or Information’ was another concept that required ‘new data’ to provide further clarity of the conditions that determined participants not seeking additional information.

*Discriminate sampling* focused on selecting participants or sites that maximised opportunities for comparative analysis (Strauss & Corbin, 1998a). For example, it was felt that those participants with a diagnosis of psychosis generally had a much more negative experience than other participants. Consequently, participants with a positive experience (as measured by a high Clients Assessment of Treatment Scale score) and a diagnosis of schizophrenia were sampled to see if their experience was different to those participants already sampled and to saturate the categories.

As part of discriminate sampling, a particular individual with two admissions to two separate sites over the course of the project was deliberately sampled. This participant was selected in order to compare what, if any, differences there were between the experiences across the two sites. Also, as the majority of participants interviewed were from a similar age group and had similar diagnoses, two participants over 80 years of age and one participant who had a diagnosis of Anorexia Nervosa were deliberately sampled to ascertain any comparison between these participants' experience and that of previously sampled participants. It was noted that some participants found Mental Health Tribunals were a 'waste of time', therefore two participants who had their status changed to voluntary at the tribunals were interviewed.

Theoretical sampling progressed until such time that theoretical saturation was complete. According to Corbin & Strauss (2008, p. 159) theoretical saturation is the point where "no new or significant data emerge and each category is well developed in terms of its properties and dimensions". This was determined when further data analysis did not discover any new or relevant concepts into the emergent theory. Corbin and Strauss (2008, p. 148) state that "only when a researcher has explored each category/theme in some depth, identifying its various properties and dimensions under different conditions, can the researcher say that the research has reached the level of saturation"

#### **4.5.1 Profile of Participants**

The participants in this study consisted of 50 adults who were subject to the MHA. The sample included 29 males and 21 females, from both rural and urban areas with both short and long admission periods. Participants were interviewed three months their

involuntary admission and/or detention had ended – the mean time was 93.53 days, the range was 6 days to 236 days. The number of detention days in hospital ranged from 2–120. The age range of the sample was 20–85 years, with the majority (54%) falling into the 25–54 bracket – consistent with national statistics. One participant declined to give consent to access medical notes; therefore, some demographics relating to this participant are not clear. Thirty-six participants had earlier experience of in-patient psychiatric care. Twenty-seven participants had previous experience of being subject to involuntary admission, while twenty-three participants did not. The number of previous involuntary admissions ranged from 0–17. Fourteen of the participants were brought to the unit by an AAT.

Twenty-one participants described how the Gardaí (Police) were involved during the process of their admission. Of the 50 participants, 40 were brought to the hospital with an application and a recommendation for involuntary admission. After examination by a consultant psychiatrist, 36 had an admission order completed (Form 6), thereby detaining them in hospital, while four were not detained and either stayed voluntarily or were discharged. Nine of the participants had initially come to hospital voluntarily and were then subject to Section 23(1) of the MHA (power to prevent a voluntary patient from leaving the approved centre for 24 hours), on examination by the consultant psychiatrist, seven had an admission order completed (Form 13) thereby detaining them in the hospital while two subsequently agreed to stay voluntarily.

Fourteen participants had a SCID (Structured Clinical Interview Diagnosis) of Bipolar Affective Disorder, 13 of Paranoid Schizophrenia, ten of Schizoaffective Disorder, two of Major Depressive Disorder and three of Alcohol Dependency Syndrome, two of Brief Psychotic disorder, one of Schizophreniform as well as one participant with Anorexia Nervosa and one with Substance Induced Psychotic Disorder. Two participants had no diagnosis while one was classed as ‘other’ due to the fact that consent to medical notes was declined. Two participants were interviewed who had their detention revoked at a mental health tribunal.

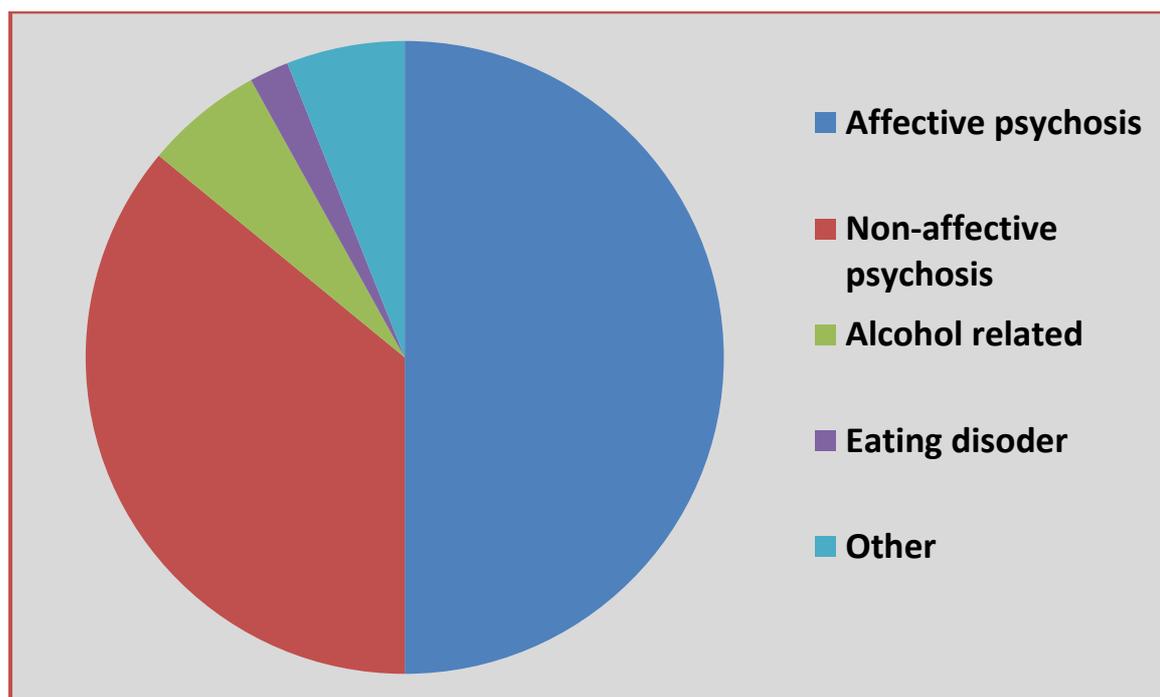
**Table 4.1: Participants’ Gender by Age**

Years	18–24	25–34	35–44	45–54	55–64	65 +
Male	2	6	10	6	5	0
Female	2	4	7	3	2	3
<b>Total</b>	<b>4</b>	<b>10</b>	<b>17</b>	<b>9</b>	<b>7</b>	<b>3</b>

**Table 4.2: Participants' Site by Form**

Form	Form 6	Form 13	Held	Total	%
Site 1	11	0	1	12	24
Site 2	5	0	0	5	10
Site 3	20	7	5	32	65
<b>Total</b>	<b>36</b>	<b>7</b>	<b>6</b>	<b>49</b>	<b>99</b>

**Figure 4.1: Participants by Diagnosis**



**Table 4.3: Site by Number of Detentions**

Number of detentions	0	1	2-3	4-5	6-7	8-9	10-15-	16-17	Total
Site 1	6	4						1	11
Site 2	16	3	7	3	2	1			32
Site 3	2	2		2					6
<b>Total</b>	<b>24</b>	<b>9</b>	<b>7</b>	<b>5</b>	<b>2</b>	<b>1</b>		<b>1</b>	<b>49</b>
<b>%</b>	<b>49</b>	<b>18</b>	<b>14</b>	<b>10</b>	<b>4</b>	<b>2</b>		<b>2</b>	<b>99</b>

**Table 4.4: Type of Applicant**

Form	Type	Total	%
1	Spouse, Civil Partner, Relative	17	34
2	Authorised Officer	1	4
3	Garda Síochána	20	41
4	Any Other Person	2	4
23(1)	Power to prevent a voluntary patient form leaving the approved centre for 24 hours	9	18

## **4.6 Data Collection**

Data was collected by means of semi-structured audio-recorded face-to-face interviews. Interviews lasted between 8 and 95 minutes – the mean length of interview was 47 minutes. The fact that the some participants who were interviewed were at varying stages of recovery of psychosis may have hampered the fluency and flow of some the interviews. For example, some had difficult in articulating and lacked the ability to find the right words to describe the experience, which affected the length of the interviews. One participant spoke at length about hospitalisation but little on the clinical practice form; nevertheless, the interview threw up some interesting points about the feeling of frustration at the lack of progress, the safety features of using the MHA, and the fact that her consultant was not on duty at that time. One participant cut the interview short as he was waiting for a lift, which was disappointing, but despite its short duration (8 minutes) it did yield information that was pertinent to analysis. A total of 50 interviews were conducted with people who were subject to involuntary admission over three sites. Permission was sought to record interviews. One participant chose not to be audio recorded, field notes were recorded in this instance.

### **4.6.1 Development of Interview Guides**

Two interview guides were developed to assist with the delivery of interviews. The first was a topic guide (**Appendix 5**) that consisted of an open-ended question as well as follow-up questions. The open ended question, phrased as ‘With regard to your recent admission, can you tell me of what happened to cause you to be admitted to hospital in your own time and in your own words?’, was posed to each participant. This open-ended question allowed participants sufficient scope to share their experience and tell their story from their perspective. However, the researcher did act strategically by asking further questions if something arose during the interview that was not clear or that required further elaboration.

Follow-up questions were also developed on certain topics that needed to be explored regarding the participants’ pre-admission, admission, hospital stay and post discharge experiences. Had the participant not shared their experiences of these topics in their response to the introductory open-ended question, then these follow-up questions were asked and used flexibly during the interview to help to stimulate the participants’

memory. The interview guide was developed and distributed to the project steering group<sup>21</sup> and was agreed on.

The topic guide was then piloted with two individuals; this was done in preparation and training for its use with future participants and the findings did not form part of the data. The pilot was used to test the ability of the introductory question and follow-up questions to generate data of sufficient quality and depth that was relevant to the research question. As a result of the piloting, the importance of using periods of silence was highlighted and the prompts for those participants who required further guidance, or for those who had little to say, were phrased differently in order to encourage participants to elaborate further on their experiences. The researcher then used this topic guide to interview participants in Phase 1 and Phase 2 of the study.

After analysing the data from the initial interviews, a second interview guide (**Appendix 6**) was developed which differed from the first guide. Derived from the analysis of the previous data, a stock of new and more focused questions needed constructing. These questions were developed to gain a deeper understanding of the experiences of being involuntarily admitted and to elaborate on concepts that required further development after the initial analysis. Comparative questions were used to enable a deeper understanding of the participants' experience and to elicit the commonalities and differences across participants. Examples of comparative questions include:

- Was this something that happened to you?
- Is that something you can identify with?
- How was it for you?
- Some people told me that they did not want help in hospital, and spoke of not talking to other patients or staff. What was the case for you? If not ... what was your experience?

Therefore, later interview questions became more focused on the emerging theory from the initial analysis and were used to help clarify how processes worked.

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<sup>21</sup> The project steering group controlled the governance of the MHC project, was chaired by the Principal Investigator and included the co-applicants, the collaborators, and a service users representative.

#### **4.6.2 Approach to the Interview**

Interviews took place in out-patients, day hospitals, day centres, participants' homes, hotels and one was conducted over Skype™. It was the researcher's opinion that the participant should decide on the location they preferred to meet. It was felt that some participants may not wish to go to mental health facilities or have any association with the mental health services, which may impact on their willingness to be open and honest about their experiences. The researcher felt that giving participants the choice of the location provided a sense of neutrality and control which may have provided a more therapeutic milieu that was responsive to any power differentials that may have ensued otherwise. However, the researcher was surprised that so many people requested to meet at mental health facilities. This prompted the researcher to be aware that many of the participants might not consider such places in a negative light.

On arrival at the agreed location, the participant was greeted and some time was spent talking to them before each interview. This centred around small talk and social chat in an attempt to make the participant feel at ease, to establish rapport, build trust and to minimise any perceived power imbalances. The fact that the researcher had already met the majority of the participants when they were being recruited for the study while in hospital was also beneficial in building trust. The researcher asked the participants if they would like a cup of tea or coffee before the interview commenced, or accepted participants' hospitality if offered a cup of tea in their home. The researcher ensured that the participant was comfortable before the interview commenced and all of the participants appeared at ease. Appropriate time was given to the participants to allow them to settle into starting the interview and the format of it was discussed. The time the researcher spent assisting the participant in settling into the interview was time well spent as it is the researcher's opinion that this contributed to participants being open and honest in the experiences that they shared with the researcher. All of this facilitated in limiting any potential power differentials in an attempt to help participants feel in control of the situation. In addition, the researcher attempted to minimise power issues through verbal and non-verbal communication and through reducing the power structures with the environment. For example, interviews took place in people's preferred location; however, when they took place in mental health facilities, the researcher made sure that he was seated beside the participant and not behind a desk.

The researcher also considered what he was wearing during the interview and made sure that he was dressed casually and not wearing a tie or a suit.

On interviewing, the researcher listened to the participants' stories whilst using verbal prompts, summary and paraphrasing to ensure that the researcher was capturing participants' experiences. Indeed, in other instances the researcher had to 'get comfortable with silences' in response to some questions – a point that was highlighted by the researcher's supervisors. The researcher learned that in such situations where there was silence at certain points during the interview, it was very often the case that eventually very important and rich data would follow if this silence was 'allowed'.

Following the interview, the researcher spent time with the participants, which allowed for some interesting conversations to take place. Participants were thanked, were made to feel that their participation was valuable, and were asked if they would be comfortable that the issues recorded in the interview be used in the study. On occasions, further conversations about detention would ensue and on two occasions the researcher asked and was allowed by the participant to turn the recorder on again to capture this very important information.

Many participants expressed the view that they never had a chance to 'tell the story' before in this way. This highlights the fact that even though mental health professionals continue to be involved with people, they may not necessarily be tapping into eliciting and assisting people in processing their experiences and feelings surrounding involuntary admission. Several participants expressed an interest in what the data would be used for and were keen that recommendations should go towards making the experience more satisfactory.

The researcher had some prior experience of conducting qualitative interviews – also with people who had been detained – as part of his Masters in Psychology. Having trained and worked as a Psychiatric Nurse was helpful in interviewing people who had been detained. The researcher recalled from these interviews the professional interference in terms of wanting the person to 'see that they needed to be detained', which he had to keep in 'check' at that time. With the prior experience of interviewing people who had been detained, the researcher can truly say that he no longer wished

that people ‘see that they needed to be detained’. In fact, what was foremost in his mind on interviewing was allowing the participant to recount their experience good, bad or indifferent. The researcher felt confident that he was not influencing the interviews and that participants were open and honest about their experiences.

The researcher paid attention to the issues that concerned the participants while simultaneously being careful not to influence the content of their responses. Listening back to the audio recording and reading the transcripts ensured that the researcher did not influence the data. Although data collection was time consuming, the researcher truly enjoyed the interview process and felt humbled that participants were so willing and open to recount their experiences which were sometimes very traumatic and emotionally laden. It also felt like it was ‘therapeutic’ for the participant to have someone to listen to their experiences and in a sense support them in ‘working through’ their experiences. Some people had difficulties in remembering certain periods of their admission and critical stages such as having been in seclusion. In the researcher’s opinion, this could have been attributable to being sedated or, in some instances, due to the fact that participants preferred not to remember. The researcher was cognisant of his responsibility to respect people’s right not to talk, as it was his opinion that it was their way of coping and moving on from their experiences.

#### **4.6.3 Style of Questioning**

The first interview guide opened with the question:

- With regard to your recent admission, can you tell me of what happened to cause you to be admitted to hospital in your own time and in your own words?’

Participants were encouraged to tell their story from their perspectives. The researcher felt that because the question stated ‘in your own time and in own words’, it allowed the participant the opportunity to be open, honest and talk about what they felt was important, thereby alleviating any power imbalance. Follow-up questions were also developed on certain topics that needed to be explored regarding the participants’ pre-admission, admission, hospital stay and post discharge experiences. Had the participant not shared their experiences of these topics in their response to the introductory open-ended question, then the follow up questions were asked.

The format of the second interview guide accommodated for participants being asked the same initial question, but follow-up questions became more specific following analysis of previous data. These questions were used to elicit variations in concepts for further comparison. The interview guide therefore became more theoretically sensitive as sampling progressed. Examples of such questions included:

- Was that something that happened to you?
- Is that something that you can identify with?
- How was it for you?
- What that the case for you – if not, what was your experience?

These were what May (1991) calls comparison questions as they elicit comparisons between participants. In addition, the researcher was cognisant of the anger that was palpable when recruiting people in hospital. This influenced the type of questions the researcher asked during the interview so that people got the opportunity to discuss this, but only if they wished.

## **4.7 Data Analysis**

### **4.7.1 Process of Data Analysis**

All interviews were audio recorded and then transcribed verbatim by a professional transcriber, after which each typed transcript was checked for accuracy. In the event of any errors in the transcripts, or where the text did not match the audio, the researcher then inserted any modifications to the transcript according to the audio recording.

### ***Three Phases of Theory Development***

Data collection and analysis were divided into three phases in order to achieve concurrent data collection and analysis. This section provides a description of these three phases involved in the development of the theory.

Phase 1 was undertaken in two stages. Four people were purposively sampled and interviewed in the first stage with each interview then being transcribed. Following this, analysis began with open coding, the aim of which was ‘opening up’ and starting to think systematically about the data in order to explore emerging concepts and to develop provisional categories. Each transcript was read and re-read whilst simultaneously listening to the audio of the interview in order to sensitise the researcher to the data. Theoretical tools were used in this Phase 1 to understand the data. This involved asking questions of the data, looking for words that indicated time, looking at

language, looking at emotions expressed and the situations that aroused them. Following this, an open code with a short descriptor depicting the research participants' experience was assigned using either: (1) the participants' own words (*in vivo* codes) such as 'scared' or 'angry'; or (2) using open codes assigned by the researcher that were reflective of the concept that underpinned pieces of text, such as 'Fighting the System'. These codes were tentative and in some instances, pieces of text were coded a number of different ways – this was done to list all possible concepts in the data. A new open code was generated every time a new concept was identified in the text. Memos were written to deepen understanding of what was going on and to raise codes to concepts.

In the second stage of Phase 1, a further 14 people were interviewed. More open coding was undertaken. The aim of this stage was to continue with open coding and to identify concepts and develop categories. Each transcript was open coded individually. Data that shared similar characteristics to an already established open code was coded to that open code. As coding continued, not only did the list of open codes rapidly expand, but new concepts began to emerge with some concepts reoccurring. Using comparative analysis, questions were asked of the data, comparisons were made to previously coded data and identified concepts were compared for similarities and differences. Some code names were changed after re-reading the coded segments. At this stage of open coding there were 345 codes for the first 18 interviews. Interview material was explored and reviewed in the process of defining concepts. A series of diagrams were drafted either on an A1 Flipchart Pad or on Microsoft® Word documents using SmartArt to facilitate the arrangement and rearrangement of codes within categories and to suggest links between categories. Concurrent with data analysis, theoretical memos were written in order to refine concepts and to aid with the theoretical development of categories.

In Phase 2, a further 16 interviews were collected using theoretical sampling and axial coding for the first 18 interviews were undertaken. The aim of this phase was to reassemble the data by developing and relating categories to their subcategories in terms of their properties and dimensions. In order to assimilate axial codes, all open codes were displayed together on an axial code development table (**Appendix 7**) and codes were then collapsed into axial codes. In order to link categories to their subcategories, data was continually compared and questioned within and between categories. Some categories were a subset of another category, while others were

renamed. Theoretical comparisons were used to think about the properties and dimensions of categories. If the links between categories were more subtle in nature, an analytical tool called the paradigm was used to establish these links, which involved applying a set of questions to data to look for evidence to explore what conditions, contexts and consequences impacted a category. Individual memos were written for the categories that had emerged from axial coding.

From this process, 345 open codes were reduced to 44 axial codes, which were then integrated and organised into a logical, coherent, emerging theory of six higher order categories. The analysis of this phase formed a preliminary coding framework and was then used to guide the analysis of the remaining 16 interviews (**Table 4.5**). Using constant comparison, the latest transcripts were coded and the coding at this stage was compared with the framework to determine its fit. If the new data emerged did not fit the coding framework, or if it required a different subcategory to explain its meaning, then either the framework was revised to accommodate the emerging data, or a new subcategory was created within the framework. Subsequent to this, the older transcripts were re-read to see if that subcategory had been overlooked in the older transcripts.

Phase 3 involved selective coding, further categorisation of data and the development of a theoretical sample based on the emerging theory. The aim was to have more focused data collection and to further explore, refine and integrate the major categories in order to select a core category as well as to integrate and write the developing theory.

Diagramming was used to visually depict the relationships between categories and to aid integration. Sorting of memos was undertaken in order to establish the relationship between generated categories and to explore how old and new categories fitted together. Using existing categories and their linkages, a storyline was written to formulate a theory of the data. Six higher order categories explained the theory as a whole and linked to the other categories. The preliminary core category, the experience of involuntary admission, was categorised 'Preserving Control' and the generated categories formed its properties.

Through further interviews, the focus now was to refine categories that were not well developed and to verify the core category. The data analysis from Phase 2 made the

researcher more sensitive of what to look for in future data. A more focused interview guide was then developed, focusing on elaborating on categories generated from earlier data analysis. Some categories such as 'Not Wanting Help in Hospital' required new data and needed to be explored in subsequent data collection with later participants. The next step of theoretical sampling aimed at recruiting such participants, meaning that sampling at this phase was therefore guided by the emerging theory. This led to more participants being selected and interviews were carried out focusing on exploring changes in insight scores.

As in the previous phases, the new interview transcripts were read, and the previous were re-read and their fit with the framework was analysed through constant comparison. Pertinent theoretical literature was concurrently examined throughout this phase to sensitise the researcher to what was going on with the evolving phenomena. The new data was repeatedly explored within and between incidents, checking for evidence or counter evidence to verify relationships and to ensure accuracy and grounding. Sampling continued until theoretical saturation was complete. Sixteen more interviews were carried out in Phase 3. On the completion of all three phases, 'Preserving Control' was identified as being relevant as the core category.

**Table 4.5: Overview of the Phases of Data Collection & Analysis**

Phase	Aim	Number of Interviews	Outcome	Strategies
1: Stage 1	<ul style="list-style-type: none"> <li>▪ To explore concepts and identify initial categories</li> <li>▪ To search for provisional categories</li> </ul>	4	<ul style="list-style-type: none"> <li>▪ ‘Opening up’ the data</li> <li>▪ Raising terms to concepts</li> <li>▪ Formation of initial categories</li> </ul>	<ul style="list-style-type: none"> <li>▪ Purposive Sampling</li> <li>▪ Listening to audio recordings and reading transcripts</li> <li>▪ Open coding</li> <li>▪ Questioning the data</li> <li>▪ Making comparisons</li> <li>▪ Memo writing</li> </ul>
1: Stage 2	<ul style="list-style-type: none"> <li>▪ To compare concepts for similarities and differences</li> <li>▪ To theoretically develop categories</li> </ul>	14	<ul style="list-style-type: none"> <li>▪ Development of tentative categories</li> </ul>	<ul style="list-style-type: none"> <li>▪ Open and Relational Sampling</li> <li>▪ More open coding</li> <li>▪ Constant comparison analysis</li> <li>▪ Use of flip-flop technique</li> <li>▪ Conceptual diagrams on SmartArt</li> <li>▪ Theoretical memo writing</li> </ul>
2	<ul style="list-style-type: none"> <li>▪ To systematically develop categories and subcategories</li> <li>▪ To determine how properties vary dimensionally</li> </ul>	16	<ul style="list-style-type: none"> <li>▪ Linking categories and subcategories at level of properties and dimensions</li> <li>▪ Development of a preliminary coding framework</li> <li>▪ Data ‘reassembled’</li> </ul>	<ul style="list-style-type: none"> <li>▪ Relational and Variational Sampling</li> <li>▪ Relabelling and collapsing codes into categories and subcategories</li> <li>▪ Axial coding</li> <li>▪ Use of a Axial Code Development Table</li> <li>▪ Use of the paradigm model</li> <li>▪ Theoretical comparison</li> <li>▪ Use of the preliminary coding framework to guide the analysis of the remaining transcripts</li> <li>▪ Development of a more focused interview guide</li> </ul>
3	<ul style="list-style-type: none"> <li>▪ To elaborate on categories</li> <li>▪ To integrate categories</li> <li>▪ To identify a core category</li> <li>▪ To verify relations</li> </ul>	16	<ul style="list-style-type: none"> <li>▪ Focused data collection</li> <li>▪ Theoretical saturation</li> <li>▪ Writing up developing theory</li> <li>▪ Verifying and theory building</li> </ul>	<ul style="list-style-type: none"> <li>▪ Discriminative Sampling</li> <li>▪ Selective coding</li> <li>▪ Sorting memos</li> <li>▪ Diagramming</li> <li>▪ Writing a storyline</li> <li>▪ Theoretical Sampling</li> <li>▪ Writing a narrative account of the theory</li> <li>▪ Checking for evidence and counter-evidence of the framework</li> </ul>

#### **4.8 Writing of Memos**

Memos were written throughout each of the three phases of theory development. This consisted of writing memos around (1) open coding, (2) axial coding, and (3) the building of concepts. Each phase outlines the approach taken to memo writing. Memos were written to deepen understanding of what was being observed in the data and to document the thinking involved in the analysis. All memos were typed on Microsoft® Word documents and imported into the computer assisted qualitative data analysis Software; QSR International Pty Ltd. Version 10, 2012 (NVivo 10).

##### ***Memos at Open Coding***

Exploratory memos were written during the open coding phase (**Appendix 8**), which enabled the articulation of open codes. In the early stages of open coding, immediately after each sentence or more frequently a paragraph, was open coded excerpts – short quotes or phrases from the raw data were copied to a Microsoft® Word document and a memo was written on each code. These memos were used to record musings on each code and to document analytical thoughts that arose from open coding. This allowed the ‘opening up’ of the data and enabled the researcher to stimulate and start thinking about the data, thereby keeping data analysis open to all possibilities.

Memos at this phase were also used to document any observational notes regarding events or interactions observed during the course of the interviews. In some instances, notes were written in memos that referred to the style of the interviewing techniques, this alerted the researcher to be cautious and to separate the role of ‘nurse’ from the role of ‘researcher’. In the later stages of open coding and in order to be theoretically sensitive to the evolving theory, memos were used to document any ideas about pieces of literature that may be relevant to the evolving theory.

As memoing continued, after each interview a descriptive account of the participant’s story was written. This was done to ensure that none of the participant’s story was lost during the process of data analysis and these were re-read after data analysis to ensure the developing theory was a true reflective of that participant’s story.

##### ***Memos at Axial Coding***

Further memos were written during the axial coding phase. These theoretical memos were written to deepen understanding of the data and to aid with the theoretical development of emerging concepts and provisional categories. These memos were also

used to caution against ‘pet theories’ and thereby allowed for the theory to evolve from the data. Memos at this phase were also used to ask questions of the data – data was continually compared and questioned within and between categories. The aim of these memos was to facilitate a questioning of the data, to develop and link categories to their subcategories. Through this further memoing, methodological-type notes were also incorporated in memos which generated ideas on what to explore in subsequent interviews in a way that directed theoretical sampling.

As data analysis progressed, summary memos were written for the existing categories that had emerged from the axial coding phase. This shortened the several memos that had been written in a more cohesive way, allowing the researcher to know if the categories were saturated and were well developed in terms of properties and dimensions.

### ***Memos on Building Concepts***

At the later stages of theory development, memos that were already written were explored and reviewed in order to compare the existing categories and concepts for similarities and differences. Following this, the sorting of memo was undertaken, a phase in which memos were compared and merged. This was implemented in order to establish the relationship between generated categories and to allow for the conceptualisation of the data analysis. As the theory was developing, concepts were identified and memos were then written (**Appendix 9**). These memos functioned to refine categories that were not well developed and to verify the core category. As the analysis progressed, the concepts were further defined and refined and developed in a way that facilitated the core category of ‘Preserving Control’. Using existing categories and their linkages, a storyline was written to formulate a theory of the data.

While data analysis was presented in a linear fashion here, it was a tremendously difficult process that was extremely frustrating and time consuming. Open coding resulted in over fracturing the data, which led to hundreds of codes. In the axial coding stage, the specific strategies to assist with axial coding were more complicated than anticipated and axial coding was initially very descriptive. As a result, it was difficult to raise the analysis from description to conceptualisation. The researcher spent days

writing memos which was just loose thinking and which deviated from theory development. The mantra ‘trust in emergence and trust the process’ was exasperating.

Undoubtedly, discussing the issues of data analysis with my supervisors was beneficial and helpful as it allowed the researcher to return and focus on the Corbin and Strauss (2008) strategies. Indeed, memoing was also useful in terms of enhancing theoretical development as well as focusing more on how the person resolved their main concern. However, what was most helpful in the end was articulating the main concern and the selection of the core category that ultimately facilitated the development of the theory. When the researcher began the difficult and time consuming process of writing the theory, this did eventually result in a conceptually dense theory. However, this did take several redrafts to ensure that the categories were integrated into the process. Like everything in grounded theory, perseverance and time was critical to the eventual theory development.

#### **4.9 Data Management**

##### **Use of Data Analysis Software**

As the transcription of interviews was completed, the first four transcripts were manually open coded on paper. Given the large amount of raw data that would be generated from the transcription of interviews, as well as what would be produced from the subsequent analytical process of the open and axial coding of these interviews, it was decided that the computer assisted qualitative data analysis Software; (NVivo 10) would be of assistance with the storage and organisation of all the data. Interview transcripts were imported into NVivo 10 as the transcription of interviews was completed, and NVivo was subsequently used throughout all phases of coding and theory development.

Open and axial coding was undertaken within NVivo; however, the auto coding function was not used and open and axial codes were therefore assigned by the researcher. In that way, the data analysis software did not carry out the data analysis but it did support it. A coding framework was developed within NVivo after the first 34 transcripts were coded and this coding framework supported the analysis of the

remaining 16 transcripts. The software also provided an audit trail of the open and axial codes.

NVivo also facilitated the storage of memos, which had been typed on Microsoft® Word documents throughout the process of theory development and were subsequently imported into the software. During the process of reviewing of coding, the software allowed for the list of categories and subcategories to be available for reference; in this way, NVivo enabled the easy retrieval of data which greatly assisted the process of theory development (**Appendix 10**).

This study produced large amounts of raw data, and NVivo allowed for: (1) the storage and management of all the transcripts; (2) the development of a logical structure to carry out data analysis and management; (3) the storage of demographics on 50 participants; and (5) the storage of quantitative data on the 50 interviewed participants.

#### **4.10 Ethical Considerations**

Due to the sensitive nature of being subject to an involuntary admission, some people may not wish to discuss the event. For such people, it was seen as an event in the past which was best put behind them and not recalled. However, for others, the interview in itself could provide a space to discuss aspects of involuntary admission not previously mentioned to others, and therefore aid in emotionally processing their experience. However, the researcher was cognisant that recalling of such events may lead to emotional distress. Therefore, procedures for the protection of participants were strictly followed as outlined by the International Council of Nurses (2003).

##### **4.10.1 Ethical approval**

The study was granted ethical approval as part of the MHC project; ‘A Prospective Evaluation of the Operation and Effects of the Mental Health Act 2001 from the Viewpoints of Service Users and Health Professionals’ (University Ethics Reference Number: 04/Mar/11) (**Appendix 11**). Approval was obtained from one academic institution and each of the three hospital-based ethics committees. Personnel on the steering group completed the research application form for ethical approval.

#### **4.10.2 Maintaining Confidentiality and Anonymity**

Many strategies were taken to maintain the principles of confidentiality and anonymity. Participants were informed that their information was treated with confidence, that they were not named and that nothing that they told was reported in a way could identify them. However, while confidentiality and anonymity, were paramount, people were informed that although data would be confidential, a disclosure which potentially placed them or others at risk (e.g. suicidal or homicidal intent) would be communicated to their treating psychiatry team.

To maximise confidentiality and anonymity, a code number only was assigning to participants. The master list was kept away from data so that it was not possible to identify participants, and only the researcher had access to the list. All data was anonymised and was kept in a safe secure setting, in a locked drawer in a filing cabinet in the researcher's office. The researcher was the only one to have access to the data. The participant's name was not attached to audio-recorded interviews or to any transcribed interview. The transcriptionist was the only professional, along with the researcher, who had access to the interview recordings and was as far as reasonably practicable not known to the participants. Audio recordings were despatched via the HEAnet FileSender and were deleted when the transcript was completed. All data collected were stored in a secure manner in the researcher's office or on a password protected and encrypted computer. As per the (Data Protection (Amendment) Act, 2003) data should be destroyed within a specified period, in this case the data will be stored for five years according to university guidelines, at which point they will be destroyed. Any research data stored on a work laptop and a desktop were password protected and encrypted as per the Data Protection (Amendment) Act 2003. The transcribed interviews and researcher's memos were as soon as reasonably practicable imported to NVivo.

All identifying material was removed from interview transcripts. Personal identifiers such as names of people and places were removed. For example, the word 'place' or name of a professional group was put in brackets, i.e. [PLACE] or [CONSULTANT]. The latter represented a professional's (nurse, GP, occupational therapist or Garda)

name that was deleted for confidentiality. Although the name was deleted, it was felt that naming the professional group was important in terms of understanding participants' experiences with professional groups. No identifying information will be used in any publications of study.

#### **4.10.3 Protection from Harm**

The very nature of the involuntary admission meant it was conceivable that topics of a sensitive and personal nature would arise. In some instances personal and ethical issues may emerge both in the process of recruiting and in interviewing participants. Given the personal nature of aspects of being involuntary admitted some participants could get distressed or upset. Applying the principle of beneficence and non-maleficence, it was incumbent on the researcher to ensure that any upset did not lead to any harm. Participants were informed that a service user advocate could be made available to the participant to accompany them to the interview with the researcher to offer support to participants during the interview and post-interview if they so wished. However, although this was offered, it was never actually enacted.

Given the deprivation of liberty and infringing nature associated with being involuntary admitted, there may be incidents that were quite sensitive or even humiliating for the participant. Therefore, the researcher was sensitive to minimising any distress or a 're-living' of these experiences for all participants. The researcher had previously met the participants in hospital and in these cases, there was an opportunity to build rapport. Therefore, it was important to build rapport and the researcher attempted to achieve this by engaging the participant in conversation, thanking them for showing interest in being part of the study, and acknowledging the personal nature of experiencing an involuntary admission. It was stressed that the purpose of the interview was to gain a better understanding of what it was like to be involuntarily admitted, the 'event', but not to interfere in the private and personal side of the participant's life. At the beginning of the interview, participants were advised that if they did not want to answer a particular question or talk about a particular issue then they were free to do so. During the interview, the researcher set out to make sure that the interaction promoted a sense of 'sharing the experience' as opposed to data gathering. This was achieved by showing interest in what the participant had to say and repeating responses to seek clarification

while illustrating the researcher's desire to really hear what participants were saying. During the course of the interview, if the participant stated that they did not recall certain events or appeared unwilling to discuss certain aspects of their experience, the researcher moved on to other questions. Throughout the interview, the researcher continuously observed participants non-verbal responses to determine if they were in distress in any way. The researcher acknowledged emotionally distressing undertones and managed periods of upset. Although some of the participants became upset and started crying during the interview, this was managed by stopping the interview and providing some time for the person to further talk about their feelings. The interview only continued after the participant and the researcher were satisfied that continuing the interview would not cause any further emotional distress. If a participant stated that they could not recall a particular aspect of the admission or hospital stay, this was not pressed lest it be perceived as painful and outside the participant's desire to be recalled. Given the varying stages of recovery that participants may have been in, the researcher remained vigilant of the pacing of the interviews and allowed the participants sufficient time to speak, as well as recognising any difficulties participants may have had in expressing themselves and tailoring the interview so that it was meaningful to where that person was at that time. On finishing the interview, the researcher asked participants what their thoughts were on the interview and to check whether it had elicited feelings that caused them distress. This follow-up interaction facilitated a potential dialogue on such issues and allowed the researcher to gain a sense of how the person was feeling on completing the interview. Invariably, participants were satisfied to share their experience and there were no negative consequences. Participant upset was a rare occurrence and the one occasion it occur, stopping the interview and recording, spending time listening to the participant and checking that they were not distressed as sufficient in managing the situation. At all times, the participants' well-being took priority over the research study.

#### **4.11 Maintaining Rigour**

Various factors were taken to enhance the credibility, transferability, dependability and confirmability of the study. As regards credibility, the emerging findings were presented at project steering group meetings and it was felt that the theory was 'recognisable' within the context of an involuntary admission (Strauss & Corbin,

1998a; Corbin & Strauss, 2008). In addition, the development of the second interview guide (derived from the analysis of previous data) enabled the emergence of commonalities and differences across participants. These more focused questions were developed to gain a deeper understanding of peoples experiences and to elaborate concepts that required further development. Examples of comparative questions were”

Was that something that happened to you?

Is that something that you can identify with?

How was it for you.?

A service user representative who was involved in the project felt that the developed theory encapsulated people’s experiences, was reflective of what was experienced during an involuntary admission, made sense and gave a viable account of the admission process and treatment experience in an in-patient acute psychiatric unit.

As regards transferability, a detailed description of the study settings was provided in this chapter. To examine transferability and fittingness of the theory, the study findings were presented at two international conferences and at academic meetings. Feedback suggests that the findings could be applied to people’s experiences before, during and after a prison sentence, which suggests that it has transferability.

As regards dependability, this study was adherent with the Grounded Theory methodology and followed the analytical strategies laid down by Corbin & Strauss (2008). A detailed account of how the study was conducted is documented in detail in Chapter 3 and this chapter and this enables the reader to follow the study process. The dependability of the study was strengthened as four experienced qualitative nurse researchers (expert in Grounded Theory), were consulted during data analysis on the accuracy of emerging subcategories and categories.

As regards confirmability, the use of participant quotes enhanced the confirmability of the study and supported the emerging theory, ensuring that it was one that was reflective of the participants’ stories - *in vivo* codes were used in the open and axial coding phase, i.e. words used by participants during the course of the interview. This ensured that the categories and subcategories that developed arose from the data itself. The appendices on memos (documenting thought processes) and the screen shots of Nvivo, gives

examples of the process of theory development and provides an “audit trail”. The role of reflexivity is detailed in the next section

#### **4.11.1 Reflexivity**

Confirmability requires that the researcher provide information on their background. The researcher, with 11 years’ experience working in the clinical environment as a psychiatric nurse and community psychiatric nurse, as well as having studied psychology to Masters level, has a keen interest in people perspectives and psychological theory. As a psychiatric nurse who worked with people who experienced involuntary admission, the researcher is only too aware that it can be an incredibly difficult experience for those involved, and is therefore not only interested in its psychological impact, but also seeks to give ‘voice’ to those who have had the experience. As a result of the ‘working knowledge’ of the sample group, there was a sense of dissonance between participants’ thinking style and the researcher’s way of thinking as a professional; however, there was also a sense of trying to ‘meet in the middle’ as a researcher. The researcher was cognisant of the importance of professional interpretation of the psychological possesses involved in participants’ experience of involuntary admission.

#### **4.12 Summary**

This chapter provided an overview of the research method used in the study with specific emphasis on the process of accessing and recruiting participants, theoretical sampling, the phases of theory development, ethical considerations and the process of maintaining rigour.

## **Chapter 5: Findings: Preserving Control**

### **5.1 Introduction**

This chapter describes the Theory of Preserving Control (ToPC) in detail. It begins with an overview of the ToPC, before moving on to describe the first category ‘Losing Control’.

### **5.2 Theory of Preserving Control**

The ToPC emerged from the description of participants’ experiences of their loss of control when faced with an involuntary admission under the Mental Health Act (MHA) (DoH & C, 2001). In addition, it describes the participants’ desire to manage the loss of control and the subsequent responses and strategies that they adopt to reinstate control over their personal, emotional and social lives.

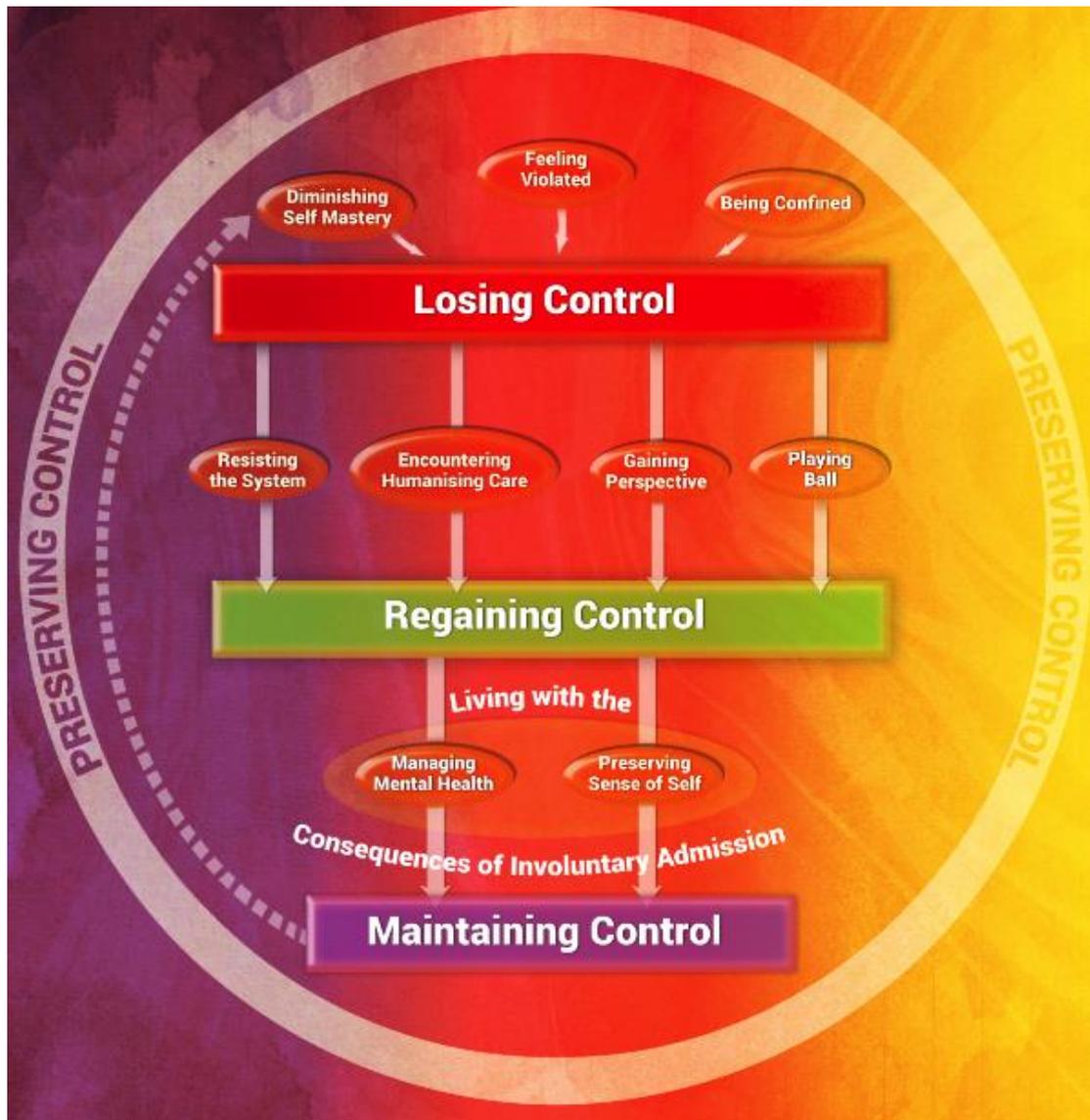
The core category ‘Preserving Control’ encapsulated the way in which participants strove for control before, during, and after an involuntary admission. ‘Preserving Control’ was generated to explain the relationship between the three categories: ‘Losing Control’, ‘Regaining Control’, and ‘Maintaining Control’. There were three subcategories that contributed to ‘Losing Control’; these were ‘Diminishing Self-mastery’, ‘Feeling Violated’, and ‘Being Confined’. Meanwhile, ‘Regaining Control’ was comprised of four subcategories, namely ‘Resisting the System’, ‘Encountering Humanising Care’, ‘Gaining Perspective’, and ‘Playing Ball’. Finally, ‘Maintaining Control’ consisted of two subcategories: ‘Preserving Sense of Self’ and ‘Managing Mental Health’, which were employed as participants made efforts to ‘Living with the Consequences of Involuntary Admission’.

The ToPC describes the ongoing efforts that participants used to resolve their internal and external loss of control in order to regain some semblance of control again. Participants did this by means of ‘Regaining Control’ and ‘Maintaining Control’. All participants progressed through each of the three phases. ‘Losing Control’ was experienced during the involuntary admission procedure, either for a short time or for protracted periods of time during participants’ hospitalisation. ‘Regaining Control’ describes the way(s) in which participants managed to regain their sense of emotional

equilibrium or indeed a lessening of the restriction associated with being in hospital. 'Maintaining Control' describes how people managed on discharge. Some participants readjusted and lived a life that was different. A number of participants were treated differently by society and by in their families as a result of their involuntary admission. As a result, they maintained control in a very tentative way and ran the risk of losing control again. It describes the strategies that participants used in an attempt to play their own part in managing their mental health and sense of identity following an involuntary admission.

The greater the extent of loss of control experienced by a participant, the more negative their experience. Where the initial loss of control was somehow minimised, the participant typically progressed more quickly through the phases of 'Regaining Control' and 'Maintaining Control'. The quicker that a return of control was perceived, the easier it then was for participants to preserve control.

A diagrammatic view of the categories and their relationship to each other is presented in figure 5.1



**Figure 5.1 The Theory of Preserving Control**

### 5.3 Losing Control

‘Losing Control’ (Figure 5.2) describes the slide towards loss of control that resulted in involuntary admission. It also relates to the factors that impacted on the extent of loss of control. Significantly, while participants expressed the desire to feel more in control, all participants did lose control at some point during the involuntary admission procedure.

