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**THE IMPLEMENTATION OF SECTION 5(4)
OF THE MENTAL HEALTH ACT 1983**

Russell John Ashmore

A thesis submitted in partial fulfilment of the requirements of
Sheffield Hallam University
for the degree of Doctor of Philosophy

July 2012

Dedication

This thesis is dedicated to Daniel Carey (State Enrolled Nurse) who was killed at
Tooting Bec Hospital on 2nd August 1974.

Abstract

Section 5(4) (nurse's holding power) of the Mental Health Act 1983 empowers mental health nurses to legally prevent an informal in-patient from leaving hospital for up to six hours. The section may be applied for the patient's health or safety or the protection of others. Since its introduction in September 1983 there have been 34,000 applications of the section, an average of 1460 per annum. The application of Section 5(4) is likely to: lead to further detention under the Act; have implications for the practice of nurses; and affect the care received by patients in the aftermath of its use. However, the literature review revealed a paucity of research on the subject. The existing research has focused on three main areas: nurses' opinions of their holding power; their knowledge of Section 5(4); and trends associated with the implementation of the section. However, no attempts have been made to examine the events before, during and after the implementation of Section 5(4). This qualitative study sought to address this deficit by examining why and how Section 5(4) was implemented from the perspective of the nurses and patients involved in the process.

A collective case study approach was utilised to generate data from one mental health NHS Trust over a period of one year. Data were generated from three sources: archival (statistical) records on 803 applications of the section; documentary accounts of the detention process, for example nursing notes; and interviews with 30 nurses and four patients. Within- and cross-case narrative analysis was undertaken on the data set. The method of narrative analysis employed was developed specifically for this study.

The analysis produced a six-part typology of nurses' stories that explained why Section 5(4) was implemented. The six types were: 'health, safety or protection'; 'lack of knowledge'; 'catalyst'; 'medical inaction'; 'self-protection'; and 'last resort'. The analysis also constructed a collective story of nurses' experiences that identified the key stages in the detention process. Stories were also constructed from patients' experiences of being detained. These stories generated in-depth accounts of patients' admission to hospital, the events leading up to their detention, the implementation of Section 5(4), and the aftermath of their experiences.

The implications of the study's findings are considered for education, policy, practice and research and focus on four main areas: informal admission to hospital; information giving; reasons for implementing Section 5(4); and the consequences of the detention for both nurses and patients.

Acknowledgements

I would like to acknowledge and thank a number of people, without whose help this thesis would not have been possible.

I would like to thank all the participants in this study who agreed to take part and gave up their time to do so. Without them there would have been no thesis.

I would like to thank Dr. Paul Ramcharan for his enthusiasm and help in the initial stages of this thesis. I wish to express my gratitude to my supervisors Emeritus Professor Gordon Grant and Dr. Alex McClimens for their guidance and support during the process of completing this thesis. A thank you must also go to Dr. Julie Repper and Dr. Peter Goward for their help.

A thank you to my friends and colleagues in the mental health nursing community (you know who you are) who have offered me support and encouragement.

Finally, a big thank you to my partner Elizabeth Collier for her support during the 'dark' days. Also for listening while I talked about my thesis and also for telling me when to stop talking about it.

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‘Sometimes I might just put in a comma in the morning, and take it out again at night.
But that’s the way it goes.’

Sillitoe (2007)

Chapter 1

The origins of the thesis

At 3.00 p.m. on June 6th 1989, I used Section 5(4) (nurse's holding power) of the Mental Health Act 1983 (Department of Health,¹ 1983) for the first time, to prevent a male patient² from leaving hospital. This was the first of 11 patients I detained under Section 5(4) in the following two years as a staff nurse working on an acute psychiatric ward.³ This event also marked the beginning of my fascination with an aspect of mental health nursing practice that has been the focus of my academic interests for over 20 years and led to the generation of this thesis. It therefore seems important for me to begin this thesis by providing some background on the circumstances leading up to my first application of Section 5(4) and the associated issues.

Between 1980 and 1983 I was a psychology undergraduate student at the University of Manchester. Despite undertaking a clinical psychology module that explored the nature and treatment of mental illnesses there was no mention of mental health legislation; therefore I remained oblivious to the debates that were taking place regarding the reforms of the Mental Health Act 1959 (Department of Health and Social Security,⁴ 1959). Following my graduation in 1983 I had no clear idea about what direction my career should take, although I did know I wanted to work in the field of psychology in some way. In the year following my graduation I secured a short-term contract working as a nursing assistant on an acute psychiatric ward, which resulted in the decision to undertake my training to become a registered mental nurse (RMN).

¹ Hereafter DH.

² In the UK a variety of terms exist to describe people who use mental health services including 'clients', 'patients', 'service users', 'people affected by mental illness', 'user', and 'survivor' (Simmons et al., 2010). Despite some commentators arguing that some terms are more empowering or stigmatizing than others (for example, see Link and Phelan, 2001; McLaughlin, 2009), Dickens and Picchioni (2011) have reported that those who use mental health services prefer to be referred to as either 'patient' or 'client'. I have chosen to use 'patient' throughout this thesis as this is the term adopted in the Mental Health Act 1983 to refer to people who use mental health service.

³ Acute psychiatric ward and acute in-patient ward are used interchangeably throughout the thesis. These wards provide mental health care for adult patients between the age of 18 and 65 years, although the upper age limit may vary between NHS Trusts.

⁴ Hereafter DHSS.

In May 1984 I started my nurse training at the Middlewood Hospital in Sheffield. As a nursing student (1984-1987) I received very little formal education on the Mental Health Act 1983 (DH, 1983). This amounted to no more than a basic introduction consisting of a one hour classroom discussion and a handout outlining the main sections contained in the Act. Furthermore, I do not recall any of the nursing tutors emphasising the new roles that had been given to mental health nurses by the 1983 Act or more specifically drawing my attention to the legal and ethical implications of the new holding powers. However, I do remember reading Larry Gostin's (1983) 'A Practical Guide to Mental Health Law'; although at the time I did not fully appreciate the implications of the Act for my future role as a RMN. On reflection, I now find this lack of education on the subject of Section 5(4) astonishing since the Act was less than eight months old at the start of my training. In addition, there had also been considerable debate within the profession and Parliament (see Chapter 2) about whether mental health and learning disability nurses should be given a holding power.

Similarly, during three years of clinical placements I do not remember Section 5(4) being used by nurses on the wards where I worked. Nor do I remember any of my supervisors making reference to it or alerting me to its existence, although I do remember discussions about other sections of the Act. This may simply reflect the fact that the section was not used during my time on individual placements or that I simply lacked an awareness of its use. However, I did witness numerous patients being prevented from leaving hospital either because they were already detained under a section of the Act or because, although informal, it was in their 'best interests'.

On qualifying in July 1987 I duly forgot about any concerns I had about using Section 5(4) as my first staff nurse post was based in a day hospital working with older adults experiencing a variety of organic and functional mental health problems. As day patients cannot be detained under Section 5(4), I did not have to address the issue of detention. Such issues were dealt with by nurses working on in-patient wards or by the medical staff.

This changed on May 2nd 1989 when I moved to a staff nurse post on an acute in-patient ward based within one of the two local psychiatric units in Sheffield. In taking up my new post I became aware again of the fact that, for their health or safety or the

protection of others, patients could be legally prevented from leaving the ward by a nurse. More specifically, I also realised that as part of my new role I might be the one who had to prevent the patient leaving.

My first experience of using Section 5(4) occurred a month after starting on the ward (June 6th 1989) when I twice made the decision to prevent a patient from leaving within the space of one Friday afternoon shift. Whilst I do not remember all of the details of the events leading up to either of the detentions, the detention itself or its aftermath, I do remember some of my anxieties about making the decision to implement Section 5(4).

Firstly, I asked myself, *'Was I doing the right thing?'* Specifically, I was concerned that I had in some way got it wrong and that I was depriving someone of their liberty inappropriately. In addition, in 'getting it wrong' I was also worried that I would be judged by experienced colleagues to be a custodial nurse who liked to exercise their power over the patients. This was something I had already come to believe as contrary to the philosophy of nursing care espoused on the ward.