Participants experienced a loss of control across one or more of three areas, i.e. in their

- self-mastery of internal experiences, particularly in regulating difficult emotions and thoughts;

- capability of managing their lives, often linked to feeling violated when people were not involved in decision making with regard to their involuntary admission; and
- being physically restricted in hospital.

The process of 'Losing Control' consists of three subcategories conceptualised as 'Diminishing Self-mastery', 'Feeling Violated' and 'Being Confined'. Each subcategory has a number of dimensions that are described in this chapter.



**Figure 5.2 Losing Control**

### 5.3.1 'Diminishing Self-mastery'

'Diminishing Self-mastery' is the first subcategory in losing control and describes participants' subjective and retrospective views of their reduced emotional well-being and personal resources before and during hospitalisation. It also describes how participants construed and attempted to deal with their emotional experiences and feelings at this time, in addition to the intervention of others prior to the activation of the involuntary admission procedure. Many were uncertain as to why their mastery was diminishing. While some participants had previous contact with the MHS, others did not. Many struggled to control their difficult emotional state, had to deal with frightening and disabling experiences, and were sometimes unaware or unable to make sense of what was happening. However, there were some participants who never felt that their well-being or personal resources were compromised at any point. This subcategory consists of the following dimensions: 'Feeling Emotionally Different', 'Experiencing Strange Happenings' and 'Feeling Imposed On'.

#### ***'Feeling Emotionally Different'***

'Feeling Emotionally Different' describes participants' versions of how their mood changed to one at odds with their normal pattern. These fluctuations in mood most commonly occurred before being subject to an involuntary admission, and in some instances got worse during hospitalisation. Such moods were experienced as unpleasant or pleasant – some participants felt '*depressed*', '*stressed*' or '*upset*', while others described feeling '*high*'. Participants described different factors that precipitated their diminished self-mastery. For some participants, their personal lives became so intolerable that they expressed a wish to no longer live.

*"[PARTICIPANT'S PARENT] died in March. I got depressed and went mad on the drink and...I wanted to commit suicide..." (M, 10, 0)*

*"I know that I wrote the note [SUICIDE NOTE]..." (F, 9, 0)*

Significant events, such as relationship breakdown, contributed to certain participants feeling this way. Some recalled arguing with family members, friends, or GPs.

*"...when things got hot and bothered in the house...[NAME DAUGHTER] said 'I'm staying in a friend's house. I'm not listening to you fighting all the time', because my husband and myself were arguing." (F, 100, 17)*

*“...I did have a lot of medical problems then as well...she [GP] hadn't been supportive...” (F, 31, 2)*

*“...I had been talking loudly, say to Dr. [NAME] in the outpatients...I felt there was a problem with confidentiality in there [OUT PATIENTS]...” (F, 200, 0)*

Others described being less able to deal with personal issues and having difficulty coping; for some, this escalated into a considerably distressing and turbulent period. Many participants described their situation as ‘being’ or ‘spiraling out of control’.

*“...it was hard to sleep...Some nights I didn't sleep any more than maybe two hours...but eventually anyway I was getting wore out...I was very...nervous...and not able to concentrate and work properly...” (M, 120, 0)*

Some described disconnecting themselves from others (family/friends and society) and said their diminishing self-mastery usually became apparent to family and friends or members of society before it did, if at all, to them. Some participants retrospectively felt that ‘not taking medication’ may have resulted in their diminishing self-mastery.

*“At the time I didn't really know myself, but my family obviously were aware of it... My sister...obviously knew...that I wasn't right...”(F, 1, 0)*

*“I think it was my behaviour...It was out of character for me and a couple of people outside had picked up on it.” (F, 63, 1)*

In many instances, participants struggled to recount the full extent of what happening to them. Some spoke of knowing something was wrong but not being sure what it was.

*“I didn't really understand what I was going through...I wasn't obviously dealing with things well...I think it's in that stage where you don't know what to do, where to go...I think I knew I wasn't right but I wasn't sure how to deal with it...” (F, 24, 4)*

Some participants, particularly those who had previously been involuntarily admitted, were reluctant to make it explicit to others that they were struggling to control this difficult and different emotional state.

*“I didn't want to call home...because that would mean...facing up to things...people maybe don't want to admit it maybe that they have issues...you often feel like a failure...” (F, 24, 4)*

Participants often wanted to shield themselves from others and found it easier to isolate themselves. Consequently, they tried to contend with their experiences alone.

*“I knew there was something going on underneath the surface...but I didn’t think of getting any help for it. I just thought it would blow over.” (M, 51, 3)*

*“Although you...have an inkling, you sort of talk yourself out of it...” (F, 63, 1)*

Emotions became so overwhelming that some participants often resorted to alcohol or illicit drugs to help them cope. While some suggested that this change in emotional well-being was solely attributable to substance intake, others said it was due to problems in their personal and social lives that caused them to misuse substances and to subsequently behave in certain way.

*“...I’ve had a problem with drink for years...I think the build-up of my marriage breaking down and the three kids not talking to me was a big factor of me drinking more, it was also depression and I’d wrote this suicidal note. And said I was going to end it all...which I would never have done.” (F, 9, 0)*

Additionally, there was a cohort of participants who retrospectively described being ‘high’. Some described ‘pontificating’ or speaking their mind, saying things they would not ordinarily say. Participants described thinking faster than others or the feeling that they did not need others.

*“I was doing things that weren’t normal...causing a scene and making a protest against religion or whatever...On my way into the [CHURCH] or whatever to...shout at the priest or something like that.” (M, 43, 0)*

In contrast, some of these were pleasant and enjoyable emotions for participants, who thought about the world in a more positive light. Indeed, some did not want to admit anything being the matter as they did not want these emotions to end. Most commonly, these people received a diagnosis of Bipolar Affective Disorder. One participant who was initially admitted voluntarily described getting even ‘higher’ during hospitalisation.

*“I was calling it [HOSPITAL] a hotel. I thought it was great and I loved meeting the other patients. I was having a good experience...but then it can get out of hand...I did lose control on the ward.” (M, 28, 0)*

Some felt that they behaved embarrassingly in front of others and regretted the impact this had on family.

*“I still like am glad I got the experience [OF BEING HIGH] but I don’t like that it affected other people around me.” (M, 28, 0)*

There were varying degrees to which participants experienced and perceived a change in their usual pattern of health.

### ***‘Experiencing Strange Happenings’***

‘Experiencing Strange Happenings’ describes the unusual thoughts and experiences that some participants had. For some, the onset of these experiences was insidious, but for others they manifested over a long period of time. It was not uncommon for participants to report feeling ‘*disorientated*’ or ‘*confused*’. This caused participants to be so perturbed that they had difficulty in making sense of what was happening. In contrast, others understood what was happening and retrospectively acknowledged that their experiences were ‘*not based in reality*’.

Participants spoke of being concerned, ‘*reading into*’ or seeing the significance in certain things. Consequently, some entered a mindset where they became ‘*embedded*’ in their thoughts.

*“...I believed everything that was happening in my head...I was anticipating what was going to happen next...I knew that something was wrong but...I was still believing what was going on in my head...strange.”* (M, 114, 0)

*“Thinking unbelievable things and thinking they might be true...I was watching a soccer match...but I thought I was connected to the TV...thinking absolute crazy thoughts...”*(M, 43, 0)

As participants’ self-mastery diminished, they perceived the world differently, with some even seeing or hearing things differently. Their thoughts frightened and tormented them, invading their lives and making it difficult to relate to others. Often, in an effort to feel a greater degree of safety in the world, they disconnected from others.

*“I started taking drugs heavily. I became paranoid...Everyone knew my business and I couldn’t do anything without people talking about me. I felt trapped...I felt like everybody...was making a laugh of me...”* (M, 50, 0)

*“...things began upsetting me...little things...there was a buzzing kind of a noise. Now, I don’t know where that was coming from because I was trying to pull out everything to see...I...ended up in the hospital after that...”* (F, 27, 6)

These happenings made participants vulnerable, with some even describing experiences with the devil. These occurrences led them to fear for their own, and in cases their families’, safety.

*“...I was afraid for my wife and afraid for me...primarily because I thought the devil was in the house...”* (M, 114, 0)

*“I was thinking I’m a good person and everybody around me is ugly, no good...I was thinking her [STRANGERS] face was different...I was thinking all people around me like devils...”* (M, 6, 1)

Some described a variety of negative emotions associated with these strange happenings. Participants’ trust in certain people became affected, making it difficult for others to intervene. They felt threatened and hence described acting or behaving atypically.

*“I thought my neighbour was going to kill me. I had the whole house rigged...I had things hanging, all types of booby traps laid out for him...and I just sat there waiting throughout the night or two nights – waiting for him to come in...Then I’d be afraid to go out...Going around with a knife in my bag just in case...I just lost touch with reality really.”* (M, 146, 1)

*“I was doing strange things...I hadn’t slept for a few nights and I was walking in my bare feet around the city for two or three days and...It finished with me throwing stones at cars.”* (M, 66, 0)

In hindsight, some participants acknowledged being ‘deluded’ or ‘paranoid’, and likened their situation to being in a ‘fantasy’ or in a ‘film’, or to ‘tripping’ on ‘drugs’. They spoke of going ‘crazy’ and being ‘irrational’. Others, however, referred to their experiences as a ‘breakdown’.

These happenings largely occurred before admission, but for some they worsened during hospitalisation. One participant felt he would be harmed whilst in seclusion, and a few retrospectively spoke of not trusting mental health professionals in hospital.

*“I got paranoid in there [HOSPITAL]...I thought people were putting stuff in food...”* (M, 50, 0)

*“...while I was in hospital...I got worse and I can’t understand it like and the whole thing about the involuntary...In the middle of the night, the nurse, I thought they were going to give me an injection... There was something written on the duvet like that. We are watching you...I tried to keep below the window [SECLUSION] level because I thought that people were going to try to shoot me through the window...”* (M, 159, 4)

Some participants recalled receiving letters about their mental health tribunal but not understanding its relevance due to their emotional state at the time. For some, due to

their continued diminishing self-mastery, they queried whether receiving letters from the MHC was *'helpful'*. Some participants at the time did not possess the capabilities to effectively process this information, and in some instances these letters made participants feel frightened and frustrated.

### ***'Feeling Imposed On'***

'Feeling Imposed On' describes the feelings that participants had when families sought the assistance of professionals in the management of their diminishing self-mastery. During the course of their diminishing self-mastery, and prior to the activation of the involuntary admission procedure, some family members obtained the assistance of professionals. Some participants felt the actions of family may have been rooted in concern; nonetheless, they desired greater communication and understanding from the outset.

*"the doctor [GP] ...and my own family thought I was imagining it [FEELINGS] ...They were saying it was all from stress...but I don't think I was imagining it. I believe it was real."* (M, 120, 0)

Although some participants were unaware or unable to make sense of what was happening, others did agree to seek a medical opinion on advice from family or professionals that they trusted, largely through GPs or Emergency Departments. Participants' perceptions of concern was often linked to the level of collaboration they experienced.

Having a trusted family member or an understanding GP was, on occasion, described as attenuating the sense of feeling imposed on. The converse, however, was frequently reported.

*"...All I did was get very upset and all of a sudden the doctor came to the house... Hadn't slept with worry...There was nobody who said 'what happened to you, are you okay?' I think if he [GP] had said 'let's sit down. What on earth is going on?', I would have said I'm drunk...He was only here two minutes when he said she's having a bipolar episode...She has to be sectioned."* (F, 217, 0)

*"...I think it was a lack of understanding of what was wrong with me, so that created loads of fear to my boyfriend...when someone is sick. The first thing that anyone has to do is to listen..."* (F, 214, 2)

Some participants said they ‘dismissed’ the advice of professionals due to their emotional distress at the time. Retrospectively, some spoke of their reduced capacity to focus on the sincerity of what professionals were saying at the time.

*“...they felt that I wasn't perceiving stuff correctly or they felt that I was unwell...My wife would see little signals that something was wrong...She'd say it to me and I'd...disregard it completely...I felt that they were at me...”* (M, 114, 0)

*“...He [LANDLORD] knocked on the door and said 'listen, I need to get a number for you to contact if you get into trouble'...I was anxious about that...It felt like you were putting your health in someone else's hands. Your decision-making capability in someone else's hands...”* (M, 46, 3)

Some later commented that they may have been so distressed that their capabilities were compromised, and that this may have made it impossible for others to reason with them.

*“I don't think anything could have helped really...Talking probably wouldn't work.”* (M, 146, 1)

Occasionally, the participants agreed to accept the advice of professionals and this resulted in their being prescribed medication as an outpatient or being offered hospital admission, and some did agree to go into hospital voluntarily<sup>22</sup>.

*“...and it was kind of ironic because I was probably moving closer towards hospital or you know that kind of scenario...but then he [FRIEND] said you better go to the hospital [ED] and get you checked out...”* (M, 46, 3)

*“They [COLLEAGUES] spotted the signs and they referred me to the psychiatric nurse and the psychiatric nurse then referred me to the consultant and then I went into hospital voluntarily.”* (M, 28, 0)

Others shunned families’ or the GP’s suggestion of admission. Retrospectively, some participants felt that family members overreacted and did not know the best way to respond at the time.

*“I was trying to say to him [PARTNER] that I just needed to relax, to be on my own and I couldn't go to hospital but he didn't want to listen to me and just say 'let's go, let's go'...I couldn't go to hospital because I was tired and I have a big trauma. [PREVIOUS TRAUMATIC EXPERIENCE OF HOSPITALISATION]”* (F, 214, 2)

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<sup>22</sup> These participants initially came to hospital voluntarily but were later subject to Section 23(1) – Power to Prevent a Voluntary Patient (Adult) from Leaving an Approved Centre.

This intervention compounded and threatened participants' personal resources and their capacity to keep control of their own life.

The subcategory 'Diminishing Self-mastery' describes the decline in emotional and social functioning that participants experienced before and in some instance during hospitalisation. In addition, it describes participant's feelings towards those who intervened in their lives at this time to suggest that something was the matter. 'Diminishing Self-mastery' is encapsulated by the dimensions; 'Feeling Emotionally Different', 'Experiencing Strange Happenings' and 'Feeling Imposed On'.

### **5.3.2 'Feeling Violated'**

'Feeling Violated' is the second subcategory in 'Losing Control'. It describes participants' feelings and emotional reactions towards the intervention of family and professionals both before and during the involuntary admission procedure as well as during the hospitalisation period. Specifically, it relates to participants' experiences and feelings when '*people*' (Assisted Admission Team (AAT) and/or the Gardaí) removed them from their home during the initiating of the involuntary admission procedure, or towards those they perceived as being involved in initiating the said procedure. Family and professional interventions added another dimension to participants' loss of control, as their ability to be independent was being encroached upon. Control was taken from participants as others took over the regulation of their personal and social world. Participants felt that their rights and ability to control their life were being taken from them as a result of being subject to involuntary admission, which resulted in their no longer feeling in control of their lives. This subcategory consists of the following dimensions: 'Being Infringed Upon', 'Feeling Shocked and Frightened', 'Being Treated Like a Criminal' and 'Being Deceived'.

### ***‘Being Infringed Upon’***

‘Being Infringed Upon’ describes the feelings that participants had when family, Gardaí or GPs intervened in their lives before and during the involuntary admission procedure. The extent to which participants were ‘Being Infringed Upon’ varied from a feeling that the intervention may have been rooted in a concern for the participant to a feeling of a gross infringement on their rights as a human being.

Participants were being infringed upon when their voice was ignored, when professionals failed to reason or listen to them, and when they felt that there was nothing mentally the matter with them.

The first time that some participants knew that they were being involuntary admitted was when members of the AAT intruded into their home.

*“I mean, the children seeing it is just ridiculous...to have the arrival of these people at your door to take you off is very hard...Like you can’t even control your own house any more”. (F, 100, 17)*

*“...I didn’t deserve to go to hospital...just the reaction you’re [GARDAÍ AND GP] taking is unusual...I said what was the mess you’re making...I am okay and there’s no need for doctors to come, like Garda comes...But truly I had not done anything wrong” (M, 11 consent to notes declined)*

*“I don’t see why all the rigmarole and paperwork...It was like going back to the mad times being put into a mad house...Nothing to do with the treatment. It was more the deciding of this paper and my right being taken off me...”(F, 32, 1)*

Participants’ homes were explicitly invaded at this time and people were taken from this home against their will.

*“...I thought I locked the back door but obviously I didn’t and the next thing, they [AAT] just all arrived in...I couldn’t understand them coming into my house and the cheek of them and who did they think they were thinking they could just come in and strap me into the trolley...was and just take me away?” (F, 139, 1)*

*“I was taken from my place of work against my will...I was very annoyed and furious...I was taken out of my surroundings...Without being explained to me why and...that a GP could turn around and do something like that and then go off about his business as if nothing happened...” (M, 230, 0)*

In addition, participants felt violated when their voice was ignored and they were excluded from all aspects of the decision-making process. On many occasions they were not afforded the opportunity to discuss or explain their perspective to professionals. In many instances, when they did attempt to assert their voice they felt that they were not listened to.

*“...how I was feeling didn't come into the equation...They had to do what they had to do...There was nothing I could do. I was surrounded... It's a no-win situation...”* (F, 208, 2)

*“...I had no say in the matter. It was all decided without consulting me...They didn't take my considerations into account at all. Or they had no interest.”* (M, 230, 0)

The following participant sums up a common thread across the data: *“So, it's you versus all these other people.”* Participants wished that they had someone to support and stand up for them.

*“I was sure that someone I knew would come and help me...I was trying to find a voice I could recognise, someone I knew to say ‘please, help me’...Someone who knew me, who loved me, who was good to me because I just wished I had that, they [NAT] just didn't care...”* (F, 214, 2)

Participants reported the lack of options and some said that at no stage were they given any other choice than to go to hospital. They felt annoyed that their family members or professionals had tried to seek an alternative approach.

Several participants perceived not to have received information or an appropriate explanation for their impending admission. In some instances, participants felt that the GP's involvement was cursory and they lacked any clarification as to why they were subject to an involuntary admission. When professionals did provide an explanation, it was perceived as being either incomprehensible or inadequate.

*“...nobody really ever said to me, you know, ‘you need to be hospitalised’...It was more ‘you're not yourself. You're not behaving yourself.’...I couldn't identify what they were actually saying. I couldn't see why I wasn't myself. I felt good, you know”* (F, 23, 0)

*“They just brought a doctor to examine me in the Garda station...He signed me in, like. He didn't say much to me at all.”* (M, 68, 4)

*“He [GP] didn't talk to me either and then I was brought in the back of a paddy wagon to the hospital...He didn't speak to me at all...No one tried to reason with me. Oh, it's totally out of your control...No one is trying to open a dialogue or talk.”* (M, 162, 3)

Many participants spoke of this lack of information during their involuntary admission procedure as contributing to their distress and frustration. Many wished they had received direct, concise and repeated information.

*“At no stage did someone say ‘you're a danger, you're sectioned’...They [GARDAÍ] should explain themselves...Rather than put on the cuffs, stay in the car, come into the station. Gruff orders...” (M, 162, 3)*

*“... he [GP] could have explained it to me or said ‘[NAME], this is the best for you’ or ‘we feel that you are really unwell now’...They just wanted to get me signed and that was it...he didn't say anything...I mean he's supposed to be my GP...If I was in a general hospital and I broke my leg, you know, they would explain what they do...No explanation or even trying to convince me...” (F, 200, 0)*

Some participants felt they could have been more involved in the decision-making process regarding their involuntary admission and lamented the needless imposition of the decisions of others.

*“I feel that I would have treatment as an outpatient but they [PSYCHIATRIST] didn't feel so. I wasn't offered any options, even though I said I want treatment ...” (F, 72, 0)*

*“The GP should offer middle-ground but he didn't in my case...A psychologist should speak to you before you're sectioned really...Just to ascertain...where your state of mind is. You know, a psychiatrist might want to section you... Whereas a psychologist might talk to you...you mightn't need to come in here at all. It's very one-sided...It can't all be based on a psychiatrist” (M, 162, 3)*

Others felt there was no point in asserting their disagreement with the professionals' intervention, especially those who had previously been admitted. Participants described feeling compelled to comply with the demands of these people. Those who reported attempting to have a say indicated that their voice was not listened to and that they were neither involved nor considered in the decision-making process, which heightened their sense of 'Being Infringed Upon'. Those who had prior experience of admission knew exactly what was happening and also felt powerless.

*“They [AAT] knocked at the door. I opened the door and they [AAT] tried to get in. Menacing kind of people...Sure I knew well they'd bring me ['Horrible' UNDER PARTICIPANT'S BREATH]...They [AAT] said you have to come with us to [PLACE]...Basically I said I'll go...Outrageous that they can come take...a person out of their own home...”(M, 219, 5)*

*“Well, I was going to work one night and the cops picked me up and brought me into [PLACE] station...There was no point in trying to fight three Gardaí like ...this is my*

*third time being picked up by the Guards, you know? So, it wasn't very nice but sure what could you do?...I'm used to it...*" (M, 68, 4)

*"They came to the door and they told me I had to go in and I told them I didn't want to go...The next day they came with the Guards... I was going to close the door on the three nurses. But...one of the nurses put their foot inside the door...and the Guards came in then...I was angry as hell because I'm going into hospital again for no reason...So, I just packed my suitcase and I knew right away when they said they were bringing me...It's happened to me now maybe six or seven times."* (M, 29, 4)

Some spoke of the embarrassment of being picked up by the Gardaí in public. However, this feeling of violation was not solely associated with involuntary admission beginning from participants' homes – many commented on being removed from a public place.

*"...I would have liked to have somebody try to approach me in some other way rather than coming into a public restaurant... I'm very embarrassed about it. It was very public and I think unnecessary. I suppose it would have been there or my house...at the house...the neighbourhood would have known..."* (F, 63, 1)

Many noted that both their 'mindset' and prior experience of hospitalisation affected the extent to which they felt infringed upon. The participants' emotional state impacted greatly on their experience and how they reacted to their removal to a hospital. In contrast to most others, a few participants felt their removal accentuated the pleasant emotions that they were feeling.

*"...I can remember going to the hospital. Sure I was singing away and I was as happy as a coot...See, that's the difference...it depends on whether you're in a good place or a bad place. If you're in a bad place it's like being in a nightmare."* (F, 32, 1)

*"...it depends on what part of the cycle they catch you on... You know, if you're sort of paranoid, relaxed, you know, if they caught you at a bad time you could be very sort of uncomfortable..."* (M, 146, 1)

### ***'Feeling Shocked and Frightened'***

'Feeling Shocked and Frightened' describes participants' experience when what they termed as 'a gang' of 'people' – or the 'cavalry' – invaded their home. These people later became known to participants as the people charged with removing and taking them to the hospital. For many, this was the first time that there was any indication they might be hospitalised. Many participants were unaware that there was anything wrong or why they were subject to an involuntary admission. The members of the AAT consisted of between three and nine males/females, plus or minus the Gardaí or GP and a form of transport – a van, a taxi, an ambulance or a Garda car) who arrived

unexpectedly to the participants' home. Those who had no previous contact with mental health services (MHS) were unaware of what was happening, who these people were or why they were there. Some were so frightened that they believed these people, unknown to them, would hurt them. Indeed, some spoke of not being informed that they were subject to involuntary admission. Being removed from their home had a further impact on their emotional well-being and contributed to feeling a loss of control.

*"I could hear them [GP, TWO PARAMEDICS] knocking at my door and asking to come in...I thought they were going to do me some harm...and I didn't open the door... then I heard them breaking in. They cut the chain off the door and came in...I ran out and they ran after me...So, it was a real nightmare... I was crying... I didn't want to go anywhere..." (F, 211, 0)*

*"...I do think there shouldn't have been a situation where there was a gang on my door and being taken off in a taxi...And I think there was enough information there for them to know that there was no need to send in five or six people and a taxi at the gate...it would have been good enough just to have, you know, maybe two people come in and talk to you and assess you..." (M, 19, 0)*

Participants spoke of the adverse impact of the unexpected nature of this level of intervention. The presence of a group of people at the participants' home was very intimidating and people felt outnumbered and pressured to comply. Others with previous experience of being involuntary admitted were shocked by the AAT's arrival, but knew they were being taken to hospital.

*"...and the lady doctor sat down and I think the three men stood around the room, four men...They were all pleasant...but it was just the underlying impression that you got...you go with us and that's it..." (M, 19, 0)*

*"...it's very frightening when that happens. When I'm diagnosed as being sick and I don't think I'm sick, I'm brought in and I get surprised all the time." (F, 100, 17)*

*"There was nothing I could do. I was surrounded. There was more of them than me and there was two males... I knew that if I didn't give in that they were going to get... forceful. I wasn't going to have that...I didn't like being escorted off..."(F, 208, 2)*

Others simply did not understand why people were there, especially if they did not feel that there was anything the matter with their mental well-being. One participant suggested that the fear was so powerful that they might not have been able to comprehend what was happening even if professionals did attempt to explain.

Participants' fear continued on their removal to the hospital or the Garda Station. This was exacerbated by the speed with which it all happened. Participants recounted not being allowed to collect personal belongings or secure their home; any such request was typically met with refusal.

One participant spoke of travelling to hospital without knowing where she was going.

*"They [AAT] didn't say where they were taking me. They just put me the ambulance...I didn't know where I was going until I got there...Once I got in the ambulance there was nothing more I could do...I thought I would never get back [HOME]..."* (F, 211, 0)

### ***'Being Treated Like a Criminal'***

'Being Treated Like a Criminal' describes participants' experience of being treated with aggression and hostility by the AAT or Gardaí. The AAT removed participants from their home or from a public space to hospital or the Garda Station. This, for many, was a traumatic removal from both their personal and social worlds. Furthermore, it describes participants' embarrassment and humiliation at being escorted against their wishes while being witnessed by neighbours or members of the public. Participants suggested that they were treated in a hostile and aggressive manner and described being forcibly taken to hospital. As a result, participants' physical integrity was also interfered with; one talked about being held down on their bedroom floor or being handcuffed while another spoke of being '*strapped into a trolley*'. Other participants spoke of being '*picked up*' in public places by the Gardaí and brought to the Station for assessment. There was a deep sense of embarrassment, shame and humiliation when people were '*dragged off*' from their home or from a public place – all of which threatened their public identity. Participants felt that professionals did not treat them with dignity and respect, thus contributing to a violation of their bodily integrity.

Some described being treated very violently and forcefully and used words such as being '*dragged in*' and '*hauled in*'.

*"...I was trying to break free but I couldn't. It was a really, really physically forced admission... I wasn't respected...I barely recall because it was such a traumatic experience for me...I know I refused admission...and they just dragged me in..."*  
(F, 72, 0)

*"...suddenly a woman called [NAME] came into my room and then a few men followed*

*her and they just dragged me...they took my wrists and ankles and just pulled me down...They put me against the floor, used violence...they handcuffed me and they put me in this plastic yellow blanket and put me in a van or something...I didn't know where I was going...*” (F, 214, 2)

Some participants were brought to a Garda Station, while others were even handcuffed, which contributed to feeling criminal and heightened participants' sense of strange happenings.

*“I just lost it totally. I was taken in by the Gardai. Taken in off the streets...He [GARDA] didn't talk to me either...Being taken to the Garda Station had an impact on me. That really sent me over the edge. Off into my own world...the paranoia came to the fore with that. All types of conspiracies emerged.”* (M, 162, 3)

Additionally, participants spoke of their embarrassment at being taken away in view of neighbours or members of the public. They described vans, taxis, ambulances or Garda cars being in the locality. Consequently, their public persona and social standing was now threatened as they felt others would judge them.

*“...These bodyguards [MEMBERS OF THE AAT]...walking down my drive and I'm seeing my old neighbour standing outside, looking across, builders over there...as I get to my gate, the cop car drives away. He was parked down the lane...So there I am walking down into a taxi with blacked-out windows. I felt like I could have been a criminal murderer or something like that.”* (M, 19, 0)

*“Well, it was only 9 o'clock. There was people on the street and stuff that seen all this happening which...still is to this day very embarrassing and very unnecessary in my opinion.”* (F, 23, 0)

'Being Treated Like a Criminal' seems to have been further compounded by being held in Garda stations. Some spoke of having to wait for protracted periods in the station unaware of what would happen to them.

*“I was left for about half an hour before I seen the doctor down there [GARDA STATION]... I was in my dressing gown because I had been in bed after being discharged that day...”* (F, 23, 0)

*“...they had to put me into the cell and ended up staying in there for three to four hours...They were like oh, you'll be out in five minutes...This went on for...three to four hours.”* (F, 55, 0)

*“They took me up...to see a doctor [AT 8PM]...I was there since 2 o'clock...down the Garda Station...a doctor should have been called straight away, the state I was in like...”* (M, 39, 0)

On their removal to the Garda station or hospital, participants continued to feel intimidated and treated forcefully.

*“...I had to come with them [POLICE] and I knew if I didn't they were going to get assertive...when they got me in the car they kind of put their two hands on both my arms so I was kind of held down...” (F, 63, 1)*

*“...I felt I was powerless from word go once the Guards got me in the back of the car and sat on either side of me...” (M, 150, 0)*

As with ‘Feeling Shocked and Frightened’, the speed and sense of urgency in which participants were escorted compounded the adverse impact on them. Participants described how they were not given time to adjust to the prospect of going to hospital.

*“They come in and say ‘if you don't come with us we'll get the Guards involved and we'll put handcuffs on you and bring you’...It's like an emergency every time and you don't know what the emergency is about.” (F, 100, 17)*

*“I couldn't even go in to get a wash bag...it was just the way you have to go straight away....I don't think I was about to run away or anything. Could I not have just stopped at my house?” (F, 200, 0)*

### ***‘Being Deceived’***

‘Being Deceived’ describes the betrayal participants felt when family members requested health professionals’ intervention without their consent or knowledge or when family members signed participants into hospital. It also portrays participants’ feelings towards people they trusted (family members or GPs) being involved in obtaining their involuntary admission. Furthermore, it refers to health professionals or members of the AAT being neither completely truthful nor fully informed about where participants were being taken and what the outcome might be.

Family members frequently sought professionals’ intervention without participants’ knowledge, causing them to feel that nobody had expressed any concerns for them prior to being subject to involuntary admission. Indeed, in some cases, the initiation of participants’ hospitalisation was perceived as a covert operation that was organised between family and GPs.

*“...they [FAMILY] were all talking together behind in the background...so that's when she went to the doctor apparently...So, I kind of blamed her...I kind of thought well okay, you know this was a group thing. Everyone was against me.” (M, 19, 0)*

*“I’ve lost friends because they were involved with getting the Guards involved and...I don’t know if that’s my family to blame...” (F, 23, 0)*

Other participants were unsure to what extent family members were involved in the process, but did suspect involvement when they did not try to avert it or show support. Participants felt alone and could not understand why family could allow this to happen.

*“...I was placed in a situation of not being supported by my family. They actually opposed me and my wife was plotting with them to do so.” (M, 150, 0)*

In other instances, participants felt deceived and betrayed by the GPs involved in initiating their involuntary admission. It was apparent in many situations that the GPs attending the Garda Stations neither explained their presence nor acknowledged the possibility of involuntary admission. One participant felt his GP gave ‘*misleading information*’ in a way that discredited him and resulted in his unnecessary involuntary admission, and he felt annoyed that professionals followed other professionals’ inaccurate account of his situation.

*“He [GP] didn’t speak to me at all...He spoke to the Gardaí...I didn’t even know he was a GP until afterwards...” (M, 162, 3)*

In other instances, participants could not understand why the GPs or the GP at the Garda station were there and were annoyed at the lack of an explanation as to why they were recommending their involuntary admission.

*“...Dr. [NAME] just smiled like a Cheshire cat and just signed the papers and didn’t say anything to me...He was supposed to be my GP...He never explained to me....” (F, 200, 0)*

During hospitalisation, participants began to form impressions regarding who was involved in obtaining their involuntary admission.

*“I just found out when I was brought down to hospital that my sister had signed me in... I didn’t think she’d do that...The nurse was there and the doctor and my family was there as well...They had a discussion and the doctor told me that I was in involuntary.” (F, 15, 1)*

Participants described how the AAT was not entirely truthful regarding where they were taking them or why. One spoke of not being told why they were going to the hospital and occasionally being ‘tricked’ and lured into the hospital under false pretence. Others felt deceived by professionals; one recounted being deliberately lied

to and taken from his home under the pretence that he was seeing his GP. Several participants were not informed that they were going to be hospitalised. Some reported being given the impression they were having a ‘check up’.

*“I was detained under false pretences...The Guards lied to me because I thought they were going into my doctor [GP] immediately, but immediately they took the road to [HOSPITAL]...I can say that I was tricked. There's no other way of describing it...”* (M, 150, 0)

*“I think it was a hint that I'd be in overnight, be assessed and I thought okay, maybe just assessed...I was kind of led to believe that in the beginning...”* (M, 19, 0)

One participant, after being detained under Section 23(1) (power to prevent a voluntary patient from leaving the approved centre), was deemed not detainable by a psychiatrist and was discharged. She later recalled Gardaí calling to her home to take her to the Garda Station to be yet again assessed for recommendation for detention by the GP.

*“...my family...refused to bring me home...they talked to the Guards...signed a form of some sort to have me brought back in...”* (F, 23, 0)

‘Feeling Violated’ describes the intense feelings and emotions that were generated for participants in response to the initiation of the involuntary admission procedure and/ the removal of the participant to hospital. ‘Feeling Violated’ is encapsulated by the dimensions; ‘Being Infringed Upon’, ‘Feeling Shocked and Frightened’, ‘Being Treated Like a Criminal’, and ‘Being Deceived’. Those who were subject to involuntary admission felt infringed upon as professionals no longer allowed them to make decisions for themselves, which resulted in a lack of autonomy and the participant feeling dehumanised. This infringement on participants’ personal space, bodily integrity and face made them feel that their rights were taken from them and, for some, the coercive intervention contributed to a sense of vulnerability and insecurity.

### **5.3.3 Being Confined**

The third subcategory in ‘Losing control’ was conceptualised as ‘Being Confined’. ‘Being Confined’ refers to the loss of freedom that participants experienced as a result of being hospitalised and treated against their will. The subcategory consists of the following dimensions: ‘Feeling Scared’, ‘Feeling Deprived’, ‘Being Treated Badly’, ‘Threatening Sense of Self’, ‘Having to Take Medication’ and ‘Feeling Frustrated’. It

describes feelings of not being cared for that some participants experienced during hospitalisation and the emotional impact that such experiences had on the person.

### ***‘Feeling Scared’***

‘Feeling Scared’ describes participants’ initial feelings at the prospect of entering hospital. Typically, participants were brought by to hospital by the Gardaí or the AAT. There was a fear of the unknown and a sense of uncertainty associated with what might happen in hospital. This sense of not being in control further compounded their loss of control. Many participants without previous experience of the MHS perceived psychiatric hospitals negatively. Some feared the service users that they might encounter and the type of treatments they might receive. A few participants were afraid that they would have to stay in hospital *‘forever’*. In contrast, those who had previously been hospitalised had apprehensions regarding certain medication they previously disliked or having to remain in hospital for a long time.

*“...I’m trying to make idle chit-chat in the van...in my heart knowing...I’m being taken to some place, like an institution...you hear stories...I was terrified of coming into the place and not getting out...it’s a horrible thing to say but I’m in a loonie bin and you know who are you going to meet? And they might start picking a fight or picking a row with you...”* (M, 19, 0)

*“...You could be in a straitjacket for all you know...”* (M, 146, 1)

On arrival, participants who had no previous experience of hospital garnered a sense of their new physical environment, the staff and service users within it. For some, their impression of the hospital ran counter to the idea of a therapeutic facility and they were frightened of being there. Some participants saw service users who appeared heavily medicated and some of these participants had fears that they might be medicated in a similar fashion. One stated he was frightened that he may no longer hold control over his own faculties if this were to happen.

*“I thought oh my God, this is awful...I saw one of the nurses walking across and she was very matter-of-fact. It looked really old-fashioned and it just looked really dingy ...and I saw one patient, really fat patient, walking around really slowly hobbling from side to side and she was looking ahead of her with really dull eyes and I thought oh my God, what am I coming here into?...That was scary seeing that...That was probably because of her medication but I didn’t like that.”* (F, 59, 0)

As time progressed, participants were frightened of the distress and behaviour shown

by other service users. Some hospitals had a mix of male and female service users, and some female participants were frightened of male service users. Consequently, hospital did not feel a safe environment and for some, this feeling persisted throughout their stay.

*“I certainly felt I was in ‘One Flew Over the Cuckoo’s Nest’...it’s that you lose your sense of control. You’re not in charge...You know, there was a girl moaning over there and a girl moaning over there...If you go into a place like that that you feel first of all very frightened...”(F, 217, 0)*

*“I find it very negative because as I said the ‘levelisation’ of, you know people being severely bad and people being not as bad and...in the same place it isn’t right. It makes the situation worse rather than better...” (F, 15, 1)*

### ***‘Feeling Deprived’***

‘Feeling Deprived’ describes participants’ loss of rights to liberty and freedom due to being legally held in hospital. The terms that participants used to describe this feeling included being ‘locked in’, ‘trapped’ or ‘stuck’. It refers to being in a heavily regulated system where psychiatrists and nurses now decided and controlled participants’ actions. In many cases, all control was taken from participants. It was difficult to adjust to an environment where one was constrained and regulated by others. The free will of the participant was restricted – they had no choice but to remain in the hospital or could not leave the hospital without the permission or sanction of others. Some participants mentioned that their right to freedom was taken from them. It was difficult having to remain in an area with locked doors and with no option to leave.

On arrival at the hospital, a certain protocol was typically followed. In some instances, the main door was locked and participants were escorted to an area to wait for a doctor.

Some described not knowing that they were being detained until they were informed by the psychiatrist or received the written notification form. Some spoke of the expectancy from doctors and nurses that they should just deal with and accept this.

*“Other people were responsible now...It was just this is where you are. This is who is in charge and you don’t have any say...I just felt that I had lost all my own independence and that I was no longer in control of my own life. That other people had decided that I was unwell. Other people now had control of what happened to me...” (F, 23, 0)*

*“It’s that sense of...knowing that you’re trapped there, could feel very much like you’ve had your human rights taken away. That you feel imprisoned...knowing that the doctors have signed your sort of freedoms away and...they’re in control of your life, it’s like a part of you is taken away by being involuntary”.* (F, 24, 4)

*“...they look at me as if it’s quite right that I should be stuck there...I don’t understand...I don’t know why I myself keep on getting trapped into these areas like...The same old stuff there...I just felt upset at having to be locked up there.”* (F, 60, 2)

There were instances where participants had to wear nightclothes and where they had their personal belongings confiscated. Other participants were not allowed to contact their families, and in some instances their families were not allowed to contact or visit.

*“They gave me something to wear for the night and that, you know...I found that traumatic enough and I suppose...the fact that all your cards and your phone...is taken and all that...somebody going through your bag.”* (F, 200, 0)

There was a feeling of being cut off and disconnected from life outside of hospital including links with family, friends or work. Some participants were frustrated with being restricted to part of the hospital owing to the type of observation that they were under – this was not seen as conducive to their recovery. In some instances, the level of observation of the participant meant that they could not move freely within the hospital itself, with participants’ movements being restricted between their bed and the smoking area. Participants also reported feeling frightened by rules and restrictions that were not explained to them.

*“...I was put into a bed in a six-bed ward or whatever and I was told I could only go from you know, around the vicinity really. Confined...I couldn’t understand the vigilance and the reason behind this, constantly everybody looking at me... ‘Give me your clothes. You can’t have your clothes’ ....”* (F, 23, 0)

*“I was constantly in pyjamas...I was not allowed go down to the other areas...I can remember times when I was getting upset, getting angry, getting frustrated because of all this, but didn’t show it. You know, I went into my room if I felt like I needed to cry...this is my what, 10<sup>th</sup> hour here today looking out the same window still in my pyjamas. Wearing the same clothes all day, every day...”* (F, 55, 0)

*“...I was in prison and I was forced to do whatever they asked me to do and if I don’t, then they would take my light away [CIGARETTE LIGHTER] or they would take my mobile phone away... I was totally in the dark every day...”* (F, 72, 0)

Additionally, some female participants felt they no longer had privacy; it was difficult sharing their living quarters, not having a single room and having to sleep in close

proximity to others. There was also an issue with no locks on the bathroom in one hospital, which impacted on participants' sense of privacy.

*"The only thing I didn't like...is the toilet situation and the shower situation. There was no locks [BATHROOM DOOR] ...like bars on the windows. It made it feel more like a prison than a hospital...Everything felt like it was impersonal and you had no privacy..."* (F, 9, 0)

Some participants felt they were now 'controlled' by professionals in that they had to request permission from nurses or psychiatrists to do anything. Participants had to abide by the rules and regulations of the hospital and some nurses did little to make life less restrictive.

*"...They wouldn't let you out in case you ran off...and not being allowed to get out and have fresh air was a major factor to me...I felt restricted...If you think you're in a prison, you're not going to get much better..."* (F, 9, 0)

*"Not being able to do the things you wanted...Like going to Mass and things like that or the shop... they wouldn't even let me outside the door like..."* (F, 27, 6)

*"It's actually very destructive for the person who is made involuntary and also a lot of doctors have never experienced being put into situations where they have no choice...Some of them are control freaks, I think."* (F, 59, 0)

Some participants described being under surveillance from nurses whilst in hospital. Participants held the impression that their behaviour was being monitored. Some attributed the intensity of the supervision to a motivation amongst staff to gather evidence to justify detaining them longer. For many participants, hospital was not seen as an environment that promoted and fostered a sense of well-being amongst people. In fact, in many ways it negated the participants' sense of well-being and further heightened their distress.

*"The nurses keep an eye on you. They're very good with that...you soon get sick when you know there's a file being kept on you and things might be...written into that. You know yourself, an ordinary person will find it hard to justify every one of their actions."* (M, 150, 0)

Some participants experienced even greater constraints on their freedom, including being restrained or secluded. Having this level of restriction imposed upon participants was seen as untherapeutic and indeed made most of them feel worse.

*"...it was breaking my heart that I couldn't get out of there [SECLUSION AREA]..."*

*There was nothing inside the room...there's not even a mattress or anything...I don't think the room was clean even.” (M, 159, 4)*

*“...I was held in this room [SECLUSION] ...and it was just one empty room with just a bed there... I had no contact with anyone...” (F, 72, 0)*

One participant even spoke of not being allowed access to previously promised ‘relaxation therapy’ due to the level of observation she was under at the time.

Another participant remarked that voluntary patients were treated more leniently while involuntary patients were treated with much more restriction. Another alluded to the fact that there was little difference in being voluntary or involuntary, as their right to discharge could be taken from them.

*“...It's very hard when you're made involuntary, but even when you're voluntary you still don't have a whole lot to say...You can't just turn around and say I'm going home, because if you say that they make you involuntary. So, it's only a word really...” (M, 3, 8)*

Indeed, some participants who initially had been voluntary now found themselves in a situation where they were subject to involuntary admission. As a result, they no longer had their rights to decide to leave the hospital or to decline medication. Some of these voluntary participants requested to be allowed out of the hospital for a specific period or requested their own discharge. They spoke of losing trust in the motives of staff and of feeling they were being treated differently, in a formal and unjust manner.

*“I didn't know you could go in voluntarily and then be kept. You can't really leave...So, she [CONSULTANT] was going off on holidays anyway and I think she was afraid that I would try to leave and she was also trying to get me, to take it [MEDICATION]. So, I think she kind of used it [INVOLUNTARY ADMISSION] to force me...to take my medication...going into hospital is all about getting people medicated.’ (M, 28, 0)*

*“One night I asked to go out just for walking and they [STAFF] said no...They locked me in a room [SECLUSION], you know? ...I just want to go outside. I'll come back in in one hour, two hours, you know...It was a bit...not proportionate, you know?” (M, 25, 1)*

*“...I was told I was allowed go when I wanted to because I was voluntary, and then because I wanted to go I was told I was involuntary and because I was on involuntary I couldn't do anything. I had no say at all like ...”(M, 50, 0)*

### **‘Being Treated Badly’**

‘Being Treated Badly’ describes participant’s experiences of being treated coercively

while in hospital. For some, this involved being forcibly given injections, physically restrained, or being secluded by nurses. It refers to participants' experiences of undignified or disrespectful encounters with professionals and where participants felt that they were treated like an inferior. There were explicit threats where the participants experienced severe restrictions to their autonomy. For some, it involved being subjected to coercive treatment such as being restrained, being forcibly injected, or being secluded. For others, it involved more implicit threats such as being pressured to conform, to remain in hospital, or to take medication. Additionally, some participants had encounters with professionals where they felt they had to take medication or where they were confined to the hospital in case a more forcible level of intervention might be used.

In many instances, participants were forcibly given an injection by what they described as *'the heavies'* shortly after arriving in the hospital. It was not uncommon for participants to report that between four and ten personnel (nurses and/or security guards) restrained them to forcibly administer an injection.

*"I mean there's just be six, eight, ten [STAFF] ...it's not like a normal injection...they put you lying on the bed and then one of them sort of gets on top of you and...like they push your shoulders down..."* (F, 32, 1)

Others described aggressive treatment where they were physically *'dragged'* into a seclusion area or a single room, an area that was even more restrictive than confinement of the hospital.

*"...and they have what they call the green room [SECLUSION AREA] ...I especially didn't want to go in that room because I was in it before and they [NURSES] sort of dragged me down the corridor..."* (F, 139, 1)

Indeed, some participants recounted experiences in seclusion where they were treated in an inhumane way. This treatment was provided in a way that utterly disrespected participant's dignity as a human being, thereby invading their self-integrity.

*"I was held in this room...I needed to use the bathroom and they [NURSES] refused... So, I had to urinate in one corner...They just give me a lot of items forcibly...they stripped me and put me into pyjamas...There were nearly ten people doing this to me in one day."* (F, 72, 0)

*“They [NURSES] gave me water and I tried to escape and then they put me back into the place [SECLUSION]. Then because of that I didn't get water any more...I thought I was going to die. I really did...I asked to go to the toilet and they wouldn't let me so I had to do that on the floor...after a while they put me down [REFERENCE TO BEING RESTRAINED]. They injected me but the day after I felt that maybe I was raped. The way they put the injection into me.” (F, 214, 2)*

Many participants spoke about feeling particularly threatened while taking medication. Some felt that if they refused medication in tablet form, they would be forced to take it by injection. Some participants felt over-powered and controlled by professionals and that they had no choice but to do what was ordered.

*“...and they [DOCTORS] put me on more medication. I didn't have a choice not to take it... ” (F, 59, 0)*

*“I was there on the bed and two nurses came over, two male nurses. One had medication in his hand. He said I have medication for you to take...I've only just arrived...I don't want to take medication and the other guy said, well, we'll give you an injection then...that was fairly threatening. So, I just said to myself well I may as well take the medication.” (M, 46, 3)*

Other participants' feelings of coercive treatment were more implicit. One recounted how he agreed to stay as a voluntary patient after he was taken to hospital under the MHA. The feeling of being threatened was just as prominent for this participant as there was a 'silent threat' of being involuntarily admitted again if he attempted to leave. There was a suggestion among several participants that the notion of being voluntary with the freedom to discharge was farcical and that there was little difference in being voluntary or involuntary. The implied threat from professionals was that leaving or attempting to leave would result in being involuntarily admitted or being returned by the Gardaí.

*“...I was told we'd like you to stay, but if you don't we can make you [INVOLUNTARY]...You are here, you know. You are ours. We have you and that kind of thing. That was the feeling I had...the 'but' was always there in that sentence. So, it was like saying you can go but you can't go...” (M, 19, 0)*

*“...I was told if I left of my own will that the Guards would come and collect me and bring me back.” (M, 50, 0)*

*“You can't walk out the door [REFERENCE TO BEING VOLUNTARY]. You can't just turn around and say I'm going home, because if you say that they make you involuntary. So, it's only a word [VOLUNTARY] really, you know.” (M, 3, 8)*

Some people were treated as though they lacked the capacity and competence to be treated like a valid human being. Participants often felt ignored or not included and spoke of not having their pleas listened to by professionals. Such participants commented that professionals did not communicate effectively with them. It was not uncommon for participants to feel that staff's attitudes and approach to care was undermining participants' sense of autonomy.

*"...a very young doctor spoke...down to me and said the words sorry, but you are [NOT GOING HOME]. There was no hint of look, we really want to help you. Let's help you, you know, let's talk about this." (F, 217, 0)*

During hospitalisation, some participants felt that a social distance was maintained between some staff and patients, which promoted a 'them and us' type culture. In this instance, they felt like they were treated like 'a second class citizen'. Some spoke of having interactions with professionals where they felt that they were being undermined and controlled by professionals.

*"...at times nurses were snappy...you're told go to sleep now [NAME] ...Go on back to bed...There was a couple of them [NURSES] that just had certain power and you know Nurse Ratched out of 'One Flew Over the Cuckoo's Nest' ... You know, giving out to ... patients. I heard 'what do you want? You're not meant to be standing here and that when you're fragile'... " (F, 217, 0)*

*"...She [PSYCHIATRIST] wanted to completely control me. She was standing right on top of me like looking right down. I didn't feel treated like an equal. I felt treated like I was stupid actually..." (F, 59, 0)*

*"...I was just another crazy person signed into the ward, you know... I was just, yeah, a number...They just don't give a shit...if you wanted to ask them a question it was a big deal. 'Oh, don't be annoying me now. We'll come to you next' ..." (F, 55, 0)*

### ***'Having to Take Medication'***

'Having to Take Medication' describes participants' experiences of not having any choice but to take pharmacological treatment whilst in hospital. It also describes the side effects of taking such treatment. Although occupational therapy and psychology was available, most participants did not have access to these services in the initial period of hospitalisation and thus medication was the mainstay treatment available in hospital. Many participants felt there was an overreliance on this treatment modality. Some were afraid of taking medication or thought that there might be a more psychologically based approach to help address their distress such as 'talking'.

*“...when I was psychotic... I felt like they just dosed me that night kind of to help me sleep...I just felt like they gave me about five different tablets which were all to knock me out really...It was just strange, you know, that they would just kind of dose you and leave you to sleep instead of letting you kind of get on with it...” (F, 1, 0)*

*“I just felt that I was having medication thrown at me...There was a lot of psychological aspects to it that aren't really addressed. Everyone seemed to be focusing on drugs as a solution.”(M, 28, 0)*

Many participants had previous negative experiences of taking medication where the dosage was increased so high that they were over-sedated. They feared that they would be assigned medications that they did not like or were unable to tolerate, but yet felt pressured to comply.

*“I went with it [MEDICATION] because I knew I had to. I'm not keen on taking medication from when I was in once before. I found that if you don't take your medication, you were forced to take it...” (F, 63, 1)*

*“Well, there's so many side effects it's unbelievable...There's salivation all night long. Constipation...not being able to put sentences together properly...I went through every drug on the market and now we finally found [MEDICATION] which Dr. [NAME] wanted me on in the first place...And wouldn't let me leave hospital without me going on it...So, I was beaten into it in the end...they over-medicate big time. (F, 100, 17)*

Participants recounted taking medications in the initial stages of their hospitalisation, and then continuing to take medication throughout their hospitalisation. Troublesome side effects were associated with this, and there was a clear consensus that this was not discussed with participants.

*“And I believe that they could have got to me through talking, but they said no, that I had to be on medication...You know, at first when I first came in they were overdosing me with the medication. They were zonking me out completely...I believe that the treatment has definitely calmed me down but it's just making me like a zombie...All they done was medicate me...” (M, 3, 8)*

Some participants felt that being made involuntary was a way to coerce them into taking medication.

*“If they can say you're involuntary...there is no real choice there...The involuntary label was used as a kind of stick to take your medication.” (M, 46, 3)*

### ***‘Threatening Sense of Self’***

‘Threatening Sense of Identity’ describes the interactions that participants had with psychiatrists which made them feel that the nature of their emotional distress was solely attributable to their underlying pathology. It refers to instances where participants were forced to assume a new identity as someone with a ‘mental illness’. The participants’ sense of self was threatened due to being in the hospital and to their encounters with professionals. Some of these interactions were seen as unwelcome intrusions into participants’ private lives. This diminished the individual’s capacity to retain important aspects of self, for example, being a mother, a working agent and an individual with a sense of purpose. These interactions impacted negatively on the participants’ concept of themselves. Typically, these suggestions were asserted in a manner that was not cognisant of stressful personal and life circumstances that many participants had.

Others found that the psychiatrists’ assessment was implemented in a way that was intrusive of their personhood. Some participants described annoyance with professionals’ preference to elicit symptoms of illness rather than to determine other circumstances that may have impacted on their emotional state, such as trauma.

*“Sometimes they ask many questions like...I am not able to explain everything in your personal life. You might have a plan. You don’t want to explain to everybody to make it...public.”* (M, 11 consent to notes declined)

*“You know, he’ll [PSYCHIATRIST] ask you do you see, do you hear? All this, you know. They have to find something to put down on the paper when you come in...he needs to think of something that you’ve said or done that doesn’t make sense to him, obviously because I’m sick”.* (F, 100, 17)

During hospitalisation, this participant spoke of disagreeing with the diagnosis that the psychiatrist had given them as a *label* for the distress that they were experiencing.

*“It made me feel like I’m in totally the wrong place and these people don’t know me and they’re saying I’ve got a mental illness and they’re saying this about me and that about me...”* (F, 59, 0)

Some participants felt unheard and that their personal opinion of what was happening to them was not listened to. Several perceived that the psychiatrist was trying to label them with a diagnosis, which felt judgmental.

*“...I just felt so scared but because of my trauma they [PSYCHIATRIST] said that was a delusion...It was really real ...all they do is look at the printout and try to label you and that’s horrible...I just find it’s very impersonal and they don’t care...I think there’s a lot behind and they actually think I was really born like that. My brain is wrong and I don’t think... they don’t really see people. They treat the disease. They don’t know who I am. They don’t know anything of my life.” (F, 214, 2)*

### **‘Feeling Frustrated’**

Frustration is often felt as a result of experiencing obstacles to having one’s needs or wants met. ‘Feeling Frustrated’ describes the participants’ response to being in an environment where they felt confined and where there was a lack of activity. Frustration was especially apparent for two groups of participants: those who felt that there was nothing wrong with them and those who felt that hospitalisation was no longer beneficial. Many of this latter cohort had specific ideas regarding what could make hospitalisation more beneficial, and these are discussed after first reviewing frustration during early hospitalisation. ‘Feeling Frustrated’ refers to the sense of powerlessness engendered within participants due being in an oppressive environment or in a situation which they felt did not foster a therapeutic and recovery ethos. The system seemed to operate in a way that fuelled participants’ sense of frustration and led to dissatisfaction.

When recalling their admission, many participants referred to the need for reassurance and of the consequent frustration at the lack of family members or professionals who could empathise and meaningfully offer such reassurance. Their need for reassurance was thus unmet, either because no effort was made to reassure at all, or because efforts were coming from strangers and did not meet their needs.

*“What do mental people who are going through a very hard time need? Kindness...A touch of reassurance...I would have preferred a cancer diagnosis than that because my fear of all of that...There was no hint of ‘look, we really want to help you...” (F, 217, 0)*

*“...I don’t need like giving me an injection, strapping me down to the bed. That wasn’t going to solve what? They could have maybe just put a nurse with me for the night to supervise...Just give me like a night to just try to settle or whatever instead of using medication or whatever...It didn’t need to be done. It was an easy solution for them, you know.” (F, 55, 0)*

*“...I heard they do it in Holland...To give the patient three of four days first in the psychiatric unit...just to get used to the place before kind of medication is seen as the first option.” (M, 46, 3)*

More specifically, on admission to hospital most participants were not given any information regarding the length of their hospitalisation. This made it difficult to adapt. Participants felt that there was nobody to advocate for them or to negotiate their ‘release’.

*“...in that situation nobody can help you really...they [NURSES] were nice, but nobody can help you...I am sure he [SOLICITOR] tried his best but anyway they kept me for a good while...So, you want to know what’s the story, how long they want to keep you like that...” (M, 11, consent to notes declined)*

*“I was really frustrated. I hated being in hospital. Just having nothing to do and not knowing when you’re going to be released...That’s how it works...You’re put on order. You go to tribunal and then you’re waiting on word of your doctor...that really got to me.”(M, 162, 3)*

As evidenced in the above quote, the theme of frustration reoccurred during admission. Some participants described being aware of their core issues and what they needed, and of their subsequent frustration when these issues were not recognised. This was particularly true for some participants who had experienced more than one admission.

*“...But they were saying it was the drink that was causing it [DEPRESSION]...but it wasn’t the drink that was really kind of making me depressed, you know, but they [PSYCHIATRISTS] didn’t see it that way...it isn’t only the drink. I got depressed with my mam being passed away...I don’t think they treated me with my right illness at all...they should have looked at my depression after that...Should they have given me some medication for it? I know the suicide thing is still in the back of my mind...” (M, 10, 0)*

*“I needed someone to tell me these things weren’t actually real like...all I felt I needed to do was talk to someone and for them to give me their take on what was going on...I was just getting frustrated with everything...I felt like I was there too long. I shouldn’t have been there at all...” (M, 50, 0)*

A lot of participants were frustrated with being in hospital, did not see the need to be there and continued to express the wish to be ‘released’.

*“...I was really frustrated. I hated being in hospital...I wanted to be released straight away...” (M, 162, 3)*

Frustration due to lack of information was also evident amongst those who were subject to involuntary admission after first being admitted voluntarily.

*“...you don’t get a good explanation about it. You get told that you’re going involuntary and that’s it...” (M, 50, 0)*

Hospitalisation was seen as very ‘long’ and ‘boring’ with a lack of activities to occupy the participants’ time. A typical day was monotonous and centred around getting medication, meals, television, smoking or walking around.

*“There’s nothing really to do. You’re just lying around reading and there’s only so many books you can read. So, I just felt at the end of my tether really...They wake you up at 7 o’clock, 8 o’clock. You’re literally up then 12, 14 hours until you go back asleep. What do you do then?”* (F, 1, 0)

Similarly, there was a sense of there being no therapeutic benefit to being hospitalised and that most of what was on offer centred on taking medication. The repertoire of activities was seen as limited and unengaging, and did little to stimulate participants’ sense of mastery. Indeed many participants did not see any point to being hospitalised and consequently tended to have little motivation to engage with occupational therapy, being focused more on getting out of hospital.

Participants repeatedly expressed a preference for a more ‘interactive’ and therapeutic environment. They expressed a desire for greater access to allied health professionals, ‘counselling’ and ‘support groups’.

*“I just find that there should be more counselling and more support help groups ...”* (F, 15, 1)

*“Like you should be allowed, you know, relaxation therapy things. You should be allowed cookery classes.”* (F, 55, 0)

*“I think the activities. If there was more. If the activities were actually on when they were timetabled...Maybe more group therapy, more group discussion ...You feel you could kind of make those choices yourself.”* (M, 46, 3)

One participant described more positive experiences she had had in the past in a different hospital.

*“In 1998 I was in [NAMES DIFFERENT HOSPITAL ]...There’s so many pros to it. ...and then they have a team of what are they called? Occupational therapists. It’s scheduled...the day.”* (F, 100, 17)

Some participants felt they were hospitalised for longer than necessary, and for some it felt like they were being punished. A few spent protracted periods of time in hospital and felt this was with the aim of making them compliant.

*“...Hospitals grind you down. You’re just ground down into nothing until the doctor*

*feels that you're supplicant.*"(M, 162, 3)

*"...after a few days I was ready to go back out into the world again...but it's very hard to get out once you get in. [LAUGHS]... You think you're perfectly fine but the consultants or whatever, they're just keeping you until...they've broken your spirit, then they let you go...It has a detrimental effect, I think..."* (M, 146, 1)

During this time, some participants felt that there was little they could do to exert any influence over their destiny other than wait and rely on professionals to reinstate their freedom. The consultant psychiatrist was seen as the person who held the power to decide whether discharge was appropriate or not, and some participants only saw their consultant once a week, which was too infrequent to make decisions about discharge.

*"...She's [CONSULTANT PSYCHIATRIST] here once a week for ten, fifteen minutes and she'd say 'okay, you're going to stay for another week'...I didn't think that was good enough...That was annoying."* (M, 43, 0)

*"I just felt I hadn't any control of what was going to happen with me...I think they had the decision made up already beforehand and that was it. Even if I was progressing in my health as the days went on, they wouldn't release me."* (F, 15, 1)

Frustration was also evident among participants who had a mental health tribunal. Two distinct reported causes underpinned this frustration: a perceived lack of information, and a perception that the tribunal's outcome was predetermined. Some participants felt that the tribunal members merely listening to the psychiatrist's opinion and thereby making the process pointless. This was more apparent to those participants who had previously experienced a negative outcome from their tribunal.

*"I kept getting these letters then all the time...there would be a letter on my pillow, which was very annoying because there was no one to talk to about it."* (F, 31, 2)

*"I should have got more information on it [TRIBUNAL], but I didn't know who to go to."* (F, 15, 1)

*"They [MEMBERS OF TRIBUNAL] wrote down the facts...They made sure that I wasn't going home anyway. The decision was made."* (M, 68, 4)

Several commented on the value of having a supportive person or familiar professional mediate the frustrating and traumatic aspects of going before a tribunal.

*"Even to have some type of support while you're going through the process which is quite a traumatic process to put yourself before a tribunal...I suppose middle-ground really is what's missing from the whole thing...I think a psychologist is needed on the tribunal..."* (M, 162, 3)

*“He told me that he was the independent psychiatrist and I asked him would he be present at my tribunal and he said he didn’t know ... He was a real understanding, lovely man and it ended up I didn’t have him at all ... What would have helped would have been [THE INDEPENDENT PSYCHIATRIST] at the time ... When I went to the tribunal...There was another psychiatrist. I didn’t know who she was...but she [TREATING PSYCHIATRIST] had the whole influence on the tribunal...”(F, 31, 2)*

The majority of participants wished to have a shorter hospital stay and many linked this to having a consultant psychiatrist who was more trusting of them. This may indicate an awareness of some level of diminishing self-mastery, but equally of being cognisant of their remaining capacity. Some participants were willing to accept the consequences that ensued if they subsequently made decisions themselves that proved unwise.

*“When I went in he [PREVIOUS CONSULTANT PSYCHIATRIST] wouldn’t take me off medication. He’d simply give me a little bit more of something until I went home and settled and then he’d take me off it again. It really was good because it meant that even though I was in hospital more frequently, it was only for a few days.”*  
(F, 100, 17)

The subcategory ‘Being Confined’ describes participants’ feelings about entering hospital and the restrictions imposed upon them. Their sense of control was further eroded because they now had to deal with being ‘*incarcerated*’ against their wishes in a restricted environment and being controlled by others. ‘Being Confined’ consists of the dimensions: ‘Feeling Scared’, ‘Feeling Deprived’, ‘Being Treated Badly’, ‘Threatening Sense of Identity’, ‘Having to Take Medication’ and ‘Feeling Frustrated’.

#### **5.4 Summary of Category Losing Control**

‘Losing Control’ is the first category in the ToPC and describes extent of loss of control that participants experienced across their personal life before and during their involuntary admission. Firstly through, ‘Diminishing Self-mastery’ secondly through, ‘Feeling Violated’ and thirdly through, ‘Being Confined’. Each of these subcategories represents a domain of their personal life that participants experienced a loss of control. Loss of control occurred due to both internal and external threats to the participants’ perceived ability to control their lives. Internally, some participants struggled to contend with difficult emotions, feelings and beliefs that they were experiencing prior to their being subject to involuntary admission. Externally, all participants lost their ability to manage themselves due to the fact that either family members or professionals activated the involuntary admission procedure, thereby taking control from them.

Finally, control was also lost when participants found themselves in hospital – an environment where participants’ freedom was restricted. The impact and extent of the loss of control varied widely in its intensity and duration across participants. For some, the loss was transient and control was quickly restored; however, for others the loss of control was much more pervasive and continued to affect the participants’ lives after their admission was over.

## Chapter 6: Findings: Regaining Control

### 6.1 Introduction

'Regaining Control' (Figure 6.1) describes the process by which participants endeavoured to regain control either during the involuntary admission procedure or throughout hospitalisation. The manner and extent in which control was regained varied. While a number of participants began to feel increasingly in control within a short period, for others the process took longer and was therefore much slower and gradual.

The category and process of 'Regaining Control' consists of four subcategories conceptualised as: 'Resisting the System', 'Encountering Humanising Care', 'Gaining Perspective' and 'Playing Ball'. 'Resisting the System' describes the 'fighting-back' type strategy adopted by some participants in an attempt to regain control. 'Encountering Humanising Care' describes how participants felt a restored sense of control through the actions of professionals after it had been lost through being subject to an involuntary admission and/or detention. 'Gaining Perspective' refers to the manner in which participants accessed and processed information, allowing them to regulate their emotions more effectively. The fourth subcategory, 'Playing Ball', involves the strategies that participants learned in order to bring about or expedite their discharge from hospital. Each subcategory has a number of dimensions that are described in this chapter.



**Figure 6.1 Regaining Control**

## 6.2 'Resisting the System'

'Resisting the System' is the first subcategory and it describes 'fighting-back' type strategies adopted by some participants in an attempt to regain control before and during involuntary admission/detention. Participants were active in the pursuit to protecting their identity as viable autonomous human beings. It is notable that 'Resisting the System' was, in some instances, more particularly associated with those who had no prior experience of involuntary admission.

When participants actively responded to their loss of control by adopting a 'Resisting the System' approach, they believed that they themselves were the agent responsible

for reinstating control and as such they actively sought to defy and reject the suggestion that they may be ‘mentally ill’. ‘Resisting the System’ comprised both overt and covert strategies and was dependent on a number of factors including the severity of loss of control (including the degree to which the participant felt threatened or forced), the perception that motives of family and professionals were not in participants’ best interests, and participants’ belief that they could exert and therefore regain lost control. Varying degrees of anger and frustration were expressed during this time.

‘Resisting the System’ consists of a number of dimensions which are conceptualised as: ‘Trying to Reason with Others’, ‘Disagreeing with Others’, ‘Fighting Back against Being Infringed Upon’, ‘Wanting a More Psychological Approach’, ‘Challenging the Structures’ and ‘Not Wanting Help and Information’.

#### ***‘Trying to Reason with Others’***

‘Trying to Reason with Others’ describes participants’ attempts to negotiate with family and/or professionals during their distress and during the involuntary admission procedures. It refers to how participants tried to explain and rationalise their distress and how they themselves felt it could be managed. Participants actively sought to restore control by strongly verbalising and expressing their voice. In some situations, family members had sought or obtained the intervention of professionals, which signalled for some the possibility of rehospitalisation especially for those with previous experience of being involuntarily admitted. There were several ways in which participants sought to regain control over their emotional well-being or feeling of distress. Some felt they had the personal resources within themselves to successfully deal with the difficulties, while others felt that they could take medication at home rather than in hospital.

*“I was trying to say to him [PARTNER] that I just needed to relax, to be on my own ...I think it was a lack of understanding of what was wrong with me...I was just trying to explain that I needed to sleep on my own...” (F, 214, 2)*

*“I just said [TO CONSULTANT AT DAY SERVICES] that day I’ll take the tablets at home, I’ll take whatever you want and she said she was going to send me in...In my head I was like I don’t need to go.” (F, 200, 0)*

Some participants felt that that they needed neither medical intervention nor hospitalisation at the point. In this way, participants articulated their feelings towards those family members or health professionals who were intervening in their lives.

*“...she [LOCUM GP] said... ‘we believe you’re feeling a bit low’ ...I said ‘well, yeah, I’m a bit fed up,’ ...she said ‘well, we also believe you said to your mother you felt like driving into a wall’ ...Everybody says these things in normal day life. If you’re fed up. It doesn’t mean literally...” (M, 19, 0)*

Some participants attached provisos in terms of agreeing to go to hospital, and some agreed to go for ‘an assessment’ thinking that they might then be allowed home. A number of participants did not want to be taken to hospital in the transport provided (Garda car, taxi, AAT van), preferring instead to take their own car or have a family member drive them.

*“...she [LOCUM GP] said we want you to come in with us now. I said now? She said yeah. I said okay...I’ll follow you in my car. No... says the...doctor...you have to come with us.” (M, 19, 0)*

*“...They [AAT] ordered a taxi to take me into hospital and I was asking if I could drive...I was insisting that I would go in but I wouldn’t go in in a taxi...they called in the Guards...I remember...trying to reason with them but they weren’t having it...” (F, 208, 2)*

Other participants agreed to go on a voluntary admission initially on the proviso that they would not take medication – in some cases they later discovered that on refusing to take medication they were not allowed to leave and were involuntary admitted under the MHA. In this way participants regaining control by asserting their opinion and their right to be involved in how aspects of the process might be managed.

*“That [REFERENCE TO AGREEING TO GOING INTO HOSPITAL VOLUNTARILY] was on the premise that I wouldn’t take any medication. In my naivety, I didn’t know you could go in voluntarily and then be kept.” (M, 28, 0)*

*“...he [ON-CALL PSYCHIATRIST] said do you want to come down to the unit...I said listen, I will go into the unit but I won’t be going there just to be given medication.” (M, 46, 3)*

### **‘Disagreeing with Professionals’**

‘Disagreeing with Professionals’ describes more intense instances where participants verbalised their disagreement with the opinion expressed by professionals involved in obtaining their involuntary admission. In this regard the participants were involved in

actively challenged and contested the label of being ‘mentally ill’ that was being given to them by family and professionals. Additionally, it refers to how participants disagreed with the diagnosis they were given and their ensuing treatment. In this way they rejected any suggestion that they needed to be hospitalised or the label that was being ascribed to them by professionals.

Despite some participants allowing GPs to visit their homes or agreeing to go to the GP on family guidance, participants subsequently disagreed with their opinions and advice. They did not agree with what the professionals believed to be wrong with them. This was particularly evident in participants who articulated that they were not mentally ill and who adamantly refuted the notion that they were unwell.

*“He [GP] was asking me would I go into the unit and all of that and I was ‘no, I told you I’d never go back into the unit again.’” (F, 32, 1)*

*“...she [CP] just said I was going [TO HOSPITAL]. I said I’m not...I panicked...” (F, 200, 0)*

*“I just tried to tell them [GARDAÍ] that I knew they were wrong...” (M, 150, 0)*

One participant spoke of how she went to her GP about physical concerns; however, her GP said she needed psychiatric intervention. This participant disagreed and felt the GP was not listening to her concerns about her physical health.

*“...the...[GP] came in and spoke to me...she said something about you need to talk to [NAME CPN] and she said something about you may need to go into hospital. I disagreed with her...I got really annoyed with her...I didn’t shout or anything, but I was very assertive...” (F, 31, 2)*

For some, the disagreeing strategy intensified out of the tying-to-reason strategy, especially when it came to the removal of the participant to hospital. Participants used their personal resources to stand up for themselves.

*“... the whole ‘sign here’ – ...that was the worst moment...It was in the kitchen and he [GP] had just arrived. He backed into the drive and I took a drawer out of my dresser and scattered it across. I said you’re not sectioning me.” (F, 217, 0)*

*“...I went berserk...I didn’t want to be admitted...I really didn’t believe that I should be going into a mental hospital at that time.” (F, 9, 0)*

*“...he [PARTNER] ended up calling a nurse...the nurse came to my house ...I said I wasn’t going...to go to hospital...I was not doing crazy stuff like...” (F, 214, 2)*

Later in hospital, participants felt that the problems they were experiencing were trivialised and that professionals failed to address their real issue.

*“She [CP] was saying to me I was an alcoholic and I was telling her I wasn’t...I was depressed but they didn’t see it that way...I got depressed with my mam being passed away.” (M, 10, 0)*

*“...they found traces of drugs and stuff in my system. Then it was point blank it's all drink and drugs...I said it isn't, I've been like this all my life...they wanted to send me to [REHAB] and I said I wasn't going to go down there because it's full of junkies...” (M, 71, 0)*

In fighting for control, participants refuted and rejected the labels ascribed to them by family and professionals. They regained control by not internalising a sense of self as someone with a mental illness.

### ***‘Fighting Back Against Being Infringed Upon’***

‘Fighting Back against Being Infringed Upon’ describes situations where participants physically attacked and fought when professionals (AAT, Nurses) encroached upon them. Participants fought back in response to feeling angry, or frightened because of force and restrictions that they experienced. This fighting back strategy typically occurred when participants were removed from their homes or later in hospital when they were forcibly administered medication, were restrained or secluded. This was an active and intense strategy, which led to physically aggressive tactics in an attempt to reinstate participants’ lost control.

On their removal to the Garda station or the hospital, some participants reacted to their loss of control by threatening to employ, or indeed by employing, physically aggressive behaviour in an attempt to reinstate control.

*“The Guards...stopped me in the street... and I started kicking, screaming, shouting... spitting, cursing...really aggressive stuff...they threw me in the back of the car.” (M, 51, 3)*

*“...it was just my survival instinct...I remember lying down on the floor, all the men pushing me down...I just started fighting...I tried to punch them...they kind of won and they handcuffed me...” (F, 214, 2)*

*“...but the next thing they were strapping...on the trolley bed. Of course I fought...I just fought against them every single inch of the way...” (F, 139, 1)*

The degree of anger engendered in response to feeling infringed upon was pivotal in determining the activation of a fighting-back strategy.

*“I was trying to break free but I couldn't. It was a really, really physically forced admission....I was so shocked and angry...and they just dragged me in and ... I was like shouting and all that.”* (F, 72, 0)

*“Because of the aggression of the admission, the aggression in me wanted to fight...if it was more gentle, I might have accepted it quicker...I was angry...I was just fighting back to prove to them that I'm all right. I didn't need this sort of intervention.”* (F, 23, 0)

Participants described fighting back when confined in the Garda station and spoke of not being told anything and having to wait for long periods for the doctor to arrive. The following participant spoke of ‘going mad’ having to wait.

*“I was going so mad...It was like you know, is [NAME] coming? Who is coming here?”* (F, 55, 0)

For others fighting back happened when they realised that they were actually being kept in hospital. This was especially apparent to those participants who felt that they had just going to hospital for an assessment.

*“The doctor made his decision. He was not going to let me out. I told her that all I had to do was pick up a bit of the sink and throw it through the glass, that I would escape that way.”* (M, 51, 0)

*“...when I first went in I was adamant...I wasn't staying in here. This wasn't the place for me...And at the time I was like, oh Jesus, just let me out of this place...I think I tried to run off once...”* (F, 9, 0)

There was anger in response to the restrictiveness of being confined without a plausible explanation on the reasons for the admission and confinement.

*“...they brought me over anyway...I was being forced into an area where there was no explanation or understanding of what was going through...I started screaming at them...I was feeling angry and upset, giving out to people when I got there first...”* (F, 60, 2)

Participants described their response to being in hospital and their desire to leave it. On admission, certain participants actively sought to restore their freedom. Such participants were proactive in their attempts and activated external systems – their right

to appeal the admission (tribunals) and access legal professionals (solicitors). There was an expectancy amongst these participants that their efforts would be successful.

*“I immediately was told of my ability to appeal [TRIBUNAL]...The top doctor, a barrister who took my side of view and he listened to me. So, I put in an appeal immediately and to my great surprise I was not immediately let out by the psychiatrist.”* (M, 150, 0)

Some participants actively sought to leave hospital.

*“...I didn't want to be there any more...I wanted to go home and I kicked up such a fuss. I rang the Guards and I rang a solicitor...family members. I remember she told me that I wasn't allowed go home...I started shouting and roaring and whatever and she told me, look you won't be going home and whatever...”* (M, 50, 0)

*“...I knew I was incarcerated... ‘You're not getting out’ ... ‘No, I'm not staying’ ... ‘Oh yes you are’...I was so adamant...to go.”* (F, 217, 0)

Typically, most participants who adopted fighting-back strategies and who did not comply with the rules of the system experienced more physical coercion while being confined and restrained, or given injectable medication.

Others fought back against the coercive measures that they were subjected to such as seclusion, restraint or the involuntary administration of injections. They fought to be released from these forced restrictions and invasions of their person.

*“I was trying to get out...the seclusion room...it was breaking my heart that I couldn't get out of there...They said that I was breaking down the door with my bare feet...I do remember banging my head against it...They would gang up on me...They said I was fighting. I don't think I was fighting. I just wanted to get out...”* (M, 159, 4)

*“...I tried to escape [FROM SECLUSION] and then they put me back into the place...”* (F, 214, 2)

*“...I wouldn't go with them [NURSES] up to the room...they grabbed me, marched me up the stairs with my arm behind my back... Put me in a room. Injected me...”* (F, 100, 17)

The following participant spoke of ‘screaming’ of being ‘scared’ and resisting because she did not want to have an injection.

*“...I don't know if they [NURSES] asked me first could I take medication or to take it, but I was like saying no...I was just screaming in the corner. Please, you know, go. Leave me alone. Get me out of here. Then...These people appeared out of nowhere...She sat me down and...when I didn't cooperate with her, two female nurses*

*came in and then it was a man with tattoos that like was holding me down.” (F, 55, 0)*

The following participant described how he was ‘*pushed back*’ by staff when he attempted to move around the seclusion area room.

*“...if I wanted to get out from one half to the other half I couldn't...They [NURSES AND SECURITY STAFF] would gang up on me and push me back.” (M, 159, 4)*

‘Fighting Back against Being Infringed Upon’ refers to participants’ reactions to being treated against their will by professionals. As a result, participants were either angry or frightened and responded in a way to protect themselves from the invasion of others in their lives. This strategy takes precedence over the person mental health and the energy is invested in fighting and reacting at the expense of the person’s mental health.

### ***‘Wanting a More Psychological Approach’***

There was an expressed need to have access to psychological-based approaches to care and management whilst in hospital. Participants wished to have treatment that was not focused on medication; many expressed dissatisfaction with sole reliance on medication. Participants wanted access to more psychological-based therapies that would help them with their emotional distress and they felt that they could recover by interpersonal communication or access to psychological therapy. Participants felt that they could have been helped through talking-based therapies and expressed a wish to be treated in this way.

*“I believe that there should be more psychologists working with the psychiatrists...Not one psychologist has approached me...I knew they [PSYCHIATRISTS, NURSES] were going to like sit here and take medication and I knew that the right people weren’t there to talk to me...” (M, 3, 8)*

*“...every time I go in I ask them to have counselling while I’m sick, not when I’m better. That’s the one big change there has to be for me. Counselling in the hospital...that would talk you through your illness.” (F, 41, 17)*

*“...I believed that psychotherapy would have been very helpful to bring me down...I felt that the doctor’s stance...was too focused on medications...I just wanted to try a different approach, which people weren’t really open to...Everyone seemed to be focusing on drugs as a solution...they didn’t seem to try and find reason or truth into some of what I was saying...the real thing that I was trying to get across was ‘look, it’s probably 50/50 psychotherapy and medication” (M, 28, 0)*

### ***'Challenging the Structures'***

'Challenging the Structures' describes varying attempts to resist and not cooperate with the mainstay treatment and usual assessments by the psychiatrist. By challenging the structure, participants displayed expressions of latent anger and frustration. Participants actively and passively exerted a protest to a loss of control that they experienced.

Some questioned the justification for their admission and did not accept advice or intervention from professionals.

*"I had done the interview. I wasn't quite sure why I was there...because I believed I was fine at the time. I would have been in defence mode anyway because I was 'why am I here? I don't want to be here and I shouldn't be here.'"* (F, 63, 1)

For many, challenging the structure involved resisting medication in order to prove that that they did not need it and that they were not mentally unwell.

*"I wouldn't take their pills or whatever..."* (M, 146, 1)

*"...I know that I angered myself into getting out of here. I resisted it...I didn't actually allow myself relax into the fact that I was that unwell and accept it and be treated for it properly."* (F, 23, 0)

It was common for participants to feel anger at the person they felt was responsible for the restriction of their freedom.

*"I wasn't allowed even go to the shop...I had to fight to get out to the shop...I was going cracked. I was very, very angry with them."* (M, 50, 0)

Examples of challenging the structure involved multiple questioning of psychiatrists and nurses regarding medications that they were prescribed.

*"...she [NURSE] was giving me medication in the morning which I'm sure I probably created a scene about...I can remember asking and asking and asking what is this? What's in these? Why are you giving me this? What is this about?"* (F, 55, 0)

*"I used to enjoy talking to the doctors because I used to be full of questions of why, why, why? What have I got? I've got psychosis. What does that mean..."* (M, 50, 0)

*"I met Dr. [NAME] the next day...she said...I'm going to have to increase your injection again. Of course, I disagreed with her totally and absolutely... We were always fighting...always disagreeing...we didn't see eye-to-eye on anything...I didn't trust her...Previous experience of her with increasing medication when I felt there was no*

*need to increase it... ” (F, 31, 2)*

*“...all my energy that I have was put into walking up and down the corridors in the hospital and talking to that doctor and trying to stand up for myself. Saying I shouldn't be here. I'm not treated right.” (F, 59, 0)*

Most participants often came to view these strategies as a mistake and learned that this approach was not effective in regaining control. In the following quotations, participants describe how they perceived that they were subjected to a longer period in hospital due to the fact that they resisted following orders.

*“Seven months in hospital for fighting the system. Just because I wouldn't go on the Clozaril when she [CP] wanted me to.” (F, 41, 17)*

*“I would have got out on that day but I refused to take the tablet...” (M, 17, 0)*

*“I mean when I think about it, it was so stupid because I was fighting with them and there was no way I was ever going to win.” (F, 139, 1)*

*“...I was deliberately obnoxious in the hospital...in hindsight that wasn't a good way to think...I wasn't going to be very cooperative...I really didn't make it that easy for them to like me.” (F, 66, 0)*

### ***‘Not Wanting Help and Information’***

‘Not Wanting Help and Information’ in hospital is a type of resistance that stems from anger. Thus, participants refused to interact with professionals or engage in efforts at intervention in hospital. It also involves refusing therapeutic measures in a way that may suggest to professionals that they were mentally ill.

*“...I didn't look for any information...I wasn't going to cooperate...they had a definite plan for me but I didn't agree...I had my own opinion and my own interest so what went on around me didn't mean anything to me...I wasn't a bit concerned...what they done or said was falling on deaf ears...I wasn't really interested in what was happening in there...” (M, 230, 0)*

*“...they just brought me into the room and sat me down and I didn't want to talk to any of them because I just didn't appreciate it...I didn't take much notice of it...I didn't want to ask anybody...No need to be there and angry...” (F, 60, 2)*

Although participants continued to be angry, they were less overt in how they displayed this anger and sometimes they described feeling frustrated. This frustration led to the development of resistance and, although more covert than other strategies, it was likely to transcend throughout the trajectory of care.

Some participants did not understand why they should be given care against their will, nor in fact did some participants want to understand or ask professionals – such was their anger. There was no desire to interact with professionals. Others resorted to being uncooperative in an attempt to show their anger with the manner in which they had been treated.

*“...he [CONSULTANT] only wanted all the information out of me...In the beginning he wouldn't make me voluntary so I told him I wouldn't cooperate with him...”*  
(M, 230, 0)

*“...they wanted more information from me. I wouldn't give more information to them.”*  
(F, 59, 0)

*“I was really angry...at the very end, maybe the tenth day of being there, one nurse...said how are you? I said I'm fine. If you didn't talk to us you're never going to leave...I didn't want to talk to her because I didn't like her since the first day so I just didn't engage with her and she was kind of telling me I had to talk to her...”*  
(F, 214, 2)

‘Resisting the System’ refers to the strategies that participants used to exert control in an attempt to regain control. Participants internally and externally defied and rejected the labels they perceived were being attributed to them as well as the any suggestion that they needed the intervention of the mental health services. These strategies were typically associated with those participants who had no prior experience of involuntary admission and consisted of both overt and covert reactions. Participants can oscillate between a number of the strategies. . Some participants were sensitive to any threats against their ability to self-regulate and having someone intervene was seen as a threat to their control.

### **6.3 ‘Encountering Humanising Care’**

‘Encountering Humanising Care’ describes how participants began to experience a regaining of control due to positive encounters with professionals and supportive interactions with fellow service users. Such encounters either happened during the involuntary admission procedure or later in their hospitalisation. ‘Encountering Humanising Care’ enabled participants to gain an understanding of their distress and led to beneficial relationships with professionals and peers during hospitalisation. These positive encounters contributed to the restoration of a sense of control. This subcategory consists of the following dimensions: ‘Meeting Kind and Nice

Professionals’, ‘Letting Me Decide’, ‘Feeling Contained by the System’, ‘Meeting Peers’ and ‘Maintaining Connection with Family and Friends’.

***‘Meeting Kind and Nice Professionals’***

‘Meeting Kind and Nice Professionals’ describes the positive encounters a number of participants had with Gardaí, the AAT, nurses and doctors during the initial stage of the involuntary admission procedures or throughout their hospitalisation. Some participants did not experience such interactions until much later in their hospital stay. While occurring in an ad hoc manner, participants described situations where professionals related with them interpersonally, enabling them to have more faith and trust in their humanity and motivations. The personal qualities of professionals’ warmth, gentleness and kindness were frequently commented upon, and participants described being treated like human beings, being shown dignity and respect, being cared for and feeling supported. Such interactions helped alleviate some of the distress that participants experienced as a result of their diminishing self-mastery or their being involuntarily admitted and/or detained. Such encounters protected the participant from feeling frightened, undermined or dehumanised, and may have contributed to the development of trust or changing the participants’ perception of the restrictiveness of some coercive practices

Participants found it easier to accept professionals’ intervention if they felt that they were not going to come to any harm. When professionals acted humanely and conveyed warmth and compassion, an atmosphere of trust was created where participants believed that the professional was genuinely concerned for their welfare, and participants thus found it easier to accept their intervention.

Despite the fact that most participants did not want to go to hospital, offers and acts of kindness generated a sense of being cared for. Being cared for did not solely relate to being given information; the mere fact that a professional did something as small as getting an ice cream from the fridge was perceived as kind.

*“I said to the Guards and I’ll go with the nurses and [NAMES FAMILIAR CMHN], she’s a nice girl, she got me two choc ices [ice cream] out of the fridge...Brought me in then.” (F, 27, 6)*

*“They [GARDAÍ] treated me very well there was no badness...no being mistreated...they just treated me like a normal person...” (F, 9, 0)*

It mattered that professionals did not rush participants during their removal to the hospital or Garda Station. When Gardaí or professionals respected participants’ dignity and personal integrity, they were more likely to feel a semblance of control and in turn were more likely to agree to their removal to hospital. The more ‘*informal*’ the interactions the Gardaí had with participants, the less distressing the experience was, and such interactions provided a sense of comfort in an otherwise frightening situation.

*“...the Gardaí...took a very caring attitude...They seemed concerned...it was ‘will you come down to the station? We’ll just have a chat’...and it made me feel like everything was okay again.” (M, 114, 0)*

*“The Guards came, bought me a coffee...gave my bicycle a lift down to the Garda station...” (M, 146, 1)*

Some participants were brought to the Garda Station and had to wait there until the GP came to assess them for a recommendation for involuntary admission. Gardaí who were calm and reassuring helped deescalate fraught situations and participants’ distress. Participants commented that Gardaí were ‘*sound*’, ‘*relaxed*’ or ‘*chilled out*’ – these qualities had a calming effect and assisted in alleviating participants’ fear. In other instances, Gardaí had a ‘*good*’ chat with participants and spoke to them about normal things, which helped minimise the extent to which participants experienced a loss of control. One described how a Garda listened to his plea not to be put in a cell. Attending to basic needs and going beyond their professional duties by offering to get tea or food conveyed to the participants an acknowledgment of their distress.

*“I can remember having a conversation with the Gardaí that night...We were talking about...hurling and loads of other stuff...making sure I had tea and something to eat...just something as basic as that...” (M, 114, 0)*

*“...They [GARDAÍ] brought me out the back...There was an old sort of vacuum packer machine someone was using for vacuum packing grass. They allowed me to scrap up the scrappings, smoke a cigarette....” (M, 146, 1)*

Sometimes Gardaí<sup>23</sup> removed participants to the hospital and it was mentioned by a few that it was helpful if the Gardaí waited with them until they were assessed. Such participants were protected from feeling alone or unsupported and derived a sense of

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<sup>23</sup> Gardaí removed 23 participants to hospital

comfort from being with someone they knew during their removal or admission to hospital.

*“...I was waiting...but Guards stayed with me...until the...very end until about three or half three in the morning.”* (M, 10, 0)

A few participants mentioned that they were accompanied to the hospital by relatives or friends. This was valued and was described as supportive since their presence occasionally helped in providing comfort and calming the participant down. This company was especially important if the participant had never been hospitalised before.

*“...my family were supportive, particularly my son [NAME]...he actually accompanied me into the hospital with my sister and my husband.”* (F, 217, 0)

*“My niece was with me...she was telling me I’d be okay...and I kind of took a bit of solace from her being there because she was somebody that I was comfortable with...”* (F, 23, 0)

*“Having my friend there was helpful.”* (M, 46, 3)

On arrival at the hospital participants felt more at ease when they met professionals who were pleasant and spoke to them. Such interactions were seen as helpful on a human level, alleviating the personal distress associated with being in hospital.

*“...The matron...was very nice...The staff were great...There was no one looking down on you. You were just like ‘hello, hi, how are you today?’”* (M, 19, 0)

*“The security guard there was helpful. It was him who suggested I go down and have a cup of tea.”*(M, 46, 3)

It mattered to some participants that professionals made time to listen and attempted to understand the circumstances surrounding their involuntary admission from the participants’ perspective. Participants who were given the opportunity to explain their thoughts and feelings felt it was important in helping them having a sense of ‘voice’ – it was important to them that their beliefs were taken seriously and they felt validated and understood when they were given the opportunity to explain their situation.

*“He [PSYCHIATRIST] was very nice. Sat talking to him for about twenty minutes, half an hour. He asked me...How I felt...what brought you here?...I don’t think he even thought I should have been there...He was kind of saying okay, yeah, well that’s kind of normal behaviour you know if you’re fed up...”* (M, 19, 0)

*“...she [NURSE] was talking to me as though she believed what was going on in my*

*thoughts...and she understood where I was coming from...I certainly remember thinking that nobody else believes me...asking me questions that were trying to make me think introspectively and I just think that engagement in itself helped relax me.”* (M, 114, 0)

*“...Nurses would...come and say ‘don't worry...You are okay’...Some [NURSES] would really understand what's going on. Really understand who I was...”* (F, 60, 2)

For those who had previously had psychiatric care or been hospitalised, having access to a familiar nurse or doctor went some way to help the participant settle more easily into the hospital and feel more secure and comfortable.

*“...I was still very frightened and I spoke with the doctor [NAMES DOCTOR WHO SHE KNOWS]...he sort of brought me down a little bit. I felt a little bit at ease that people were being more normal and talking to me...”* (F, 23, 0)

*“I met a lovely nurse the first evening, [NAME], and she was very nice to me. She remembered me and she said that I was a lady and all of that. She said you're a lovely person and you won't be here long. She gave me encouragement.”* (F, 31, 2)

*“...it was nice to see a face that I knew...there was this nurse...I took the medication for her...She just had a woman's touch or whatever. Just like cajoling me or gently pushing me into taking it.”* (M, 43, 0)

Empathy was also seen as important. Having someone acknowledge the distress that participants were experiencing engendered a sense of comfort in an otherwise uncertain and frightening situation.

*“They [NURSES]...were helpful to me and they tried to comfort me...I was very distressed going into the hospital because I didn't want to go in against my will. So, they were good...Just asking did you want tea or coffee, trying to relax you...”* (F, 15, 1)

*“...there was an intern there...a very kind of consoling person...She was really nice...she kind of held my hand. She said you're only here for a rest...”* (F, 200, 0)

*“...when Dr. [CONSULTANT PSYCHIATRIST] came back I was put at ease big time...she said if you ever need to talk...I'll talk to you... she goes, 'I'm going to talk to you as a friend now rather than as a doctor.'...”* (M, 39, 0)

When professionals engaged participants in simple conversation and used humour, it helped detract from the distressing reality of their situation and from the distress that they may have been experiencing during coercive practices.