Secondly, I asked myself, *'What were my grounds for detaining the patient?'* I believe I had concerns for the patient's and/or others' safety and that he needed to stay on the ward but was unwilling to do so. I can only presume now that no doctor was available to undertake a medical assessment with a view to implementing Section 5(2) (doctors' holding power) of the Act (DH, 1983). I am unclear about how I assessed the risks as the ward did not use any formal risk assessment tools and even if they had I am not certain there would have been time to use them. I recall consulting my colleagues about whether I was about to make the correct decision; an attempt perhaps to draw on their experience and clinical knowledge. There appeared to be a collective and culturally defined set of criteria used by the nurses to determine potential risk on the ward. However, it was not always clear where this knowledge had come from or whether any discussion had taken place as to the appropriateness of these criteria or what evidence, if any, was being used to support their use.

Thirdly, I asked myself, *'How do you go about doing it?'* I remember being worried about the actual implementation of Section 5(4), an issue that mental health nursing students continue to be concerned about (Ashmore and Carver, 2011). This raises an

important question; that is, what does happen in those situations when nurses are faced with the possibility of having to prevent a patient from leaving the ward? The Mental Health Act 1983 (DH, 1983) and the Mental Health Act 1983 Code of Practice (DH, 1999) offer some guidelines about when, where, who, why and how a patient should be prevented from leaving by the nurse; however this is purely from a legal perspective. In reality, based on my own experience, implementing Section 5(4) is 'messy'. That is, the circumstances of any situation frequently mean that plans cannot be followed and any pre-existing protocols are rarely followed. Cavadino (1989: 1) has made a distinction between the 'law in the books' and 'law in practice'; that is, while legislation may tell us what the law is, it provides little guidance on how to use it. In my own case, the first time I implemented Section 5(4) I had some awareness of what the law said but I had no experience of applying it. Therefore, I was required to make sense of how to use the law there-and-then in order to manage the situation I found myself in at that time. Despite this piece of legislation being over 28 years old, surprisingly there are still no accounts of how nurses interpret this law in practice.

My experience of using Section 5(4) gave me a desire to find out more about how it 'should' be implemented, and therefore I consulted my colleagues in an attempt to learn from their knowledge and experience. However, this proved frustrating as their replies consisted of comments such as, 'It rarely happens so don't worry about it', 'It only occurs at weekends or after five o'clock when there's no doctors around', 'It'll damage the therapeutic relationship with the patient', and 'It'll result in the patient not being able to get a visa to travel to other countries.' There was also a prevalent belief among my colleagues that the use of the Act was associated with the medical model and therefore a medical responsibility. For many of my colleagues, to use Section 5(4) also constituted a failure of the nurse's therapeutic skills and therefore it was discouraged.

During 1989 my quest for more knowledge on the subject and dissatisfaction with my colleagues' responses led me to seek answers from the medical and nursing literature. However, I was surprised to find that there was a paucity of literature on the subject particularly that based on research evidence. This dearth of information led me to make the decision to undertake my own small scale research project on the subject. This consisted of a retrospectively study of all Section 5(4)s that had been implemented over a one-year period on the five wards comprising the acute services in Sheffield. This led

to my first publication (Ashmore, 1991) and from the findings I was able to dispel some of the myths about Section 5(4) raised by my colleagues.

Others studies followed this piece of research, both by myself and others but none attempted to explore the 'law in practice'. I did on one occasion seek to explore nurses' reasons for implementing the holding power by attempting to undertake a content analysis of nursing notes following the use of Section 5(4). Unfortunately this project had to be abandoned as either no entries existed or they simply stated that, 'the patient had been detained under Section 5(4)'.

The patient's perspective on their detention by a nurse was also an area of personal interest. This was prompted by the need in 1991 to detain a patient with whom I had been working closely. The implementation of the Section 5(4) was fairly straightforward. However, in the aftermath the patient Nikki (a pseudonym) refused to believe that I had detained her, and targeted her anger to the colleague who was assisting me, because, she said, 'You wouldn't do anything like that'. Intrigued by this, Nikki and I discussed the events surrounding her detention on a number of occasions. On her discharge from the ward I asked whether she would provide me with a written account of her experience. With her permission, I reproduce her thoughts in full:

'Well when you are very chaotic it is the nurses' only option to section you to keep you on the ward. At first you become very irate with the nurses because they are stopping you doing what you want to do.

One of the first things you learn is sectioning by the nurses can lead you to being detained for a very long time. A 5(4) can lead to a 5(2) - which is 72 hours, a 5(2) can lead to a Section 2 - which is 28 days - and a Section 2 can lead to a Section 3 which is a six month section.

So once you have calmed down a bit you have to walk around showing everyone that you are stable to be left alone until the doctor arrives but you can't wait until you are informal again.

The power that the RMN has is very threatening but until you know your rights all you want to do is abscond. The more you attempt [to leave] the tighter the nurses get on you and it normally results in you being locked in the [seclusion] 'room'.

It starts to be a very deceitful process. All you need is one good chance [to abscond], but that will be your only chance.

The doctor - this is where you have to prove the nurses were wrong and you are perfectly stable.

Your relationship with the nurses changes. It starts to become a 'them' and 'us' feeling. You feel vulnerable; as if you try to leave they will section you.

If you can't get away you just need to hope there is a good nurse on duty and a good doctor who you can wind around your finger.

I don't think sections on the ward I was on are misused, most of the time it is done for your safety and that is the only way a nurse is able to get your respect back and to enable you to work as a team again.'

Nikki (September 1992)

The experiences - both my own and Nikki's - described above have raised a number of issues that are not addressed in the literature and as a result have provided me with the motivation to undertake the study detailed in this thesis.

This thesis is divided into ten chapters. This chapter has provided an introduction to my background as a mental health nurse and how I became involved with the nursing practice of implementing Section 5(4) both clinical and academically. It has also begun the process of identifying issues associated with the implementation of Section 5(4) from both the nurse's and patient's perspective.

Chapter 2 consists of three parts. The first part outlines Section 5(4) as it is described in the Mental Health Act 1983 (DH, 1983). This part also includes details of the guidance offered to nurses by the Mental Health Act 1983 Code of Practice (DH, 1999) on implementing Section 5(4). The second part explores the factors leading to the decision to provide nurses with legal powers in the 1983 Act (DH, 1983), for example changes to hospital admission procedures, and National Health Service (NHS) resource deficiencies. The third and final part of the chapter consists of a review of the empirical literature relating to the implementation of Section 5(4). In the literature review it is argued that that empirical research has focused on three main areas: nurses' opinions of their holding power, their knowledge of Section 5(4), and trends associated with the implementation of the section. The review also identifies a number of gaps in the

literature that have potential implications for how mental health nurses practice and the quality of care received by those who are detained under Section 5(4).

Chapter 3 focuses on the methodological aspects of the study. A rationale is given for undertaking a doctoral level study and the aims of the research are stated. The study is positioned within a relativist ontology and social constructionist epistemology. The choice of the case study as the most appropriate research strategy is also discussed as are the data generation methods used in the research.

Chapter 4 describes how the research design was unfolded and consists of three main sections. The first provides a detailed account of how access to the study site was negotiated. The second provides an account of how formal permissions were obtaining, the problems encountered and how they were addressed. The final part describes the process of generating data and the management of associated issues such as undertaking interviews with nurses and patients in clinical environments.

Chapter 5 provides a rationale for the analysis of the different types of data generated in the study and outlines in detail the stages and procedures involved in this process. Specifically, the chapter focuses on justifying the narrative approach to analysis used in the study and presents my own nine stage method for the generation of the stories reported in the thesis.

Chapters 6-9 present the findings of the study. Chapter 6 focuses on the data set and trends associated with the use of Section 5(4) in the Trust. Some of the trends identified in this chapter led to the development of topic areas that were then explored in the interviews with both nurses and patients.