*“There was a gorgeous nurse who came into me after my clothes were taken...she was lovely...one very funny nurse who brought me in some clothes...she said ‘isn't this*

*beautiful...this is your negligée'...she mattered actually in that week.*" (F, 217, 0)

Other participants commented on professionals that were available to 'talk' with them while in hospital. Being able to talk with someone about their feelings, if participants wished to do so, was beneficial in terms of connecting with professionals.

*"...They'd [NURSES] come down and talk to you...I'd have good chats with them...They'd ask me how I feel..."* (M, 10, 0)

*"They [STUDENT NURSES] were really kind to me...really supportive...It was usually them I'd talk to...I found them more accessible."* (F, 31, 2)

Some participants felt there were professional on their 'side', which helped them feel that others would advocate for them. These people included a member of Advocacy Ireland and some 'younger' nurses.

*"I was talking to someone from Advocacy Ireland...He helped me a lot..."* (M, 71, 0)

*"...they're [YOUNGER NURSES] willing to listen and...to adjust...to say, 'well I think he's good today...he's okay...he's improving'. Whereas the older ones don't really want to get involved..."* (M, 3, 8)

One participant, who after a period of being voluntary was held against her will (for a 24-hour period – Section 23(1) of the MHA), recalled having a 'diplomatic' nurse help by checking on her, offering advice, and gently persuading her to remain in hospital. In this period, she was waiting for an independent psychiatrist to determine whether she would be discharged, agree to remain as a voluntary patient, or be admitted involuntarily. This interaction was seen as helpful despite the participant's wish not to remain in hospital and that she was being held against her will.

*"...the nurse helped a lot...They'd check on you all the time and see how you are and say 'well, you should really stay.' They were...diplomatic about it...It was kind of trying to convince you that you're better off here..."* (F, 1, 0)

It was important to participants that their identity beyond that of a 'patient' was maintained and that professionals acknowledged that participants had a life outside of hospital. Participants therefore valued professionals who were non-judgmental and who attempted to form a relationship that was not subsumed by an illness orientation. Some did this by trying to get to know participants or by showing an interest in their life outside of hospital. It mattered to some that conversations were not solely based around questions on 'mental illness'. When the nurse could see the person 'behind the patient',

participants regained control by not being forced to internalise a sense as ‘mentally ill’. The following participant describes how a familiar nurse talked to him on a human level, thereby acknowledging life outside of ‘*being a patient*’.

*“...I remember [NAMES NURSE] being quite good...Just talking to you like a human sort of outside of the...job...description.”* (M, 146, 1)

*“There was some staff that I got on with. I...felt they had my best interests at heart, that they could see the person behind the patient...some staff just saw me as...a patient unit until I’d taken medication. Others...appreciated that I had a life outside of being a patient.”* (M, 46, 3)

Conversely, other participants felt being listened to or understood was not important, primarily because they saw their admission as unnecessary and that there was nothing wrong with their emotional well-being. Such participants felt they possessed the capacity to regulate their emotions and in this regard were already in control. Receiving therapeutic intervention was perceived as unnecessary, but some did appreciate that staff treated them with dignity and respect. Ultimately, however, they were waiting to have their liberty reinstated and be allowed home. While these participants did not require a therapeutic relationship with professionals, their hospitalisation was nonetheless easier if professionals were compassionate towards them. Thus, having interactions with kind staff made the lack of freedom more bearable.

Other participants’ perception was that while some staff were ‘*nice*’, they could not ‘*help you*’ be discharged from hospital. Therefore, although participants felt their detention was unjustified, they did feel that they were being treated well during their hospitalisation.

*“I’m not faulting any of them [STAFF] ...most of the staff were very helpful...when they got to know me better they responded differently...”* (M, 230, 0)

*“...They’ve got their own thing to do...they don’t make other people’s lives more difficult because that makes their own job more difficult...they were always good to me...”* (M, 146, 1)

*“...the nurses were personally very, very caring...the hospital stay was no problem for me...I quickly realised the staff were personable enough individually and they only have to do things in certain ways because it’s mandated.”* (M, 150, 0)

Other participants encountered humanising care at a later stage in their hospitalisation and for some of these participants it was not about getting help but about making the

stay in hospital easier. Some spoke of having a ‘chat’ to certain staff and this made hospitalisation easier. When participants felt that they got to know a professional, a relationship formed and in some instances they named certain staff with whom they got along well.

*“I like the staff ordinarily...on the whole they are very nice ...There's one nurse in particular everyone loves, [NAME NURSE] and say when he does nights you can have a cup of tea any time you want...and the domestic staff, they were very, very nice...but I still thought I shouldn't be there.”* (F, 139, 1)

### **‘Letting Me Decide’**

‘Letting Me Decide’ describes situations where professionals allowed or gave participants the opportunity to decide, participate or be involved in some regard during the involuntary admission procedures or throughout hospitalisation. In this way, professionals restored some of the control the participants had lost by being subject to an involuntary admission. Additionally, it describes examples where participants were involved in the decision-making process regarding certain aspects of their treatment in hospital.

Even though participants were still subject to involuntary admission, they were given a sense of control over certain aspects of decision-making. By allowing participants to dictate the pace of events, participants felt that professionals were giving them some control. During the initiation of the involuntary admission procedures, some participants attached provisos to how smaller aspects of their removal to hospital should be implemented. Participants recalled professionals allowing them to tend to personal belongings. Having some say in aspects of their removal helped in limiting the perception of loss of control.

*“...I was like let me finish this coffee [TO GARDA ON REMOVAL TO STATION] ...Can we bring the bicycle?”* (M, 146, 1)

One participant recounted Gardaí allowing him to drive his own car to the Garda Station. This promoted a sense of self-responsibility as the participant felt the Gardaí had enough respect for his autonomy to go to the Station unaccompanied. It also communicated a sense of the participant’s ability to make responsible decisions regarding his welfare.

*“...I had my car with me...He [GARDA] drove the squad car back to the station and had me follow, so he was actually trusting me to do that as well...the independence is important, the trust... that was important...”* (M, 114, 0)

Within 24 hours of hospitalisation, the consultant psychiatrist (CP) assessed the participant to decide whether to complete the admission order for detention or not. In some cases, the CP offered the participant the opportunity to remain in hospital voluntarily and as such they agreed not to proceed with detention. Having this option was empowering and eased participants' transition into the hospital environment.

*“I was a voluntary...you'd come and go as you please...You'd just say to them I'm going out now for an hour. They'd say...Yeah, you're grand [NAME]...I could go across to the shop...That was good...If I wasn't let out at all, I would have lost it altogether.... I was told that I could walk out any time...I had the freedom...coming in voluntary is a good thing because you know you can leave if you want...it's really up to yourself”* (M, 10, 0)

Other aspects of 'Letting Me Decide' were evident during the administration of medication. One participant recalled choosing a familiar nurse over other nurses to give her an injection, which allowed her to regain some level of control.

*“...the previous time I went in I was asking [NAMES NURSE] and she said you had your injection but you wouldn't let anyone give it to you only me.”* (F, 139, 1)

Another participant recalled being given the opportunity to negotiate taking medication in tablet rather than injectable form.

*“They were going to force the injection on me and I said no, I'd take the tablets instead. So, I took the tablets instead.”*(M, 3, 8)

*“...They [NURSES] were attempting in the beginning to give me very strong medication, you know, and they gave me just a small one...”*(M, 25, 1)

In other instances, the CP revoked the involuntary admission order within a few days and participants remained in hospital voluntarily and this was seen positive, especially if the participant felt involved in the decision-making surrounding it.

*“...My doctor, he had told me that he wasn't going to see me until the tribunal and that he'd put me voluntary if I'd stay another two weeks...”* (F, 15, 1)

One participant, who was initially voluntary, found herself being subject to involuntary for a 24-hour period after she requested to leave hospital over a weekend period. She highlighted that on later speaking to her treating CP, they mutually decided she would

remain in hospital voluntarily. In this instance the participant perceived that she was involved in decision-making.

*“I was kept in and then I saw Dr. [CP] ...she said ‘what’s going on?’ And she spoke to me and we both decided...I’d stay. So, she said we’ll rip up this form...Keep you as voluntary.”* (F, 1, 0)

For some, hospitalisation became a more positive experience with time. This was especially evident when participants’ sense of confinement and restriction lessened – where they were no longer confined to certain areas of the hospital ward and they could get permission to go to the shop or to get home for a few hours. This gave participants a sense of control over what they did and when they did it. Not being restricted and having the freedom to walk in the garden and other areas of the hospital helped minimize the feeling of being confined.

*“I knew I could say to one of the guys can you let me out for a walk? Once they got the trust with me...I could walk around the block or they brought in a hurl and a ball.”* (M, 34, 0)

*“...I got to daily Mass...It was a great source of comfort to me...I met Dr. [NAME] ...and I said I need to get out. My hair needed to be cut and I needed to get a few personal things done and she allowed me to do that...She gave me three hours out that day...”* (F, 31, 2)

Other participants recalled certain nurses showing flexibility when enforcing rules. When nurses made concessions or were relaxed in their approach, it engendered a greater perception of having control. The following participant recounts being allowed to smoke in an undesignated area of the seclusion area.

*“...they [NURSES] brought me down to the...[SECLUSION AREA]...You’re not supposed [SMOKE] really but you are allowed smoke in the bathroom, but that’s an understanding type thing.”* (F, 139, 1)

Additionally, some participants’ views were considered when making decisions regarding the medication they received. Participants described situations where doctors listened to them when they asked to have their medication reduced or switched.

*“I was given this medication...I said that they’re making me very tired...she changed them then...”* (M, 39, 0)

*“First it gave me side effects. I got it changed and Dr. [NAME] changed it.”* (M, 52, 0)

Some participants recalled expressing a preference to having their injectable medication switched to tablets. When the psychiatrist did so, participants perceived that their pleas were listened to which gave them a sense of control over their medication regime. This in turn provided participants with a degree of ownership and personal responsibility.

*“...I’m glad that they listened to me. The fact that I didn’t want to have injections...The doctor...put me on [ANTIPSYCHOTIC] then which is a much better drug.”* (F, 100, 17)

In other instances, participants were given the options to accept or decline certain supports. In some cases, this right to decline a recommendation or form of treatment promoted that feeling of control.

*“...they asked me, Dr. [CONSULTANT]...would I go to the AA meeting...I said I wouldn’t go...I like to talk to a person one-to-one...I didn’t want that...”* (M, 10, 1)

A few participants said they were given some choice as to which type of medication they received. The following participant recalls asking to be prescribed a medication that she had found helpful in the past, enabling her to exercise her right for preference.

*“...I had to ask for [ANTIPSYCHOTIC MEDICATION]...because that was the only thing that used to help me...I’m back on them now...”* (F, 27, 6)

### ***‘Feeling Contained by the System’***

‘Feeling Contained by the System’ describes the relief that some participants experienced with the intervention of professionals (Gardaí or the AAT). This encompassed the prospect of receiving help that might assist some participants in regaining control over their lives. Additionally, it describes the safety and protection that participants felt from physically being in hospital. Although participants did not feel intervention was needed at the point of involuntary admission, some later came to trust professionals’ professional expertise. Participants agreed to do what was required of them, despite in some instances not being sure that this was the right course of intervention or that it was necessarily warranted. For those who never felt hospitalisation was needed they either had remained in ‘being confined’ or had adopted other strategies to regain control.

Some participants came to trust the motivations of professionals and developed awareness that something was the matter. Participants began to feel that this intervention might give them help to regain control over their emotional well-being again. In this regard they felt they might now have access to the necessary competent professionals.

*“When that occurred [GARDAÍ ARRIVAL]...it made me think there was something wrong...I also felt...more at peace with myself...from a safety perspective I felt that they would actually protect me from what was going on so the psychosis was still there...once the Guard was there, I honestly...felt that I was going to be looked after now. I'd get the treatment...” (M, 114, 0)*

*“...I thought to myself....I could do with something. Programme, a chat...maybe a bit of therapy because I have issues...my dad died the year before...I was always a quiet person... I was sexually abused by my uncle which I had kept to myself.” (M, 19, 0)*

*“I knew that I'd went mad....and knew that only for the ambulance came into the yard I'd be dead like...” (M, 71, 0)*

Some participants began to accept the intervention of professional and felt relieved that they were going to hospital. There was a sense that at least some of their basic needs may be attended to.

*“...no one wants to feel like being picked up by the police or end up in that situation and be taken to hospital...I didn't fight it. I...accepted the fact that I was going to be sectioned again...I was very tired, I was very hungry...I'd kind of been living off cigarettes and coffee...they said you're here and you've got to come in and I did. I remember just feeling relieved...” (F, 24, 4)*

*“...I felt relieved because I was exhausted. I was very tired...I was delighted I could get a bit of rest...I was delighted when I arrived there...” (M, 39, 0)*

One participant recounts experiencing a sense of safety on admission as it provided a reprieve from the inhumane and aggressive treatment that she experienced during the involuntary admission procedure. Additionally, hospitalisation constituted a reprieve from the stresses participants may have experienced beforehand. This controlled physical environment protected some participants as they no longer had to contend with personal struggles in the outside world. Indeed some spoke of how the hospital provided a ‘holiday’.

*“...it was probably a relief to me to get out of the madness of the world...a break is good...it was sort of pleasant...it was helpful because...there was no place left for me to go. I was sort of completely paranoid...a danger to myself and to others, and...there*

*was no other choice really.*” (M, 146, 1)

*“...I was still elated...I was probably relieved that I was out of the environment I had been...”* (M, 39, 0)

*“...the night that I came in I felt a lot less stressed because I got to sleep and I wasn’t thinking God, [NAME] is in the next room...I didn’t feel any kind of pressure that I was under at home...”* (F, 1, 0)

Extra control, such as supervision, was viewed by some participants as a safety measure that promoted feelings of protection and being looked after. In retrospect, the coercion that some participants experienced during their involuntary admission/ detention was perceived as necessary when it was protecting them from inflicting harm against themselves or others.

*“...I think I would have done myself harm...I probably wouldn’t be sitting here today...”* (M, 10, 0)

*“I knew it was the best place for me...”*(M, 71, 0)

One participant recalled feeling safe in the seclusion room as he felt he could not be shot.

*“...I was safer than in the far room because I thought it was a bullet-proof window...”* (M, 159, 4)

Some participants who experienced ‘paranoid’ thoughts found it difficult to be around other people. The stress of these feelings could be alleviated by the comfort and quietness of a single room or being allowed to remain in an area where participants felt safer.

*“They [NURSES] wanted to put me in a bed with six other people around me and I refused. I was still paranoid. ...I asked them would it be okay if I had a room on my own and I did eventually... It was grand...”*(M, 50, 0)

*“...going to the shop...you could be paranoid, people looking at you...you might be a bit safer [REMAINING IN THE UNIT]. If you’re that paranoid you feel safer.”* (M, 159, 4)

The hospital also gave participants a structured routine they might not otherwise have had. For some of those who had previously been hospitalised, there was a sense of familiarity and regularity with being in hospital. During this time participants read, had

their meals and watched television. Some participants quickly adjusted to their hospitalisation – it was a place that promoted a sense of rest and recovery.

*“...Your meals at a certain time every day and.... You couldn't ask for better.”*  
(M, 150, 0)

*“I...needed a break...from the outside world...it was grand. I...played a few games of pool, smoked fags and had my dinner...It was a nice, safe environment to be in...”*  
(M, 50, 0)

Some felt that the hospitalisation assisted in containing their emotional difficulties. They felt supported and understood through receiving treatment or having beneficial dialogue with professionals. It was seen as a necessary step in their regaining control and managing their thoughts and feelings again.

*“...I would have hung myself that night if I hadn't come to the hospital for the night...I was all over the place...I know one of the nurses...from before...I was talking to him...I felt safer here...I was suicidal...I always got the help I needed from the hospital...”* (M, 74, 7)

### ***‘Meeting Peers’***

‘Meeting Peers’ describes the support and understanding that some participants garnered from interactions with some fellow service users during hospitalisation. Such interactions helped pass the time, were therapeutic, and played a role in promoting a sense of their recovery.

When participants got along with other fellow service users, this sense of camaraderie made hospitalisation more pleasant. Participants recalled having ‘*craic*’ and ‘*hanging out*’, which was helpful in enabling them to cope with the difficulties of being in hospital during this time. This was equally important for those who felt that their hospitalisation was unnecessary as well as those who thought it was necessary.

*“Another girl...had a psychotic break and she was kind of all over the place...Some of the things she was doing were funny...giving out to the nurses and stuff...That helped...I was just laughing...”* (F, 1, 0)

*“...there was a girl there and she used to hang out with me...So, that...didn't make it like an institution. It made it more like a forced stay, but it took away all that time that you have...”* (M, 146, 1)

Some participants developed relationships with certain service users, who they felt

offered support, which was seen as helpful and therapeutic. Having other people to talk to and share feelings with was mutually beneficial and gave participants a feeling of emotional containment. Indeed, this was sometimes seen as being more beneficial than some of the staff interventions. The following participant highlights that it was another service user that enabled him on his road to recovery.

*“...some of the patients have helped me more than some of the staff...And there’s one girl in particular who has really helped me...by giving me...spiritual books...she’s just helping me a lot because she’s...going through her own problems and she’s bouncing off me and I’m bouncing off her...It was that person getting into my spiritual side that has really mellowed me out...” (M, 3, 8)*

Hospitalisation was difficult, especially for those who thought it unnecessary and having someone to talk to helped alleviate this distress and was a means of providing solidarity during hospitalisation. Participants recalled feeling understood by others in the same position – their experiences were at times similar which made it easier to relate to each other. Indeed, some participants described building friendships with fellow service users.

*“...I formed...a bond with a couple of patients who would have been sort of similar to myself...that kind of carried me through...People you could just talk to about what it’s like when you’re down....” (F, 63, 1)*

*“...all the patients were really nice and sound...very supportive and they all understood what you were going through...because they’re going through the same thing themselves...We all look out for each other and be supportive...I’d say that helped me get better...”(M, 43, 0)*

If participants perceived their problems as less severe when compared to another’s, it instilled a sense of mastery that at least they were not such a ‘bad’ case, which occasionally helped put things in perspective and allowed them to take ownership of their recovery.

*“...it helped to see other people...their [SERVICE USERS]...illnesses kind of scared me to think oh my God, you can get that bad, but then it helped to think well, I’m obviously not that bad. I know what’s going on...” (F, 1, 0)*

*“...it’s only when you look at somebody else’s problems you realise your own are small in certain respects.” (M, 3, 8)*

### **‘Maintaining Connection to Family and Friends’**

‘Maintaining Connection to Family and Friends’ describes the benefits that participants

derived from visits with family and friends during their hospitalisation.

Receiving regular visits or phone calls from family during hospitalisation contributed to alleviating the distress of being confined and isolated, especially for those who felt the day was very long. One participant compares herself to others, and is implicitly highlighting her sense of connectedness with her life as a wife, and a sister.

*“...that did shorten it a bit all right...[PARTICIPANT’S HUSBAND] did come twice every day and that was great...then my brothers, you know...They would come or maybe sometimes I’d ring [NAME] ...He’d say ‘I’ll come out for an hour’ ...I was very lucky...in comparison to some. Some of them I really felt sorry for...They just wouldn’t have any visitors whatsoever.” (F, 139, 1)*

*“...Only for them calling I’d be awful bad, the support of my family.” (F, 15, 1)*

Another important aspect of family visits was maintaining contact with life outside of hospital, thus conveying the sense that the participant was a person beyond their illness. Having someone bring in personal belongings was important.

*“I had my...internet phone and...I was able to sort of chat...keep in touch with certain people. I felt like it was my connection to the world.” (M, 19, 0)*

*“...I had someone coming every day [BOYFRIEND] and bringing me stuff. Then my sister actually came from [PLACE] and stayed for a weekend.” (F, 214, 2)*

The subcategory ‘Encountering Humanising Care’ constituted participants’ reprieve from their experiences of losing control in that participants began to experience being helped. When participants felt that professionals were genuinely concerned for their welfare – treated them like human beings and cared for them – this enabled participants to regain a degree of control. Having the right to being given choices engendered a sense that participants were listened to and that their voice carried weight, while the hospital allowed them to experience a sense of safety, relief and support. Participants therefore began to regain control over their emotional well-being by having the offer of a space that allowed them to receive the treatment, care and support that they perceived necessary. Although the ultimate choice to leave hospital did not reside with the participant, their involvement in some decision-making enabled them to feel more in control. For those participants who felt that their hospitalisation was not necessary, it was only the aspects of ‘Meeting Kind and Nice Professionals’ ‘Maintaining Connection’ to Family and Friends and ‘Meeting Peers’ and made things easier in

hospital.

#### **6.4 ‘Gaining Perspective’**

‘Gaining Perspective’ is the third subcategory in regaining control and describes how participants developed an understanding of what was happening to them either during the involuntary admission procedure or during hospitalisation. Participants developed awareness either by receiving information or an explanation from professionals, which justified the latter’s intervention. ‘Gaining Perspective’ also describes how various external and internal supports assisted in returning participants’ cognitive capacity to a level that enable them to understand what was happened to them. Additionally, some participants, with time, became able to regulate their emotions and feelings again. ‘Gaining Perspective’ consists of the following dimensions, ‘Receiving Information and an Explanation’, ‘Getting Treatment’ and ‘Making Sense’.

##### ***‘Receiving Information and an Explanation’***

‘Receiving Information and an Explanation’ describes instances where Gardaí, nurses or doctors gave verbal information or an explanation to the participants in a way that helped rationalise what was happening and why. It also describes the written information participants received on admission to the hospital informing them of their rights under the MHA (Guide to the MHA and the Patient Notification Form (PNF)). The timing, extent and means of imparting this information were important in terms of participants’ ability to comprehend. Additionally, for some receiving a diagnosis during their hospitalisation helped some participants accept how and why they were feeling the way that they were feeling.

Getting an explanation was seen as helpful in gaining perspective at an informational level. Participants appreciated when professionals (Gardaí or the AAT) were open, direct and truthful at the outset of the procedure regarding where they were going – which alleviated fear borne out of uncertainty.

The following quotation highlights how the intervention of the Gardaí during the involuntary admission procedure was influential in assisting the participant to gain an understanding of what might be happening for him emotionally. The Gardaí’s offer of

'help' thus helped the participant make the first step in taking ownership of his situation and also alleviated the distress that he was experiencing.

*"...they [GARDAÍ] ...sat me down...they said look, I think you need a bit of help. I think when I heard the word 'help', that resonated with me as well because I knew I was in a bad place...actually helped put the...'just go with it and it'll be okay type' mentality..."* (M, 114, 0)

When participants perceived that they were getting an adequate explanation it made it easier to accept what was happening.

*"I mean the police brought me in and...I sat down with one of the doctors...I knew I was being sectioned which is why I didn't fight it...I think the police doctor had already explained things at the police station..."* (F, 24, 4)

On admission, some participants spoke of receiving information on their rights as a detained person under the MHA, sometimes distributed in the form of a booklet: "A Guide to the Mental Health Act 2001". In other instances, psychiatrists informed participants of their rights under the MHA and explained their right to appeal in the form of a mental health tribunal.

*"I read all the Mental Health Act things again to make sure that...something strange wasn't going on... they gave me all the leaflets...I found that pretty good..."* (M, 146, 1)

*"...she [CP] said you're involuntary and I said what does that mean...she said it means you have a right to a solicitor. You have a right to an assessment...and she handing me the thing [PNF] then...and said I had fourteen days to appeal it..."* (F, 31, 2)

*"...the nurse...ran me through everything...Nurses...were very insightful...They always made sure that I was aware of what was coming up next...I was given plenty of information...They gave me the mental health booklet. Somebody talked to me about the tribunal..."* (M, 114, 0)

In the following quotation the participant spoke of the importance of getting an explanation rather than receiving information.

*"...if it [PNF] was printed out and given to me I would have...gone through it cynically, thinking oh here we go again...To talk with someone would have been the important thing..."* (M, 46, 3)

Some participants recalled the benefit of getting an explanation from staff regarding their medication and management in hospital. This was extremely helpful in knowing

what to expect and having an idea of the plan of care.

*“...she [CONSULTANT] was helpful as in explaining what’s going to happen...and they’re going to put me on these tablets...I said what’s that for? She said that’s to take the...drink out of your blood-system...I wouldn’t take anything if I didn’t know what it was...” (M, 10, 0)*

*“I went in then and met Dr. [NAME] and she said to me I’m increasing your injection. I didn’t mind that now...She said I’m giving you 25 a week...” (F, 31, 2)*

The following participant describes how she was told she would not be kept in hospital forever, which eased her fears.

*“...when I was in the hospital for a while I realised that people were helping me more than doing anything to me...they told me that they wouldn’t keep me...any longer than was necessary.” (F, 211, 0)*

When psychiatrists provided participants with a diagnosis, participants got a sense of comfort from knowing that the difficulties they were experiencing were attributable to mental ill health and were treatable. Getting clarity on why they felt the way they did was important.

*“...I’m a schizophrenic. In fact, before...I didn’t know what was my problem...” (M, 25, 1)*

*“Well, she [DOCTOR] sat me down...and she explained to me that I had a manic episode...Dr. [NAME] has been able to diagnose me that I had bipolar...It’s a relief to know what I have...” (M, 39, 0)*

It was not until later in hospitalisation that others reported getting verbal information on the likely duration of hospital stay and what happens with medication. For some, this was the most important type of information and as a result they could garner a sense of when they might be discharged, which gave them perspective. Being informed enabled participants to understand what might happen or led them to be informed in terms of their treatment and management.

*“...There was a night nurse there...She was very nice...she kind of said these medications you’re on, they agree with you. Once you’re on them, you’d go out...” (F, 200, 0)*

*“...I was told Wednesday evening that the doctor would see me the next morning and there was a good chance I was getting out.” (M, 150, 0)*

The following participants described receiving information about the Tribunal.

*“...that book they gave you at the beginning. Having to go through a tribunal.”*  
(F, 63, 1)

*“...they kept telling me the doctors that would be on your tribunal. I got all the letters of course, the solicitors’ letters...they told me how many people would be there [AT TRIBUNAL]. There would be somebody independent and that...it was the Sister who told me that usually...you don’t get out of them. That you continue on for another few weeks afterwards...”* (F, 200, 0)

A few participants highlighted the importance of receiving letters about their tribunal from the MHC at a time when they possessed the faculties to process and the information.

*“...they give you those letters...I don’t know if...for somebody that’s unwell, if it’s a good idea handing them those letters...I think you’re still in a bit of a state of shock for the first three weeks...It was too much to be taking in.”* (F, 200, 0)

### **‘Getting Treatment’**

‘Getting Treatment’ describes the psychosocial and pharmacological approaches that assisted participants in gaining an understanding of what was happening to them emotionally. In this subcategory, some participants described receiving treatments and forming therapeutic relationships that reconnected them with the reality of their situation and helped them regulate their emotions and cognitions again.

The importance of having the ‘*expert*’ perspective of a Garda, nurse or doctor was influential in challenging the basis of some participants’ thinking. One participant spoke of how a nurse demonstrated the ability to question his thinking processes in a way that orientated him to question its legitimacy. The participant felt he was believed, taken seriously, and understood.

*“...the direct nature that they used was definitely beneficial in...making me actually think about what was going on...the Guards provided one perspective...the nurse and the hospital another perspective. Family...another perspective...she [NURSE] was also asking me questions that were trying to make me think introspectively...I just think that engagement in itself helped.”* (M, 114, 0)

The extent to which professionals or the individual hospital promoted ‘*freedom*’ (in the sense of meeting or responding to participants’ individual preferences and needs) varied. The following participant spoke of being less restricted and how having more

space to move around in the seclusion area slowly helped her orientate herself to her environment in a non-frightening way.

*“The secure area...they have...an ordinary bedroom and a sitting room area...It was just a cell five years ago and a bathroom...the door was locked the first time around, whereas this time they left it open...when you wake up...you were able to walk... and say right, okay where am I? Until you...realise right, I’m back in reality and this is where I am...it was a lot easier even having the door open...rather than the door being locked and you’re going Jesus Christ, where am I?” (F, 32, 1)*

Some participants who were troubled by their thoughts described how ‘*working through*’ them with their doctor was therapeutically beneficial and helped them question the reality of their thinking. Additionally, participants did not feel alone and abandoned in their distress. Being provided with a rationale of why participants may come to think in a certain way helped them understand their experience.

*“...I was with [PSYCHOTHERAPIST] and she was saying why did you have this thought? I thought my house had been robbed...and she said it's a strange thought. Why did you think it? Probably because I lost my keys in [PLACE] ...She said oh, well that was the explanation. It made sense then...” (F, 100, 17)*

*“...I accepted their help...There was a guy [DOCTOR] there from [GAELTACHT AREA]. He explained the Irish things...That was good...Things I wrote down in my head or something. I'd read it out to the doctor...” (M, 159, 4)*

Getting medication was another factor that contributed to the participant gaining perspective and for some it was the catalyst that contributed to their regaining control of their emotional wellbeing.

Participants described how medication enabled them to calm down, to sleep and to think more clearly. Participants perceived that medication gave them the ability to regain control over distressing thoughts and feelings. As a result this enabled participants to have a less distressing emotional experience and for them to return from a state of heightened alertness to a state of equilibrium and calm. Despite feeling like a ‘*zombie*’, some participants felt medications assisted in restoring their sleep pattern.

*“...[CP] gave me good medication...I had good sleep from Thursday...I was sleeping...so happy. I was so scared.” (M, 6, 1)*

*“...They had me on tablets ...It probably relaxed me...so that I could sleep...before that you couldn't sleep...this was going through your head all the time...” (M, 120, 0)*

The following participants describes how, after taking medication, they began to realise what had happened to them.

*“... It takes you a couple of days to get your bearings, where you are and what’s going on...and the memory is not great after it [MEDICATION] ...I was in the right place and I needed that treatment at the time...” (F, 32, 1)*

*“I was given antianxiety tablets. I slept. I think within two days I started obviously to realise what was going on...” (F, 1, 0)*

Participants spoke of the medication altering their thought processes and enabling them to perceive situations differently, with some speaking of being a ‘different’ person and with a different outlook and point of view.

*“...my way of looking at things has changed a bit. The medication is pretty good.” (F, 100, 17)*

Some commented on the helpfulness of certain medication in slowing down their thinking, which allowed them to garner an understanding of what was happening at an emotional level for them and thereby alleviated the distress.

*“...they gave me some serious drugs the last time...that brought me down fast...You gain sort of normal function of the brain where I could actually, you know, see somebody and talk to them if I had to without sort of imagining scenarios or different things...” (M, 146, 1)*

For others, it took longer to recover.

*“...many weeks and medication that has sort of helped stabilise moods and things...I knew I needed...different sorts of medication...Knowing I need medication to keep me sort of level...” (F, 24, 4)*

*“...My injection works for me...” (F, 31, 2)*

Some spoke of the initial medication prescribed as not working, as they continuing to experience strange happening until the psychiatrist changed medication to an alternative drug.

*“...She [CONSULTANT] changed my medications. The medications started working...She put me on the [MEDICATION] ...I found that great help ...” (M, 39, 0)*

*“...she [PSYCHIATRIST] put me on [MEDICATION] then which is a much better drug...When I was on the [ANTIPSYCHOTIC MEDICATION] I was still*

*paranoid...It's a better drug I'm on now...The paranoia is not there.” (M, 159, 4)*

*“...The [MEDICATION] by itself wasn't working...so I think...they gave me injections and said try this out...” (M, 43, 0)*

### ***‘Making Sense’***

‘Making sense’ describes participants’ retrospective cognitive appraisal of the necessity of their involuntary admission. It describes the perception that participants formed about their involuntary admission when they began to appraise or emotionally process what had happened and why. ‘Making sense’ was an internal process and participants used their cognitive capabilities to develop an understanding of the reasons for their admission and the perceived effectiveness of treatment. Participants made sense in one of three ways: ‘A Wake Up Call’, ‘An Overreaction’ or ‘Feeling Persecuted’. Simply, while some felt that their admission was necessary, others were ambivalent about its necessity, while some more formed the opinion that it was unnecessary. Forming these perceptions was a turning point in participants regaining control.

‘A Wake Up Call’ describes participants who retrospectively appraised their admission as necessary. Participants now believed that they were experiencing mental health difficulties at the time. These participants held positive views of their admission and treatment. They felt that they benefitted from the treatment that they received.

Participants described developing an understanding of the necessity of the actions of professionals at the time. They came to have faith in the motivations and expertise of professionals.

*“You’re in a different mind state...to look back...I know now that they [PROFESSIONALS] were right [BEING SUBJECT TO INVOLUNTARY ADMISSION] but at the time...they were 100% wrong and now I think they were 100% right” (F, 1, 0)*

*“...they [PROFESSIONALS] changed me to involuntary because my illness was more severe....That's why I was involuntary” (M, 159, 4)*

Participants described forming an impression of the reasons for admission. Many felt that the admission averted a continuation on a negative trajectory and expressed relief at being looked after. In many instances, participants felt that the admission was necessary and that hospitalisation provided a safe place to recover.

*“I understood the fact that they were admitting me for my own self really. They thought*

*I was going to take my life...I understood because of my alcoholism...It was...even clearer to me as I went along...I think it was worthwhile...I needed it...I think it was the biggest wake-up call ...I'd probably still be drinking away...so I do actually appreciate that I had to be admitted...” (F, 9, 0)*

*“I knew it was the best place for me, to tell you the truth, because I frightened the life out of myself like [ATTEMPTED SUICIDE].” (M, 71, 0)*

*“...it probably grounded me...I think you can get wrapped up in things and you can get overwhelmed...I needed a wake-up call...” (M, 19, 0)*

Some participants came to develop an awareness that the difficulties they were experiencing were attributable to mental ill health. Hospitalisation enabled participants to obtain a diagnosis from professionals and to get treatment.

*“Dr. [NAME] said a manic episode I had like...she was able to tell me what was wrong with me like and put me on the right medication.” (M, 39, 1)*

*“...you have to get to hospital a few times to finally sort of get the right diagnosis...to take the right medication...” (F, 24, 4)*

For some, it was a personal journey of self-discovery into who they were as an individual and during hospitalisation participants had time to reflect more coherently. Participants spoke of becoming able to recognise what had led them to think in the way they did at that time. In this way, participants developed self-awareness and began to take responsibility for themselves and their lives. They were then able to develop a perspective on why they were experiencing what they were experiencing, which in turn enabled them to regain control of themselves as individuals. Some came to identify triggers that they felt had led to their diminished self-mastery and involuntary admission, which gave participants the motivation to approach their life differently.

*“...when I was in [NAMES HOSPITAL] I really sort of faced up to my issues...I think I had a lot of built-up anger, resentment, regrets and other things that had been below the surface for many years and I hadn't sort of dealt with things...things were maybe triggered when my ex...the relationship wasn't going well...I feel like I've finally come out the other side...I think part of me has always wanted to understand...what's going on...I feel that I can look back and maybe take positives out of things...now I understand more about myself...” (F, 24, 4)*

*“...I was thinking differently than everyone else. I thought everyone was on my case... I just know I needed to get in here to get my head sorted out because it wasn't right outside...It was good to me like...Just having someone there to talk to. That's all.” (M, 23, 0)*

Participants looked back and spoke of not recognising what was happening at the time. Some participants became ‘upset’ when they realised what had happened to them

emotionally. For these participants, 'Making Sense' was difficult as they came to understand how stressful experiencing strange happenings or feeling emotionally different was for them and those close to them. Some expressed guilt over their behaviour at the time and spoke of the impact this had on others. For some, the process of being involuntary admitted and hospitalised provided them with this self-awareness, while others spoke of continuing on this continuum and of coming to accept later that they had a mental ill health.

*"...it [MEMORY] all started to come back... I started to remember everything and that obviously started to upset me...I really just felt totally deflated and at that stage I just said to myself I don't care how long I have to stay in here...what tablets I have to take...just once I get better basically..." (F, 1, 0)*

*"...by the time I got to hospital and my head cleared I was really down on myself...I was still a bit unaware of how bad...I was having a schizophrenic episode. I know now, but I didn't know what was going on back then...it was so depressing...I was living with what I had done...I had built up rage over years because I wasn't taking my medication...Now I know that...I thought I was going to be on this crappy road for the rest of my life..." (M, 51, 3)*

*"...when I first came into hospital...I was slightly off the wall...So, as I say being in [NAMES HOSPITAL], it was a turning point...I sort of finally came to terms with...I have been diagnosed with bipolar...I think...I understand my illnesses better." (F, 24, 4)*

A 'Wake up Call' describes the understanding that participants formed about their diminished self-mastery. Participants accepted that what had happened was an appropriate intervention under the circumstances and was necessary in order to get treatment.

'An Overreaction' describes participants' who retrospectively appraised the necessity of their admission ambivalently. They believed that the severity of their mental health problems may not have warranted the level of intervention that professionals undertook.

Some felt that professionals' intervention was a cursory exercise of power and that they did not allow adequate time to find an alternative. Others later felt that they needed some acute treatment but did not believe that they needed involuntary admission.

*"Even my doctor [GP] that knows me for years, I don't think he did what he was meant to do that day...He [GP] could have given me like a stronger dose of the tablets to get me to sleep at home...and maybe calm me down but just he was in a hurry..." (F, 30, 2)*

*“...because of work commitments I refused admission and I say I am willing to take treatment as outpatient, but they said [NO]...” (F, 72, 0)*

Appreciating the need for involuntary admission if someone was a risk to themselves and others, they did not appraise their situation to be of such severity.

*“I would have been confused obviously but I knew at that point there was something wrong...I don't think there's any point [IN BEING BROUGHT TO HOSPITAL] I would not have been dangerous or mistreated anyone or anything like that” (F, 48, 2)*

*“...I wasn't that bad anyway.” (F, 30, 2)*

*“...It would be different if I was a violent, aggressive patient... but I'm not ...” (F, 47, 1)*

Some retrospectively questioned the type of treatment received, with some favouring a more psychological-based approach. The participants who appraised their involuntary admission as an overreaction were ambivalent and questioned the necessity of involuntary admission. While they agreed that something was wrong they felt that the level of intervention was disproportionate.

'Feeling Persecuted' describes participants' who retrospectively appraised the necessity of their admission as unnecessary. Their hospitalisation and treatment was wrong. These participants did not believe that they were mentally unwell at any point.

*“I shouldn't have been kept... I was perfectly sane.” (M, 150, 0)*

Typically participants felt factors external to the self were attributable to their involuntary admission. Participants attributed blame on the professionals or family members for initiation of hospitalisation.

*“...my own family thought it [HOSPITALISATION] was for my betterment. I knew damn well it wasn't...” (M, 150, 0)*

Participants attributed blame to the professionals or family members. Some felt that professionals deliberately manufactured reasons to have them hospitalised.

*“I shouldn't be in it [HOSPITAL] at all sure, but one of those feckers of Guards signed you in...you've to go in...I got out of it anyway and lived to tell the tale, I suppose...she [CP] made out it I was a bit uneasy. They made out for three months before that I'd too much to say” (M, 17, 0)*

*“...I presume all the information that's sent into the psychiatric unit came from...my...GP at the time...he said that I said that id go out on my boat and never come back in. Now, that was ridiculous so I knew that kind of misleading information I felt I shouldn't have been in there...It annoyed me and it was unnecessary in my opinion...it didn't help me or it didn't do anything for me to improve me...And as I say again, I blame the GP for that...” (M, 230, 0)*

*“Every time I've been brought into hospital...people said I was...walking in my bare feet to the local pub. I've been locking people out of doors...Things I've never done. That's what...my family said...They [PROFESSIONALS] wanted me in hospital... It's happened to me now maybe six or seven times...If they wanted me back on medication, the only option that had really was to take me into hospital...that's the only way I'd take it.” (M, 29, 4)*

*“...somebody...had mentioned that I had been in hospital years ago...That's what I believe...I have a feeling there was somebody in the background said something to them...” (F, 59, 0)*

There was a reluctant acceptance that these things just happen and that they perceived that they were overpowered and controlled by powerful others. As such, some of the participants were powerless and indifferent to their admission and hospitalisation.

*“...these situations [BEING INVOLUNTARILY ADMITTED] don't suit me at all. I think it's wrong to have these places where you're trapped into these areas and there's no sense. It doesn't mean anything to my mind...having to be forced in here...my feeling was it never seems to get to the end where I can totally understand why these situations are happening, I thought that perhaps my mother was being a bit aggressive with me and she was getting me involved in a negative situation when she thought she was right...my mother is very much above me in certain ways...she likes to take care of me...she's above me and she likes to control things herself...There's nothing wrong with the people but I don't like the situations.” (F, 60, 2)*

Many of the participants had previous involuntary admissions and they did not trust the motives of professionals.

*“I was going to work one night and the cops picked me up and brought me into [PLACE]...this is my third time being picked up by the Guards...” (M, 68, 4)*

The third subcategory 'Gaining Perspective' refers to the varying perspectives and factors through which participants began to understand what was happening to them on an emotional and informational level. Some gained perspective from professionals who provided them with an explanation and information of what was happening to them. Others began to think more clearly and rationally regarding what was happening to them on an emotional and cognitive level. Receiving treatment, getting a diagnosis or making sense were seen as influential in enabling participants to regain control.

## 6.5 ‘Playing Ball’

‘Playing Ball’ is the third subcategory and describes the strategies that participants adopted in order to delimit the extent of control (coercion) that was exerted upon them or to increase their likelihood of expediting their discharge. There was a cohort of participants who felt controlled by the system or did not see any benefit from being hospitalised – for these, control would not be fully restored until they were no longer detained. ‘Playing Ball’ involved participants knowing and using specific strategies to convey their compliance to professionals and conformity to the system. By employing such strategies, participants perceived that they could achieve a restoration of their liberty and freedom and ultimately their discharge. The subcategory consists of ‘Learning the Way’ and ‘Keeping the Head Down’.

### *‘Learning the Way’*

‘Learning the Way’ describes the knowledge that participants gained of what facilitated a quicker discharge from previous experience of hospitalisation, what participants read from being in hospital or advice from other service users. ‘Learning the Way’ consists of developing direct strategies to demonstrate compliance with professionals. This typifies a change in approach to one that may be more savvy in terms of navigating ‘*the system*’. This process began with participants realising that the only way of securing freedom and ultimately discharge was to comply with professionals. There is a sense that some participants used a resisting the system strategy initially and with time they conformed and learned the way.

Other participants, most of whom had been hospitalised previously, knew what was happening when the AAT brought them to hospital and construed this intervention as involvement.

*“As soon as I saw them [AAT], I knew where I was going. I didn’t fight against them ... I didn’t really want to go in...”* (F, 27, 6)

Participants recalled reluctantly agreeing with what professionals were saying and communicating that perceived agreement back to professionals.

*“I was kind of agreeing and nodding with everything just to get through...I'm thinking to myself...you...shut your mouth and go along with it...and hopefully get out fast...One of the patients said to me when I got in...you agree with everything. You say yes to everything, you toe the line or else...” (M, 19, 0)*

*“...I just had to basically agree with them and say I will take whatever medication in order to be able to be let out ...I had to say the right thing to everybody to get out, you know, of jail basically...” (F, 200, 0)*

*“ You're just ground down into nothing until the doctor feels that you're supplicant ...Until you agree with them...They break you down like that...I don't walk off thinking oh, I have a mental health problem. Isn't it good that the good doctors and nurses took care of me?” (M, 162, 3)*

The following participant spoke of how she got her status revoked to voluntary.

*“...I'd been told by other patients you're going to have this meeting [ASSESSMENT PRIOR TO TRIBUNAL] and...that they ask you all these questions...I lied in that thing... 'if we put you voluntary now would you still stay in for a few more days?' I was like yeah ...” (F, 55, 0)*

While other service users provided support and empathy, they were also a source of information on the system and how to navigate the system. Participants learned from other service users to do what was requested of them.

*“...She [CP] knew I was taking the tablet...I had to in the late stages anyway because if I didn't I'd never come out of it...once she'd seen...I was taking the tablets and it was put down on paper...” (M, 17, 0)*

*“Just from talking to the patients. I was hearing stories...This man in there was like you won't be getting out for a while. I was like, shit I'm getting out of here...Really buttered up the nurses and the doctors...” (F, 55, 0)*

*“...I don't think I bothered them too much...I was doing what I was asked... I never questioned it...The only way you'll get out is if you listen to them...so in the end...I listened to them and didn't nag them...It was the only way of getting out...” (M, 23, 0)*

For most, learning the way involved taking medication despite initially refusing and not wanting to do so. There were participants who did not see the point of being involved in treatment decisions, and they conveyed agreement with the psychiatrist decision on what treatment they wanted to administer. Participants felt there was no other option but to continue taking medication for fear of an extended stay in hospital. In contrast, to those who took medication to assist them in regulating their emotional well being, some participants took medication solely to demonstrate compliance in a bid to heighten their case of securing discharge

*“I went with it because I knew I had to [MEDICATION]. I’m not keen on taking medication from when I was in once before. I found that if you don’t take your medication, you were forced to take it so I just went along with it and took it.”*  
(F, 36, 1)

Participants perceived that if they took medication that they would get out of hospital faster. Consequently, some made a conscious decision to accept any medication they were given.

*“...when I was sectioned I thought crap. The only way I was leaving here now was to take my medication...from then on I took it...the section really was all about getting me to take my medication.”* (M, 28, 0)

*“...If I had refused to take it then, I might have been there even longer...Whatever I was given, it had to agree with me because I didn't want to be staying there...”*  
(F, 200, 0)

*“...I agreed to take the medication...I knew I had no choice. I’d be in all year...I took it on board myself to take it, yeah because previously I had learned from that...”*  
(F, 60, 2)

The following participant recalls feeling ‘*beaten*’ into taking a medication that she initially resisted.

*“...I preferred the [DEPOT INJECTION]...but then when it was changed...we finally found [TABLET] which Dr. [NAME PSYCHIATRIST] wanted me on in the first place. And wouldn’t let me leave hospital without me going on it...I was beaten into it in the end...”* (F, 100, 17)

‘Learning the Way’ also involves active behavioural strategies that participants adopted to avoid being labeled as someone with a mental illness. Such participants attempted to prove that nothing was wrong with them and deliberately adopted certain ‘*ways of being*’ in order to give professionals this impression. For some, it involved proving themselves and knowing what to say and who to say it to. Other participants formed relationships with nurses and talked nicely to them to ensure that this good behaviour was relayed to professionals. Participants thus regained control in a conflicting way by not internalising their sense of self as ‘*mad*’ while simultaneously portraying an outer exterior of self as accepting of treatment.

*“...I had to have a good relationship with the nurse...that was my boyfriend telling me. He was saying that the nurses would explain to the doctors how I was so I had to be the good behaviour...You have to find your way out. The fastest way out. You need to know*

*what to say and who to say it to...*” (F, 214, 2)

The feeling of not being hospitalised for too long was important for participants – being discharged early contributed to their regaining control. Some gave examples of having their status revoked to voluntary or of being pleasantly surprised that they were ‘*let out*’ earlier than expected.

*“He (PSYCHIATRIST) still let me out. He made me involuntary on the Tuesday...but he still let me out on the Thursday...”* (M, 120, 0)

*“...I got out two weeks this time around...It’s usually a month.”* (M, 29, 4)

### ***‘Keeping the Head Down’***

‘Keeping the Head Down’ describes the indirect strategies adopted by participants to insidiously impress upon professionals that they were conforming to the regulations of hospital. Most commonly, these strategies were associated with being in the system. Previous familiarity with hospitalisation was formative in adopting this type of strategy.

For some, ‘Keeping the Head Down’ involved monitoring what they said and deliberately repressing the expressions of emotional responses in reaction to their involuntary admission, thereby feigning control of their emotions. Despite being angry about their involuntary admission and detention, participants did not express this anger in case professionals perceived them to be unwell or in case they received forcible treatment. These participants did not outwardly contest their admission at this point.

*“I just shut up...and let stuff happening...I put aside what I wanted to do...You have to follow what we do, you know...It’s not allowed to have a temper.”* (M, 25, 1)

*“I was really angry. I couldn’t express...If you do express that then...”*(F, 214, 2)

*“...I couldn’t say what I wanted to...he might think I’m rocking the boat. Tablet for him later on...”* (M, 19, 0)

Other participants described monitoring what they said in front of professionals in a bid to convey a sense of normality. For some, this involved deliberately acting or controlling behavioural expressions in order to instill the perception that they were well. For others, it involved not saying anything that might jeopardise their discharge, embedded in which was an underlying fear of the repercussions of saying the wrong

thing. Therefore, by changing their personal behaviour and controlling what they said, participants gave the impression that they were in charge of their emotions and well-being. Thus, participants reluctantly accepted that they must do what professionals asked of them to avoid a prolonged stay in hospital.

It was not uncommon for participants to know that their behaviour was being observed by nursing staff. Some therefore believed that certain behaviour was indicative of being unwell, and so participants did not engage in behaviour that might indicate that they were behaving appropriately.

*“...if you stay up until after 12, oh, she’s obviously not relaxed, up her medication, you....”* (F, 20, 0)

Others kept the head down by minimizing contact with other service users in case it was observed that they were unwell. In contrast to those who felt supported by fellow service users, these participants did not wish to be associated with service users who were unwell. In this way participants did not give professionals any evidence to suggest that they were unwell.

*“...I just focused on myself and I knew that the fastest place to leave...is not talking to anyone because if you are even smiling...”* (F, 214, 2)

*“...Cut myself off from the other people...That looked good from their point of view ...I might have been going out to the smoking area to chat to whoever was diagnosed with schizophrenia like. That obviously...wouldn’t look too good...”* (F, 55, 0)

Most typically, ‘Keeping the Head Down’ involved not questioning professionals. These strategies increased the likelihood that freedom would be restored.

*“...you learn the less you do...keep your head down, say nothing. Don’t do anything and you’ll fly it.”* (F, 100, 17)

*“It was quite difficult but...I realised immediately that I had to be calm. Not cause any trouble. Not ask for anything...”* (F, 217, 0)

*“...you have to...try and get them on your side so you can go home...That’s exactly how it was...then you had to try to be nice and quiet and just go about your business, you know? And eventually you’d get out...”* (M, 50, 0)

‘Keeping the Head Down’ also involved behavioural strategies adopted by participants to avoid being labeled as mentally ill. As such participants denied to professionals that

anything was wrong with them. Indeed, some spoke of retaining certain ‘beliefs’ and exerting the self-control to not talk about them in case doing so would impact on their potential discharge. Participants thus described not divulging anything that might be seen as pathological or denying that they retained certain ‘crazy’ beliefs from fear of being kept in hospital longer. This was a protective strategy that did not grant the professional access to their world view should it enlist a repertoire of actions which would further threatened their control, such as an increase in medication or a prolonged stay in hospital.

*“Sometimes it feels hard because...even though they’re getting better they still feel crazy and they don’t show it...they still have beliefs...I’ve heard other people saying that...when the doctor asked them were they still hearing the voices. In their head they’d say yeah, but then like they’d be saying no...Sometimes I say I’m better than I am...but sometimes...I’m not 100%, that’s all...They just keep you in for longer...Unless you’re right completely like, they just lock you up.”* (M, 51, 3)

Participants spoke of the smaller aspects of ‘Keeping the Head Down’ in terms of biding their time in hospital. Some adopted the strategy of ‘keeping quiet’ within the environs of the hospital in order to achieve the end target of discharge. Such participants were resigned in the knowledge that things had to run their course and they complied with formalities until they were discharged.

*“...what could you say? Just get your bed and go to sleep...it’s always a difficult time in there...Trying to get home...Just keep peace with them...Try not and blackguard them ...What can you do sure.”* (M, 68, 4)

*“...you just go through the motions and you get out the other end...there’s formalities and there’s rules and regulations... so you just have to follow the pattern and go with it...You just learnt to be quiet and try and keep the peace...you can get out. Keep your head down...I just saw it [TRIBUNAL] as a formality I had to go through...I just wanted to get in and get out of there fast...”* (F, 36, 1)

*“I keep to myself. I pass the day walking around.”* (M, 29, 4)

‘Keeping the Head Down’ may also be used to refer to strategies participants employed to manage the inactivity of the hospital and fill in their day so as to keep out of the way of staff.

*“Got up, ate, went back to bed for a while...do a bit of jogging, eat again, watch a bit of TV, lie around for a while, read a book, eat again, play a bit of chess, watch a bit of TV and go to bed.”* (M, 26, 3)

*“I...did the crossword which I wasn't enjoying doing...then got my iPod...Started listening to music...” (F, 20, 0)*

The following quotation highlights how one participant left hospital as soon as her day clothes were returned. The participant recalled that when she was ‘*made voluntary*’, a fellow patient told her not to appear ‘*too excited*’ and that ‘*if you tried to leave straight away they put you back involuntary*’. In this instance, without mutually agreeing on discharge, the participant attempted to leave hospital and was apprehended by nursing staff. In a bizarre set of circumstances, she met a tribunal solicitor who informed the nurse of her right to leave hospital.

*“I was made voluntary...this is what I think is important...I tried not to get too excited because I knew I'd been told...if you try to leave straight away they put you back involuntary and you have to wait another 21 days for your next tribunal. So, I was ...you're so close. Don't fuck it up... So, back to my room. Was told oh, we're getting your clothes...so just waiting in my room” (F, 20,0)*

‘Playing Ball’ involves the direct and indirect strategies that participants adopted in order to negotiate the system, professionals and themselves with the ultimate aim of expediting discharge. The participants employed one of two strategies: the direct strategies of ‘Learning the Way’ or indirect strategies of ‘Keeping the Head Down’. Such strategies were employed to restore their control over their situation. ‘Playing Ball’ encompasses a behavioural change but not an attitudinal one whereby participants realised that to get out of hospital they had to succumb to the wishes of the health professionals and learn the way. Previous experience of involuntary admission and advice from fellow service users was be formative in adopting a ‘Playing Ball’ strategy.

## **6.6 Summary of Category Regaining Control**

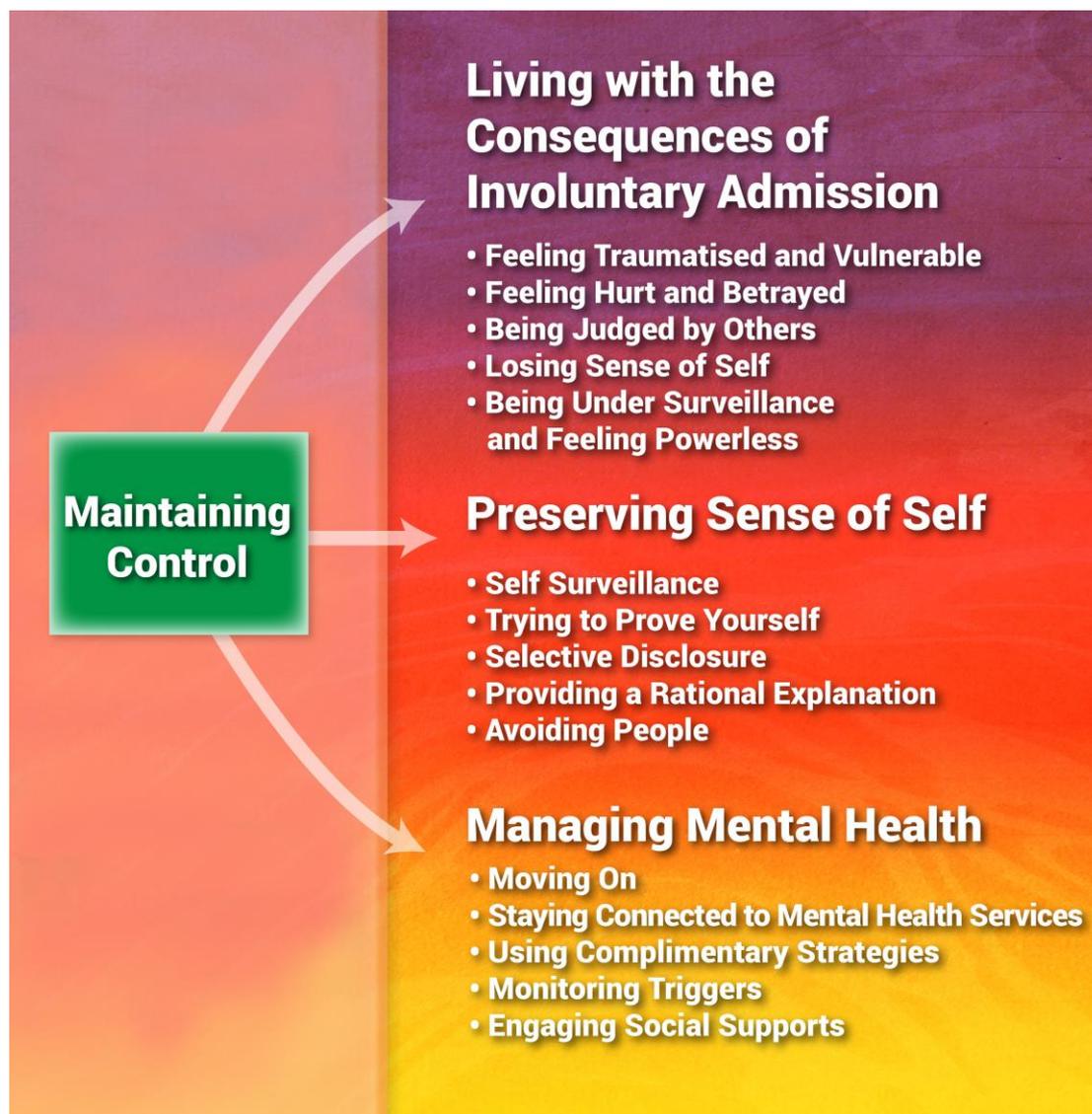
The category ‘Regaining Control’ refers to the factors that contributed to a restoration of participants’ control as well as the strategies participants developed to assist in the regaining of their liberty. Regaining Control consists of the subcategories: Resisting the System, Encountering Humanising Care, Gaining Perspective and Playing Ball. The extent to which participants began to feel in control varied and although some experienced a regaining of control while in continued detention, others only did so when their freedom was returned on discharge. Some described feeling more in control when allowed to make certain choices or have ownership of smaller daily activities,

which renewed participants' faith in the motives of professionals. Such choices enabled participants to reclaim their sense of responsibility, thereby contributing to a perception of having control over their lives again. In other ways, participants regained control by developing a personal and emotional awareness of what happened to them through the information and explanations they received from professionals. During this time, participants regained the capacity to regulate their emotions and retrospectively came to think that hospital may be the place to get help. Finally, 'Regaining Control' can be seen to refer to the strategies that participants adopted to achieve a restored liberty and, in contrast to what is mentioned previously, participants deliberately acted in ways that maximized their chances of restoring their freedom from hospital.

## **Chapter 7: Findings: Maintaining Control**

### **7.1 Introduction**

‘Maintaining Control’ (see Figure 7.1 highlighted in red) is the final category in the ToPC, and it describes participants’ endeavours to maintain control over their emotional, personal and social lives following their discharge from hospital. It describes the strategies employed by participants to maintain control of their mental health, manage the emotional impact of their involuntary admission, minimise stigma and deal with people’s perceptions of them. The process of ‘Maintaining Control’ consists of two subcategories conceptualised as ‘Preserving Sense of Self’ and ‘Managing Mental Health’. Participants not only had to struggle with managing their recovery and readjustment to family, work and wider society, but also had to deal with the consequences of an involuntary admission. The first part of this chapter, ‘Living with the Consequences of Involuntary Admission’, describes the adverse context within which participants attempt to, and indeed at times are compelled to, engage in efforts to maintain control. It achieves this by describing the impacts that an involuntary admission had on participants.



**Figure 7.1 Maintaining Control**

## **7.2 ‘Living with the Consequences of Involuntary Admission’**

‘Living with the Consequences of Involuntary Admission’ describes the emotional and societal impact that involuntary admission had on participants’ well-being and their relationships with others on discharge. The distress of being involuntarily admitted continued to impact participants’ lives well beyond discharge. Some participants’ identities were threatened and their concept of self was eroded. Other participants struggled to adapt and found themselves in a situation in which they were controlled by the MHS. ‘Living with the Consequences of Involuntary Admission’ consists of the dimensions: ‘Feeling Traumatized and Vulnerable’, ‘Feeling Hurt and Betrayed’, ‘Being Judged by Others’, ‘Losing Sense of Self’ and ‘Being Under Surveillance and Feeling Powerless’.

### ***'Feeling Traumatized and Vulnerable'***

'Feeling Traumatized and Vulnerable' describes the emotional impact that participants experienced as a result of their experience of being forcibly removed from their home or their being treated coercively in hospital. The emotional impact was so severe in some cases that participants likened it to a post-traumatic type illness and described a reliving phenomenon.

*"I have nightmares about it [INVOLUNTARY ADMISSION AND HOSPITALISATION] ...Seeing the staff. Experiencing the choking again...sometimes I wake up in the middle of the night screaming. It was the most traumatic and stressful experience...it left a scar...It's going to be like that for the rest of your life."* (F, 72, 0)

*"...I started going back to my room trying to sleep and that was this place where people [REFERENCE TO MEMBERS OF THE NAAT] handcuffed me. Treated me with so much aggression, I couldn't sleep. I had lots of fear...I couldn't feel safe in my room. I couldn't feel safe in the world...I was remembering them coming into my room...The whole thing was...very traumatic."* (F, 214, 2)

Some participants recalled the admission procedure being much more distressing than the actual experience of their diminishing self-mastery. They felt the added trauma of being involuntarily admitted compounded existing difficulties and impacted negatively on their ability to recover.

*"...the whole experience [INVOLUNTARY ADMISSION AND HOSPITALISATION] ...more traumatic than a manic state...they [PROFESSIONALS] cause trauma. They cause more problems."* (F, 214, 2)

*"...this thing [INVOLUNTARY ADMISSION] was thrown on top and that made everything an awful lot worse...that's always going to be with me. When I came out of here I felt I needed more therapy than when I came in..."* (M, 19, 0)

Some participants felt that during or prior to discharge they were not given the option to emotionally process the experiences associated with being forcibly held down or being injected with medication. They wanted access to psychological-based therapy to help them make sense of what had happened.

*"...I was never given the option to speak to a psychologist afterwards...it's quite traumatic to be asked to remove all your clothes. To be secured onto a bed while they inject you...To go through all of that and just be released with nothing said."* (M, 32, 3)

*“When I went to the psychiatrist after three months...I said look, I want to go and talk to someone myself...Even to help you with the post-traumatic stress of being in the hospital in the first place.” (F, 217, 0)*

Some participants continued to live with a fear of being involuntarily admitted by professionals or family again. Consequently, many felt vulnerable, no longer in control and lived with the threat that others could decide their fate. This was especially apparent to those participants who were shocked and surprised at their involuntary admission.

*“...it’s the fear of the reoccurrence of it [INVOLUNTARY ADMISSION]...that this abuse...can happen again. That other people can decide how well I am...it made me aware of how vulnerable I am with this illness and the system that’s there, how aggressive it is...it’s very controlling and...Now life is a fear.” (F, 23, 0)*

*“That was the predominant fear that I would be sent back...” (F, 200, 0)*

The following highlights the sense of terror that was evoked within a participant when he saw the Garda at his home on the day of his discharge.

*“...there was the squad car parked in the drive so literally I started crying... I said to [DAUGHTER’S NAME]...what the hell is going on now...I was terrified I was going back in again...then I got out...I was kind of trembling talking to him [GARDA]...he says, oh don’t worry about us there’s nothing wrong...” (M, 19, 0)*

The pervasiveness of the fear was apparent when the same participant describes another scenario where he felt he was going to be ‘taken away’ again.

*“I froze thinking hang on, this van is coming to take me away... I remember feeling that cold feeling of ‘hang on, you’re still not out’...I was still terrified of being taken back in...” (M, 19, 0)*

The following participant describes her fear that her son might witness her forcible removal and worries about the psychological impact on him.

*“...I’m afraid that something could happen again that would involve him [SON]...Seeing something with me and medics or Guards...I’m...frightened for him to experience that because I know how bad it affected me...” (F, 23, 0)*

Consequently, many participants were reluctant and fearful of going back to hospital for follow-up as it reminded them of their time there.

*“I’ll surely never forget that [INVOLUNTARY ADMISSION]. I didn’t like going in [OUTPATIENTS]...bringing back bad memories to me of having to go in there to see him [CP]...” (F, 139, 1)*

### ***'Feeling Hurt and Betrayed'***

'Feeling Hurt and Betrayed' describes the impact of having family, friends or GPs involved in the initiating of involuntary admission. Some participants continued to feel upset and angry and described issues of mistrust and disbelief with their family members or with professionals. Participants perceived being betrayed by family and friends and they spoke of the damage to relationships on discharge.

*"...it upset me so much. Knowing that my husband could hate me enough to sign me in...he didn't want me at home...He went to the doctor and...put me in hospital."*  
(F, 100, 17)

*"... [I] lost...an awful lot of...trust...with family and friends...because they were involved with getting the Guards involved..."* (F, 23, 0)

*"... [WIFE] called in the heavies...I kind of blamed her...Everyone was against me...I don't know if I want to be part of the family any more...I was railroaded out, brought in and I was violated, I was trapped, I was locked up, I was stigmatized...I want nobody to mention to meddle or mess in my life ever again."* (M, 19, 0)

*"I was still angry with him [FATHER] because he got me brought in here again..."*  
(M, 3, 8)

There was a pervasive sense that participants could no longer trust family members, with some keeping hidden the hurt and betrayal they felt and re-evaluating their relationships.

*"I would be angry with my husband that he did sign me in but I couldn't express it in case he'd put me back in again...He said to me 'it wasn't me that signed you in'...I said... 'You signed me in...a mental institute.'"* (F, 200, 0)

*"I cannot forget that [BEING SIGNED IN] very easily. I felt very betrayed by my wife...I can't trust her any more...Obviously it has affected my relationship...That made me a very disillusioned person."* (M, 150, 0)

One participant described how her husband appeared annoyed that she was being discharged after her status was revoked at tribunal.

*"Even the day I was coming out...I just felt his face was like 'oh, you should have stayed there'...I could see it in his face, oh God, she's coming out..."* (F, 200, 0)

Other participants were so angry that their GPs had not done anything to prevent their involuntary admission that they did not want anything further to do with them.

*"He was supposed to be my GP...I don't think I'll be going back to him..."* (F, 200, 0)

*"...I think a different GP would have...it wouldn't have led up to that...I want no more to do with him..."* (M, 230, 0)

### ***'Being Judged by Others'***

'Being Judged by Others' describes participants' perception that they are now treated differently by family, friends and the wider society as a result of their involuntary admission. As well as dealing with the stigma of involuntary admission, participants also believed they were judged negatively on how they had behaved when their self-mastery was diminished prior to admission. As a consequence, participants believed their status in society and relationships with family and friends were negatively impacted upon.

*"...I know I've made mistakes...but at the time I wasn't in my right mind...I think some people would judge me for that."* (F, 24, 4)

*"...it [POINT OF REMOVAL FROM HOUSE] was only 9 o'clock. There were people on the street...that seen all this happening which was...very embarrassing...people judge you as well on that actual admission or involuntary admission. There's a stigma with it no matter what anybody says..."* (F, 23, 0)

*"...all the neighbours seen...you are a little bit conscious...People don't understand..."* (F, 32, 1)

*"...the thing I have to live with for the rest of my life is that I actually told [CHILD] that I was off to kill myself apparently and I wanted [CHILD] to come over and watch me do it..."* (F, 9, 0)

There was a large degree of stigma attached to being hospitalised. One participant felt that when society knew that participants had to be 'signed in' or had a lengthy stay in hospital, they would be judged more negatively than if they had a voluntary admission or a shorter hospital stay. This impacted negatively on participants' ability to engage with society in a way that they previously would have done.

*"...the longer you're in hospital, the worse people think about it from the outside...if you were out in two weeks it would be like going in for some type of minor operation..."* (M, 146, 1)

*"...people look at you differently when they realise where you've been...I felt that anyway... 'she must have been very bad if she had to be signed in'..."* (F, 200, 0)  
*"...The worst thing...that happened to me is I'm now 'stigmatised'. I have 'been in'...a deep sense of shame is how I feel having been in there..."* (F, 217, 0)

Participants frequently felt misunderstood or unsupported by their family and friends, with some returning to different and difficult relationships.

*“...My family...won’t help out at all. They never call to see me...they don’t understand the illness... They just think I put it on...that I do things deliberately...My brother told me never to go back to their house again...That’s what really gets me...”*

(F, 27, 6)

*“...I ended up in the hospital...when I came back none of my friends would speak to me...once they found out I had schizophrenia...That’s why I never wanted anyone to know...you lose all your friends...”*(F, 27, 6)

*“...I was told, ‘yeah, you’re crazy.’”* (F, 55, 0)

*“Some friends hadn’t been very supportive...some of them hadn’t come to visit me...And I felt really bad. I felt really annoyed with them...”* (F, 31, 2)

Participants also commented on ‘*having a record*’ after discharge and had a sense this could be used against them in the future.

*“If you’ve been in a psychiatric ward in the past...people can easily kind of frame you...because you might be different...unconventional, and then you’re on record as having mental health problems.”*(F, 59, 0)

One participant spoke of her relief that the admission order to have her detained was not signed, as a record of that would have been kept.

*“I was glad that the form didn’t have to go through because I know that will always be there...you’re just thinking to yourself surely that’s kept on a record somewhere that you were held against your will... You’re a nut job.”* (F, 1, 0)

### ***‘Losing Sense of Self’***

‘Losing Sense of Self’ describes the impact that being involuntarily admitted or receiving a diagnosis had on participants’ personal identity. Participants now had to contend with a perception of them that was different to their previous view of themselves, resulting in a reduced ability to maintain control over their lives. Additionally, ‘Losing Sense of Self’ refers to the erosion of the participants’ role within their family or professional life. Being involuntarily admitted and/or detained compromised participants’ view of themselves as viable autonomous human beings. Consequently, participants’ perceived control was threatened and some no longer trusted their ability to successfully regulate their lives. Some described no longer being able to rely on themselves as capable individuals and questioned their ability to manage themselves and the responsibilities they had previously held.

*“...it’s [INVOLUNTARILY ADMITTED AND DEAINED] ...destroyed some of the very important things in my life...One of them is my relationship with my family. Another thing is separation from my son... I don’t see myself the same. I see myself as completely*

*demoralised person...I really felt like I'd lost myself completely.”(F, 59, 0)*  
*“It's changed my life [INVOLUNTARY ADMISSION]...You're doubting your gut, doubting yourself constantly...All those thoughts...I didn't have them before...the reality of life as is so different from previous to this experience for me...I don't feel capable of making decisions because I'm unsure of whether it's right or wrong now...it's changed my life...I don't feel like I'm good enough to be [NAME]'s mother now...It's very painful.” (F, 23, 0)*

A participant described how their hospitalisation resulted in the loss of their job and financial status.

*“I had to pick up the pieces that was damaged during my admission, like I couldn't give sick certs to my employer...so they stopped my pay...I have to pay my bills and then I've lost my job...it also ruined my relationship...I have to restart everything...”*  
(F, 72, 0)

Being involuntarily admitted and/or detained was a gross infringement on some participants' sense of control, which directly impacted on how participants now came to view themselves.

*“I don't feel fine. I don't feel okay. I don't feel that I'm in control...”* (F, 23, 0)

For other participants, 'Losing Sense of Self' described how they had to adjust to a diagnosis of ill mental health. Some began to feel that they were maybe susceptible to ill mental health owing to family members having a similar experience (a vulnerability that participants would not openly concede to at the time of hospitalisation).

*“...I would have had a weakened personality due to my upbringing...With the family history...there is a precedence towards depression...I'm now battling for my sanity for the rest of my life. I do not want to end up like my mother...I now have to think of myself having that propensity...”* (F, 217, 0)

*“...my mother's had this depression and my father, I don't know what he has. ...there's obviously vulnerability in myself.”* (F, 55, 0)

The following participant was worried about his son developing a form of ill mental health.

*“...my young son at home, now 9...his personality is similar to mine...and now I've been here...is my son going to be here as well?”* (M, 34, 0)

Participants struggled to deal with their altered sense of identity as a result of diagnosis. Receiving a diagnosis exposed vulnerability and many had to contend with a different perception of themselves.

*“I’ve an awful problem with accepting the diagnosis...I thought of myself as living alongside a difficult life... I’ve had natural grief due to terribly upsetting things that have happened in my life ... a sense of self is lost through that... I now feel that I have been labelled as having very severe mania...for the rest of my life I should consider myself, you know, at great risk...I’d lost my sense of identity...50% of having a recurrence...” (F, 217, 0)*

*“...I’ve been diagnosed with bipolar disorder...I don’t have the full symptoms of any of those disorders...Okay, I have bad days or whatever but I don’t get manic episodes of depression...for me to be diagnosed with something that I don’t even have the full symptoms of...I don’t have half the things they say...” (F, 55, 0)*

*“...when I was out of hospital the first week was a bit strange...I was a bit down over it...Bipolar like because that’s something serious, you know?” (M, 39, 1)*

Many participants described changes in their relationships with family and friends in that people now treated them differently as a result of involuntary admission and hospitalisation. One participant described how her friends no longer come and divulge things of an emotional nature to her and felt that they were careful with what they said.

*“...I had to tell my closest friends...but a sense of self is lost through that because now they have to be careful with what they say to me...I would have been a person who would have come and said look, I’m going through this...nobody ever edited what they said to me...” (F, 217, 0)*

### ***‘Being Under Surveillance and Feeling Powerless’***

‘Being Under Surveillance and Feeling Powerless’ describes participants’ sense that they were being closely monitored by family, friends and professionals as a consequence of their involuntary admission.

They felt that family treated them as though they needed supervision, and some were not trusted to take tablets.

*“My family are always checking up on me...I know they’re doing it out of caring...it still fries my head a bit...they’re keeping an eye on me...” (M, 43, 0)*

*“My husband was still looking at me.....I had been to a birthday party to a sister-in-law....and she kept saying ‘are you okay?’” (F, 200, 0)*

Some participants felt frustrated with having lost much control over decision-making regarding their own lives during hospitalisation. This was evident for many in their implicit or explicit exclusion from decision-making processes around reducing or discontinuing medication after discharge.

*“...I’m going to give it a while on the medication...I don’t like it [INJECTION], but I’m going to take it...until I feel I don’t need it anymore and then I’m going to talk to them [TEAM] ...which I don’t think will go too well...I know further down the road I’m not going to need it...” (M, 3, 8)*

They felt inhibited to make decisions about their lives and felt family and professionals were making decisions for them.

*“...I’d rather...get away from all that...they [CPNs] interfere too much...and they just kind of bully you...domineer you...They think they know best...” (F, 27, 6)*

Some felt misunderstood and deemed at ‘risk’ by the professionals now involved in their follow-up.

*“...some people, social workers...don’t understand me...they’ve never met anyone who has been in a mental hospital...They think...‘how can we ever give her son back to her?’...They believe once you have the thing...it can still occur.” (F, 59, 0)*

*“...[COMMUNITY NURSES] there was two...thinking I’m going to kill her...I thought do they think they need two because I’m going to stab one of them with a knife...?” (F, 200, 0)*

### **Summary of ‘Living with the Consequences of Involuntary Admission’**

‘Living with the Consequences of involuntary admission’ describes how participants were emotionally, personally and socially impacted by the involuntary admission procedures and their treatment in hospital. Being involuntary admitted impacted on relationships with family and friends as well as leaving participants with a perception they were stigmatised by society. Participants’ sense of self was threatened as a result of their involuntary admission or their diagnosis. Some continued to feel under surveillance by health professionals despite being discharged, part of which involved complying with the commands of professionals or family for fear of a readmission.

## **Maintaining Control**

Feelings of traumatisation, distrust and stigmatisation described by participants negatively impacted and in some cases impeded their recovery. In an attempt to manage the consequences of their involuntary admission, participants developed strategies to maintain control. The process of ‘Maintaining Control’ consists of two subcategories conceptualised as ‘Preserving Sense of Self’ and ‘Managing Mental Health’.

### **7.3 ‘Preserving Sense of Self’**

‘Preserving Sense of Self’ is the first subcategory in ‘Maintaining Control’ and describes the strategies employed by participants to prevent family from viewing them as mentally unwell or needing re-hospitalisation. Additionally, it describes the strategies that participants used to protect themselves from professionals’ actions or from further involuntary admissions. ‘Preserving Sense of Self’ also describes the strategies that participants employed in dealing with negative perceptions that members of society might have of them due to their being ‘*signed in*’ to hospital or having a diagnosis. This subcategory consists of the dimensions ‘Self Surveillance’, ‘Trying to Prove Yourself’, ‘Selective Disclosure’, ‘Providing a Rational Explanation’ and ‘Avoiding People’

#### **‘Self-Surveillance’**

‘Self-Surveillance’ describes how participants suppressed what they said and controlled their behaviour in front of family or health professionals. Participants believed that they were now under constant surveillance or being observed by others – they did not do or say anything that could be construed as a reason for readmission. Therefore, opting not to express certain thoughts as well as behaving in a socially appropriate way allowed participants to maintain control in that it would not jeopardise their freedom.

Participants described ‘*watching what they said*’ as they were fearful of expressing or discussing specific concerns and opinions with family members and professionals in a way that they previously did. Consequently they remained silent on issues. The following participants speak of refraining from expressing certain opinions that they felt had led to their previous involuntary admission.

*“I'm really afraid to say anything to my husband...I don't give out about people...I think I couldn't start saying any of those things I was saying before that led me to be brought in...I couldn't express it in case he'd put me back in again...”* (F, 200, 0)

*“...I have to mind by Ps and Qs because my husband needs a certain amount of time to himself and he's my carer...he's good but if you got into a mood and it lasted too long, he'd probably sign me in again...When I communicate and fight for what I believe now I get railroaded [READMITTED]...”* (F, 100, 17)

In addition to watching what was said to family, participants also described being conscious of what they said to health professionals and spoke of hiding certain feelings and emotions.

*“...Everything I say now, I monitor...Every time I have a conversation with the doctor or a psychiatrist or whatever, that it's been naturally analysed in one sense...It's a constant fear of putting a foot wrong or thinking a wrong thought or saying a wrong word...”* (F, 23, 0)

The following participant describes restricting what he says, again in an attempt to minimise professionals' interpretations in case it resulted in another admission.

*“...I'd too much to say but I'm watching myself since what I say now...because they made out I'd too much to say...and I haven't said that much since.”* (M, 17, 0)

Checking their behaviour was another way that participants adopted self-surveillance and involved participants observing how they acted in front of family and professionals. As a result, participants were deliberately trying to behave in a socially acceptable and desirable manner and were eager to portray and impress upon others that they were of a mentally healthy disposition.

*“There is a bit of anxiety about you're not doing things right. Worrying about what other people think... They might think your behaviour or something is not right.”* (F, 211, 0)

One participant spoke of being cognisant that a manner of her behaviour which she calls 'freezing' may be an indication to family that she was becoming mentally unwell. She deliberately adopted a strategy of talking more in order to hide from family that she may be becoming unwell.

*“...It used to be that I'd go blank and stare into space...and now to stop them thinking that I'm freezing, I talk too much.”* (F, 100, 17)

### ***‘Trying to Prove Yourself’***

‘Trying to Prove Yourself’ describes the strategies that participants used to bolster their self-esteem and to protect their sense of self while being judged and stigmatised due to their admission – all of which impacted on the participants’ ability to maintain face in society at large. Some participants wanted to maintain their privacy and their identity of themselves as an individual. Others were concerned about how they could best manage society’s interpretation of them, which impacted on their ability to maintain their face in the community at large. Participants did not want to internalize a perception of themselves as someone with a mental illness.

*“...I wouldn't treat myself as someone with a mental health disorder. I've met people who are given a diagnosis of depression and just latch onto it and it becomes their world...” (M, 162, 3)*

Participants relied on their personality traits to help fight and protect their image as worthy human beings by facing back into the community and not hiding away.

*“...I'm a very strong person so I'd be, well, feck it [REFERENCE TO STANDING UP TO BEING JUDGED]...there is that tendency oh, hide away...you have to be sort of brave and just go out there...” (F, 32, 1)*

*“You have to prove your piece that you're pretty normal to stay out in the normal world...” (F, 200, 0)*

Participants spoke of returning to work and reconnecting with their role in society. Meaningful occupation was beneficial in strengthening participants’ place in society and to impress upon others their worthiness.

*“For me it's going to be getting back to [WORK]. That's going to validate me...you've got to get back your function and you've got to create your own story.” (M, 146, 1)*

The following participant described how his impression of himself directly influenced how other members of society came to perceive him. Therefore, in his opinion, it is the participants’ responsibility to manage other people’s judgement of them.

*“...it depends on yourself. It's your own sort of perceptions that you're giving out...it's about yourself being able to bounce back and show them [SOCIETY] that you're not a waste of time, that you were a valid human being before you came in. You're still a valid human being...” (M, 146, 1)*

### ***'Selective Disclosure'***

'Selective Disclosure' describes a strategy employed by participants where they only divulged to certain people that they had a mental illness or had been hospitalised. This was done in order to limit negative attitudes members of society may have had about them. Some participants protected their identity by not disclosing anything that associated them with the MHS. They described the stigma that might be associated with telling others that they had a diagnosis of schizophrenia or telling others that they were involuntarily admitted. In this way, participants described the perceived difficulties that they might encounter on discharge were they to explain to others that they had been '*involuntarily*' admitted or '*signed in*' to hospital. Central to 'Selective Disclosure' was participants' desire to manage disclosure about being in hospital, therefore enabling them to maintain control.

*"...They're [FRIENDS] the only people I told the whole story to of everything that happened."*(M, 34, 0)

One participant spoke of his hesitancy to disclose his diagnosis of schizophrenia, believing it to be something you did not advertise. The perceived dangerousness of mental distress seem linked to the assumption that people with schizophrenia or those who have been detained must be really crazy or must be really '*bad*' if they had to be '*brought in*'.

*"...there are levels of disclosure with regards to other people...There's my innermost thoughts and my innermost understanding of my diagnosis of schizophrenia. I never disclose that to anyone ever and then I have a shallow interpretation of it which I could disclose to you or someone else...if you had depression, you could say 'oh, I have depression.'...Whereas with schizophrenia...it doesn't play itself out socially well at all...you're trying to explain yourself to others and at the same time you're trying to understand your own biography and all the time making sure...to manage how other people view you and how other people understand you...I wouldn't tell everyone offhand that I have schizophrenia...it could make relationships trickier in that now I have schizophrenia and it's not something you'd advertise...Is that the right thing to do? I don't know. I think it is."* (M, 162, 3)

*"...because of the nature of the illness you can't go around telling everybody...it's not a physical disability...You know you have to withhold the information. You have to be careful about who you disclose the information to because...you can't talk about it really and that's a pressure in itself."* (F, 63, 1)

*"...being brought in involuntary...It's much harder to explain being brought in involuntary than it is to be brought in of your own will...This makes it more difficult...It sounds much better if you check yourself in...it sounds like you're in control. It sounds*

*like you're not crazy. It sounds like you're sane. Involuntary sounds awful dramatic. It sounds like you've totally lost it.*" (M, 162, 3)

Other participants spoke of not disclosing that were in a 'mental' hospital. Such participants would not voluntarily disclose that they were in a hospital if they felt that they did not need to. In this way, participants were able to maintain their privacy and protect their identity of self.

*"...I don't know how you talk about not having your son. Then you've got to say why you don't have your son because I was in a mental hospital. You know, you don't want to say that to people...You just don't generally talk about things like that to people if you don't need to."* (F, 59, 0)

### ***'Providing a Rational Explanation'***

'Providing a Rational Explanation' describes how participants attempted to defend their reason for involuntary admission to others. There was a view that neighbours and friends could view participants differently once discharged from hospital. Participants spoke of being stigmatised and having to find confidence within themselves to negate this experience and prove that they were a person beyond any illness or involuntary admission. Some described having to explain or rationalise why they had been in hospital.

*"...I looked at him and said [NAMES GUARD]...I told him the story of what she had done, what she had said a year before...and I explained the whole situation to him..."* (M, 19, 0)

*"It's much harder to explain being brought in involuntary than it is to be brought in of your own will...In the past if you had depression, you could say...oh well, I had a bit of depression...Went to the doctor...I went into hospital for a while and I came out. That could explain it for you."*(M, 162, 3)

In contrast, the following participants describe no longer feeling able to defend or protect herself her sense of identity due to her being involuntarily admitted.

*"I have no desire to go and say to people I'm fine, I'm well, I'm okay...when I was admitted before with voluntary admission, I was able to do that...I was able to go and say to people well, this is a health condition. It's something I'm not in control of...this time it's different. This time...I'm the one that was frightened...I'm not convinced to say to somebody else it's okay...I'm not at that point."* (F, 23, 0)

### ***‘Avoiding People’***

‘Avoiding People’ describes how participants socially disengaged and avoided contact with their peers after being discharged. This avoidance strategy was used to avert being labelled because of their mental health problem or facing up to others after discharge. Participants spoke of being afraid of meeting people and having to justify where they had been – it was easier to isolate themselves.

*“...I feel like if I even look across the road at that woman, you’re going to be down after me again...what do I do if I meet her in the street? Just ignore her. So, I was thinking okay, apart from being taken into there, now all of a sudden I’m going to be watchful...”* (M, 19, 0)

*“...I’m afraid to get in contact with my friends...I don’t want them to see me as this person...the person I am now is very...I feel like I’m under the carpet...Rather than standing tall looking at the sun... Kind of sluggish...and I don’t want people to...see me as not being the person who is in charge of my son...I didn’t feel I could get in contact properly with them because I couldn’t deal with the whole thing myself...I didn’t know how to answer questions about it...I didn’t want to be that person in front of people.”* (F, 59, 0)

While some participants highlighted the importance of building a life outside of hospital, others described how they avoided social encounters.

The subcategory ‘Preserving Sense of Self’ identifies how participants attempted to manage the negative perceptions associated with being involuntarily admitted to a psychiatric hospital. Difficulties in maintaining control were not only associated with an altered sense of self, but also with these negative perceptions from society. Central to this was the wish of participants to discard what people perceived as the label given to them as a result of hospitalisation, and they describe three strategies to delimit this ‘*new script*’. In this way, participants were attempting to protect their identity to society as valid human beings.

### **7.4 ‘Managing Mental Health’**

The second subcategory, ‘Managing Mental Health’, describes the strategies that participants employed or identified as useful in helping them maintain control of their mental well-being after their involuntary admission. Some of these strategies involved engaging with the MHS, while others were activated independent of the MHS. Participants used strategies in order to maintain control of their emotional well-being and in achieving better mental health. Additionally, ‘Managing Mental Health’

describes participants' identification of what they should and should not do to aid recovery. Some participants struggled more than others to move on. While participants ultimately wanted to live a healthy life and avoid being re-hospitalised, many continued to have difficulties and some described having a voluntary admission shortly after their discharge. 'Managing Mental Health' consisted of 'Moving On', 'Staying Connected to Mental Health Services', 'Using Complimentary Strategies', 'Monitoring Triggers' and 'Engaging Social Supports'.

### ***'Moving On'***

'Moving On' describes how participants attempted to adjust and reconnect with their lives after discharge. Additionally, it describes the coping strategies employed to manage difficulties in participants' mental health as well as to deal with the consequences of being involuntarily admitted. Some of these participants quickly reconnected with their life, while others struggled to incorporate the experience into their life world. Most participants were happy to no longer be in hospital.

*"...I remember the day I arrived out. I had no bag to carry all my clothes. I just got a black bag, grabbed it and flung everything into it and marched to the car...and then just felt, you know, terrified of wanting to stay well."* (F, 217, 0)

*"It was a relief to be home...It was not difficult...It was lovely...more freedom."* (M, 52, 0)

The following participants describe how quickly they transitioned from hospital to normal daily life after discharge. Such participants felt that they benefitted from their hospitalisation.

*"Oh, it's been brilliant. I went back to work...I'm coping brilliant with it now..."* (M, 10, 1)

*"Great...No problem...I'm not taking any drugs...I don't have any paranoia...I'm back playing sport...I'm interacting again with people. It's like I wasn't even in..."* (M, 50, 0)

*"It [DISCHARGE] was good...I do breakfast for kids. I help my wife with lunch...I go for walk with my dog. I go meet my friends just for talk...everything is fantastic...I'm so happy...I now ready go for job..."* (M, 45, 1)

In the following quotation, the participant describes how for a period he was still subject to the MHA while on extended leave from hospital.

*“...I don't know how it works legally...It was part of the process of moving on. It wasn't a big deal...It was definitely better to be at home.” (M, 162, 3)*

However, many others felt that their discharge left them more exposed to vulnerability within themselves. These vulnerabilities became more apparent as participants no longer had to fight to prove that they were worthy of discharge, a fight that had given them motivation to be involved in something meaningful. They were now faced with a situation where they no longer had to achieve freedom and any vulnerabilities they had previously denied came to the fore, resulting in a struggle to move on personally and emotionally.

*“It [DISCHARGE] was the first time...I was no longer, you know, fighting to survive and to maintain my equilibrium I then became ill.”(F, 217, 0)*

*“...it's the part you've got to do yourself...I'm having huge difficulty...But it's just a matter of sitting down with yourself and going okay, I can't take any more of this level of existence...you decide okay, I can't do this anymore. I've got to do the right thing now...” (M, 146, 1)*

The period following discharge was a time where participants struggled emotionally. Returning home was more daunting than participants had envisaged, and many continued to struggle with life problems and circumstances that were still present on discharge. Participants had to contend with no longer being in a protected environment where they had a temporary containment from difficulties they had been experiencing prior to involuntary admission.

*“...I kind of came back into the same thing again...It's difficult...the last two weeks I went through an awful low...” (M, 34, 0)*

*“...that's [DISCHARGE] when...the fear comes in to your normal life. You have to go to work and keep living...I was crying loads...I really thought I was touching for suicide...I was really, really, really, really down.” (F, 214, 2)*

For some it was difficult to transition from the routine in hospital to being back in the ‘real world’. Participants described taking some time to adjust.

*“It's hard when you leave the hospital...your dinner has been made for you and you don't have to think about anything and you don't have to pay bills. So when you actually come out first...It's hard to slowly adjust back into everyday life and worries and problems...” (F, 39, 1)*

*“After I left...nervous about getting back into the real world...in the hospital here it's like...being on holiday...from work and from people...you're just one of the many or whatever and no one really understands you as much as the people would in here*

*[HOSPITAL] ...I just have to figure out what I'm going to do with the rest of my life..."* (M, 43, 0)

*"...you have somebody there constantly, giving you tablets, telling you when to go to bed. Your meals are provided...then you come out and it's a big wide world out there and you're all by yourself..."* (F, 9, 0)

Other participants described not having motivation to deal with daily life on discharge. Some described being low or being nervous. They spoke of trying to cope with losing self-esteem and self-confidence in their personal capabilities and sense of competence.

*"...at the moment I'm still extremely low, still coping...It's the fear factor, the fright of losing control and all that type of things...You're doubting...yourself constantly...the self-loathing...the emotions have been stifled so I live my life now almost totally isolated. I interact with my son...husband and...family on a sort of a...haphazard kind of an uninterested way. I feel that something died inside me..."* (F, 23, 0)

*"...then [AFTER DISCHARGE] the low came. I was still carrying that low with me...Just the motivation to get up every day and face the world...It's tough...You need lots of motivation...You get into a rut..."* (M, 51, 3)

*"I just found after the episode and that when I came out I couldn't pick myself back up...I really, really couldn't...it was probably a combination of everything..."* (F, 32, 1)

Several participants noted frustration with a perceived lack of follow-up support at the time of and after discharge, meaning some felt alone and isolated. Participants were not given any meaningful direction on how to proceed with life after discharge.