Chapter 7 outlines a six-part typology of how and why Section 5(4) was implemented. One example of each story type is presented to illustration its differences and similarities to other narratives outlined in the chapter.

Chapter 8 presents the four patients' (Mark, Carl, Shaun, and Asif) stories generated in the study. These stories provide in-depth accounts of their admission to hospital, the

events leading up to their detention, the implementation of Section 5(4), and the aftermath of their experiences.

Chapter 9 presents a collective story of the implementation of Section 5(4) that makes visible for the first time a process concerning the events before, during, and after the nurse makes the decision to implement Section 5(4). It demonstrates that the decision to implement Section 5(4) is a complex process involving a number of factors other than the patient being considered a risk to themselves and others, and a doctor being unavailable to undertake a medical assessment.

The final chapter summarises and critiques the key findings and considers the implications for education, policy, practice and research. The discussion is organised around four main areas: informal admission to hospital, information giving, reasons for implementing Section 5(4), and the consequences of the detention for both nurses and patients. Finally, the trustworthiness of the research is evaluated by exploring its credibility, dependability, confirmability, and transferability.

Chapter 2

Background

2.1 Introduction

This chapter consists of three parts. The first part outlines Section 5(4) as it is described in the Mental Health Act 1983 (DH, 1983). In addition, it also provides details of the guidance offered to nurses by the Mental Health Act 1983 Code of Practice (DH, 1999) on implementing Section 5(4) before, during and after the event. The second part explores the factors leading to the introduction of Section 5(4) under the 1983 Act (DH, 1983). The third and final part of the chapter is a review of the empirical literature relating to the implementation of Section 5(4).

2.2 Section 5(4) (nurse's holding power) of the Mental Health Act 1983

The National Health Service Information Centre for Health and Social Care (NHS ICHSC, 2011) reported that in the one year period 2010-2011, 27,471 people were admitted to NHS facilities in England under a section of the Mental Health Act 1983 for their health or safety or for the protection of others.⁵ A further 16,448 people were detained after admission.⁶ This may be the result of an inappropriate informal admission, deterioration in the patient's mental health and/or their unwillingness to remain in hospital at a time of perceived risk. One option available to mental health nurses when a patient who is considered at risk, expresses a desire to leave the ward and cannot be persuaded to wait until a doctor arrives to discuss the matter further, is to prevent them from leaving by applying Section 5(4) of the 1983 Act (DH, 1983).

Section 5(4) accounted for 10.6% (n = 1748) of all detentions after admission; that is 4% of all sections implemented during the period 2010-2011. Official statistics on the use of the Act (DH, 1995; NHS ICHSC, 2011) also report that the number of patients detained under Section 5(4) has risen significantly since its introduction in 1983 to an average of 1460 per annum (Range 789-1948 per annum). Between 1988 and 2011 approximately 34,000 people have been detained under Section 5(4) of the Act. In addition, the application of Section 5(4) leads to further detention under the Act in 70%

⁵ A further 2,621 people were formally admitted to independent hospitals in the same period.

⁶ A further 449 people were detained after admission in independent hospitals for the same period.

of cases (NHS ICHSC, 2011) and may require nurses to lock the ward door or restrain, seclude or closely observe the patient to ensure they remain on the ward.

Section 5(4) of the Mental Health Act 1983⁷ permits nurses of the 'prescribed class' to detain an informal in-patient receiving treatment for mental disorder for up to six hours or until a doctor arrives if it appears:

(a) that the patient is suffering from mental disorder to such a degree that it is necessary for his health or safety or for the protection of others for him to be immediately restrained from leaving hospital; and

(b) that it is not practical to secure the immediate attendance of a practitioner for the purpose of furnishing a report under subsection (2) above.⁸

Section 5(4) can only be used when the patient is still on the hospital premises. Implementing Section 5(4) is the personal decision of the nurse who cannot be instructed to exercise the holding power by anyone else. Section 5(4), should it lapse, is non-renewable.

2.2.1 The prescribed class

The Mental Health (Nurses) Order 1998 (SI 1998/2625) defines the 'prescribed class'⁹ as a nurse registered in:

⁷ As data in this study were generated before 2007, all references to the Mental Health Act 1983, unless otherwise stated, refer to the original document (DH, 1983) rather than the recently amended version of the legislation (DH, 2007a).

⁸ This refers to Section 5(2) of the Act (doctor's holding power). In the amended Act (DH, 2007a) Section 5(2) has been widened in scope to include 'approved clinicians', for example social workers and nurses. In the amended Act (DH, 2007a) this section now reads, 'that it is not practical to secure the attendance of a doctor or approved clinician who can submit a report under section 5(2).'

⁹ Since the introduction of the 1983 Act the types of nursing qualifications described in the register maintained in Section 7 of the Nurses, Midwives and Health Visitors Act 1997 have changed. These changes are reflected in the amended Act (DH, 2007a) The 'prescribed class' now consists of: (i) Registered Nurse Level 1 Mental Health; (ii) Registered Nurse Level 2 Mental Health; (iii) Registered Nurse Level 1 Learning Disability; and (iv) Registered Nurse Level 2 Learning Disability. Part 3, 4, and 13 now fall under (i) and (ii); and Part 5, 6, and 14 under (iii) and (iv).

- (a) Part 3 (first level nurse¹⁰ trained in the nursing of persons suffering from mental illness) or
- (b) Part 4 (second level nurses trained in the nursing of persons suffering from mental illness) or
- (c) Part 5 (first level nurse trained in the nursing of persons suffering from learning disabilities) or
- (d) Part 6 (second level nurses trained in the nursing of persons suffering from learning disabilities) or
- (e) Part 13 (nurses qualified following a course of preparation in mental health nursing) or
- (f) Part 14 (nurses qualified following a course of preparation in learning disabilities nursing).

2.2.2 Informal patient

The Mental Health Act 1983 is concerned with making provisions for compulsory admission to hospital of patients with a mental disorder. Section 131(1) is the only provision within the Act which relates to informal admission. It states:

‘Nothing in this Act shall be construed as preventing a patient who requires treatment for mental disorder from being admitted to any hospital or mental nursing home in pursuance of arrangements made in that behalf and without any application, order or direction rendering him liable to be detained under this Act, or from remaining in any hospital or mental nursing home in pursuance of such arrangements after he has ceased to be liable to be detained.’

If a person requires hospital admission and they are willing to be admitted informally, the Code of Practice¹¹ (DH, 1999, 2.7: 10) states, ‘this should in general be arranged. Compulsory admission should only be the last resort.’ Furthermore, where the person is assessed as lacking the capacity to consent, ‘but does not object to entering hospital and receiving care or treatment, admission should be informal’ (DH, 1999, 2.8: 10).

¹⁰ First level refers to a registered nurse. Second level refers to an enrolled nurse. Enrolled nurses were introduced in 1943 in an attempt to overcome a shortage of nursing staff (Nolan, 1993: 102).

¹¹ As data in this study were generated before 2008, all references to the Mental Health Act 1983 Code of Practice, unless otherwise stated, refer to the 1999 version of the Code (DH, 1999) rather than the more recent version (DH, 2008).

Any person admitted informally to hospital for mental health care is not subject to the legal restrictions which apply to detained patients. Therefore, they are equivalent in law to those patients admitted to general hospitals. Informal patients differ from formal patients in two main ways. The informal patient can refuse to accept any form of treatment offered to them, and they may leave hospital whenever they like. However, in reality the patient may be prevented from leaving by a nurse or doctor implementing their holding powers. Therefore, as Houlihan (2000: 865) notes, 'in practice the notion of informal status may be no more than a legal fiction.'

2.2.3 Procedure

Although the criteria outlined above (see section 2.2) may have been met, the Code of Practice (DH, 1999, 9.2: 40) recommends that before implementing Section 5(4) the nurse should assess, 'the likely arrival time of the doctor as against the likely intention of the patient to leave.' The Code also suggests that at such times, 'most patients who express a wish to leave hospital can be persuaded to wait until a doctor arrives to discuss it further' (ibid). When persuasion fails the Code suggests that the nurse attempts to assess the impact of any delays upon the patient and the consequences for the patient or others should they be allowed to leave hospital.

2.2.4 Assessment and acute emergencies

The decision to implement Section 5(4) should ideally be preceded by assessment taking into account the guidance offered in the Code of Practice (Table 1). However, it may not always be possible to conduct an assessment before the patient is restrained from leaving. The Code (DH, 1999, 9.3: 40) states that:

'...in extreme circumstances it may be necessary to invoke the power without carrying out the proper assessment. The suddenness of the patient's determination to leave and the urgency with which the patient attempts to do so should alert the nurse to potentially serious consequences if the patient is successful in leaving.'

Table 1 Factors to be considered before applying Section 5(4)

The patient's expressed intentions including the likelihood of the patient committing self-harm or suicide.

Any evidence of disordered thinking.

The patient's current behaviour and in particular any changes in usual behaviour.

The likelihood of the patient behaving in a violent manner.

Any recently received messages from relatives or friends.

Any recent disturbances on the ward.

Any relevant involvement of other patients.

The patient's known unpredictability and any other relevant information from other members of the multi-disciplinary team.

Source: Mental Health Act Code of Practice (DH, 1999, 9.2: 40)

2.2.5 Reports

If the patient refuses to remain on the ward for the arrival of the responsible medical officer¹² (RMO) or their nominated deputy,¹³ the nurse should implement Section 5(4) by completing Form 13¹⁴ (Appendix 1). This requires the nurse to state the patient's name, the date and time the patient was detained, their own name and to indicate - by deleting other possible categories - their 'prescribed class' (that is the part of the nursing register under which their qualification is listed). Legally, Section 5(4) commences as soon as the nurse implementing the power completes Form 13. Form 13 must be sent to the Hospital Managers, or to the person acting on their behalf, as soon as possible after completion. The nurse should record their reasons for implementing Section 5(4), for example in the patient's nursing (and medical) notes, as well as completing a local incident report (Appendix 2). The incident report is sent to the Hospital Managers.

¹² Doctor or approved clinician under the amended Act (DH, 2007a).

¹³ Section 5(3) of the 1983 Act (DH, 1983) allows the RMO to nominate one other Section 12 doctor to delegate in her/his absence. The nominated doctor cannot nominate another doctor.

¹⁴ Although essentially the same in content, Form 13 has been replaced by Form H2 in the amended Act (DH, 2007a).

Finally, it is recommended that good practice would mean that if the patient remains on Section 5(4) at the time of a shift change, relevant information is communicated to staff coming on duty (DH, 1999).

2.2.6 Informing the patient

Section 132 of the Act (DH, 1983) requires Hospital Managers to ensure that all patients who are detained receive information about their section. The Mental Health Act 1983 Leaflet 1 Section 5(4), *Your rights under the Mental Health Act 1983* must be completed. Leaflet 1 should be given to the patient. In addition, the nurse should explain to the patient why they are being detained and their rights under the section. As far as possible the nurse should ensure the patient understands what has been said (Killen, 1992). This process and the degree to which the patient understood the information should be recorded in writing, for example in their nursing notes.

2.2.7 Restraint and medication

The nurse implementing Section 5(4) may use the minimum force necessary to prevent the patient from leaving hospital. Where force is necessary nurses are advised to follow the general principles of restraint set out in paragraphs 19.6-19.8 of the Code of Practice (DH, 1999).

If medication has been prescribed before the implementation of Section 5(4) it may be offered to the patient. However, they retain the right to *refuse* the medication if they wish, and *cannot* be medicated against their will. If the patient lacks the capacity to consent and it is considered to be an 'urgent necessity', that is the nurse believes it should be administered to prevent serious harm to self or others, it may be given.

2.2.8 Medical responsibilities

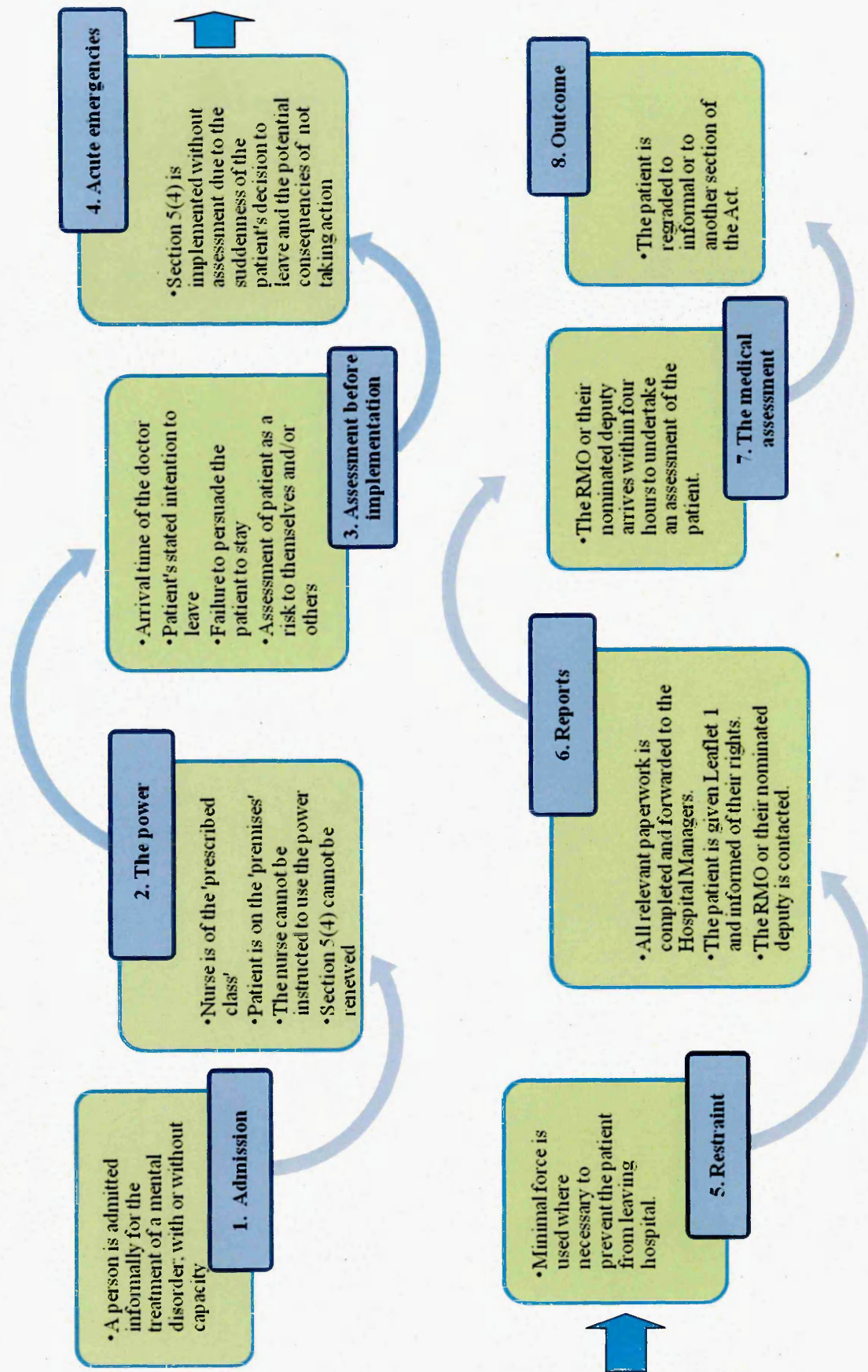
As soon as possible following the implementation of Section 5(4) the nurse should contact the RMO or their nominated deputy to inform them of the decision. The 1990 Code of Practice (DH, 1990: 29) noted that, 'a psychiatric emergency is no different from any other medical emergency' while the 1999 Code (DH, 1999: 39) states that, 'a psychiatric emergency requires the urgent attendance of a doctor.' Although the Code of Practice (DH, 1999) recognises that, 'a doctor may not be immediately available' they should treat the situation as an emergency and arrive on the ward as soon as

possible and 'not wait six hours before attending simply because this is the maximum time allowed' (ibid: 41). It is expected that the doctor will arrive within four hours of the patient being detained. Section 5(4) lapses when the doctor arrives on the ward and this is recorded by the nurse completing Form 16 (Appendix 3). Any time spent on Section 5(4) counts as part of the 72 hour holding period if the doctor decides to detain the patient under Section 5(2) of the Act.