*"...I think somebody giving me...guidance because I was at a complete loss when I came out...I felt like I was just thrown out and say okay, we've just destroyed your life, now you go and find your way and work it out yourself..."* (F, 59, 0)

*"I just felt like I'd been pushed out of the hospital...and you're like oh Jesus, where do I go from here?"* (F, 9, 0)

Others wished to have access after discharge to a person who could provide support and reassurance in times of distress.

*"The follow-up is not good...I needed someone I can talk to but there isn't really anybody. It would be lovely to have somebody outside...Just an independent person to talk to...This has been going on a while now and I don't feel I'm getting any better....It's tougher now than ever..."* (F, 63, 1)

*"...I think for the initial two, three weeks...there should be somebody who should be able to drop out to the house...I always found the initial weeks after coming out of the unit the hardest..."* (F, 32, 1)

Indeed, some participants spoke of being voluntarily readmitted to hospital soon after discharge.

*“...I ended up going back up to [PLACE]...and by the Tuesday I was admitted into [HOSPITAL] for one night because I got so stressed...I ended up taking [AN OVERDOSE] tablets...” (F, 1, 0)*

*“I actually became suicidal when I came out and I ended up in the hospital...” (F, 59, 0)*

In addition to having to deal with these problems, some participants also tried to process the actual involuntary admission experience. There were two coping strategies that were used to maintain control and move on from the consequences of involuntary admission. Firstly, some participants attempted to integrate their experience of being involuntarily admitted into their lives – these participants tried to process what happened to them and regain a normal life.

*“I tried to get my life as fast as possible...there's no real point being at home and wondering what happened. It's good to have distraction...I always recover from my things very fast. I'm not that sick...and slowly I'm better. I'm not 100% recovered.” (F, 214, 2)*

*“I was five or six weeks in there and it was a long time and I'm still trying to get it out of my system...it takes a long time to get over...but it's over now anyway and I'm in better form...”(M, 68, 4)*

Some of these participants coped and held a more positive relationship with their mental health and their experiences of mental distress.

*“It doesn't bother me [INVOLUNTARY ADMISSION]...I'm not too bothered by it. You can do nothing about the past...It's the future you can look to...I've a good sense of humour and I laugh...” (M, 150, 4)*

*“I'd like to do some sort of work. I'd like to get back into living some sort of a normal life as it were but I'm not sort of making any decisions...I'm taking life slowly...You come to terms with things and...understanding and accepting the illness.” (F, 24, 4)*

Secondly, there were participants who attempted to maintain control and move on by trying to forget and put their experience behind them. While some found it difficult to think back and share the distress of their experience, others felt it was the easiest way to move on. Many wanted to forget about their experiences and found it difficult to be reminded or to talk about aspects of their admission. Many did not want to be reminded of it and indeed many people in the recruitment phase of this research did not want to be interviewed stating they wanted to forget about it. Those who described trying to forget felt that it was futile to begin to think about it

*“...it put a black mark in my memory. I've put it behind me now...” (M, 230, 0)*

*“I don't look back on it really...I just put it out of my mind...” (F, 211, 0)*

*“...the faster you can get back to your life...the sooner you forget...” (M, 146, 1)*

*“Just moved on and forget a little bit about it now...” (F, 200, 0)*

During some of the interviews, there was a reluctance to be reminded or talk about specific aspects of participants' experience. Some described not remembering aspects of their hospitalisation and attributed some of this to being medicated. The following participant appears to no longer want to be reminded of the experience.

*“...It destroyed me entirely but I got out of it anyway and hopefully I'll keep out of it...” (M, 17, 0)*

*“...it's all in the past. That's what happened now. It's over and done with. I never want to be there again.” (F, 31, 2)*

*“Just the feeling of being locked up is awful. It's just a terrible situation so I don't really want to talk about it...It makes me upset...I don't know what to say.” (F, 60, 2)*

### ***‘Staying Connected to Mental Health Services’***

‘Staying Connected to the Mental Health Services’ describes a majority of participants who engaged with the follow-up and support provided by the MHS in order to assist them in alleviating on-going mental health difficulties. For most, this involved continuing on pharmacological treatment.

Some participants continued to express the need for support after discharge and attempted to manage their mental health by attending the statutory services (outpatient clinics, day hospitals or day centres). This connection and support after hospitalisation mattered to participants.

*“...there was services put in place which was good...I was linked in with the day hospital...I suppose the day hospital is good for that because there are things to do...” (M, 46, 3)*

*“...I want to be well...I've been over in the outpatient's clinic constantly since I came out...” (F, 23, 0)*

*“And seeing a doctor up there [DAY HOSPITAL] once a week or every second week. One of the nurses up there the other week...that was good. Somebody to check in and see how I was doing...” (M, 43, 0)*

Knowing and having access to someone that was there to check in with participants mattered greatly to them. Specific professionals (Occupational Therapists (OTs), Psychologists, Community Nurses, Doctors and Addiction Counsellors) within the MHS were described as ‘helpful’. Participants mentioned having a good relationship with certain professionals, and having somebody to trust and talk to honestly was seen as important.

*“...I talk to...an addiction counsellor and he helps me...it’s as good as being in the hospital. You’re still getting your medication. You still have nurses there for support.”* (F, 15, 1)”

*“...they [PROFESSIONALS] are trying to help...I can go talk to the [CP] last Tuesday and [CPN] called out to my house and I speak to them...about the way I feel ...I find it helpful to be honest with people...”* (F, 23, 0)

*“...the team here in [NAMES DIFFERENT COUNTRY] have been good. I have a CPN who comes around and who I have regular contact with... someone to talk to, check in and checking I’m doing all right...I’ve been open and honest as much as I can be with people...my GP has been supportive...it’s been very sort of helpful to be able to talk through a lot of things with CPNs...”* (F, 23, 4)

More specifically, professionals educated participants about the nature of their mental distress and what might assist them in maintaining mentally healthy lives.

*“...I was educated about what was necessary to keep myself on the right track and I try to follow that as strictly as possible...it keeps me going. It was also the outpatient visits and the conversations that I had with the doctors in the outpatients that really helped as well in educating me in terms of what been happening and what I should do to maintain a healthy kind of mind-set...”* (M, 114, 0)

*“I see a nurse and it’s been very helpful and they...tell you must avoid stress...Your house will keep. You’re number one...I have an excellent doctor...”* (F, 47, 1)

A few participants described the benefit of attending a group in the day hospital to manage and maintain control over their mental health. The following participant described the benefit of ‘talking over...things that bother’ him in his daily life.

*“...the therapy sessions are a huge bonus because if I get a bad day, or two days...the therapy sessions are brilliant...the anxiety and the mood, this stress and coping one...it’s helping to...get yourself out of a situation...”* (M, 47, 0)

Participants spoke of getting support or access to more practical supports from professionals (Social Workers, OTs & CPNs) in terms of accommodation, access to courses and financial assistance.

*“I had a social worker and she was very good...then St. Vincent de Paul came along and they helped me...I got a new flat...and they’re helping me with the deposit and they bought me bits and pieces...Without her [SOCIAL WORKER] I would have been very stuck...She was there for me...” (F, 44, 0)*

*“I don’t have any support except [CPN], that’s all. [NAME] is a community nurse and she calls about every fortnight or three weeks...to see that I’ve enough of food...” (F, 41, 6)*

In contrast, other participants spoke of changing to a more understanding health professional as they felt it was important to be listened to and understood.

*“...now I’ve got another GP...I’m a lot happier with him...Because he’ll sit down and talk to you and listen to you...” (M, 47, 1)*

One participant felt she was ‘talked down to’ during her hospitalisation and changed her consultant on discharge. In this way the participant felt that she wanted someone more on her level that she could trust.

*“I said he’s talking down to me [REFERENCE TO CONSULTANT] and I said I never would trust him. I just don’t like him at all and I said there’s another man, Dr. [NAMES CONSULTANT] and he’s more on my level...I asked her [COMMUNITY NURSE] would she see if would it be possible...to be transferred to Dr. [NAMES ANOTHER CONSULTANT]...two weeks [NAME] said to me an appointment has been arranged for you with Dr. [NAME]...I’ve only this time met him once...he’s been so good...” (F, 68, 1)*

For some participants avoiding alcohol and drugs was important in maintaining good mental health. They described deciding not to drink or cutting down on their drug intake. In this way, alcohol and drugs no longer interfered with their ability to manage their mental health or to keep their job.

*“I like being in control. Like being my own boss. I don’t like being held by the hand or brought anywhere...I’ve had like a spiff or two since I got out of hospital and I’ve refused more than I’ve taken. I’ve been in pubs and I haven’t drunk.” (M, 71, 0)*

*“...if I had kept drinking I was going to lose it [JOB]...So, I’ve stayed off it now.” (M, 10, 1)*

The mainstay of treatment focused upon taking medication, which was an aspect of managing and regulating many participants’ mental health difficulties. Some spoke of the benefits of medication in managing their mental health and in keeping self-mastery in equilibrium. Many participants expressed a reluctance to take medication, due to the side effects, but were compliant in order to avoid readmission.

*“Most of my treatment is medication and the medication is necessary...because of sleeping patterns...suicidal thinking...” (F, 23, 0)*

*“I’m comfortable enough in myself at the same time that medication is probably keeping me stable.” (M, 39, 1)*

*“I had to ask for [SPECIFIC MEDICATION]...because that was the only thing that used to help me...I’m back on them now...” (F, 27, 6)*

Some participants spoke of getting a certain medication or taking extra medication when they felt they needed to. The following participants speak of taking the initiative to go to their doctor and increasing their medication or switching to something that might help them.

*“...I got my tablets yesterday because I promised myself that I wouldn’t be there again...I’m on 600 Seroquel...Now it’s seven...Dr. [NAME] ...said I could actually go as high as nine if I really have to...I would do everything I could ever do to not be in there [HOSPITAL].”(F, 139, 1)*

*“I got the antidepressant off my GP...I remember taking...a certain antidepressant I found had worked very quick like after about five days when I wasn’t drinking. The medication is helping me now...I definitely needed medication...” (M, 74, 7)*

Many participants would have preferred not to take medication but nevertheless took it as they feared a diminished self-mastery. Some felt they would become reliant on medication and would relapse if they stopped.

*“...if I was to come off this medication, that would begin a chemical imbalance in my brain...when I’m on medication, it doesn’t happen...I take medication for schizophrenia.” (M, 162, 3)*

*“...I’d prefer not to be on medication...but it seems to be working so life seems good enough at the moment...I put up with it...the last time I crashed was pretty out there...taking medication is a good thing because I’d be daft...” (M, 43, 0)*

Despite the fact that some participants did not want any involvement from the psychiatrist or nurses on discharge, some felt compelled to take depot injections or other medications in case failure to do so would result in their readmission. They described a situation where they felt powerless to refuse taking it, ‘Sure, what can you do...?’ Some felt that by taking medication they would no longer experience professionals being ‘after them’.

*“...I’ve decided...to keep taking the tablets...if I don’t take my tablets, they’ll be after me again...they [CPN] come to visit me and they give me an injection every second week...I’m taking injections now to stay out of there...They kind of stuck with you. It’s very hard to get rid of them...” (M, 68, 4)*

*“When I came out...I was an outpatient for three weeks and she [CP] did say to me if I didn’t take it I’d be back in there [HOSPITAL]. So, it’s kind of a threat, isn’t it?” (F, 200, 0)*

The following participant describes being promised by the psychiatrist that she would be switched from injectable to oral medication, but this never happened and she now has to take both.

*“I never really did [AGREE WITH TAKING MEDICATION] but I felt like I had to...I sense it helps in some ways...I suppose I have to but I have to take the injections in that situation as well...I thought that if I started the injections I’d be moving away from the tablets...” (F, 60, 2)*

Central to some participants being compliant was having prior experience of discontinuing medication and ending up with family or professionals bringing about readmission to hospital. Participants described feeling powerless over having to take medication and that any attempt to exert control over their life was met with another hospitalisation and being ‘railroaded’.

*“...I was put on [ANTIPSYCHOTIC MEDICATION] and I felt so good after about six weeks that I said there’s nothing wrong with me and I threw out the medication. I lasted about six months and then all of a sudden back in the hospital again...I was five years on [INJECTION] and feck this I’m going to get thin so I started walking and my determination was back. Started walking, lost two stone...A few weeks later, bang, in the hospital again...” (F, 100, 17)*

*“...I’m going to stay on it [INJECTION]. I don’t want to be in hospital so I have no choice but to stay on it.” (M, 29, 4)*

Others described complying with the direction of family and professionals in order to avert a further admission.

*“...my mother is very much above me in certain ways...she likes to take care of me...and she likes to control things herself” (F, 60, 2)*

*“...I kind of have to take it [MEDICATION] because my family would be worrying and my sister would be crying and they’d be all freaking out. So, in a way that is forcing me to take it...” (M, 43, 0)*

Another participant spoke of continuing to engage with the MHS simply to avoid the risk of not getting her son back.

*“...my life now has become dealing with hospitals and going to court and seeing my son once a week and social workers...the reason I’m going to see the mental health people now in [PLACE] is so I get my son back... ...I don’t want to have anything to do with the mental health service whatsoever...It’s not letting me make my own way in life...” (F, 59, 0)*

Participants perceived that addressing the issues that led to their breakdown would remove any need to take medication. Participants wanted to live a life that was independent of taking medications and they felt that if they were able to control certain aspects of their lives they could avoid doing so. There was an expressed need for something other than medication to be the treatment of choice.

*“I want to come off it [MEDICATION] ...I have addressed a lot of the issues that led to my breakdown...It’s the fact that I’ve been on this medication for so long and I shouldn’t have been on it in the first place...I can’t very well easily come off it...I’d like it if the outcome of it was we can take this guy off medication.” (M, 162, 3)*

Some participants concealed the fact they had stopped taking their medication.

*“I’ve since stopped one of those medications myself. I did tell the nurses coming here every day that I was taking it...I felt it was making me agitated so when my husband gave it to me I threw it in the bin...I was also on [NAMES ANTIDEPRESSANT] and that was making me really agitated...” (F, 200, 0)*

*“...I don’t need it [MEDICATION] ...because of my personality and everything else, if I keep taking those tablets I’ll be addicted to them soon enough...I feel like I’ll become dependent on them... ...So, I just decided I was going to stop taking them...and take them when I feel like I needed to take them.” (M, 50, 0)*

It was apparent in some interviews that taking medication only assisted in controlling illnesses like schizophrenia, mentioned below, and some participants continued to have experiences associated with their diagnoses.

*“It’s a good treatment [MEDICATION] ...Now I have my medication...It’s not the end of the schizophrenia, you know.” (M, 25, 1)*

*“...I don’t think about it [REFERENCE TO A STRANGE HAPPENING] so it’s grand. The medication is working pretty well...” (M, 43, 0)*

Side effects were frequently mentioned and some participants did not like taking medication that caused drowsiness or that were otherwise intolerable. Participants

spoke of having to take medication that caused them to lose interest in the world and affected their ability to interact.

*“...Life’s not as rich...Like sometimes when I was off the medication...the world is more beautiful...Being back on medication, I don’t really care as much...When I was off medication things seemed to matter more...”*(M, 43, 0)

*“...They’re all right, the ones I’m on now except for the confusion...I know I have to take tablets and all that for the illness...but I’m sure there’s some kind of different tablets that wouldn’t make you sleep so much.”* (F, 27, 6)

*“...when I got home I was really ill...I’d been put on the [MEDICATION] and...It was horrific. I felt terrible anxiety on it. It didn’t suit me in any way.”* (F, 217, 0)

One participant described having strong doubts about conventional treatment due to its effect on his father and consequently sought and found alternative treatments such as homeopathy that he perceives are an effective substitute in managing his mental health.

*“...I’m probably a bit skewed in my belief towards medication [REFERENCE TO PSYCHIATRIC MEDICATIONS]...but I just see with my father it hasn’t worked...He’s obeyed the rules, been compliant and taken his medication but he’s not in a good place physically at all...I just feel there’s easier ways to deal with my own problem...I know I’m not 100% aware of where my mind could take me...”* (M, 46, 3)

### **‘Using Complementary Strategies’**

‘Using Complementary Strategies’ describes the alternative approaches or therapies participants pursued independently of the MHS in order to achieve a mentally healthy lifestyle. These strategies were beneficial and meaningful to recovery, and most were employed while participants continued to take medication.

In the absence of help from traditional mental health services, some participants sought the opinion of the less traditional HSE services in an attempt to deal with underlying unresolved issues they felt were attributable to mental health difficulties. Participants accessed this support on their own volition through private professionals (Psychologists and Psychiatrists) after their discharge.

*“I’m seeing a psychologist at the moment to come to terms with the past and my diagnosis...Initially I saw one really just to get me back on my feet...that went a long way towards me accepting my diagnosis...since then I’ve been working on motivation...”* (M, 162, 3)

*“...I’ve made a decision...I’m going to go and talk to somebody [PSYCHOLOGIST] ...”* (F, 217, 0)

The following participant highlighted how a private psychiatrist helped her feel better in that she spent time with her, normalised her feelings of distress as post-natal depression, gave hope that recovery was possible, and reassured her that she was on the correct medical treatment.

*“I saw her [PRIVATE PSYCHIATRIST] for one hour and I felt a million times better just speaking to her. She basically said...nothing on the list of what’s happened is in any way abnormal...she said basically I think everything that’s been done is perfectly normal and anything that’s happened to you, that you’ve gone through is perfectly normal for postnatal.”* (F, 1, 0)

Others spoke of occupying their time by volunteering for various organisations. They spoke of how they could use their experiences in a positive way to partake in something that was meaningful.

*“...Stuff like voluntary work is quite helpful...A two-way system. You’re equally helping out with your community and helping yourself as well, feeling more involved or more worthwhile as kind of a member of society.”* (M, 46, 3)

Other spoke of practising compassion towards themselves and promoting a sense of their kindness towards themselves as an individual, thereby changing their perspective and priorities in life and reducing stress levels.

*“I’m putting myself first and I’m getting more respect for it...I went for a pedicure. That’s fifteen quid. I could buy them a school jumper or something with it, but I went ahead and...I came back feeling brilliant...”* (F, 100, 17)

*“I’m much more in mindful of my own mind...and doing all of the things I should have been doing to look after it...that’s one of the best things that came out of this...Life is great...I’ve got a son which has changed a lot. It’s changed my focus certainly and my priorities...”* (M, 114, 0)

Keeping busy and working were important factors in participants’ recovery and provided a sense of purpose and self-worth.

*“...I keep active. I have something to do every day...Finding interviews, leaving out CVs for work, going to the gym, helping people, meetings...”* (M, 51, 3)

*“I’m living with my mother and father now...I go off and do the shopping for them and I tidy up around the house for them...”* (M, 39, 1)

Exercise was a helpful factor in participants’ maintaining control of their emotional and mental well-being. The benefits of exercise included a healthy sleep pattern and a sense of relaxation, as well as building confidence and bolstering self-esteem.

*“...I joined the gym...it helps me feel good about myself...if I do a good, hard session, it helps me sleep at night time...” (M, 39, 1)*

*“...Every second day I go for a run...I find when you relax after that...it’s a lot deeper relaxation...” (M, 46, 3)*

Participants also described smaller things (supplements, a healthy diet, and music, writing and spiritual rituals) that they felt assisted them in managing their recovery.

*“...I am literally reading up everything I can about vitamins and anything that will help...like B12, folic acid. The fish oils...I have found them very good...I know to keep myself eating the proper food...I played beautiful music...I had all my people who I pray for here...All these beautiful people that very personally know to me...I pray to Buddha’s...That’s what got me well...I would come in here every evening and put on my mindfulness CD and lie down...calm myself...” (F, 217, 0)*

*“...a way I have dealt with a lot of things is to write things down...that for me has been very helpful, to write down my experiences...my emotions and my feelings and that’s something you know I can look back on and understand...”(F, 23, 4)*

*“...I have plenty of low days and but I’m doing a bit of writing. I like to write about my future.” (M, 51, 3)*

Socialising was also an important aspect of participants’ recovery. Participants identified the importance of meeting other people, having someone to talk to and not isolating themselves.

*“...meeting my friends...They have a drink I have a Lucozade...they meet and say will we go for a drink. I say yeah...It’s been important since I went in as well because I used to have the craic with them...” (M, 10, 1)*

*“...I’m going out tonight...I’m going to a flower demonstration. I love to garden. I love flowers...A friend of mine is bringing me. This friend is very good...” (F, 31, 2)*

### **‘Monitoring Triggers’**

‘Monitoring Triggers’ describes participants’ identification of the factors that contribute to a decline in their mental health. In doing so, the participant becomes aware of these factors and attempts to either eliminate them or implements strategies to maintain their mental health in order to protect themselves from a diminishing self-mastery.

Some participants described the importance of the role they themselves or their family members played in identifying signals that may suggest a decline in their mental well-

being. In this regard, participants described getting ‘early intervention’ in an attempt to avert further decline in their condition.

*“...I’m trying to be proactive. I’m saying to myself okay, if there has been some sort of deterioration in my brain I’m prone to that ever happening again. I want people around me to actually recognise it first and go for early intervention...”* (F, 217, 0)

*“...I’m watching myself very carefully because my sleeping is very erratic and I’m very, very stressed out. I’m pacing a lot.”* (F, 63 1)

For others, alcohol or drugs were contributing factors in their emotional problems and avoiding these was critical.

*“I’m not going to need it [MEDICATION] because I’ll be able to control the cannabis addiction...when I get drunk sometimes I get high as well...I believe once I can control the cannabis, I’ll be able to control myself.”* (M, 39, 8)

One participant spoke of how he had ‘acted’ and implemented strategies (running and going home) that were successful in managing his mental well-being and preventing any further decline.

*“...a lot about health is picking up on these signals...and kind of following through...I’ve acted on stuff and it has improved...maybe sometimes go for a run. That’s a kind of more a habit at the moment as well, but I knew before to get a bus home or that instead of staying in the city...”*(M, 46, 3)

Only one participant, now in England, spoke of working with her CPN to identify triggers that might lead to a relapse.

*“...I still work with the medical team here in [PLACE IN ENGLAND] and we work on sort of being aware of what my triggers may be, things to be aware of to make sure that I don’t sort of slip again...”* (F, 24, 4)

Physical inactivity or social isolation was seen a key determinant of living a less healthy and happier life. Therefore participants tried to be more sociable.

*“You need to be active. You need to be kept busy...You need to have...some motivation in your life to keep yourself healthy and...in good mental health.”*  
(F, 15, 1)

*“It’s important you’re not isolated...That you have people to talk to...”* (M, 71, 0)  
*“...I don’t stay in bed during the day because that depresses me...Just try...not to isolate myself...A lot of people with depression, they isolate...Once I’m around people like, I feel better...”* (M, 74, 7)

*“I think if I sit around or don’t get out and do things...it’s not good for me.”* (F, 24, 4)

One participant describes himself as being ‘*vulnerable to symptoms because of lack of activity*’, and as such he emphasises being active as key in establishing a routine and in bettering his mental health.

*“...Just to give you a better idea of how you’re using your time...That you’re not kind of wasting your time and leaving yourself vulnerable to symptoms because of lack of activity or that...”* (M, 46, 3)

### **‘Engaging Social Supports’**

‘Engaging Social Supports’ describes how participants sought or received emotional support from family, friends or from service users after their discharge. This assisted in participants’ recovery.

It mattered that participants had someone they felt they could trust, someone in whom they could confide. If trust was present, participants felt that it was easier to divulge and disclose their personal problems and feelings.

*“...okay, you need say professional advice on certain things or whatever, but your friends are the best...there’s one guy in particular I’d consider to be my best friend...There’s two people I know that I can trust... They’re the only people I told the whole story to...You can talk things out...”* (M, 34, 0)

Participants also spoke of feeling supported by family members and of no longer hiding their emotional distress and actively sharing it with them. This provided a sense of ease to participants and helped them cope with distress. As such, these participants felt understood and helped by family members and this contributed to their recovery. One participant mentioned the usefulness of getting a different perspective on situations from his spouse.

*“...my family...have been a great help...it's only since the event that I've started to kind of talk about stuff. My father would always kind of say to me if there's anything on your mind, talk it through...I've had very good conversations with my wife where she wanted to understand what was going on...I think that's another part of it that it really helped as well because she understands me...the person that I am without the psychotic episodes...she's able to frame for me in a different perspective...”*  
(M, 114, 0)

The participants’ families also contributed to maintaining that sense of control for participants by giving help and encouragement in times of emotional distress. Having people that could understand participants’ ongoing emotional distress was important and this in itself provided a means of support.

*“...my family have been very understanding and they're a strong connection...Some friends have been very understanding. They know me, the old me...I think obviously people close to me have been understanding...I just prefer to know there are people in the background I can turn to...to feel that there's a support network is what I need.”* (M, 24, 4)

*“Obviously my own family has been a support like...they don't know the ins and outs...They don't interfere...they're there if I need them.”* (M, 34, 0)

Some participants really struggled to cope with their emotional well-being and described the importance of having family members who comforted and empathised with them. The participant below also highlighted the importance of having what she described as ‘normality’ in terms of managing her mental health in daily life.

*“The family were very supportive...I'm very lucky I have my mother and family for support...I'd say 'I really don't think I can do this.' 'Yes you can, love, come on. Just keep you going'...I wouldn't like to be on my own...I have a sister as well...I talk to her on the phone. She's very helpful...normal. There's normality going on but they check in with me...”* (F, 46, 1)

*“[NAME] has been very good, my daughter, excellent and [NAME]...My next-door-neighbour called into me the day I came home and she was very supportive...”* (F, 31, 2)

Other participants spoke of having contact with other service users that they had met in hospital and how they helped each other manage their emotional well-being. They described talking through their problems together and how this assists in getting them through difficult times.

*“...I made friends in the psychiatric unit and we're like that to this very day...and we help each other out...and talk each other through the worst parts and that's how we keep going.”* (F, 31, 6)

*“...we would text each other now to this day. 'How's things and how's it going?'”* (F, 63, 1)

*“I still keep in contact with another girl and she's very sound.”* (M, 51, 3)

Some participants noted a preference to access peer support rather than more traditional, HSE-based mental health services. These were supports that participants received or intended to use independently of the MHS to help manage their mental health. Many spoke of the benefits of attending Alcoholics Anonymous (AA), Narcotics Anonymous (NA), or Aware in terms of managing problems, having someone to talk to, receiving support and feeling understood.

*“I have friends that are in the rooms with me...Recovery rooms...The same kind of mentality as myself, especially towards gambling and drinking. Just people that are close and I've met over the last year that are good to me.” (M, 50, 0)*

*“I’m attending NA meetings and AA meetings every day...I know it’s going to be a struggle...but I attend meetings every day and I have a sponsor. I’m on a programme...I was still very depressed and stuff, but I just attended the meetings like I was advised and started getting addiction counselling...The only people I’m in contact with now are NA members and AA members...” (M, 74, 7)*

Additionally, a need was identified for support groups for those who had experienced similar challenges, and being able to share with others in this forum was seen as important.

*“I think it would be helpful if there was a group session of people that suffer with bipolar disorder...like they have for Alcoholics Anonymous...they offered me the day hospital but the day hospital was relaxation and there was no...open groups...” (F, 23, 0)*

The subcategory ‘Managing Mental Health’ refers to the strategies which participants employed to move on after discharge. Some strategies involved the MHS while others stemmed from participants’ own volition, independently of the MHS. Many of the strategies were multifaceted, and in several instances participants used a combination of strategies to contribute to their mental and emotional well-being.

### **7.5 Summary of Category Maintaining Control**

‘Maintaining Control’ describes the impact of involuntary admission on participants’ lives and the difficulties they faced in coming to terms with self, society and family life on their discharge from hospital. ‘Maintaining Control’ also outlines the struggles that participants experienced within their personal and social lives that impacted negatively on their ability to maintain control of their emotional well-being. It describes how participants employed strategies to contain and regulate these feelings and maintain a sense of control. The difficulties encountered in ‘Maintaining Control’ were not only concerned with the ability to manage oneself, but also with the difficulties in managing others’ stigma.

## Chapter 8: Discussion of Findings

### 8.1 Introduction

In this chapter, the Theory of Preserving Control (ToPC) is discussed in the context of existing theoretical literature. Although some of this literature was examined during the preliminary literature review it was not reviewed in depth. Now that the concepts of ToPC are developed, the literature will be returned to, to compare the concepts of ToPC and identify the similarities and differences within the existing theoretical literature. This literature offers further enhancement of the ToPC. The ToPC represents a contribution to theoretically understanding the varying extents to which some participants experienced a loss of control when subject to an involuntary admission, the way(s) in which they experienced or managed to regain control, as well as the strategies they used to attempt to maintain control, within the context of living with the consequences of their involuntary admission. The ToPC will be considered in the context of theoretical perspectives namely Skinners (1996) conceptual review of the constructs of control, the Self-Regulation Model (Leventhal *et al.* 1984), a classic grounded theory of going home from hospital entitled 'Managing Preconceived Expectations' (Keogh *et al.* 2015), and the concept of Procedural Justice (Tyler, 1992). In addition, the relevance of the ToPC to the MHA 2001 will be discussed. Finally, a section on reflexivity is included. Firstly, the relevance of 'control' as a concept to assist in understanding people's experiences of involuntary is explored.

### 8.2 Theory of Preserving Control: Comparison to Skinners Constructs of Control

This section provides an overview of Skinner's (1996) conceptual review of the constructs of control and then compares these constructs to the concepts within the ToPC.

There are significant differences and commonalities in how researchers describe constructs related to control. For example, there has been confusion about which constructs lie within and outside the concept of control, resulting in theoretical confusion about what the constructs that constitute control actually are. This Skinner (1996) suggested, contributed to confusion in the study of the effects of control of adaptive functioning when under stress. Findings to date offer little consensus on 'when' and 'what types' of control may be experienced as helpful. The problem lies

with a lack of consensus about what the key constructs of control actually are. Some of this lack of consensus undoubtedly reflects the breadth and complexity of the dynamics that influence control.

Skinner's (1996) conceptual review delineates between constructs that are aspects of perceived control and constructs related to aspects of perceived control. Despite the variety of constructs across the literature around control, Skinner (1996) states that what is common is that many of the constructs are aspects of perceived control or are related to aspects of perceived control. According to Skinner (1995), perceived control is the "naïve causal models of how the world works; about the likely causes of desired and undesired events, about their own role in successes and failures, about the responsiveness of other people, institutions, and social systems" (pp xvi–xvii).

Skinner (1996) guide to the constructs of control can be used to identify and locate related concepts within the ToPC. Relating concepts within the ToPC to Skinners constructs, the ToPC highlights control in practical terms while Skinners guide to the constructs of control highlights control in theoretical terms. Skinners' constructs of control assists in our understanding of the theoretical constructs that are relevant to and underpin the concepts within the ToPC, while the ToPC provides a practical example of the application of Skinners constructs of control as well as the factors that influence participants behavioural responses. Skinners guide to the constructs of control provides a map to situate the ToPC within the domain of perceived control.

Constructs that Skinner (1996) states that do not describe perceived control but nonetheless are directly related to perceived control are conceptualised as:

1. Objective and subjective control conditions (e.g. contingency)
2. Potential antecedents of control (e.g. choice)
3. Potential consequences of Control
  - a. Primary control
  - b. Secondary control
  - c. Relinquishment of control
4. Motivation for control (e.g. mastery)

For the purposes of the discussion and in light of the ToPC the first part of this section will outline one of Skinners sets of constructs identified as 'objective and subjective

control conditions' and within this will differentiate between agents, means and ends of control as it applies to objective and subjective control conditions. Following this a further three sets of constructs as identified by Skinner (1996) will be outlined: 'sources of motivation for control', 'potential antecedents of perceived control' and 'potential consequences of control'. The following section is headed used in Skinner (1996) review namely: 'objective and subjective control conditions', 'agents, means, and ends of control'.

The first set of constructs, 'objective or subjective control conditions', according to Skinner (1996), describes the amount of control *actually* available in the situation and the *actual* relationships that exist between means-ends or agents-means and outcomes (ends) (outlined later). Skinner (1996, p. 551) distinguishes between 'actual' or the objective control present in the context and the person, and 'perceived' control, i.e. the individual's beliefs about how much control is available. Objective control essentially refers to the **actual** controls or contingencies (for example 'if A, then B') present in the individual and their environment. In contrast, Skinner refers to subjective control as that which is **perceived** by the individual. According to Skinner (1985, p. 40), subjective control refers to "the amount of control perceived by the individual". As far back as 1977, Bandura observed that objective control alone is insufficient for individuals to be effective agent of control – according to Skinner (1996, p. 552) "even if individuals believe that outcomes can be influenced by behaviours or responses, they will not attempt to exert control unless they also believe that they themselves are also capable of producing the requisite responses" The experience of subjective control has frequently been found to have predictive validity much more so than, and independent of, objective (actual) levels of control. Skinner (1996) noted that the distinctions between agent-means and ends of control have appeared more frequently in theories of perceived control but such distinctions are also applicable to objective or subjective control conditions. According to Skinner (1996, p.557) 'objective or subjective control conditions' describes "the actual opportunities provided by the social and physical context for people to meet the need for competence". Learned helplessness (Seligman, 1975) is considered an objective control condition. When one learns that an aversive consequence is unavoidable in a situation, irrespective of one's actions, a phenomenon has been observed whereby other animals and people 'give up' (Wortman & Brehm, 1975). In contrast to learned helplessness, self-regulation (Leventhal *et al.* 1984) is also

an objective control condition. In this instance, when one learns that with one's actions a consequence is avoidable/manageable, some people activate their own meaningful actions in a bid to avoid/manage certain consequences. The next section will outline how Skinner differentiates between agents, means and ends of control

### **Agents, Means, and Ends of Control**

Skinner's distinguishes between agents of control (the 'who' of control – those who exert it); means of control (the 'how' of control – the pathways through which control is exerted); and ends of control (the 'goals' or outcomes of control). According to Skinner (1996, p.552), "ends (of control) refer to the desired and undesired outcomes over which control is exerted, agents (of control) refers to the individuals or groups who exert control, and means (of control) refer to the pathways or factors through which control is exerted". Skinner (1996) noted that these distinctions have appeared more frequently in theories of perceived control but apply equally to the study of objective control conditions such as the ToPC.

#### *Means-ends relations*

According to Skinner (1996), means-ends relations refer to the connections between particular classes of potential causes and particular desired or undesired outcomes, irrespective of whether the focus is on perceived or actual control conditions. Locus of control refers to an individual's attributions as to the cause of outcomes (Rotter, 1966), or the degree to which one believes in their ability to influence outcomes (Berrenberg, 1987) and is considered to be a means-ends relation. According to Rotter (1966), locus of control consists of internal (under one's control) versus external (or not under one's control) locus of control, i.e. agent-related causes versus non agent-related. An internal locus of control refers to the perception that outcomes are contingent upon an individual's own behaviour (Senior *et al.* 2005). Locus of control then divides internal causes into attributes (e.g. ability) and actions (e.g. efforts, responses, or behaviours) (Skinner, 1996). Actions may be further divided into those that are cognitive and those that are behavioural. In contrast, an external locus of control refers to the perception that events are not contingent upon one's actions and that external factors are responsible for an outcome (Senior *et al.* 2005). External causes have also been subdivided into those beyond human control (e.g. due to chance or fate) and those under the control of 'powerful others' (institutions and the system) (Skinner, 1996).

Skinner (1996) states that a proposed singular, bipolar dimension of the beliefs of categories of causes of the internal versus external causes has not been supported by research. Rather, internal/external causes appear to form separate dimensions with the relationship between them changing with age (Skinner, 1990). Furthermore, Skinner (1996) highlights that the impact of different means on subsequent emotion and behaviour is mediated by causal dimensions underlying the categories of means (Weiner, 1985). The literature suggests that people can oscillate between internal-external loci of control. According to Reid (1984), having internal or external control is determined by people's ability to recognise what can and cannot be controlled and the need to acquire help from others.

#### *Agent-means relations*

According to Skinner (1996, p.553), perceived or objective agent-means relations refer to the extent to which a potential means is available to a particular agent (those who exert control – individuals or groups). However, the agent may or may not have access to the necessary tools to attain the outcomes of control. Self-efficacy refers to an individual's perceptions of his/her ability to succeed in a particular task (Bandura, 1977; Bandura, 1999) and is considered to be an agent-means relation.

However, agent-means does not only encompass beliefs regarding whether a particular response or action is in one's repertoire. Skinner (1996) rightly argues that it can be broadened to include beliefs about the extent to which one has access to: powerful others; luck; developing attributes. Coming from a Western, less collectivist cultural frame, most researchers have assumed the individual as agent and that beliefs in powerful others would be detrimental to perceived control. Research has not borne this out however. According to Skinner (1996), where external agents are perceived to: have legitimate authority, act on the individual's behalf, and are responsive to the individual, their power can be viewed as benevolent and be experienced as augmenting rather than detracting from perceived control and therefore influencing outcomes. Bandura equally refers to the 'collective efficacy' of groups, i.e. the concept of control can thus be applied to more collectivist cultures / sub-cultures in addition to more individualist cultures.

### *Agent-Ends relations*

According to Skinner (1996), agent-ends relations refer to the connections between people and outcomes of control. According to Skinner *et al.* (1988), control generally refers to the extent to which an agent can intentionally produce desired outcomes or avoid undesired outcomes. Personal control, perceived control and sense of control are considered agent-ends relations. Skinner (1996) notes that whilst very diverse ‘ends’ or outcomes of control have been studied, they have generally been categorised as desired versus undesired by researchers.

Agent-ends constructs tap into the extent to which an individual has control over outcomes. According to Au (2015) agent-ends constructs are commonly operationalised where individuals are asked about the extent to which they have control over a particular outcome. Furthermore, Skinner (1996) observes that the self can be an end, i.e. people have beliefs about how they might be able to control (regulate) their own behaviour, emotions and cognitive functions. As such, beliefs about control may encompass preventing undesired or achieving desired outcomes within the internal environment of one’s self, as well as within the environment as more typically defined as external to self.

The second set of constructs, ‘potential antecedents of perceived control’ (i.e. information control, decision control and process control) have potential effects on perceived control and whilst they are not descriptions of actual control conditions (given that they do not refer to means ends or agent means) they nonetheless refer to ‘actual’ or objective conditions, albeit only hypothesised to be antecedents that may influence experiences. According to Fiske & Taylor (1991, p. 201), “information control refers to a sense of control that is achieved when the self obtains or is provided with information about a noxious event” and decision control refers to “the ability to make a decision or decisions with respect to a forthcoming stressful event” (Fiske & Taylor 1991, p. 201). While process control refers to “the degree to which the procedure gives those affected by a decision the opportunity to express their views about how the decision should be made” (Tyler *et al.* 1985, p. 72). Whilst some theorists purport that information control, decision control and process control influence the experience and perception of control, Skinner (1996) states that their labelling as control is unfortunate as other theorist have found that they do not always effect

perceived control. Given this, Skinner (1996) cautions that their effect on perceived control needs to be empirically tested.

The third set of constructs, 'potential consequences of control' describes peoples' "reactions to opportunities and losses of control, that is, to descriptions of actions and reactions in the face of differing objective or subjective control conditions" (Skinner, 1996 p.556). According to Skinner, reactions to threat and loss of control have typically been studied under the rubric of coping. As such, in situations where people perceive a high degree of control, they exert efforts and actions in a bid to restore their threat or lost control in contrast to situations where individuals perceive a low degree of control and may react by giving up and possibly display passivity, depression and helplessness. In such instances, learned helplessness may ensue where individuals believe that the contingencies from an original situation to still be active, and one fails to attempt actions in subsequent situations that may reduce aversive experience.

Individual's appraisals about the possibilities for control in a specific stressful situation determine the coping reactions individuals will adopt. According to Bandura & Schunk (1981, p.80), appraisals "determine how much effort people will expend, and how long they will persist in the face of obstacles and aversive experiences". In instances where appraisal of control is high, the more searching for information the more action (the more active the effort). In instances where appraisal of control is low, the more passivity there is (the less active the effort). Appraisals of control can change as an event occurs, for example, as a result of new information or as a result of coping efforts (Senior *et al.* 2005). A time-honoured principle of effective coping is to know when to appraise a situation as uncontrollable and hence abandon efforts directed at altering that situation (Silver & Wortman, 1980a).

Coping reactions have been variously referred to in the literature as primary control, secondary control and the relinquishment of control (Miller, 1980). Skinner (1996) asserts that labelling these terms' as 'control' has been unfortunate in that they are in actuality potential actions and reactions to loss of objective or subjective control.

Primary control and secondary control are both active reactions to a threat to a loss of control. According to Skinner (1996), primary control refers to the persons' motivation to feel in control and attempts to change the environment to fit with his or her wishes.

Secondary control (Rothbaum *et al.* 1982; Heckhausen & Schultz, 1995; Heckhausen *et al.* 2010) “... is active and goal directed ... however, unlike primary control, it is aimed not at the environment, but at the self” (Skinner, 1996 p.556). By initiating secondary control in a bid to minimise loss of control, people change their values, priorities or behaviour in ways that delimits the loss of control or prevents undesirable outcomes. In contrast, relinquishment of control can be defined as perceived uncontrollability and abandonment of motivation for control (Rothbaum, Weisz & Snyder, 1982) but others have defined it as the voluntary yielding of control to another person, usually a more competent one (Burger, 1989). Choosing to exercise or relinquish control is influenced by perceived degrees of efficacy and the uncertainty of outcomes (Bandura, 1997; Skinner, 1996). Miller (1980) states that people can relinquish control to others they perceive to be more powerful or competent than themselves. In these instances, relinquishment of control to others is done as a means to control (Skinner, 1996). People adopt relinquishment of control based upon a perception that their innate ability to control is not as stable as external factors (Rotter, 1966; Bandura, 1997; Miller, 1980).

The fourth set of constructs, ‘motivation for control’ (desire for control), refers to research exploring why people form perceptions of control and why these perceptions seem to pervasively impact physical and psychological wellbeing (Skinner, 1996). Control theorists state that we try to exert control over things that are important to us. One explanation has been that the desire to interact effectively with our environment is innate – often referred to as the need for competence. The need for competence encapsulates instances where individuals seek opportunities for interacting with the environment in a bid to produce desired outcomes as well as instances where individuals experience distress as a result of a threat or loss of control and they attempt to regain control or avoid a situation. Such instances form people’s perception of control.

In summary, based on the literature reviewed, it appears that control encompasses social, psychological and environmental factors. Skinner’s (1996) guide to the constructs adds significant value to researchers and practitioners as it stresses, amongst other things, the importance of attending to both aspects of control when attempting to measure control or to engage in explanatory conceptualisation. Only then can research

identify the circumstances in which either aspect of control has the primary effect, and the circumstances in which they have unique, additive, or synergistic effects.

The next part of this section compares the ToPC to Skinner's (1996) guide to the constructs of control. The ToPC is a theory about the loss of control that participants experienced when subject to an involuntary admission and/or detention (Losing Control) and how participants acted and reacted to different objective or subjective control conditions (Regaining Control) as well as the strategies that people use to live with the consequences of an involuntary admission (Maintaining Control). The ToPC provides concrete examples of some of Skinner's theoretical work and how people are likely to respond to as Skinner states are "reactions to opportunities and losses of control, that is, to descriptions of actions and reactions in the face of differing objective or subjective control conditions" (Skinner, 1996 p.556). The ToPC describes a means whereby participants effectively produced a desirable outcome or avoided an undesirable outcome through the processes of 'Regaining' and 'Maintaining Control'.

Comparing the concepts in the ToPC to the constructs in Skinner's (1996) guide to the constructs of control, two out of the four sets of constructs were reflective and relevant to concepts within the ToPC. These constructs were 'objective and subjective control conditions' and 'consequences of control'

The ToPC illuminates further the sets of 'objective and subjective control conditions' that impact on loss of control before and during an involuntary admission. The loss of control that participants experienced when subject to involuntary admission ranged from being transient to being more extensive. The ToPC provides insights into the conditions that exacerbate the loss of control. The concepts: 'Diminishing Self-mastery', 'Feeling Violated' and 'Being Confined' identify the objective control conditions that contribute to loss of control. 'Diminishing Self-mastery' illuminates the difficulties that affected participants in terms of regulating their distress, which contributed to their losing control. This loss of control was further compounded when participants were 'Feeling Violated' and were 'Being Confined' and this made the loss of control more extensive. All of these concepts can be grouped together on the basis that they provide further insights into objective and subjective control conditions by illuminating the conditions that may result in a loss of control.

By the very nature of being subject to an involuntary admission participants choice and decision-making regarding the decision to enter hospital is removed by professionals. All participants experience a loss of control although for some participants the loss of control was much more extensive than for others. Some participants did not perceive they had the power to participate in any aspect of decision-making regarding any part of the process and as such objective control conditions were limited. However in the face of differing objective or subjective control conditions, for example allowing participants the opportunity to participate and/ or be involved in any aspect of the involuntary admission and/or treatment, involving participants in the decision-making process, peoples experience of control can vary and by altering objective and subjective control conditions the experience can be quite different. Therefore, it is likely that conditions matter and relationships matter when subject to an involuntary admission and/or detention. While the opportunities for participants to experience control were minimal when subject to an involuntary admission, there were different kinds of approaches to aspects of the process that influenced objective and subjective control conditions. For example, there were small aspects of the admission procedure that enabled some people to believe that they had some control. Providing choice and options like (getting food before hospitalisation) or deciding on the means or the way that they were transported to hospital, influenced the experience of control. The objective and subjective control conditions were dependent on the relationship with the assisted admission team that was involved in the removal of the participant to hospital. Therefore while objective control conditions were constant for all, the way processes were enacted influenced people's objective or subjective control conditions. For example, in the ToPC subjective control conditions refers to the perception that professionals motives were genuine, that participants had faith and trust in the expertise of professionals, that professionals were acting out of concern and on the individual's behalf. In addition subjective control conditions were influenced when participants received adequate and meaningful information and explanation of what was happening and why it was happening.