If the RMO or their nominated deputy has not arrived within four hours of Section 5(4) being implemented the nurse is advised to contact the duty consultant who should attend. If no doctor has arrived after six hours an 'oral report (suitably recorded) should be made immediately to the responsible senior manager, and a written report should be submitted to that manager and the Hospital Managers on the next working day' (DH, 1999, 9.7: 41). The patient becomes informal and should they be unwilling to stay in hospital then, 'the responsible senior manager should nominate a suitable person to supervise the patient's leaving' (ibid).

The stages in the process of implementing Section 5(4) - based on the Mental Health Act (DH, 1983) and the guidance given in the Code of Practice (DH, 1999) as discussed above - are summarised in Figure 1.

Figure 1 The 'official' process of implementing Section 5(4)



2.3 The origins of Section 5(4) of the Mental Health Act 1983

This part of the chapter identifies and explores a number of factors that contributed to the introduction of Section 5(4) in the 1983 Act.

2.3.1 From certification to informal admission

One factor influencing the introduction of Section 5(4) is arguably the successive changes made to hospital admission procedures dating back to the 1890 Lunacy Act. The introduction of the 1890 Lunacy Act was, in part, a response to a number of well documented cases¹⁵ in which corrupt doctors colluded with relatives to unlawfully incarcerate their kin to mental asylums (Rose, 1986). The 1890 Act aimed to prevent this happening (Baruch and Treacher, 1978; Glover-Thomas, 2002). Jones (1993: 93) described the 1890 Act as the 'triumph of legalism', that is admission to hospital focused on the rules of law and these took priority over therapeutic considerations. Under the Lunacy Act the final decision for admitting a person to hospital (certification) was made by a justice of the peace in a court of law rather than by a doctor. Therefore, at this time there were no informal admissions to hospital. From the nurse's (or attendants as they were at known that time) perspective the situation was clear; all patients were detained and they were legally empowered and protected in law to prevent a certified person from leaving the hospital should they attempt to do so. Furthermore, the likelihood of a patient being able to leave the hospital or ward was greatly reduced as most were locked.

The Mental Treatment Act 1930 saw the re-emergence of medicalism over legalism (Glover-Thomas, 2002); where the treatment of the mentally ill was seen as more important than guarding against wrongful detention in hospital. For the first time a distinction was made between involuntary and voluntary admission.¹⁶ A person could be admitted as a voluntary patient if they wished 'of their own free will to undergo mental treatment' (Jones, 1960: 120). The person was required to make an application in writing for voluntary admission to the person in charge of any approved establishment. A voluntary patient could discharge themselves at any time but had to

¹⁵ For example, see the case of Julie La Roche outlined in Jeffrey Masson's (1988) book *Against Therapy*.

¹⁶ Jones (1960: 10) notes that limited approval had been given by the Government in 1862 and 1890 that made provision for 'voluntary boarders' to be admitted to private asylums. In addition, prior to the introduction of the 1930 Act the Maudsley Hospital and to a lesser extent the City of London Hospital were the only public hospitals where in-patient treatment was offered without certification.

give 72 hours notice. This requirement was criticised by some in Parliament who believed that the voluntary patient 'should be free to walk out at any moment' (Jones, 1960: 116). While it was recognised that the three day period might be considered detention 'in a purely legal and technical sense' (ibid) it was seen as having a number of advantages. Namely it: provided the patient with the opportunity to change their mind; allowed for the hospital to make arrangements for the patient's discharge, or to make an assessment of whether the patient needed certifying. Therefore, from a legal and practice perspective the introduction of 'voluntary' status did not present nurses with any problems when the patient expressed a desire to leave. As the patient was required to give 72 hours notice, nurses were legally able to enforce this should a person attempt to leave before this period expired. As with the 1890 Act, this was easily enforceable as most wards were still locked.

However, the introduction of the 1930 Act marked the beginning of a period of change that would ultimately lead to the introduction of Section 5(4). Jones (1960) argued that the distinction between involuntary and voluntary patients led to more and more ward doors being unlocked so that at least some patients could come and go more independently. Inevitably, this development resulted in nurses being placed in a potentially difficult position as their constant presence on the hospital wards meant that in all probability they were the professional group making the day-to-day decisions about whether it was safe for a voluntary patient to leave when they requested to do so. While mental health legislation protected nurses in law when enforcing the Act their position was less clear when they felt the need to prevent a voluntary patient leaving. Any uncertainties may also have been compounded by a history in many asylums of nurses being dismissed for losing the ward keys (Jones, 1960) or being held responsible for allowing a patient to escape (Clarke, 1993).

The final piece of mental health legislation that contributed to the need for the introduction of Section 5(4) was the Mental Health Act 1959 (DHSS, 1959). The philosophy of the 1959 Act has been described by Unsworth (1987: 231) as 'anti-legalism'; that is its main focus was to ensure that patients received treatment as quickly as possible rather than the rules of law that had characterised previous legislation. Significantly from a nursing perspective voluntary admission became informal admission; this reflected the view that nothing in the Act should prevent a person in

need of psychiatric care from being admitted to hospital. The patient no longer had to apply in writing for admission or more importantly, give 72 hours notice to leave. The new admission procedures also allowed non-volitional¹⁷ patients to be admitted informally. Therefore, in law this meant that the informal patient could leave hospital whenever they liked.

The management of both volitional and non-volitional informal patients, who could leave when they wanted, presented nurses with a new problem. Specifically, nurses had no statutory powers in law to prevent an informal patient from leaving hospital in circumstances where a nurse had made a clinical judgement that a patient should be prevented from doing so (Fennell, 1984; Houlihan, 2000; Houlihan, 2005). This problem was further compounded by the fact that by the time of the introduction of the 1959 Act a large number of hospital wards were now unlocked, therefore making it easier for patients to leave. Although there is no evidence to support the assertion, it is possible that nurses were uncertain about how to manage such situations and also concerned about the consequences for them of allowing an informal patient to leave who then harmed themselves or others. At the time the 1959 Act was introduced there had been public criticism about the consequences of allowing patients to leave the ward. For example, in October 1957, following the death of a patient the Southwark Coroner commented on 'the doubtful legality of allowing voluntary patients to wander away from mental hospitals' (Butler, 1985: 174).

2.3.2 Section 30(2) and its limitations

Under the 1959 Act nurses were dependent on the doctor responsible for the patient's care being available to detain the patient under Section 30(2). Section 30(2) allowed the doctor responsible for the patient's care to detain them for up to three days (72 hours) to provide time to make arrangements for compulsory admission for assessment and/or treatment. Section 30(2) required the doctor to be physically present to undertake an assessment of the patient and complete the paperwork to the effect that they required compulsory admission. The doctor was not allowed to 'give authority over the telephone or leave a signed form in readiness for such an eventuality' (DHSS, 1976: 16). In addition, the responsible doctor was *not* allowed to nominate a deputy in their

¹⁷ This refers to a patient who may lack the capacity to consent but does not object (verbally or physically) to being admitted to hospital admission.

absence other than to cover temporary periods of absence such as sickness or holidays (Bean, 1986).

The review of the 1959 Act (DHSS, 1976; DHSS, 1978) identified several problems in the implementation of Section 30(2). The Royal College of Psychiatrists (RCP) reported that they believed that the section was widely 'misunderstood and misinterpreted' (DHSS, 1976: 16-17) and that doctors other than those designated in the Act were completing the section. In addition, because of the restrictive nature of the clause, there were practical difficulties in contacting a doctor at nights or at weekends. Furthermore, Gostin (1975) reported examples of doctors providing nurses with blank, signed and dated paperwork which allowed them to detain an informal patient for up to 72 hours in the absence of the responsible doctor. The RCP recommended that the implementation of the section should be made clearer and easier, for example widening the scope of the clause to enable any 'approved' doctor to act in the absence of the consultant.

2.3.3 Legal protection and nurses' uncertainties

Mental health legislation has recognised for a long time that forcibly admitting a person to hospital, ensuring that they stay there and comply with treatment - sometimes against their will - carries 'a risk that those responsible for operating the procedures may be faced with legal actions initiated by patients or ex-patients arising out of actions taken in the course of their duties' (DHSS, 1976: 51). In recognition of this issue, legislation has provided protection for those implementing the statute. For example, Section 330 of the 1890 Lunacy Act allowed court proceedings against staff to be halted upon application to the High Court or one of its Judges if they were satisfied that the defendant had shown that they had acted in good faith and with reasonable care. Section 16 of the Mental Treatment Act 1930 strengthened the position of staff by requiring the plaintiff to show sufficient grounds that the action had been carried out in bad faith or without reasonable care. The Royal Commission's review of the 1930 Act suggested that this protection should be retained in the 1959 Act and was provided under Section 141.¹⁸ This protection extended to 'all those performing functions purporting to be carried out under the Act' (DHSS, 1976: 51).¹⁹

¹⁸ This became Section 139 in the 1983 Act.

However, what remained unclear was nurses' legal position when preventing an informal patient from leaving whilst waiting for the doctor to arrive to complete Section 30(2), and their position in relation to the treatment and control of informal patients in general (DHSS, 1976: 2.17). It was argued that the protection offered under Section 141 did not extend to nurses when dealing with these situations. However, it was suggested at the time that nurses had a common law defence if acting to prevent a breach of the peace, or to prevent violence to save life or in self-defence. In addition, it was also noted that there existed a common law right to confine a person who was mentally ill, as illustrated in the case of *Fletcher v Fletcher* (1859) 1 El. & El. 420. Finally, Section 3(1) of the Criminal Law Act 1967 established the right to all citizens to use reasonable force to prevent a crime.

However, although it seemed that nurses could resort to common law to prevent a crime it was argued that there were occasions when nurses were concerned about a patient but no emergency had occurred since no harm to self or others had been committed, but the nurses believed it would. There were also times when the behaviour of an informal patient required nurses to physically restrain and seclude them to prevent them leaving the ward or hospital because of the danger of violence to others. It was suggested that in such circumstances nurses felt uncertain about the legal justification for their actions (DHSS, 1978: 2.31).

The issue of nurses' uncertainty was highlighted by the public inquiry published in November 1975 (South-West Thames Regional Health Authority, 1975) which investigated the circumstances leading to the death of Daniel Carey - a State Enrolled Nurse (S.E.N) - at Tooting Bec Hospital on 2nd August, 1974.²⁰ The inquiry suggested

¹⁹ *R v Bracknell Justices ex parte Griffiths* (1975 3 WLR 140) established the protection given by section 141 to nurses while undertaking duties specified in the Act and also to the control of detained patients. In this case, a nurse working at Broadmoor Hospital, having been convicted of common assault, appealed to the High Court on the grounds that his action, were necessary in controlling the patient and therefore should have been protected by Section 141. The High Court agreed, as did the House of Lords on appeal.

²⁰ Samuel Hall, a male patient at Tooting Bec Hospital, inflicted a number of stab wounds on Daniel Carey, resulting in his immediate death. Daniel Carey's death occurred in the grounds of Tooting Bec hospital when the deceased and other nurses were attempting to transfer the patient from an open to a closed ward.

that the lack of clarity surrounding nurses' legal position in such situations meant that they were increasingly reluctant to deal with difficult patients, particularly when some form of physical restraint may be required to prevent an informal patient from harming themselves or others or to prevent them from leaving hospital (DHSS, 1976). This was particularly relevant for Section 30(2) in that any delay in implementing the section as a result of the doctor's absence, extended the period in which nurses had to manage the potentially increasingly difficult behaviour of the informal patient.

The review of the 1959 Act (DHSS, 1976) argued that nurses' uncertainties could be resolved by amending the existing Section 30. In the first instance it was proposed that the section would be amended to allow the holding power to be applied by an experienced Registered Mental Nurse - it was suggested that this would be the senior nurse on duty in the hospital - in conjunction with a doctor available at the time.²¹ The consultation document proposed that the need for two practitioners 'would provide sufficient protection for the patient against unnecessary detention (DHSS, 1976, 2.18: 17).

It was suggested that granting legal powers to nurses recognised that they are, 'likely to have a closer knowledge of the individual patient and his condition than other members of staff' (DHSS, 1976, 2.19: 17) and would, 'enable action to be taken more quickly [and] would help reduce the period of uncertainty for both staff and patients' (DHSS, 1976, 9.10: 54). In addition, it was argued that the section would give nurses, 'extra support in making the difficult decisions which confront them when the condition of an informal patient changes or deteriorates and when they feel positive action is required to prevent a potentially tragic incident either within or outside the hospital' (DHSS, 1976, 2.19: 17). Finally, it was hoped that 'nurses would welcome the extra responsibility' (ibid).

However, it is argued that the original proposed amendment outlined in the consultation document (DHSS, 1976) seemed impractical and unlikely to resolve the difficulties faced by nurses should an informal patient wish to leave the ward immediately. For example, there would have been a need to make contact with *both* the senior nurse in

²¹ It was recommended that this doctor would be experienced in psychiatry and would normally be the senior doctor on call approved under Section 28 of the 1959 Act (Section 12 of the 1983 Act).

the hospital and a doctor who would have to then be present on the ward to implement the section before the patient attempted to leave. Therefore, two rather than one practitioner would be required to make the decision. Nor did the proposed amendment of Section 30(2) say what would happen should the nurse and doctor disagree about the patient's detention. In addition, it could be argued that the proposed amendment implied - by the need to have a second practitioner present - that nurses were not perceived to be sufficiently competent to make an accurate clinical judgement as to whether the patient should be prevented from leaving or not.

In response to the proposals the RCP supported widening the number of doctors who could apply Section 30(2) but were opposed to extending legal powers to nurses. This was mainly on the grounds that they believed that it was, 'inappropriate for nurses to be involved in medical decisions' (DHSS, 1978, 2.30: 30). This seems ironic in view of the established medical practice at the time of leaving pre-signed Section 30(2) forms on the wards for nurses to complete should they wish to 'legally' prevent an informal patient leaving the ward (Gostin, 1975; DHSS, 1978). In contrast, nursing opinion generally supported their involvement in the legal process.

The conflicting responses to the suggestions made in the consultation document (DHSS, 1976) were resolved by granting nurses a holding power²² of their own, 'for a period of not more than six hours to enable the necessary report under Section 30 to be obtained from a doctor in charge of the patient's treatment or his nominated deputy' (DHSS, 1978, 2.32: 21). This proposal was accepted by Parliament and entered legislation as Section 5(4) of the Mental Health Act 1983.

2.3.4 Responses to the new legislation

While the RCP did not support the introduction of Section 5(4) the organisations²³ representing nurses responded positively to the legislation. Both the Confederation of Health Service Employees (COHSE) and the National Union of Public Employees (NUPE) welcomed the new legislation unreservedly, believing that it would resolve the

²² Originally this was to be Section 30(4).

²³ These organisations were: the Confederation of Health Service Employees (COHSE); the National Union of Public Employees (NUPE); the Psychiatric Nurses Association (PNA); and the Royal College of Nursing (RCN).

uncertainties faced by nurses in managing informal patients. The Psychiatric Nurses Association (PNA) reported that the holding power was, 'generally welcomed by psychiatric nurses...but a small number of nurses [were] opposed to the clause.'²⁴ The Royal College of Nursing (RCN) also offered their support for Section 5(4) but also reported that many nurses were, 'fundamentally opposed to further restrictions on the liberty of patients as indicated in the Bill.'²⁵ The RCN also suggested that a period of up to six hours was unacceptable and proposed that, '...the holding power should be no longer than one hour.'²⁶

Within the nursing literature there were also positive responses to the introduction of the new legislation. Summer (1983: 14) commented that it was, 'another step in our quest for professional status', as nurses had been granted powers that not all doctors had and therefore it recognised their ability to make a clinical judgement regarding the severity of the patient's mental state. Meanwhile, Shanley (1983) argued that it secured nurses' legal position and lessened the likelihood that they would face litigation. In addition, he also believed that it would lessen any potential abuse of patients' liberty by making nurses' detention of patients transparent and open to external scrutiny from the Mental Health Act Commission. Shanley (1983), like Summer (1983), believed that the legislation enhanced the professional standing of the profession. Shanley (1983: 10) commented that:

'A beneficial aspect for nurses of this legislation is that nurses are recognised as members of a responsible discipline who are capable of making important legal decisions... As a result nurses may be seen as having credibility as professionals.'