Skinner's objective control conditions provides some insights into why under the same circumstances people respond to and perceive the experience differently. Whilst involuntary admission is a largely uncontrollable event the way in which participants

experienced the context of the involuntary admission was different. For example negative encounters with professionals and the degree to which people experienced being restricted in hospital contributed to a much more extensive loss of control objective and subjective control conditions. As such the objective and subjective control conditions present in the context of involuntary admission determined the experience that participants had. Being subject to an involuntary admission can have a broad array of effects on perceived control. Losing control is complex and if the loss was extensive then the impact on perceived control was harmful and for many participants it had a profound impact on perceived control in the longer term.

Most particularly the concepts: 'Resisting the System', 'Encountering Humanising Care', 'Gaining Perspective' and 'Playing Ball' helps to identify participants' reactions in response to their experiences and interpretations of control. Some of the reactions to loss of control and accompanying experiences of control have been described and operationalized in Skinners' 'consequences of control'. Participants adapted to loss of control through, primary control, secondary control and relinquishment of control. While some theorists might describe this in terms of coping, Skinner (1996) helps us to understand that in the ToPC these reactions can be described as a control process given that the process of 'Regaining' and 'Maintaining Control' was a means whereby participants effectively produced a desirable outcome or avoided an undesirable outcome.

Within the ToPC participants had four reactions to 'Losing Control': 'Resisting the System' 'Encountering Humanising Care', 'Gaining Perspective', or 'Playing Ball'. Participants adopted one or more of these reactions, with some alternating between each of them, as they attempted to exert control, achieve desirable outcome or avoid an undesirable outcomes. For some participants the self was not always effective in producing desired outcomes and preventing undesired outcome. For some it was not so much about one's actions in achieving a desired outcome but more about avoiding an undesired outcome. As such the way in which professionals treated participants had a role in determining what reaction participants adopted.

One reaction that some participants adopted was through initially trying to exert control through 'Resisting the System'. This concept is comparable to the construct of primary

control in that participants attempted to change the system (environment) in order to meet their wishes. 'Resisting the System' involved actively attempting to regain control, for example all participants initially refused admission to hospital. Initially participants may have believed that they had control and could exert control but this was not the case as the objective control conditions was that they were admitted against their will.

Another reaction to loss of control that some participants had was 'Gaining Perspective'. This reaction is comparable to secondary control. In the ToPC some participants regained some subjective control through a cognitive means by gaining an understanding and awareness of what was happening and why, by information or an explanation that was provided, by the treatment (medication and therapeutic relationships), and by self-appraising or altering their experience of what was happening. As a result participants started to make sense of what was happening and in line with secondary control they altered their behaviours in order to adjust to an environment in an attempt to regain control. In addition, for some previous experience of being subject to an involuntary admission/ and or detention may have harmful cumulative effect on the consequences of control. The conceptualisations of perceived control that participants who had previously being subject to involuntary admission had already formed and for some were subtly reinforced. The encounters that participants had with professionals validated and reinforced their existing perceived control conceptions. As objective and subjective control conditions were reactivated when they were subject to an involuntary admission again. Objective and subjective control conditions influences the type of behaviour that participants adopt irrespective of the fact that the situation – that of involuntary admission was the same.

Another reaction that some participants adopted was 'Playing Ball'. 'Playing Ball' is a reaction comparable to secondary control as participants diverted attention away from the experience and actively altered behaviours in order to regain control. It is fair to say that a subset of participants were 'Playing Ball' on the initiation of the involuntary admission procedure and, as such, loss of control was minimised– thereby avoiding an undesirable outcome (i.e. being given injectable medication, a prolonged stay in hospital) and negating a pervasive loss of control. 'Playing Ball' involves a realisation that participants could not control certain aspects of their involuntary admission but

participants refocused their attention on certain aspects that were controllable in line with secondary control. This kind of regained control refers to the perception that a connection existed between the behaviour of the participant and the prevention of an undesired outcome.

In the 'regaining control' phase participants altered their primary control, secondary control and relinquishment of control either to achieve a more desirable outcome or to prevent an undesirable outcome. Perceived control plays a central role in determining the reaction that people adopt.

The reactions to loss of control in ToPC viewed through the theoretical constructs of primary control, secondary control and relinquishing control enable our understanding of the practical application of the Skinner theoretical constructs. In the ToPC the self was not always an effective agent in producing desired outcomes and avoiding undesired outcomes and as such professionals were instrumental in the 'Regaining Control' process. Although Skinner argued that primary control, secondary control and relinquishing control are incorrectly labelled as a control process, in the ToPC the reactions to a loss of control constitute a control process as they influence the consequences of control.

'Maintaining control' are strategies adopted to preserve control after participants were discharged from hospital, all of which are done in the context of 'Living with the Consequences of Involuntary Admission'. Within the 'Maintaining Control' phase participants adopted two strategies 'Managing Mental Health' and 'Preserving Sense of Self' to manage the longer-term consequences of their involuntary admission or having received a diagnosis. For example, strategies were adopted to maintain control of their mental health and to deal with societies perceptions of them following their involuntary admission. Some participants continued to live with a fear of being involuntarily admitted again and control now became about preventing further hospitalisations in addition to preserving a sense of self. Indeed Skinner (1996, p.554) states that – "... after experiencing a traumatic event, people are concerned not only amelioration and prevention, but also with damage, repair and restoration of functioning".

While the ToPC illuminates the factors that contributed to ‘Losing Control’, as well as the ways that participants strove in ‘Regaining Control’ and ‘Maintaining Control’ there are very important differences between the concepts within the ToPC and the sets of constructs within the domain of perceived control. The ToPC examines control within the very specific context of involuntary admission and identifies the components that contribute to regaining and maintaining control in the context of an involuntary admission. By doing so it provides insights into the ways this can be done. As such the ToPC is only relevant to people who experience involuntary admission. The ToPC provides insight into factors that can impact on control in one key area, that relates to the concepts within ‘Encountering Humanising Care’. The experience of humanising care can influence subjective control conditions. ‘Encountering Humanising Care’ was central to the way in which some participants regained control. Positive encounters with professionals contributed to a less extensive loss of control and indeed in some instances to an early regaining of control. For example while there may be minimal actual control, the loss of perceived control was minimised when participants experienced ‘Encountering Humanising Care’ especially at an early stage of being subject to an involuntary admission. As such the relationships that were formed between professionals and participants influenced the way in which participants regained and maintained control. In this instance, participants began to relinquish control to benevolent others and experienced a regained control as they came to put their confidence and trust in a professional they perceived as caring and competent and that could assist them in dealing with their experiences of distress. Although their being subject to an involuntary admission was a largely uncontrollable situation, participants’ involvement in some aspect of decision-making created subjective control conditions or negated a pervasive loss of control (objective control conditions). For example, when professionals generated a sense that they were acting on participants’ behalf or involved participants in aspects of decision-making for example, what medication they might take. Therefore, this helps us to understand the steps in regaining control. That is, participants who relinquished control to professionals experienced a regaining of control in that participants came to temporarily assign control to professionals’ which eventually contributed to influencing and effectively achieving their regaining control.

The ToPC illuminates the role of information, process control and developing relationships as an effective way of minimising the loss of control that people

experience when subject to an involuntary admission/ and or detention. It may well be that, rather than the relatively crude yardstick of voluntary versus involuntary status, one's perception of one's levels of control throughout the admission and hospitalisation episode(s) may be an underlying and greater predictor of experiences during and outcomes after discharge.

In summary perceived control is key as it provides an explanatory framework that enables to see why people reacted in different ways to the loss of control. The applicability of Skinner's (1996) constructs of control to the concepts that emerged from the analysis of people's experience of involuntary admission is apparent. For this particular group of people the context of control is important. All people's starting point is a loss of control and recovery is contingent on regaining and maintaining control therefore the conditions that allow this to happen are very important. Depending on 'objective and subjective control conditions' some participants perceived that they benefitted from their admission and treatment while others perceived control was harmed. Participants who perceived that they benefitted from admission did not experience the same degree of loss of control in the way that some other participants did. What appears to be important is that professionals can alter a person's objective and subjective control conditions by involving them in decision-making and by providing humanising care. The ToPC extends understanding of what is important in identifying the elements that contribute to regaining and maintaining control. If participants felt that they had control over some aspects of the decision-making around the condition of the involuntary admission or their treatment they regained control in a more positive manner. In some instances the way participants regained and maintained control was not ideal to the participant in terms of effectively managing their mental health and it became more about preventing undesirable outcomes rather than achieving better or optimal mental health. What was important was not contingency, but subjective control. The ToPC shows that way in which perceived control is impacted upon influences how people regain and maintain control. In addition, loss of perceived control can have a negative outcome on mental health and well-being on discharge and this may have a long-term effect on perceived control. People subject to an involuntary admission might be seen as vulnerable people within the mental health service users and therefore there is a need to delimit the long-term consequences on perceived control that some participants experienced.

### **8.3. The Theory of Preserving Control: Comparison to Leventhal' *et al.*'s. (1984) Self-Regulation Model**

This section compares the ToPC to the Self-Regulation Model (Leventhal *et al.* 1984). The SRM is a theoretical model for understanding illness perception. The premise from which the SRM operates is based on the belief that people form, what Leventhal *et al.* (1984) calls 'illness representations'. These are interpretations that influence the way (s) that people cope with changing states of health and their selection of coping behaviours and strategies.

Leventhal *et al.* (1984) identified five dimensions to 'illness representations'. These are:

- (1) *identity* – focusing on beliefs about labelling conditions or symptoms and whether people believe these experiences are part of a illness (either by a doctor offering a diagnosis or a self-diagnosis);
- (2) *causes*– referring to beliefs about factors that cause the experiences (stress or worry, life circumstances, biological cause, or hereditary);
- (3) *timeline* – referring to beliefs about how long the condition will last, acute, chronic recurrence, or cyclical;
- (4) *control* – referring to beliefs about one's own behaviour in influencing the control or cure of a condition and what control can be gained by treatment;
- (5) *consequences* – referring to beliefs about outcomes of the condition (minor or major/negative).

People's beliefs about their health are borne out of what Diefenbach & Leventhal (1996) suggest are current experience with illness, cultural knowledge of illness, formal education (from perceived significant others or authority figures such as doctors) or lay information (stories from family and friends). In addition, Leventhal *et al.* (1984) states that previous illness experiences are formative in people beliefs about changing patterns in their health. Bishop (1991) states that 'illness representations' is a process by which people integrate internal and external stimuli with existing cognitive structures to give meaning to their experiences. Inherent to the SRM are people's 'cognitive and emotional representation' of their changing state of health. In the SRM processing occurs, which involves processing of the cognitive and emotional representations.

Depending on the cognitive representation made, coping will be implemented and appraised. It is vital for clinicians to appreciate the multiple levels at which these representations operate and how they guide patients' preference for treatment and the behaviours in which they engage with over time (Hale *et al.* 2007, p.904).

A systematic review of the literature explored illness perceptions in mental health and found support for the utility of SRM to mental health difficulties (Baines & Wittkowski, 2013). According to Baines & Wittkowski (2013, p.263) "information about the illness or changes in symptoms have been hypothesised to cause a re-evaluation of the illness perceptions and a subsequent shift in coping patterns, help-seeking or emotional response". Illness representations are cumulative, with information being adopted, discarded or adapted as necessary (Hale *et al.* 2007, p. 904).

The ToPC provides a practical application of the SRM to those whose changing state of mental health culminated in participants being subject to involuntary admission. The SRM provides theoretical insights that assist in our understanding and exploring the interplay between the dimensions that underpin participants' beliefs about their changing state of health and how this influences coping strategies that participants adopt. While the SRM provides understanding of the beliefs about physical illnesses in general the ToPC pertains to how people perceive mental health difficulties in particular in the specific context of being subject *to* and living *with* the consequences of involuntary admission. However, the SRM offers some theoretical insights that assist in our understanding that the ways in which participants in the current study perceived their changing state of health can be at odds with how family members and professionals and helps to explain why some participants may have resisted the system.

Comparing the concepts within the ToPC to the dimensions within Leventhal *et al.* (1984) SRM, the concepts 'Diminishing Self-mastery', 'Resisting the System' 'Gaining Perspective' and 'Managing Mental Health' have similarities to three of the five dimensions within the SRM namely, *identity*, *causes* and *control*.

'Diminishing Self-Mastery' will be compared to the dimension *identity*. 'Diminishing Self-mastery' describes the way(s) in which participants understood the nature of their changing state of health or their mental health difficulties before being subject to

involuntary admission. It describes participants' subjective account of what they believed was wrong with them at the time and how they labelled and interpreted of what was wrong. Participants described multiple beliefs about what was wrong with them at the time. Some believed that their problems were attributable to deteriorating mental health, others did not believe that there was anything wrong with their mental health, while others were unaware or unable to identify what was happening to them. The latter group spoke of retrospectively only being able to identify what was wrong. 'Diminishing Self-mastery' illuminates further the beliefs that impacted on 'identity' in the context of people with mental health difficulties being subject to involuntary admission. Dealing with 'Diminishing Self-mastery' may have specific challenges for the participants themselves in terms of identifying what is happening emotionally for them. The ToPC provides some insights into why under the same circumstances participants perceive their changing health status and experiences differently. The concept 'Diminishing Self-mastery' helps illuminate the factors that impact on the *identity* dimension for the unique perspective of those with a mental health problem who were subject to involuntary admission.

'Gaining Perspective' will be compared to the dimension *identity*. In the ToPC participants' describe external and internal strategies that assisted in their beliefs about the identity of what was wrong with them either as early as during the involuntary admission procedure or later during hospitalisation. This occurred through 'Receiving Information and an Explanation' and or 'Getting Treatment'. Central to this was medication - which helped participants think more clearly and enable them were able to regulate their emotions and feelings again. For some participants their thinking processes were reframed with the assistance of a professional. As a result therapeutic relationships enabled participants to think about things differently which resulted in a change in the identity of the condition. As such participants came to form or reappraise beliefs about the *identity* of their changing state of health through, the receiving of information and explanation provided by professionals and/ or getting treatment. This facilitated and enabled participants in developing or reappraising beliefs about the *identity* of their condition. In this way some participants believed the labelling of condition or that their experiences were symptoms and part of an illness. For some receiving a diagnosis from the psychiatrist was useful in forming their beliefs about the identity of their condition. The ToPC highlights that the way in which participants

received information, timing of which participants receiving information and who presented this information was important in terms of participants readiness or willingness to process this information and explanation. Some participants may not believe that they had a mental illness despite receiving a clinical diagnosis. The ToPC highlights that some participants rejected the label of having a mental illness during their hospitalisation and this continued on their discharge. In addition 'Gaining Perspective' highlights strategies that enable a person to form and reappraisal beliefs about the identity of their condition. These strategies provide a condition to assist in the reappraisal of beliefs about the identity of the condition.

'Making Sense' will be compared with the dimension *cause*. 'Making Sense' enabled participants to cognitively reappraise why this had happened to them – the *cause*. Participants held various beliefs about the reasons behind their condition. For some participants these beliefs changed with time but for others their beliefs stayed static. In the ToPC some participants attributed the cause of their condition was a psychological reaction as culminating from stress, physical illness, bereavement or thinking about things too much. Other participants retrospectively appraised the *cause* of their condition as attributable to a relapse of a mental health condition or as a result to 'not taking medication'. However in the ToPC some participants never felt that their experiences' originated from a 'mental illness' and felt that factors external to self, such as 'actions of professionals and family', caused their admission. The ToPC provides insight to perceptions of the causes of mental health conditions and highlights the extent to which participants felt that their condition was attributable to factors external to the self - including psychological stressors.

'Wanting a More Psychological Approach' will be compared with the dimension *control*. In the ToPC participants held varying beliefs about what they perceived would be effective in helping them manage and cope with their condition. Some perceived that they would be able to control and regulate their changing state of health on their own. Some participants spoke of 'Wanting a More Psychological Approach' in this instance they felt that a more psychological based approach would be more effectively in managing their condition rather than an approach that focused on hospitalisation and medication. They believed that a more psychological approach would have been more effective than a sole biomedical approach in coping and controlling their condition.

While some believed that control might take a biomedical course others believed that they were not adequately treated with biomedical treatment. These beliefs are important as they provide a theoretical understanding as to why people believe that biomedical treatment and hospitalisation may not be effective. The ToPC provides useful insights for professionals to determine why people perceive *control* over their changing state of health in different ways and why people did not want or did not perceive the need to seek biomedical treatment/ hospitalisation.

‘Managing Mental Health’ will be also be compared to the dimension *control*. On discharge participants adopted strategies to assist in their control and coping with and managing their mental health. In the ToPC participants stayed connected with MHS as they perceived this as an effective way of controlling their mental health condition. Some participants came to believe that biomedical treatment would be effective in their recovery. Others believed that control of the condition was manageable within a biomedical treatment approach in conjunction with complimentary strategies. Other participants became educated about the nature of their mental distress and came to control stressors, which involved reducing stress, seeking support of others, exercising and avoiding alcohol and drugs.

Within the ToPC, many participants did not possess an illness *identity* and as such this is where the two models differ. It is conceivable that admitting having a condition may offset the idea that they need to be hospitalised, which for many participants was something that they feared. The SRM does not take into account that the *identity* of having a psychiatric diagnosis and being in a psychiatric hospitalisation is stigmatising and this may impact on participant’s willingness to accept treatment or go to hospital. Participants struggled emotionally to process what had happened to them as well as thoughts about the possible consequences of potentially having a psychiatric diagnosis. In addition, the ToPC does not provides any insight into the reason why others who took medication despite not believing in the need for it to *control* their condition.

The ToPC illuminates factors that contribute to the dimensions of illness representations in the context of people who were subject to involuntary admission and/or detention. For example peoples’ beliefs about their changing state of health before involuntary admission. People’ ‘cognitive representation’ of what they believed

was wrong with them may well be at odds with that of family members and professionals believe. By comparing SRM and the ToPC we understand how important it is to explore peoples 'cognitive representations' of what they believe is wrong, what caused it and how they can control it. Some participants in ToPC perceived that the only way professionals believed that was effective in control condition was through biomedical treatment while participants believe that there was a more psychological based approach that they considered effective. As such, what participants wanted was a more meaningful and person centred approach to control their mental health difficulties. The ToPC provide details of what people believe may help manage mental health such as a more psychological approach to control their condition. What is clear is that participants perceive that there needs to a substantial shift in culture within the health care system, focusing more on recovery and being more cognisant of psychological approaches to treatment that the person finds beneficial and meaningful. What may additionally be required is a cultural shift in how care is delivered – enshrining a move away from professional dominance and overreliance on inpatient care to more community care services and supports.

In summary, the SRM contributes to our understanding of how people conceptualise, and cope their changing health states. How people experience, interpret and respond to their changing state of health is important to understand so that professionals can respond in a more supportive and meaningful way. Many of the participants did not label their changing state of health a mental illness, and it is time to acknowledge and account for the disparity that exists between a professional's understanding and peoples experience of mental distress in order to capture the latter's wish to feel understood. The SRM model thus enables an understanding of the factors that influence perceptions of illness, which are important for health professionals to attempt to understand if they are to be responsive to participants' needs. In addition, it can offer some explanation as to why some participants felt that they needed a more psychological approach to control their condition while others believed that biomedical treatment was effective in controlling their condition. The SRM can be useful for professionals in attempting to provide acceptable treatments.

## **8.4 The Theory of Preserving Control: Comparison to Keogh *et al.*'s (2015)**

### **'Managing Preconceived Expectations'**

This section compares the ToPC to 'Managing Preconceived Expectations' (Keogh *et al.* 2015). 'Managing Preconceived Expectations' is a classic grounded theory study of mostly voluntarily admitted people's experience of going home from psychiatric hospital. It describes the strategies that people use to deal with the negative perceptions (stigma) that people have about themselves in addition to those that others (family and society) hold, which developed as participants were now ascribed an identity of 'psychiatric patient'. These negative perceptions were not only ascribed by society, but also by the individuals themselves due to their altered identity.

The core category 'Managing Preconceived Expectations' helps in our understanding of the negative perceptions that people experience on going home from hospital. In addition, it assists in our understanding of the strategies that people use to deal with these negative perceptions. The core category 'Managing Preconceived Expectations' had seven related categories, namely: 'Absorbing Preconceived Expectations', 'Acquiring Preconceived Expectations', 'Validating Preconceived Expectations', 'Maintaining Preconceived Expectations', 'Avoiding Preconceived Expectations', 'Reassessing Preconceived Expectations' and 'Defying Preconceived Expectations'.

'Absorbing Preconceived Expectations' refers to the negative perceptions (something to be ashamed of) that people hold of mental distress and psychiatric hospitals before any experience with the MHS (Keogh *et al.* 2015). 'Acquiring Preconceived Expectations' refers to the new perceptions that formed on foot of experiences with the MHS (i.e. 'illness' is something that is 'lifelong' and 'life limiting') (Keogh *et al.*, 2015). 'Validating Preconceived Expectations' refers to how the conceptualisations that people had had about mental illness were reinforced on their discharge from hospital. This reinforcement happened through the encounters they had with members of society, family and professionals, for example, the perceptions that mental distress was 'lifelong', 'life limiting' and something to be 'ashamed' of (Keogh *et al.* 2015). 'Maintaining Preconceived Expectations' refers to mental distress-based stigma that maintained people's perception and identity of themselves as a 'psychiatric patient' and how participants 'internalised' this experience (Keogh *et al.* 2015); this identity was also 'maintained' when society shunned them. 'Avoiding Preconceived Expectations'

refers to the ways people socially disengaged from others or used ‘cautious disclosure’ processes (including selective disclosure) to minimize the stereotypes associated with being a ‘psychiatric patient’ (Keogh *et al.* 2015). ‘Reassessing Preconceived Expectations’ refers to the ways that people reconceptualised their experiences through a range of psychological and social occurrences (‘internal and external recovery catalysts’) in order to achieve better mental health (Keogh *et al.* 2015). ‘Defying Preconceived Expectations’ describes the process whereby people re-evaluated their identity as a ‘psychiatric patient’ and challenged the negative perceptions that others had about them (Keogh *et al.* 2015).

In comparing the subcategories within ToPC to the categories within ‘Managing Preconceived Expectations’, there were similarities and some differences between the subcategories ‘Resisting the System’, ‘Preserving Sense of Self’ and ‘Managing Mental Health’, and four categories within ‘Managing Preconceived Expectations’. These categories were: ‘Defying Preconceived Expectations’, ‘Avoiding Preconceived Expectations’, ‘Reassessing Preconceived Expectations’ and ‘Maintaining Preconceived Expectations’.

‘Resisting the System’ will be compared to ‘Defying Preconceived Expectations’. In ‘Defying Preconceived Expectations’, participants developed strategies to manage and contest others’ view of their ‘illness’ as lifelong. Similarly in the ToPC, because of the implications and connotations associated with having a mental illness, people refuted the label given to them. In this way, parallels can be drawn between ‘Resisting the System’ and ‘Defying Preconceived Expectation’. While the participants in ‘Managing Preconceived Expectations’ defied others’ view of their ‘illness’ as lifelong, the participants in ToPC contested the assumption of family and professionals that they needed to be re-hospitalised. In the ToPC, participants contested others’ view of their ‘mental illness’ at a much earlier stage in the process. In ‘Managing Preconceived Expectations’, by virtue of the fact that people had voluntarily come to hospital, the ‘Defying Preconceived Expectation’ happened at a later stage.

Aspects of ‘Preserving Sense of Self’ such as ‘Trying to Prove Yourself’ are also comparable to ‘Defying Preconceived Expectations’. Similar to the participants in ‘Managing Preconceived Expectations’, the participants in the ToPC wanted family and

professionals to perceive them as valid human beings on discharge and, as a result, adopted the strategy of 'Trying to Prove Yourself'. Not unlike 'Managing Preconceived Expectations', this typically involved obtaining employment in order to bolster other people's perception of them as viable autonomous human beings. Like the participants in the ToPC, not all people progressed to the stage ('Defying Preconceived Expectations') or adopted these strategies. The ToPC illuminates the fact that given people's admission was involuntary, its associated connotations may be another significant challenge in people reaching the 'Defying Preconceived Expectations' stage in the process. However, unlike the participants in 'Managing Preconceived Expectations', the participants in the ToPC were not only trying to prove their validity as human beings to society, they were also trying to prove this to themselves.

Aspects of 'Preserving Sense of Self' such as 'Avoiding People', 'Providing a Rational Explanation' and 'Selective Disclosure' can also be compared to 'Avoiding Preconceived Expectations'. In 'Avoiding Preconceived Expectations', people perceived that others might have a negative view of them as a 'psychiatric patient' if they revealed this part of their lives. As a result, they avoided contact with others or were cautious as regards to what information they divulged to others. In both theories, participants described how they tried to limit negative attitudes people may have of them, which included avoiding people or selecting what to disclose to whom. Furthermore, in both theories, some participants described the need to socially disconnect in order to preserve their sense of self, and while the labels used were different, the strategies were comparable. Similar to 'Avoiding Preconceived Expectations' in 'Avoiding People', participants socially disconnected and avoided contact with others after being discharged. This was done in order to limit negative perceptions members of society may have about them as someone with a 'mental illness'. In addition, participants in ToPC used a strategy ('Providing a Rational Explanation') to explain their 'absence' from society as a result of being in hospital. In 'Providing a Rational Explanation', participants provided a reason for their admission that was deemed more socially acceptable, and like the many strategies used in 'Avoiding Preconceived Expectations', this was done in order to minimise people's perception of them as a 'psychiatric patient' or a severe 'psychiatric patient'. Most specifically, identical to the participants in 'Managing Preconceived Expectations', people in the ToPC used 'Selective Disclosure' which involved disclosing to certain

people that they had a 'mental illness'. 'Selective Disclosure' was imported as an in vitro code from 'Managing Preconceived Expectation' to describe this phenomenon. In the ToPC, however, 'Selective Disclosure' conceptualised those participants who only divulged to certain people that they had being 'signed into' hospital.

'Managing Mental Health' can be compared to aspects of 'Reassessing Preconceived Expectations' such as 'Internal and External Recovery Catalysts'. 'Internal recovery catalysts' were used to assist in people's reassessing of what they should and should not do to aid recovery. 'Internal recovery catalysts' consisted of supportive relationships (from family, service users, professionals) and the use of physical and mental activity and 'routine' tasks that assisted in their recovery. In addition, 'external recovery catalysts' consisted of support and encouragement provided by family and friends that instilled a sense of hope that recovery was possible. Similarly, in the subcategory 'Managing Mental Health' in the ToPC, participants used and availed of comparable strategies in order to achieve better mental health. Similar to the people in 'ToPC', they mobilised the support of family and friends. However, 'Reassessing Preconceived Expectation' was about reappraising and reconceptualising people's experience to aid in their personal development. It was done when people became less concerned with society's perception of them and redirected their attention to achieving positive mental health. In the ToPC, some participants later felt that that they had unresolved issues and/or that they had compounded mental health difficulties after discharge and, as a result, sought the help of psychologists sometimes independent of the MHS.

While aspects of 'Managing Preconceived Expectations' are comparable to aspects of ToPC, there are also some differences. In the subcategory 'Maintaining Preconceived Expectations', people internalised negative perceptions of 'mental illness'. In contrast, some participants in the ToPC did not internalise or did not allow the internalising of these negative perceptions and instead actively refuted any association with a mental illness ('Resisting the System' and 'Preserving a Sense of Self'). Consequently, for some people in the ToPC it was more about the strategies that participants used to adapt to the negative experience of being treated against their will rather than strategies used to manage self-stigma. However, other people, while initially 'Resisting the System', in reverse order to the participants in 'Managing Preconceived Expectations', later

came to reappraise that what they were experiencing was actually a mental health condition ('Maintaining Preconceived Expectation'). Consequently, it was after 'Resisting the System' that they began to internalise a sense of self as someone with a 'mental illness'. Therefore, participants in the ToPC had the added challenges of adapting to this, which further impacted on their transitioning from hospital to the community.

Participants in both studies were admitted to psychiatric hospital, however, in the ToPC the focus was exclusively on those involuntary admitted. Many participants felt that they were judged negatively on the basis that their admission was involuntary as well as the public manner in which some were removed to hospital. Their removal was sometimes very public and therefore re-entering the community was often difficult and embarrassing. As well as dealing with this societal stigma, they also had to adapt to the traumatic nature associated with being treated against their will and many had to process the actual involuntary admission experience. Although some participants in the ToPC did experience stigma, it was more about 'Living with the Consequences of Involuntary Admission' such as being brought into hospital against their will and with adapting to that experience rather than stigma per se. Additionally, in the ToPC aspects of 'Preserving Sense of Self' also refers to strategies that participants used on discharge to prevent family members thinking that they needed to be hospitalised again. Some participants in the ToPC described that they lived a life under the surveillance of family, friends and professionals as they now closely monitored their behaviours in case it suggested that they were becoming unwell again. The ToPC highlights the added pressure that participants had in contesting other people's perception of them as a result of their admission being involuntary or that they were somebody who were always on the cusp of needing readmission. As a result, many participants continued to live with a fear of being involuntarily admitted again and consequently adopted strategies to avoid this prospect. Therefore, the ToPC differs in that it provides insights into the strategies employed by participants to prevent family and professionals from viewing them as mentally unwell or needing re-hospitalisation.

In addition, 'Managing Preconceived Expectations' further illuminates (exclusive of selective disclosure) the many processes that people used to avoid and cautiously disclose to others in order to manage negative perceptions.

In summary, the similarities in 'Managing Preconceived Expectations' and the ToPC relate to the stigma that people experienced on coming home from hospital. In addition, there were similarities in the strategies employed by participants to minimise stigma and deal with people's perceptions of them after admission. Similar to the ToPC, the period after discharge was a vulnerable time for the participants in 'Managing Preconceived Expectations'. However, differences pertain to the fact that participants in the ToPC attempted to manage negative perceptions in the context of dealing with the consequences of their involuntary admission and, in this way, their being subject to an involuntary admission which may further compound the stigma associated with being in a psychiatric hospital. Although the fear of being stigmatised is similar in both theories, the fear of being readmitted to hospital against their will may override the fear of being stigmatised and thus strategies can become more about preventing further hospitalisation rather than solely quelling people's perception of them as a 'psychiatric patient'. The negative impact that involuntary admission and/or detention potentially needs to be acknowledged. Professionals need to be sensitive to people before, and after, the hospital experience and the impact of involuntary admission and/or detention has on one's sense of self. Professionals may need to offer the assistance of working through any trauma and distress that these people may have. Therefore, people have issues as regards stigmatisation, fear of being readmitted involuntarily, trauma associated with being involuntarily admitted, and the possibility of being left to deal with the consequences of internalising a self of themselves as someone with a mental illness.

### **8.5 The Theory of Preserving Control: Comparison to Tyler's (1992) Concept of Procedural Justice.**

This section outlines the concepts of procedural justice before then comparing its principles to the concepts within the ToPC.

Tyler (1992) proposed a theory which drew on his work within organisational justice (involving people in court proceedings) which showed that the presence of perceived fairness for the person via a third party in due process hearings is associated with greater satisfaction with the outcome. Adopting findings from the procedural justice literature to their influence during commitment hearings (Tribunals), Tyler suggested that the

perception of procedural justice (perceived fairness) could have relevance to the area of commitment hearings (Tribunals). The procedural justice literature proposes that if people feel that the procedure for resolving a dispute is fair and legitimate and that they have been listened to, they find it easier to justify and accept coercion (Tyler, 1992). This can be irrespective of a favourable outcome (Lind & Tyler, 1988). Elements include having the right to legal representation, a tribunal and the appointment of a solicitor.

Tyler (1992) postulates three principles that may lead to greater therapeutic outcomes and enhance the perception of procedural justice. The first principle in Tyler's model, 'Participation', involves being given accurate information and being communicated with effectively. In addition, it outlines how having a 'voice' (opportunities for expression) and control over the presentation of evidence and arguments (process control (Thibaut & Walker, 1975) regardless of foregoing the ability to influence the final decision (decision control Thibaut & Walker, 1975) leads to procedural justice perception. Tyler proposes that being able to express and articulate views and perspectives, sometimes in conjunction with the ability to influence decisions, enhances procedural justice perception. Voice also incorporates the experience that what is said is being taken seriously (validation). Indeed, Monahan *et al.*'s (1996) seminal article explored the relevance of the area of social cognition and procedural justice in understanding coercion and detention and highlights that the 'process control' is more important than 'decision control' in dispute resolution.

'Dignity' is the second principle in Tyler's model. Dignity is preserved through being shown respect and politeness, in addition to an acknowledgment and adherence of people's human rights as citizens and legal rights under mental health legislation. These all contribute to a perception of procedural justice. 'Trust' is the third principle in Tyler's model. According to Tyler, people find it easier to accept a decision if they feel that the motives from health and legal professionals originate from a genuine concern and there is a perception of professional benevolence. As such, in instances where people felt that they could participate, felt treated with dignity, and felt that they could trust professionals, then they are likely to have a reduced perception of coercion and a perception of procedural justice.

Comparing the concepts in the ToPC to the principles of procedural justice, aspects of ‘Encountering Humanising Care’ and ‘Gaining Perspective’ were reflective of and relevant to all three principles in the concept procedural justice.

Aspects of ‘Encountering Humanising Care’ such as ‘Letting Me Decide’ will be compared to the principle of ‘Participation’. Even though participants were still subject to involuntary admission and/or were detained, some participants felt involved in the decision-making surrounding certain smaller aspects of the admission procedure and treatment. A few participants said they were given some choice as to which type of medication they received; in this way participants perceived that their pleas were listened to.

The ToPC illuminates that, despite being detained, permission to decide on smaller aspects of procedures surrounding admission and treatment engendered a perception of participation and made it easier to adapt to detention. The ToPC highlights that even being involved in smaller aspects of involuntary admission and treatment was sufficient to fulfil the criteria of participation, which echoes the principle of ‘Participation’. In those instances where participants were given the option to accept or decline certain supports, a sense of being listened to and having a voice with weight was engendered, which further echoes the principle of ‘Participation’.

Aspects of ‘Gaining Perspective’ such as receiving information will also be compared to the principle of ‘Participation’. A few participants felt that professionals provided them with information of what was happening to them during the admission process, which may have enhanced the perception of procedural justice. Through receiving information, some participants came to accept their admission as it was seen as being helpful in gaining perspective at an informational level. Participants appreciated when professionals (Gardaí or the AAT) were open, direct and truthful at the outset of the procedure regarding where they were going. When participants perceived that they were getting adequate information, it made it easier to accept what was happening. On admission, some participants spoke of receiving information on their rights as a detained person under the MHA and their right to appeal in the form of a mental health tribunal. The ToPC highlights the importance of interpersonal communication at an early stage in the involuntary admission procedures. However, some participants spoke

of receiving an explanation as being more important than receiving information.

Aspects of 'Encountering Humanising Care' such as 'Meeting Kind and Nice Professionals' will be compared to the principle of 'Dignity'. 'Meeting Kind and Nice Professionals' conceptualised participants' experience of being treated with respect. Some participants recalled certain nurses showing flexibility when applying rules. Similar to the principle of 'Dignity', the personal qualities of professionals' warmth, gentleness and kindness were highlighted. Participants described being treated like human beings and being shown dignity and respect when professionals acted humanely and conveyed warmth and compassion. It mattered to some participants that professionals made time to listen and attempted to understand the circumstances surrounding their involuntary admission from the participants' perspective.

Aspects of 'Encountering Humanising Care' such as 'Feeling Contained by the System' will be compared to principle of 'Trust'. Participants in the ToPC find their involuntary admission easier to accept if they feel that other people's (professionals, family, peers) motives originate from a genuine interest and concern about their well-being and welfare. In the ToPC, some participants came to trust professionals' motivations and perceived them as having expertise through their encounters with them. Participants described situations where professionals related with them interpersonally, enabling them to have more faith and trust in their humanity and motivations. Some participants felt that they were being protected, looked after and helped. Being able to talk to someone about their feelings, if participants wished to do so, was beneficial in terms of connecting with professionals. For some, being in hospital offered a space that allowed them to experience a sense of safety and care that some now perceived as necessary. Some encounters with professionals engendered a sense that they were dealing with competent professionals who had the necessary skills to help them. Similar to the concept of procedural justice, in many instances there was a perception of professional benevolence.

The concept of procedural justice is relevant to the ToPC given that the context (that of experiencing tribunals, coercion and involuntary admission) is the same. The ToPC further highlights the factors that contribute to the principles of participation, dignity and trust. However, the ToPC illuminates one key aspect of a concept that might

influence procedural justice effects – that is ‘Gaining Perspective’. While aspects of ‘Gaining Perspective’ are comparable to participation, other aspects such as receiving and explanation and ‘Making Sense’ are not. ‘Gaining Perspective’ involves external and internal supports that assisted people in returning their cognitive capacity to a level that enabled them to understand what was happened to them and why. This relates to the way that professionals can assist the person in understanding and conceptualising their experience of mental distress. This kind of supportive interaction with professionals enabled participants to gain an understanding of their distress and led to beneficial relationships with professionals. The ToPC sheds light on the fact that receiving information is not that sole way to enhance the procedural justice principle of participation and that supporting the person in making sense and providing an explanation is equally important. Participants developed awareness by receiving verbal explanations from professionals in a way that helped rationalise what was happening and why it was happening. Some participants who were troubled by their thoughts described how ‘*working through*’ them with their doctor was therapeutically beneficial and helped them reconceptualise their thinking patterns. This is critically important aspect for people who are experiencing mental distress. Additionally, receiving a diagnosis during their hospitalisation helped some participants accept how and why they were feeling what they were feeling. In this way, participants began to think more clearly and rationally regarding what was happening to them on an emotional and cognitive level. Receiving treatment, getting a diagnosis or making sense were all seen as influential in enabling participants gain perspective. Participants spoke of the medication altering their thought processes and enabling them to perceive situations differently, which allowed them to garner an understanding of what was happening at an emotional level for them. They felt supported and understood through receiving treatment or having beneficial dialogue with professionals.

However, some authors critique Tyler’s model. Sydeman *et al.* (1997) drawing attention to its failure to address the significance of ‘information control’ (potential antecedents of control), which is the perception of perceived control that may result when the self obtains or is provided with information about a noxious event (Fiske & Taylor, 1991). According to Monahan *et al.* (1996), having information about the specific procedure one will encounter during a stressful event has been found to counter difficulties in adjusting. According to Fiske & Taylor (1984, p.122), informational

control can be achieved in instances where an individual “understands a stressful event” and that in such instances individuals need not be involved in all aspects of the event. Fiske & Taylor (1984) go on to state that informational control “implies an individual need not be actively involved in an event to adjust to it, but that, at least in some cases, understanding is sufficient”. Interestingly, what is important is not the information about the stressful event, but the person’s understanding of that stressful event. Similar to what Fiske and Taylor (1984) show, the findings of this study highlight that the timing of supplying information is important. For example, a few participants highlighted the importance of receiving letters about their tribunal from the MHC at a time when they possessed the faculties to process and the information.

Building on Tyler’s model, Sydeman *et al.* (1997) proposed two procedural justice enhancements that they suggest will increase therapeutic outcomes and call for the integration of ‘information control’ and more aspects of consumerism into Tyler’s existing framework. Sydeman *et al.* (1997) drew on the work of Tyler & Lind (2001) suggesting that the civil commitment hearing (tribunal) itself can provide information for the person regarding how clinicians conceptualise the nature of their problems and the recommendations they have for treatment. In addition, the tribunal is also a platform through which they can obtain information about the legal options available to them. Obtaining this information was thought to have an effect on perceived fairness and contribute to the person’s appraisal of the level of benevolence on the part of the clinician and legal professional. The second enhancement that Sydeman *et al.* (1997) highlight is incorporating more aspects of the consumerism (Service User Experience) literature, such as being able to verbalise views, and being treated with dignity and respect. This echoes the voice effect in procedural justice, but Sydeman *et al.* (1997) suggest that this should be implemented at the outset of the involuntary admission procedure as it is an important backdrop to how people come to perceive the fairness of tribunals. Sydeman *et al.* (1997) suggest that these two procedural justice enhancements heighten the perception of procedural justice. In addition, they highlight the importance of the treating psychiatrist in instilling a perception of procedural justice and not just the solicitor involved in the tribunal.

Another important point identified in Sydeman *et al.*’s (1997) critique is what they allude to as ‘respondent cynicism’. According to Sydeman *et al.* (1997, p. 216),

“cynicism occurs when authorities violate individuals’ expectations about events or experience in which their rights are at stake”. Therefore, Sydemann *et al.* (1997, p. 217) suggest that some people might be immune or impervious to the perception of procedural justice stating that “patients who have experienced multiple involuntary admissions and perceive themselves to have been mistreated by mental health professionals may as a result hold hostile and suspicious views about the mental health system”. In addition, people may hold negative attitudes about tribunals based on previous unfavourable outcomes or due to the nature of their mental distress (acuity of illness). Furthermore, Sydemann *et al.* (1997) contend that people with psychosis may not be able to attend or process the information in a tribunal and therefore may not be amenable to procedural justice effects.

Researchers such as Lindz *et al.* (1995), Hiday *et al.* (1997) and Casardi *et al.* (2000) have explored the perception of procedural justice during psychiatric admission. Importantly, Casardi *et al.* (2000) found that people were able to detect procedural justice behaviour from professionals irrespective of presence of psychosis – contrary to Sydemann *et al.*’s suggestion that people with psychosis may not be amenable to procedural justice effects as discussed previously. This is a very important finding – that people with psychosis are not impervious to procedural justice effects despite some professionals perceiving so. However, they also found ‘downstream effect’ of procedural justice manipulations, such that in instances where people do not perceive procedural justice on initial tribunals, the likelihood of experiencing a perception of procedural justice on subsequent tribunals is diminished (and vice versa); therefore, such individuals are not amenable to procedural justice effects. It is equally important to note that previous experience of involuntary admissions may make people impervious to procedural justice effects. Similarly in the ToPC, if participants’ appraisal was that their hospitalisation and treatment was unfair, these participants did not believe that they were mentally unwell at any point. As such, participants attributed blame to the professionals or family members for initiation of hospitalisation and this finding may also suggest that not all people are amenable to procedural justice effects.

Professionals should make every effort to actively optimise procedural justice principles. We know that what people think about their involuntary admission in the first week plays a significant role in an overall positive experience. Therefore, the

implementation of procedural justice principles at the outset of the initiation of the involuntary admission procedure is paramount and as such, professionals should systematically adopt the principle of procedural justice at an earlier stage.

The ToPC further highlights the factors that may contribute to procedural justice effect. In addition, the TOPC highlights the importance of professionals' involvement in assisting people to make sense of their experiences. The ToPC provides practical insights into why so many people may not perceive procedural justice effect. The findings from the ToPC add further evidence to Tyler's suggestion that process control is more important than decisional control. Procedural justice sheds some important insights into how the perception of fairness can be enhanced by fostering a sense of participation, dignity and trust. Sydeman *et al.* (1997) question whether the procedural justice effects are directly comparable across different populations (i.e. those with mental health difficulties). Multiple involuntary admissions may have a cumulative effect on perceived control and contribute to respondent cynicism and Sydeman *et al.*'s (1997) critique questions whether those who experienced respondent cynicism are responsive to procedural justice effects or not.

Procedural justice may be a useful and alternative theoretical framework through which to explore the way control may be optimised. The concept of procedural justice can provide an alternative lens to look at how people regain control. Implementing procedural justice principles in a systematic way (other than in mental health tribunals) much earlier in the involuntary admission procedure may be one way that control could be optimised. Initial experiences are what is most important; therefore, implementing procedure justice manipulations at the point of being subject to an involuntary admission is paramount. Some of the ways in which people in this study perceived that they were treated was the complete antithesis of a perception of procedural justice. In stark contrast, there were many instances where procedural justice principles were absent and the ToPC describes these in the subcategories 'Feeling Violated' and 'Being Confined'

In summary, the procedural justice literature suggests that perceived fairness is an important determinant of satisfaction. These studies highlight the importance of the actions of and interactions with professionals, family and peers, as well as the systems

one encounters, in determining one's experiences and possible effects on therapeutic outcome. One cannot hope to understand people's behaviour or experience without considering the systems and relationships in which they are embedded. How people are treated is central to the perception of procedural justice. The studies reviewed highlight that people pay attention to the way things are done and the nuances of their treatment by others. It is conceivable that subjective control is a by-product of procedural justice. The constructs of subjective control have not, however, been studied very extensively in relation to involuntary admission and/or detention. It is proposed that the concept of control may provide a valid account of the mechanism of coping with the loss of control (antecedents and consequences of loss of control) associated with being subject to involuntary admission and/or detention.

### **8.6 The Theory of Preserving Control: Relevance to the Mental Health Act 2001**

This section discusses the relevance of TOPC to the MHA 2001 and then discusses alternatives to involuntary admission.

While there have been considerable improvements since the enactment of the MHA 2001, there are also potential areas of reform. The ToPC, in particular the subcategory 'Feeling Violated', highlights that some people's experience of how the involuntary admission procedure was initiated and implemented resulted in extensive loss of control. This was a critical time in the formation and shaping of people's overall experiences – both positive and negative. Extensive loss of control was experienced in the implementation of the MHA 2001, particularly due to the arrival of AAT at the person's home, not knowing what was going on, and the realisation that family members may have covertly initiated their involuntary admission. People were often unaware of the reasons for their being subject to involuntary admission. Under the MHA 2001, the person is given information about their reasons for admission, their legal status and their rights in clear language on detention. However, the subcategory 'Feeling Violated' highlights that explanation and information is required at a much earlier stage of the initiation and implementation of the involuntary admission procedure. While the provision of the MHA 2001 can ensure that people are given information about their rights on detention, the ToPC highlights that this information should be provided on the initiation of involuntary admission and include an

explanation on the reason for admission, and this should be conveyed in such a way that people are able to understand it. The MHA 2001 does not specifically require that the reasons for detention are provided to people. In the ToPC, people were subject to involuntary admission and not subsequently detained. The senses of 'Feeling Violated', 'Being Confined' and 'Living with the Consequences of an Involuntary Admission' were just as pronounced for those who were not subsequently detained as those who were detained. At present the MHC does not collect data on people that are subject to involuntary admission under the MHA 2001 and are not subsequently detained – a practice that deprived people of their control and liberty. Involuntary admission should be a practice of last resort when all other possible and viable alternatives have been tried to no avail.