However, as noted above, the introduction of Section 5(4) was not accepted without reservations. For example, some were concerned that Section 5(4) would not reduce the legal restraints on patients as envisaged by the new Act but in fact introduced 'new restrictions on patients' liberties' (Rogers and Pilgrim, 1996: 88). In addition, Shanley (1983: 10) believed that the possibility existed that some nurses may implement the

²⁴ Hansard HC Volume XI Column 40 (10 May 1982)

²⁵ Ibid Column 85 (27 April 1982)

²⁶ Ibid Column 86 (27 April 1982)

power to, 'play safe and avoid the possibility of being accused of negligence' or that the legislation may be exploited by psychiatrists.

Others questioned the Government's true motivation for introducing Section 5(4). Nolan (1993) believes that the introduction of the holding power was resource driven. He argues that the introduction of the 1983 Act should be viewed against the backdrop of cutbacks taking place in the National Health Service (NHS) at that time that resulted in staff shortages and lack of resources. Nolan (1993: 142) suggests that the granting of legal powers was, at least in part, an attempt to resolve a resource issue. He states that:

'This apparent regard by Government for the authority and status of mental nurses was also a cost-cutting exercise in that the Act devolved power to a professional group within the mental health services who were less highly paid and therefore more cost-effective than doctors.'

Support for Nolan's position came from the RCN who believed - as noted above - that the suggested period of up to six hours was 'totally unacceptable'.²⁷ The RCN representative argued that any debate for the section being longer than one hour was an attempt to use it to address resourcing issues. He commented that:

'Whilst the implication for medical staff is recognised it cannot be expected that the nursing profession should cover for either manpower shortages or administrative disorganisation in the psychiatric medical services.'²⁸

In addition, the Member of Parliament Christopher Price²⁹ suggested that:

'...we should not amend legislation to provide an alibi for the deficiencies of the National Health Service. There is a suspicion that giving nurses the power to detain a patient for six hours will be an excuse for the DHSS to take no action to ensure that there are enough psychiatrists in hospitals.'

²⁷ Ibid Column 85-86 (27 April 1982)

²⁸ Ibid Column 86 (27 April 1982)

²⁹ Ibid Column 378 (20 May 1982)

Bean (1986) conceded that the introduction of Section 5(4) ended the legal uncertainties experienced by nurses under the 1959 Act; however he believed that this could have been achieved without resorting to statute. He suggested that the widening of the role of the doctor under Section 30(2) was sufficient to address the problems faced by nurses. Bean (1986: 50) saw the solution to nurses' difficulties as a simple one:

'One would have thought the simplest thing to do would be [for nurses] to inform the registered medical practitioner, or his nominated deputy, and to allow the normal procedure to be followed. After all, these situations rarely develop without some warning. If they do, common law powers exist to restrain patients anyway.'

As an academic rather than a clinician, Bean failed to recognise the situation faced by nurses in managing difficult clinical situations and also the limitations of common law. Bean's suggestion that, 'these situations rarely develop without some warning' is not true for all situations. For example, based on my own clinical experience, a patient may attempt to leave there-and-then without warning and before the nurse has had the opportunity to contact the doctor. In other cases, even when the doctor has been contacted, the patient may attempt to leave before they arrive to make their assessment.

Bean (1986: 50) also proposed that the granting of legal powers to nurses was in fact the result of a political agenda fuelled by trade union activity. He argues that at the time of the review of the 1959 Act COSHE was, 'demanding more and more status and influence for its members.' He also suggests that nursing staff at this time were making demands, 'for greater influence in the hospital in general and about which patients should or should not be admitted and the type of treatment to be given...' (ibid: 51). Bean (1986)³⁰ cites as an example of this influence COSHE's successful challenge to the European Commission of Human Rights which prevented the transfer of a patient from Broadmoor Hospital to an ordinary hospital in Oakwood, Kent because they did not have the resources for dealing with such patients.³¹ He suggests that the threat of union action that surrounded this case had the potential to, 'seriously disrupt and place patients in a vulnerable position' (Bean, 1986: 51). Bean (1986) believes that the

³⁰ For other examples of industrial action by psychiatric nurses at this time see Sedgwick (1982).

³¹ Council of Europe, *Ashingdean v. United Kingdom*, 12 May 1983).

decision to grant legal powers to nurses was not based on the difficulties they faced in relation to informal patients but an attempt to placate trade union demands. He comments that the holding power was, 'a sop to COSHE...to help secure cooperation to run the 1983 Act' (Bean, 2001: 54).³² Bean (1986: 51) believed that the power 'can do little to increase the respect for psychiatric nurses and may do harm to them'.

It was also suggested that granting nurses the holding power would negatively impact on their relationships with patients (Hoggett, 1984; Bean, 1986; Unsworth, 1987; Hoggett, 1996). For example, Unsworth (1987: 332) noted that:

'Section 5(4) for the first time formalizes the role of the nurse as gaoler, accentuating the custodial aspect of the nurse-patient relationship...'

Hoggett (1984: 15) believed that the low usage of the section reflected the fact that nurses were:

'...most reluctant to jeopardise their relationship with informal patients by holding this sort of threat over them'.

Hoggett (1996: 12) later conceded that there had been 'considerable use of it in some hospitals' but maintained that nurses were reluctant to use the section. However, she offered no rationale or evidence to support this claim other than there were less applications of Section 5 of the Act compared to other sections. However, during this debate there does not appear to have been any attempts to ask patients what they thought the potential impact of Section 5(4) on their relationships with nurses might be.

³² If Bean is correct, then this would not be the first time a profession had taken industrial action in relation to mental health legislation. For example, in 1884 doctors staged a certification strike, which effectively prevented patients from being admitted to hospital. Doctors were angry that patients were allowed to take 'legal retaliation' (Unsworth, 1987: 109) when they claimed they had been wrongly detained. They demanded and secured legislation to provide them with 'adequate protection against harassment by ex-patients' (Unsworth, *ibid*). Unsworth (*ibid*) commented that, '...it would seem that the state only conceded protection reluctantly, in recognition of doctors' power to disrupt the lunacy system to demonstrate a grievance.' Similarly, in 1924 doctors brought another certification strike in response to the outcome of the Harnett v. Bond case. Harnett, an ex-patient, sought compensation for eight years' alleged wrongful detention. Harnett was awarded £25,000 in damages. Although the decision was overturned on appeal doctors made demands for an inquiry into lunacy laws which was agreed in principle by the Government.

However, Gittins (1998: 46) does cite one patient's experience of detention in general in which a reference is made to Section 5(4):

'I was sectioned this last time. That had never happened to me in all my life! ...It's sort of a stain on one's character to be sectioned, and it was this young girl who did it, she'd just qualified, a young nurse. It was awful. I felt so humiliated.'