Given that some people perceived their involuntary admission was an overreaction, the ToPC suggests that there is a need to establish community interventions that might decrease the frequency of being subject to involuntary admission and detention. In light of the fact that some people felt that alternatives to involuntary admission were a very real possibility, there should be a greater emphasis on seeking alternatives. Therefore, the provision of adequate community-based services and supports are necessary and also critical for the enjoyment of human rights.

Based on the ToPC, in particular the subcategory 'Being Confined', the lack of treatment options other than medication has been highlighted as contributing to a loss of control. Hospitalisation was not seen as a therapeutic environment by many participants and some people described experiences of dehumanising care with lack of emotional and psychological support. In the ToPC there was lack of evidence to suggest that the people encountered effective and meaningful therapeutic interventions. At present, the MHA 2001 fails to provide for supplementary treatment other than medication to support people in their recovery. The ToPC emphasises the importance of the factors that inhibit and promote control.

The ToPC, in particular the subcategory 'Living with the Consequences of Involuntary Admission', highlights the trauma that some people experienced after discharge as a result of being involuntarily admitted and hospitalised. Some people described 'Feeling

Traumatised and Vulnerable’, ‘Losing Sense of Self’ and ‘Being Under Surveillance and Feeling Powerless’. The discharge phase has largely been neglected with little attention from MHA 2001 as to what type of support should be in place to help people who are impacted by being subject to involuntary admission. The ToPC suggests that the mental health services should consider providing support to people involuntarily detained to enable people to maintain control both during and after their hospitalisation. At present, there is no provision in the MHA 2001 to debrief people of their experiences or to legally appoint an advocate to support the person after their involuntary admission.

A recent meta-analysis (albeit only including 13 randomised clinical trials) identified which interventions that effectively reduce involuntary admissions (de Jong *et al.* 2016). Comparing advanced directives, community treatment orders, compliance enhancement, and integrated treatment, it was found that advance directive was the only intervention to show a significant risk reduction of involuntary admission by 23%. Therefore, one potential strategy of maximising control in the context of involuntary admission and treatment is to develop advanced directives as per the ADM Act 2015. However, at the moment, according to ADM, Act 2015 advanced directives are not legally binding during involuntary detention unlike other jurisdictions, such as Germany, and a number of states in the U.S. and Canadian provinces (Morrissey, 2015).

Future research could help us to identify the factors in legislation that can enhance control. It is paramount to introduce factors in legislation that would minimise the use of coercive practices within the mental health services. Whilst legislation is important in terms of safeguarding, the concern is that professionals focus on the legalities and operation of the MHA 2001 and run the risk of losing focus on preserving the person’s sense of control within the process of being subject to involuntary admission. What may additionally be required is a cultural shift in how care is delivered – enshrining a move away from paternalistic care to a more empowering based approach to care. What is required is a change in service provision, delivery and shaping a mental health care system that is more responsive to the person’s understanding of their mental health difficulties. While no system will completely eradicate loss of control, additional service related supports are likely to improve the negative experiences for people.

## **8.7 Reflexivity**

I have found this to be an invaluable opportunity to conduct research with people subject to involuntary admission. Completing this work has further strengthened my sensitivity to people's experiences of the mental health services beyond that gained in my own clinical experience. I have gained an interest in promoting alternatives to involuntary admission and attempting to minimise coercive treatment within the mental health services. I coordinated a submission for the review of MHA (2001) based on research with people's experience of involuntary admission. In addition, I also coordinated a stakeholder's submission to the draft seclusion and restraint reduction strategy. I am committed to understanding people's experiences. This clinical experience has helped me take a more person centred approach and effective standards of care. When professionals assist service users in their pursuit of preserving control, then their experience was more positive. Focusing recommendations on the factors that enhance subjective control will make the experience more positive. There is a wide variation in the attitudes towards care and treatment with many negative attitudes persisting. Subsets of people likely to have persistently negative attitudes can be identified in advance. One third of people transferred are not detainable, but no information is systematically collected about them. There is great dissatisfaction with assessment in community and transfer to hospital, and with unfamiliar staff perceived as overly intrusive.

The ToPC, in particular the subcategory 'Encountering Humanising Care', highlights the positive experiences reported that centre on instances of kind and humanising care from professionals. Minimising the loss of control in the early stages and fostering the regaining control can contribute to making people's experiences more positive. The ToPC identifies the importance of staff-person interactions in shaping people's overall experiences. This enables us to identify the attributes of professionals that are key in making the experience more positive. Such interactions require no additional legislative change, but are of potentially substantial benefit to people. These deficiencies need to be addressed and may not need reform in primary legislation, but rather in its application and implementation through codes of practice or training.

## **8.8 Summary of Discussion**

The aim of this discussion was to compare the existing theoretical literature to the ToPC in order to provide additional understanding of the ToPC. The role of 'control' as a theoretical concept for understanding people's experience of involuntary admission was considered most particularly to its association with perceived control and its associated constructs as outlined by Skinners (1996). The ToPC was first compared to Skinners' 'Consequences of Control'. It was then compared to the Self-Regulation Model and how people conceptualise their changing state of health and how, with information, re-evaluate the effectiveness of their coping strategies. The ToPC was discussed in the light of a grounded theory study entitled 'Managing Preconceived Expectations' which describes how people recover and deal with stigma on discharge. Finally, the concept of procedural justice was discussed in relation to the ToPC.

## **Chapter 9: Contribution to Knowledge, Limitations, and Recommendations**

### **9.1 Introduction**

This is the final chapter of the thesis. As such, it sets out the unique contribution to knowledge development that this research provides before then outlining concluding comments on the main findings, which are divided into two sections. Section one discusses the limitations of this research, and Section two outlines practice, legislation, and research recommendations.

### **9.2 Contribution to Knowledge Development**

This research has contributed to knowledge in that it

1. developed a substantive theory (ToPC) of people's experiences before, during, and after involuntary admission and/or detention.
2. built a comprehensive account of people's experiences before, during and after involuntary admission.
3. developed a framework that enables code comparison and assists with the organising and development of axial codes.
4. situated 'control' as a critical concept in people's experience of involuntary admission.

### **9.3 Research Limitations**

The potential weaknesses and limitations of this research are identified and discussed in this section.

The first limitation relates to the comprehensiveness of data. Some people did not consent to partake in the interview because they did not wish to be reminded of or to discuss their involuntary admission. While every attempt was made to include this group of people, they would not have been interviewed and it is therefore not known if this group had a different perspective from those interviewed. Their inclusion would have enhanced the theory and made it more comprehensive.

The second limitation relates to the use of NVivo. Concerns have been raised about the appropriateness of using such software in grounded theory (Glaser, 2003). The problem relates to the influence of such software on the analysis of data in general and on constant comparative analysis in particular. While NVivo 10 was used in this study, it was only used to provide an audit trail of open, axial codes and to store and organise memos. It was not used as an analytical tool. The auto coding function was not used: open and axial codes were developed by the researcher.

The third limitation relates to the reviewing of literature prior to Grounded Theory data analysis. While it is recommended that reviewing the literature is kept to a minimum in Grounded Theory, this PhD formed part of a larger project and, due to the requirements of preparing a research bid, a preliminary literature review was drafted prior to the start of the PhD. However, as the literature review was only preliminary, as concepts emerged during the research further literature was added in accordance with constant comparative process.

#### **9.4 Recommendations**

The ToPC describes to professionals, families, researchers and legislators people's experiences before, during, and after involuntary admission and/or detention. It describes 'control' as central to people's experiences and describes the ways in which control was enhanced or diminished by the interactions that people had with their family members and professionals at that time. Control is a unifying and accessible concept for families, Gardaí, GPs, members of the AAT, nurses and all members of the MDT to assist in understanding people's experiences. The ToPC can inform the tailoring of recommendations that minimise the extent to which people experience a loss of control when subject to involuntary admission. In terms of practice, if professionals can limit the extent to which control is threatened by using persuasion and employing a maximally humanising approach to care, then the adoption of primary, secondary and relinquishment of control would be less important and outcomes may be much more favourable. The goal is to develop recommendations to optimise people's control in a manner that is beneficial for the person. A focus on optimising control is helpful in generating a shared understanding within and across disciplines of quality of experience of care for people. Working to optimise control may be more tangible for

staff than a potentially ‘tick box’ focus on the legalities of the Act. Pro-active efforts at ‘Preserving Control’ will also be helpful in changing the way professionals engage with people subject to an involuntary admission and/or detention. The recommendations outlined are three-fold and pertain to: practice, legislation, and research. These recommendations are discussed in the context of the ToPC.

#### **9.4.1 Practice Recommendations**

One way that the principle of least restrictive care might prevail may be for professionals working in the MHS to interact with people in a way that minimises the perception of paternalism and maximises the approach of collaborative care at all times. The overall approach should also aim to reduce the need for involuntary admissions. This should involve a commitment to advancing community mental health services in a greater effort to support people in the community. The practice recommendations relate to the three subcategories, Losing Control, Regaining Control, and Maintaining Control.

##### **Losing Control**

The primary focus was on more humane interactions as opposed to solely focusing on the legalities of the MHA, for example, making sure the criteria for involuntary admission are met and that involuntary admission is only being used as a last resort because community treatment is unlikely to be safe or effective. The following recommendations may assist in minimising the loss of control.

1. Prior to the initiation of involuntary admission procedures, it may be feasible in some circumstances for members of a CMHT or a GP to seek alternatives to involuntary admission and appropriate pathways to care for the person. For example, this could be implemented by assisting the person to identify possible avenues of support and by focusing on what might be useful and indeed what may have been useful in the past in dealing with similar mental health difficulties. This CMHT could have a specific remit of seeking an alternative to involuntary admission. The CMHT would provide an explanation of the reasons and purpose of any assessment and a plan might entail the person being offered some alternatives to involuntary admission. Such alternatives may include some choice in relation to ascertaining treatment (pharmacological, psychological and

social) wherever possible, including the provision of homecare treatment. People should also be given time to consider these alternatives before any initiation of the involuntary admission procedure. Therefore, it is recommended that members of a CMHT and/or a GP undertake an assessment of the person and propose a community plan in line with the least restrictive care principle (DOH, 2014, p.15), prior to initiation of the involuntary admission procedure.

2. In light of the fact that some participants perceived they were violated on their removal to hospital, their removal should involve as few members of the AAT as is possible and, if the person wishes, should include an individual that the person indicates, is familiar with and trusts such as a relative, friend, peer support worker or a known professional. This study supports the Expert Group recommendation that the MHC should develop a code of practice for the AAT. Therefore, it is recommended that robust clinical guidelines on the respectful dignified and sensitive procedures for removal to hospital should be developed and implemented.
3. The numbers of people subject to involuntary admission not subsequently detained in hospital are not notified to the MHC (forms for application and recommendation, or the form to power to prevent a voluntary person from leaving hospital) despite the fact that these participants sometimes perceived that they too were 'violated' and/or felt 'confined'. This research supports the expert group recommendations that where a person chooses to remain in hospital voluntarily after they no longer meet the criteria for detention, the MHC should be notified of the subsequent voluntary admission in addition to the recommendation that every time section 23 (power to prevent a voluntary person from leaving hospital) is used to initially detain a person (even if section 24 is not subsequently used to detain the person) the MHC should be notified. Furthermore all people removed to hospital for assessment for involuntary admission (i.e. Form 5 medical recommendation has been made) have been subject to the MHA and therefore, clinical information should be collected on such individuals for collation by the MHC. Therefore, it is recommended these activations of the MHA should be notified to the MHC and a reduction strategy aimed at reducing these numbers should be published.
4. A number of participants retrospectively appraised their involuntary admission as an 'Overreaction'. Participants felt that there was an alternative solution to

their involuntary admission. This study supports Fiorillo *et al.*'s (2011) suggestion that the CMHT should conduct the first comprehensive clinical assessment before any initiation of involuntary admission. Therefore, it is recommended that members of the CMHT should, if possible, play a more active and extended role in the assessment and treatment of people prior to any initiation of involuntary admission.

### Regaining Control

Providing care and treatment in an environment that is therapeutic and in a manner that optimises control is desired. Some felt that care and treatment focused mainly on biomedical treatment. Family and professionals are in a position to assist the person in regaining control of their lives in a way that is cognisant and supportive of people's wishes and preferences in as much as this is possible. The ToPC highlighted the importance of focusing on explanation, information, and receiving treatment.

1. More assistance should be given to people in making sense of their emotional experiences and cognitive perceptions in line with the principle that "the person's own understanding of his or her mental health should be given due respect" (DOH, 2014, p.15). For example, professionals should use a language that is most in keeping with people's perspectives of their concerns. The ToPC highlights the need to focus on developing effective interpersonal and communication skills as well as the need to develop therapeutic relationships. In addition, the development of an idiosyncratic psychological formulation of the person's difficulties may lead to greater sense of control. Therefore, it is recommended that additional psychotherapeutic support from team members, if they wish, could assist the person in conceptualising and making sense of what is happening for them emotionally as well as why it is happening.
2. This study highlights that many people perceived that the focus on hospitalisation and biomedical management undermined their sense of the important role of other psychotherapeutic approaches in managing their mental health difficulties. For example, having access to psychotherapeutic approaches that they are more likely to perceive as being person-centred, therapeutic and recovery focused. Members of the MDT should explore what people perceive

might be effective in controlling their condition. Therefore, it is recommended that all those involuntarily detained should have access to therapeutic activities, peer support, supportive psychotherapy and other specific forms of psychotherapy as supported by evidence for the mental health difficulties they are experiencing.

3. In light of the fact that some participants perceived that they did not encounter Humanising Care on their removal to hospital and/or during hospitalisation, intervening and providing care to people requires sensitive and effective interpersonal communication on the side of family and professionals. Specific emphasis should be placed on developing more personal interactions and the skills of persuasion and being flexible. Therefore, it is recommended that a training programme should be provided to develop the skills of 'Encountering Humanising Care'.

### Maintaining Control

Employing optimally therapeutic strategies and knowing what and what not to do is paramount to people's recovery. In addition, assisting the person in becoming aware of the factors or circumstances that contributed to their 'Diminishing Self-mastery' might be helpful with future preventative efforts. Supporting the person at this stage may undo some of the harm that people perceived, which sometimes led to the formation of negative perceptions of the MHS.

1. Being subject to an involuntary admission and/or detention continued to impact participants on discharge. Assisting the person in accessing services and professionals, providing information on the support mechanisms available to the person as well as supporting the person should be the hallmark of care after involuntary admission. Therefore, it is recommended that each person is assigned an advocate, if they so require, to help that person access appropriate supports to deal with their experience of involuntary admission on discharge.
2. Discharge for some participants was a vulnerable time in terms of 'Managing Mental Health'. Being involved in identifying the triggers leading to 'Diminishing Self-mastery' and having a plan to implement in times of crisis should be the focus. Therefore, it is recommended that all people should have a documented recovery focused aftercare plan prior to discharge, which should

be developed in tandem with the person and shared with key carers/professionals in the community.

#### **9.4.2 Legislative Recommendations**

Implementing the involuntary admission procedure in a way that is perceived to be fair and beneficial to the person and is not overly coercive should be the hallmark of interactions with people subject to involuntary admission. This might involve CMHT members familiar with the care of the person playing a more prominent role and assuming greater responsibility in the admission procedure. The manner in which participants were treated by professionals during their removal from their home or society in terms of the level of coercion or humanising care that they perceived is a critical element in the formation of their overall experience and needs focused attention from professionals. In some instances the way the removal of the participants to hospital was carried out was perceived as disrespectful and undignified for the person. Members of the AAT have the potential to minimise the loss of control during the involuntary admission procedure by optimising the sense of control for people at every stage, for example, by emphasising communication and humanity, involving people in decision-making whenever possible, providing care in a humane way and providing information and assisting the person to make sense of their feelings and emotions, and by engaging the support of family and friends.

Some recommendations could be incorporated into existing legislation (MHA, 2001) in order to provide more support at this critical phase, whilst others may best be supported through broader practice initiatives.

1. This research supports the expert group recommendation that Authorised Officers (AO) should have a more active role in the involuntary admission procedures. The role of AO's should be strengthened so that it becomes the norm rather than the exception: i.e. that it is standard that applications for involuntary admission are performed by professionals with significant experience of the practices and procedures applicable to involuntary admission even before a medical recommendation takes place. In addition, they should document that community treatment plan has been considered and why it is unsuitable in this situation. The role of AO is likely to ensure that

inappropriate use of the coercion is minimised and that procedures and rights can be explained to the person and their family from the outset. Therefore, it is recommended that CMHT members could play a more active role as authorised officers, such as CPNs, who may be very familiar with the person.

2. Many participants perceived that they did not receive information or an appropriate explanation for their impending admission. In some instances, participants felt that the GP's involvement was cursory and they lacked any clarification as to why they were subject to an involuntary admission. Therefore this research supports the expert groups recommendation that the registered medical practitioner should 'personally examine' the person and 'clearly certify' that the person meets criteria for both a mental illness and involuntary admission.
3. The remit of the 'advocate' role proposed earlier could extend to overseeing the protection of the person's rights, the provision of information, and the provision of support through the process and the system if the person so wishes. This advocate would independently monitor processes to ensure humane treatment and protection of the person's human rights. Therefore, it is recommended that each person subject to an involuntary admission should be legally entitled to an 'advocate' if they so require.
4. Advance directives have been found to be effective in reducing the risk of involuntary admission. Therefore, it is recommended that each person with a history of being subject to involuntary admission should be legally entitled to an advanced directive which should be legally binding.

### **9.4.3 Research Recommendations**

Finally, recommendations are outlined on methodological approaches that could be used in future research on control.

1. Further testing of the utility of the ToPC in terms of its ability to guide future legislation and practice is needed. Its usefulness in offering recommendations that will preserve control in patient groups with varying clinical characteristics, thought processes and treatment experiences is also required. Therefore, it is recommended that a mixed method approach could be used to assess how combining quantitative measures and the qualitative data might provide useful

information into identifying differences between people who hold varying experiences of involuntary admission, for example, investigating how people with certain diagnosis and varying levels of insight preserve control.

2. Finally, the implications of the theory in practice should be further researched in future research including multiple methods of assessing control, including a range of mediating factors and including multi-centres, in order to robustly test the utility and generalisability of the ToPC. In addition, notwithstanding methodological difficulties, future research should aim to be longitudinal and should include multiple informants and triangulated findings. Therefore, it is recommended that an intervention study, for example, using a cluster randomised design where certain sites have control enhancing practices implemented and outcomes for service users, carers and professionals are assessed in comparison with treatment as usual sites.

## **9.5 Summary**

This chapter outlined the unique contribution to knowledge that this research provided, and a number of limitations and recommendations were described. This thesis provides the findings of a grounded theory study that demonstrated the extent to which people experience a loss of control as a result of involuntary admission. Negative emotions are directed towards all the stakeholders involved, including family members, police, psychiatrists, nurses and tribunal members. The ToPC outlines that even though legislation has been enacted to protect human rights, loss of control is experienced as a central problem for people. On a positive note, the ToPC did describe situations where professionals facilitated the regaining of control and how some people did feel that they benefitted from admission.

People go through a process of preserving control to varying degrees and the study highlights recommendations which, if implemented, should minimise the extent to which people experience a loss of control. These recommendations pertain to legislation, practice and research. The findings of this research suggest that there is a link between the level of control that was taken away from people and more negative experiences. There was a perception that the care that was delivered tended to centre on meeting minimal legal obligations under the MHA (2001) and was often seen as

coercive and controlling. Therefore, paying attention to factors that promote subjective control conditions and minimise 'loss of control' before and during the involuntary admission procedures will likely lessen the adverse impact that the traumatic experience of involuntary admission has on people's lives. The regaining control phases will then be facilitated for people, as creating a sense of 'control' is likely to make the person's experience less traumatic.

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## Appendix 1: Recruitment Poster

 **NUI Galway**  
OÉ Gaillimh

# “A prospective evaluation of the operation and effects of the Mental Health Act 2001 from the viewpoints of service users and health professionals”

We are involved in a Mental Health Commission project and want to get the opinions of all service users from May 1st 2011 in relation to their experience of the involuntary admission process including

1. Service users who are brought to hospital on Mental Health Act forms (whether detained or not)
2. Service users who are initially voluntary but who are subsequently detained
3. Any service user to whom the holding power is applied whether subsequently detained or not

Please inform eligible service users about the study and ask them if it is okay to pass their name onto the researcher. If a service user agrees to participate please contact us at any time and we will come and meet with the service user and discuss the project in more detail with them.

Recruitment will be ongoing until October 2013 for those who are admitted involuntarily between May 2011 and October 2013

**CONTACT DETAILS**  
Dr Emma Bainbridge or David McGuinness  
Mobile 087-3556505, or 091-495771  
Email: emma.bainbridge@nuigalway.ie

Thank you for your help!



**MHC**  
Mental Health Commission  
Mental Health Commission

## Appendix 2: Information Leaflet

FUNDED BY THE MENTAL HEALTH COMMISSION



Conducted by researchers from  
National University of Ireland, Galway

**HOW TO CONTACT US**

Please ask your nurse/doctor to pass on your details and we will contact you directly

Alternatively you can contact us directly  
Dr Emma Bainbridge  
or  
David McGuinness  
on 087-3556505  
or 091-495771

Email: [emma.bainbridge@nuigalway.ie](mailto:emma.bainbridge@nuigalway.ie)

**Service Users-  
HAVE YOUR SAY!**



We need your views on the  
Mental Health Act 2001




This project aims to find out more about your experience of involuntary admission.

You would have a face to face interview with a researcher which lasts about an hour and a second interview after your involuntary admission is finished.

**YOUR RIGHTS**

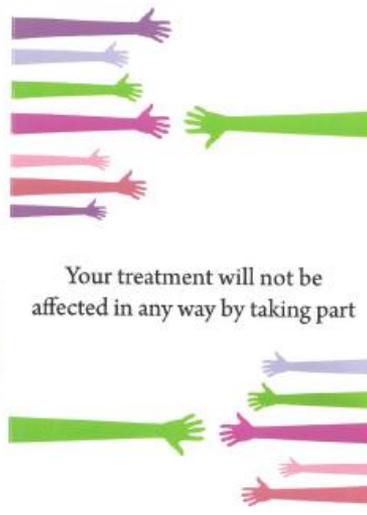
**DIGNITY AND RESPECT**

**YOUR RIGHT TO REVIEW**

**YOUR BEST INTERESTS**

**YOUR RIGHT TO BE LISTENED TO**

**YOUR RIGHT TO BE FULLY INFORMED**



This project is entirely separate from your hospital care

Your treatment will not be affected in any way by taking part

Any information provided is completely confidential



## **Appendix 3 -Information Sheet for Service User**

**Study Title:** A prospective evaluation of the operation and effects of the Mental Health Act 2001 from the viewpoints of service users and health professionals

My name is \_\_\_\_\_. I am asking you to take part in a research study. This research study is looking at the Mental Health Act 2001. This research will help us learn more about the Mental Health Act. We hope to find out your views on your treatment in hospital and on your admission to hospital. We will also ask you about your symptoms of illness.

### **What will happen in the study?**

- There will be an initial interview shortly after your admission to hospital. This interview will involve answering some questions and filling in some forms. The interview should last no longer than 60 minutes. We would also like to look at your medical notes to find out what tablets you might be taking and what diagnosis you may have.
- A second interview will occur 3 months after your involuntary admission is over. You will be asked similar questions again and you will be asked to fill in the same forms. If you have been in a mental health tribunal, we will ask you about this. We will also ask you about your relationship with your mental health team and family members. This interview should also take no longer than 60 minutes.
- Some people will be invited for further interviews at this time to find out in greater detail their experiences in hospital and to find out the effects of their hospitalisation on their life in general. These more detailed interviews will be recorded on audio-cassette tape and will take no longer than 60 minutes.

### **What else do I need to know?**

- You do not have to answer if you do not want to and you can stop the interview at any point.
- There are no correct answers to questions.
- Your information will be treated with confidence. You will not be named and nothing you tell me will be reported in a way that could identify you. However, if you mention something that places you or others at risk (e.g. thoughts of harming myself or someone else); this will be mentioned to a member of your treating team.
- We will ask you if we can speak to a family member of yours about their views of the Mental Health Act 2001.
- We will interview other health professionals about their views of the Mental Health Act.

### **What if I do not want to be in this study?**

- You do not have to agree to be part of the study.
- You can stop being part of the study at any time.

- Your treatment will not be affected by not taking part in the study.

**If I have further questions?**

You can ask me any questions you have about the study. If you have any further questions you can call me \_\_\_\_\_ at (091) 49XXXX. I will be visiting the ward frequently and will check to see if you have any further questions. If you have any concerns please feel free to discuss these with a service user advocate or family member.

## Appendix 4: Consent Form –Interview

**Study Title:** A prospective evaluation of the operation and effects of the Mental Health Act 2001 from the viewpoints of service users and health professionals

I have read the patient information sheet and understand the information enclosed. I have also discussed the study and what it entails with the researcher. I understand that the study is voluntary and I do not have to consent to this study. Furthermore I can refuse to give consent for any aspect of the study that I do not wish to participate in. If I withdraw consent, all data relating to me will be destroyed. I understand that the data collected will not be shared with my general practitioner or hospital consultant. *However*, if there is a disclosure which potentially places me or others at risk (e.g. suicidal or homicidal intent), this will be communicated to my treating psychiatry team.

I give consent to being interviewed by the researcher in relation to my views about the Mental Health Act 2001 and for this interview to be recorded on audio-cassette.

Participant Signature

Researcher's Signature

\_\_\_\_\_  
\_\_\_\_\_

I give consent to being interviewed by the researcher in relation to my thoughts about being treated and being in hospital involuntarily and for this interview to be recorded

Participant Signature

Researcher's Signature

\_\_\_\_\_

## Appendix 5: Interview Guide

### PRE-ADMISSION

Explore perceptions of what caused them to come into hospital

Reactions

Information

With regard to your recent admission, tell me of what happened to cause you to be admitted to hospital?

How did you feel

What did you think was happening

### ADMISSION

Information

Understand what the initial admission felt like for the person

Initial experiences

What was it like for you when you first arrived at the hospital?

Who was there?

How did you feel?

Did you understand what was happening?

Did you feel like you knew what was going on?

Was there anyone or anything that was helpful?

What made it better?

What made it worse?

Was there anything that made it more difficult?

## HOSPITAL STAY

Explore experiences of hospital stay

Identify the factors that impacted on experience

People

Medication

Other treatments

Other patients

Relationships

To explore if admission affected their relationships with family, psychiatrists, staff and advocates

Feelings about the admission

## Tribunal

Did you know what the tribunal was for?

## Stay

What was your stay in hospital like?

Was there anyone or anything that was helpful?

What made it difficult?

Did you feel you were involved in decisions about your treatment?

Did you agree with the treatment given to you?

What do you think about it now?

Did staff involve you in your care?

Can you give me an example?

Looking back, how do you feel about your admission now?

Do you still think it was (was not) needed.

Is there anything else you think I should understand?

In light of your experience is there any advice you would give us to help others in the same situation?

Did you attend a tribunal?

What do you think the tribunal was for?

Can you tell me what it was like?

What preparation did you get for attending the tribunal?

Who gave it to you?

Who was there?

Did you feel your views were represented?

What would have made the process easier for you?

POST ADMISSION

Explore the experiences of  
person when discharged home?

What was it like immediately after  
hospital?

What has it been like since you left?

What is life like now?

## Appendix 6: Second Interview Guide

### Introduction

I'd like to thank you for showing an interest in taking part in this study.

As *you* have direct experience of being detained under the Mental Health Act. I'm *really interested* in ***talking*** to you about your experience, so that *I understand* more about it *whilst also* make sure that this research is as accurate and complete as possible, of what it really feels like to be detained.

So far I have talked to a...people of *their experience* of detention. Whilst there are commonalities across people there are also some differences. Lots of people experience things differently and *indeed you may think* that the things that I mention today are not relevant to you.

If you think that they are relevant...I d love to hear why?

***But similarly*** I want you to stop me and say, if they are not relevant

Today, I'm interested in getting a hint of *your experience*, to see if that *you say* matches or differs to that of what others have told me to date.

Before *we* start I'd now like you to think about the last time you were detained under the Mental Health Act.

## WHAT'S GOING ON?

Explore what they *understood to happening at the time* before admission

Explore the factors that influence/hindered there understanding

Explore supports

Can you *describe* for me what *you felt* caused you to be admitted to hospital?

How well was the way you *saw* yourself understood at that time?

How you do think people responded to you?

Some people were *confused* in describing what was happening to them at the time. Was this something that happened to you?

What were the types of things that *impacted upon* how *you felt* during this time?

I'm wondering about your supports before hospital...  
- What kind of supports had you then ?  
-

Did you *look* for support anywhere before hospital?

Understand the <i>process</i> of being compulsorily detained	Can you <i>describe</i> for me <i>how</i> you were last detained?
	Who was involved?
	Where were you detained?
	How did you respond?
	How did this make you feel?
	Who signed you into hospital?
	Was it something that you expected?
	What <i>kinda</i> things <i>impacted</i> on the way you felt during that time?
Improvements	Can <i>you</i> think of any ways in which the detention process could be improved? - particularly for individuals with who had levels of distress similar to yours?
Explore persons' <i>awareness</i> of what was happening	Some people have said that there was part of them aware of what was happening to them and apart of them not aware. Is that something you can identify with? How was it for you?
Explore feelings of <i>frustration</i>	Some participants told me how frustrated they were during detention. Was that something you experienced? What was that frustration about? What caused it? If not ... OK tell me how you felt?
What would <i>help</i> ?	Can you think of anything at all that would have helped you in this situation?

the person that *signed* them in

Understand *what they thought might happen*

When you first realised that you may be detained, what do you think might happen?

What could have helped in that situation?

Understand how *feel* regarding

Some people were upset that family members signed the papers for their detention. I was *wondering* what you that something that bothered you?

If not ...*ok* what was your feelings' on that?

## INTERACTING WITH THE ENVIRONMENT

What was it *like* for you when you were admitted to the hospital?

Explore issue of safety

*Some* people I have interviewed have described a change from being in the community to being in the hospital in terms of feeling safer/sense of relief. Was that how you experienced it or not?

Understand how the person responded to the admission

If not ...Please *tell* me how you responded to being in hospital?

Explore sense of accepting changing mindset

I have been told that some people felt that they were *locked up*. Is that something you felt?

If not... Please *tell* me how it felt for you?

The need to be more direct

Some people felt frustrated that this *piece of paper* was signed even though they might think that they should stay. They felt that they should be given the opportunity to decide to stay voluntary Was that something that *concerned* you?

Some people told me that they were given very little information. Was that something you experienced? Were you given reasons for your admission?

## ENCOUNTERING CARE

Explore experiences of *hospital stay*

To explore relationships with staff, advocates

What was the hospital stay *like for you?*

Some people described how they felt a difference of opinion with the staff on the treatment they received. Was that something that was a concern for you?

Some people felt that the care that they received was limited to medication. Was that something you experienced?

What treatments did you receive?

What type of things might help you during your time in hospital?

How well do you think the staff responded to you and your needs?

What did you feel about the standard of care you received?

Was there anyone that was helpful?

What impacted upon the way you felt during this time?

## LEARNING A WAY

Under what conditions did people *not seek additional information?*

Some people told me that they didn't want help in hospital, and spoke of not talking to other patients or staff.

What was the case for you?

*If not ....what was your experience?*

TRIBUNAL

What was the tribunal for?

Can you tell me what it was like?

Who was there?

What issues were discussed?

What else would have been helpful]

What preparation did you get for attending the tribunal?

Who gave it to you?

What would have made the process easier for you?

Did you feel your views were represented

*Unnecessary paperwork*

When I was interviewing certain people they felt that the paperwork involved in detaining someone was unnecessary and involved a lot of fuss and red tape.

Would that have been something you found?

Does this paperwork bother you in any way?

If not, do you think the paperwork is necessary... why?

*How do you think the whole process impact upon you?*

What do you think about the *overall process* of being detained now?

(E.g. helpful/unhelpful, short/long-term effects of detention?)

Did the admission help any part of you?

If yes .....in what way?

If no ... in what way did it not help you?

Explore the concept *ineffective treatment*?

*Some* people I have talked to, have comment that the admission failed to address their real problem. Or that the treatment was insufficient or even inappropriate. Was that something that you thought about?

What *kind* of help did you feel would benefit you more?

## MOVING ON?

Explore the experiences of  
person when discharged home?

Has the fact that your admission was  
involuntary made things easier in any  
ways..?(if yes - in what ways) ...  
and did that make it harder in any  
*other* ways..?

Can you think for a minute about when  
you came home from hospital?

What did it feel like in the first  
few days?

What is life like now?

Has that changed much for  
you?

Thinking about now and  
comparing that to when you  
first came home....  
Is it same or different?

... if different how?

What impacted upon how you felt  
during this time?

For some people there was something  
that affected them a lot “being signed”  
into a psychiatric unit. Does that mean  
anything to you, if so how, if not what  
is your opinion on that?

Has the fact *that you were*  
*detained* affect how people are  
with you?

What do you perceive as necessary for you  
in the future.

Is there anything else you think I should understand?

## Appendix 7: Axial Code Development Table

Open Codes	Merging open codes due to overlap/repetition.	Axial Codes
<p>I didn't have the right treatment            Needing help            Unresolved aspect            They thought they helped me            They didn't see the real problem            The wrong place            Medication vs talking            Psychology            Needing spiritual intervention</p>	<p>Developing a perspective            Needing help            Failing to address the real issues            Needing something else</p>	<p style="text-align: center;">Making Sense</p>
<p>Being treated badly            Being doped up            Being held down            Being told how to be            Putting words in my mouth            Other peoples interpretation            Powerlessness            Scared            Threatening sense of identity            Cold hearted            Violent</p>	<p>Damaging self integrity            Paralysing            Not knowing what to expect            Whats going on</p>	<p style="text-align: center;">Feeling Violated</p>

## **Appendix 8: Memo at opening coding**

28/08/2012.

For some people, prior to their detention, there may at some level be a feeling that something may be wrong but people are not sure what it is. On the other hand, there are people who feel there was nothing wrong with them. This feeling is made worse by the perceived interference from others immediately prior to and during hospitalisation. There is real divide between the health professional's opinion and the person's opinion. The central notion during the detention piece is there is a real feeling of; "what is going on"? There is a battling with a sense of confusion related to reasons for detention, why is this happening?- for the people experiencing their first detention versus, why is this happening again?- for those who have had a previous detention.

For those who this is the first admission, there is a real sense of not knowing what to expect. Do I need to be here?. This is sometimes compounded by the perceived severity of "illness" of other service users in the hospital and the going to a "mental hospital". There is a lack of information and a feeling of why is this happening? There is an erosion of self concept with health professionals implying "this is actually who you are". The strategy that most people use to cope with this is fighting back and questioning phase for the former and a "let's go with the flow" and succumbing for the latter (those with previous detentions). Although, these people may still wonder what going on, previous experience of detention has possible shown them that it is easier to adapt and conform than to "fight the system" thereby speeding up the end vision of "getting out". It may go on a continuum from "fighting the system" to "learning the way". Reaching the "learning the way" phase can be achieved by the person listening to other patients' advice on how to come to terms with hospitalisation. There is a reluctant acceptance of detention as time progresses, the person may be advised to take medication, don't show your emotions and basically "keep the head down". That said for some people there may be a realisation with time in hospital that may be I do need to be here?

Experiences of treatment are mixed, negatively and positively. The approach to care is significant piece of the person story and there is a sense of it being aggressive at times. There is a great sense of loss of; rights, control, contact, integrity, family, power, self concept, freedom, dignity, trust and respect. Health care staff that minimise these

feelings for the person may go some way in connecting with the person. For those who have not had a previous experience there is also an emotional processing and adjusting to hospitalisation, in a health way or an unhealthy way.

What's striking is the emotional impact of the detention and how people adjust to it. There is much more than a detention here that is going on here. This appears to be related to the type of recovery style the person adopts. On the one hand some people wish to forget the experience (sealer recovery style) and other people accept the experience (integrators). Some individuals may not feel that the admission was necessary but in order to "keep people of their back" they reluctantly accept treatments such as long term injections even though they feel there is nothing "wrong with them". There is a fear of reoccurrence that they may be hospitalised again. There can be a great sense of isolation and vulnerability. There is a feeling here that the person needs to rebuild their lives and sort out unresolved issues, ironically the very people that could provide some help and intervention in this area (health professionals) are sometimes not wanted by the person who has had the experience of detention .

The notion of constructing, deconstructing, reconciling and reconstructing self is central phenomena to the people who have had an experience of detention.

## **Appendix 9: Memo on building concepts**

30/01/2015

People are struggling to make sense of situations and events. They are grappling with the inside and outside sense of self, and are disconnected and confused. In that time that people attempt to restore a sense of equilibrium, they are met with a superior force intervening in this situation. How one construes this intervention can vary and it depends on their mind- set at the time. Such intervention is frequently interpreted as nonsensical, unwarranted and is seldom recognised as helpful. Intense emotions and reactions follow at a time that is critical in the persons' life. Depending on the schema it activates it can be construed as helpful or not helpful, the intervention can be seen as non- identifiable and at odds with there the person is at. Professionals sometimes pursue a path that is not recognisable and totally at odds with what the person see as the problem. As a result the person sometimes enters into a conflicted journey with the professional. Two reactions can occur: fighting back or resigning. With frustration, some people searched for information. Various agents are seen as helpful and unhelpful, the environmental, physical surroundings and other patients. Some people construes the environment as untherapeutic. Vision and acceptance ensues in some instances and in others the detention is still seen as an injustice, unnecessary and unhelpful. This activates certain schemas such as "I'll have to resign and accept that it happened to get on and to get out, to keep them off my back."

## Appendix 10: Examples of NVivo process of theory development

Experiences of Involuntary Admission.nvp - NVivo

File Home Create External Data Analyze Query Explore Layout View

Go Refresh Open Properties Edit Paste Copy Cut Merge Format Paragraph Styles Editing Proofing

Workspace Item Clipboard

Look for: Search In: Axial codes Find Now Clear Advanced Find

**Nodes**

- Nodes
  - Axial codes
  - Generating Themes open codes
  - Preserving Control
  - Profiles
  - Query based codes
  - Relationships
  - Node Matrices
- Sources
- Nodes
- Classifications
- Collections
- Queries
- Reports
- Models
- Folders

**Axial codes**

Name	Sources	References	Created On	Created By	Modified On	Modified By
Feeling violated	16	146	09/10/2012 21:20	DMG	08/07/2014 09:54	DMG
Being held down	1	2	09/10/2012 21:24	DMG	29/05/2016 11:46	DMG
Being treated badly	2	5	09/10/2012 21:24	DMG	29/05/2016 11:46	DMG
Cold hearted	1	2	09/10/2012 21:24	DMG	29/05/2016 11:46	DMG
Confining	8	15	09/10/2012 21:24	DMG	18/09/2012 16:57	DMG
I was not able to leave	1	3	10/10/2012 12:10	DMG	29/05/2016 11:46	DMG
Imprisoning	5	18	09/10/2012 21:24	DMG	29/05/2016 11:46	DMG
Intrusive	7	16	09/10/2012 21:24	DMG	29/05/2016 11:46	DMG
Restricting	8	24	09/10/2012 21:24	DMG	24/09/2012 10:13	DMG
Rules	5	9	09/10/2012 21:24	DMG	18/09/2012 16:57	DMG
Scared	4	8	09/10/2012 21:24	DMG	29/05/2016 11:46	DMG
Surveillance	4	6	09/10/2012 21:24	DMG	29/05/2016 11:46	DMG
Threat	9	22	09/10/2012 21:24	DMG	29/05/2016 11:46	DMG
Violent	3	16	09/10/2012 21:24	DMG	29/05/2016 11:46	DMG
Fighting the system	11	63	10/10/2012 12:25	DMG	08/07/2014 14:29	BM
Denying	3	8	10/10/2012 12:27	DMG	08/07/2014 14:29	BM
Fighting the system	7	15	10/10/2012 12:27	DMG	08/07/2014 14:29	BM
Not wanting help in hospital	2	2	10/10/2012 12:27	DMG	29/05/2016 11:04	DMG
Questioning	1	5	10/10/2012 12:27	DMG	08/07/2014 14:29	BM
Reacting	5	14	10/10/2012 12:27	DMG	08/07/2014 14:29	BM
Resisting	6	19	10/10/2012 12:27	DMG	08/07/2014 14:29	BM
Finding a way	12	65	08/10/2012 17:25	DMG	08/07/2014 09:54	DMG

DMG 430 Items

13:05 29/05/2016

Experiences of Involuntary Admission.nvp - NVivo

File Home Create External Data Analyze Query Explore Layout View

Go Refresh Open Properties Edit Paste Copy Cut Merge Format Paragraph Styles Editing Proofing

Workspace Item Clipboard

Look for: Search In: Preserving Contr Find Now Clear Advanced Find

**Nodes**

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**Preserving Control**

Name	Sources	References	Created On	Created By	Modified On	Modified By
Losing Control	47	338	14/07/2014 06:48	DMG	10/07/2015 18:21	DMG
Feeling Violated	38	326	14/07/2014 10:22	DMG	29/05/2016 13:36	DMG
Diminishing Self-Mast	47	561	22/07/2014 16:17	DMG	10/07/2015 12:00	DMG
Feeling Confined	45	712	14/07/2014 06:50	DMG	10/07/2015 18:56	DMG
Maintaining Control	49	917	14/07/2014 05:54	DMG	10/07/2015 18:48	DMG
Living with the Conseq	32	249	14/07/2014 14:51	DMG	07/07/2015 18:24	DMG
Managing Mental Heal	36	329	14/07/2014 10:38	DMG	10/07/2015 18:48	DMG
Preserving Sense of S	25	122	27/08/2014 18:36	DMG	10/07/2015 11:56	DMG
Regaining Control	49	937	14/07/2014 06:32	DMG	10/07/2015 16:35	DMG
Encountering Humani	35	251	15/05/2015 06:18	DMG	29/06/2015 07:49	DMG
Gaining Perspective	39	294	16/07/2014 09:34	DMG	10/07/2015 17:40	DMG
Playing Ball	32	193	03/05/2015 15:23	DMG	10/07/2015 19:30	DMG
Resisting the System	42	365	28/05/2016 09:30	DMG	28/05/2016 08:35	DMG

DMG 49 Items

13:37 29/05/2016

## Appendix 11: Ethical Approval

Page 1 of 1

O'Connell, Eithne

**From:** O'Connell, Eithne  
**Sent:** 10 May 2011 15:40  
**To:** McDonald, Colm  
**Cc:** McGuire, Brian  
**Subject:** Ethics Application Ref: 11/MAR/04 - Full approval

Sent on behalf of Dr Brian McGuire, Vice Chair, Research Ethics Committee

Dear Prof McDonald

**RE: Ethical Approval for "A prospective evaluation of the operation and effects of the mental health act 2001 from the viewpoint of service users and health professionals"**

I write to you regarding the above proposal which was submitted for Ethical review. Having reviewed your response to my letter, I am pleased to inform you that your proposal has been granted **APPROVAL**.

All NUI Galway Research Ethics Committee approval is given subject to the Principal Investigator submitting an annual report to the Committee. The first report is due on or before 31<sup>st</sup> March 2012. Please see section 7 of the REC's Standard Operating Procedure for further details which also includes other instances where you are required to report to the REC.

Yours Sincerely

Dr Brian McGuire  
Vice Chairperson  
Research Ethics Committee

Should you require a signed hard copy of this letter please contact me – Eithne O'Connell - details below)

**From:** O'Connell, Eithne  
**Sent:** 29 March 2011 15:38  
**To:** McDonald, Colm  
**Cc:** nic Gabhainn, Saoirse  
**Subject:** Ethics Application Ref: 11/MAR/04

Dear Prof McDonald

**RE: Ethical Approval for "A prospective evaluation of the operation and effects of the mental health act 2001 from the viewpoint of service users and health professionals"**

I write to you regarding the above proposal which was submitted for ethical review. At a meeting of NUI Galway Research Ethics Committee held on Tuesday March 15<sup>th</sup> 2011, it was a decision of the Committee to grant this project **PROVISIONAL APPROVAL** with the following conditions:

- Please clarify that assent will be 'sought' not 'obtained' where the service user does not have the capacity or competence to give consent
- Please amend the participant information sheet as follows; "Your information sheet will be kept in confidence" (not 'treated with confidence'); "Thoughts of harming yourself (not 'harming myself'); "You can ask me any questions (not 'a questions')

When the decision was taken I was chairing the meeting and the following members were also present:

08/05/2011



Féidhmeannacht na Seirbhíse Sláinte  
Health Service Executive



Merlin Park University Hospital  
Ospidéal na h-Ollscoile, Páirc Mheirlinne  
GALWAY UNIVERSITY HOSPITALS

Clinical Research Ethics Committee  
Unit 4  
Merlin Park Hospital  
Galway.

21<sup>st</sup> May, 2011.

Dr. Brian Hallahan  
Senior Lecturer  
Department of Psychiatry  
Clinical Science Institute  
National University of Ireland  
Galway.

*Ref: C.A. 524 - A prospective evaluation of the operation and effects of the Mental Health Act 2001 from the viewpoints of service users and health professionals*

---

Dear Dr. Hallahan,

The Chairman's decision to approve the above study was ratified at the recent Clinical Research Ethics Committee meeting on Wednesday 15<sup>th</sup> May, 2013.

*Yours sincerely,*

---

*Dr. Shaun T. O'Keeffe*  
*Chairman Clinical Research Ethics Committee.*