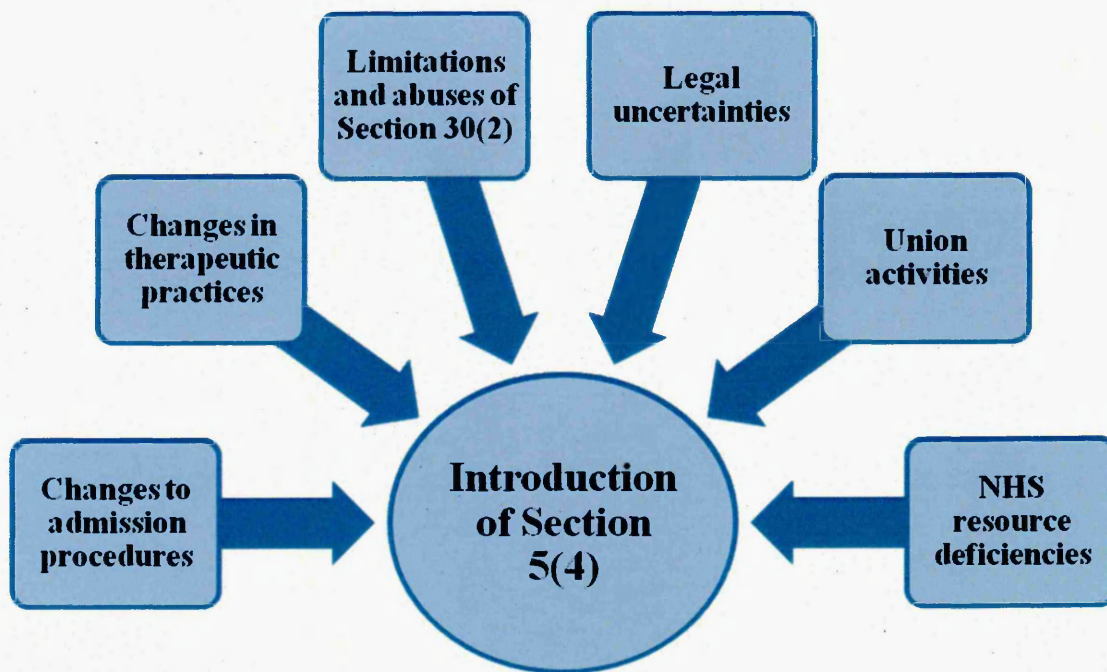
Finally, Rogers and Pilgrim (2005) believe that Section 5(4) was a retrograde step for psychiatric nursing as a developing profession. They believe that the granting of the powers, 'presents something of a contradiction within the professional ideology of psychiatric nursing' (Rogers and Pilgrim, 2005: 204). Rogers and Pilgrim argue that nurses' claims to, 'an original body of knowledge rests on nursing's unique skills of 'caring'' was undermined by seeking greater professional power, 'via their coercive role in relation to psychiatric patients' (ibid). Similarly, during the Parliamentary debates on Section 5(4) Price (1982) commented in relation to the nursing profession that:

'The moment it is given powers of detention by Parliament, the inherent nature of nursing as a caring profession starts to be eroded... The job of a nurse is to look after, comfort, and make the patient comfortable, and not act as a jailor.'³³

The main factors influencing the introduction of Section 5(4) are summarised in Figure 2.

³³ Hansard HC Volume XI Column 377 (20 May 1982)

Figure 2 Summary of factors influencing the introduction of Section 5(4)



2.4 Literature review

2.4.1 Introduction

The aim of this section is to outline the steps involved in locating and summarising the empirical literature relating to the implementation of Section 5(4). The main findings of the literature review are then presented.

The literature located and reviewed in this section is the end product of an ongoing process that began in 1989 when I was undertaking my first piece of research on Section 5(4) (Ashmore, 1991). From that point forward I regularly updated my knowledge of the literature by: searching electronic databases; following up references cited in book chapters on the Mental Health Act; accessing official reports, for example Department of Health annual statistics on the use of the Act; and by accessing proceedings from the major mental health nursing conferences held in the United Kingdom for the period

1996-2011.³⁴ This awareness of the literature provided me with valuable insights for substantiating my primary research question.

2.4.2 Search techniques

Following the guidance offered by a number of authors (for example; Alexis and Vydelingum, 2005; Holopainen et al., 2008, Creswell, 2009) a number of systematic steps were taken to identify and summarise the empirical literature relating to the implementation of Section 5(4).

2.4.2.1 Step 1

The first step in developing a comprehensive literature search strategy was to identify a number of relevant search terms. Key and associated key words were generated from my awareness of existing literature and by reading literature on topics relevant to the Act. For example, the systematic review of research relating to the Mental Health Act (1983) undertaken by Churchill et al. (1999) using the keywords 'Mental Health Act', 'the Act', 'MHA', and 'mental health legislation'. As many words as possible were written down that might help to generate material on the topic and then these were refined until a final smaller number remained that were used to search the literature. In addition, subject headings contained in electronic databases were also used to improve the sensitivity of the search.

2.4.2.2 Step 2

In Step 2 a literature search of the electronic databases Applied Social Sciences Index and Abstracts (ASSIA), Cumulative Index to Nursing and Allied Health Literature (CINAHL), British Nursing Index (BNI), Medline, PsycINFO, and Lawtel was undertaken using the search terms 'Section 5(4)', 'nurse's holding powers', 'holding powers', 'Mental Health Act 1983', 'MHA', 'compulsory detention', 'formal detention', 'emergency psychiatric interventions', 'containment interventions', and 'involuntary commitment' for the period 1st January 1983-31st December 2006 inclusive

³⁴ The conferences were the: European Mental Health Nursing conference; International Network for Psychiatric Nursing (NPNR) conference; Royal College of Nursing Mental Health Nursing conference; National Mental Health Nursing conference; and the English National Board Mental Health Nursing conference.

of dates.³⁵ Advanced search options were utilised in all databases which enabled the use of a thesaurus and/or Medical Subject Headings (MeSH). However, most searches were keyword searches as subject headings were not available for most search terms. The subject heading 'involuntary commitment' was available in CINAHL/BNI, Medline, and PsychINFO.

The following inclusion criteria were used for this literature review. First, only articles published in peer reviewed journals between 1st January 1983 and 31st December 2006 were included in the review.³⁶ It was reasoned that this period of time was likely to identify any research leading up to the introduction of the section along with more up-to-date and relevant empirical information up to the point when the data generation period in this study was concluded. Second, only articles written in English were included. This decision was unlikely to exclude any relevant articles as Section 5(4) relates specifically to mental health legislation in the United Kingdom, although nurses in New Zealand have a similar holding power. Articles that did not focus on primary research were excluded as were duplicate publications.

2.4.2.3 Step 3

The initial search of the databases generated a large number of abstracts (n = 25,923) (Appendix 4). In relation to the search terms 'Section 5(4)', 'Mental Health Act 1983', 'MHA', and 'involuntary commitment' an information management strategy was introduced to reduce the number of abstracts. This strategy was to utilise the Boolean operator 'NOT'. 'Section 5(4)' was combined with NOT midwifery NOT caesarean, and the search terms 'Mental Health Act 1983', 'MHA', and 'involuntary commitment' were combined with NOT treatment. This reduced the number of abstracts to 4405.

³⁵ **Assia** (1987-Present) provides a comprehensive source of social science and health information for the practical and academic professional. It contains records from 650 journals in 16 different countries, including the UK and US. **BNI** (2004-Present) is an extensive and up-to-date nursing and midwifery database. **CINAHL** (1937-Present) is a database for nursing and allied health, provides full text for 760 journals. **Lawtel** (1980-Present) summarises articles from 50 legal journals. **Medline** (1950-Present) provides information on medicine, nursing, dentistry, veterinary medicine, the health care system and pre-clinical sciences. **PsychINFO** (1806-Present) covers articles including 2,450 professional journals from a range of disciplines related to psychology such as psychiatry, education, business, medicine, nursing, law, linguistics, and social work.

³⁶ A further search of the literature was undertaken in January 2012 for the period 1st January 2007-1st January 2012 in order to identify any new research on the topic that may have been missed during previous searches. It was reasoned that any new material could be relevant for the discussion undertaken in Chapter 10.

The titles and abstracts for these articles were then read and a decision made regarding their relevance to the literature review, leading to the exclusion of a large number of publications. A complete copy of each of the remaining articles was obtained either electronically or as a hard copy from holdings in the University of Sheffield Library and Sheffield Hallam University Library. Where this was not possible a copy was obtained from The British Library.

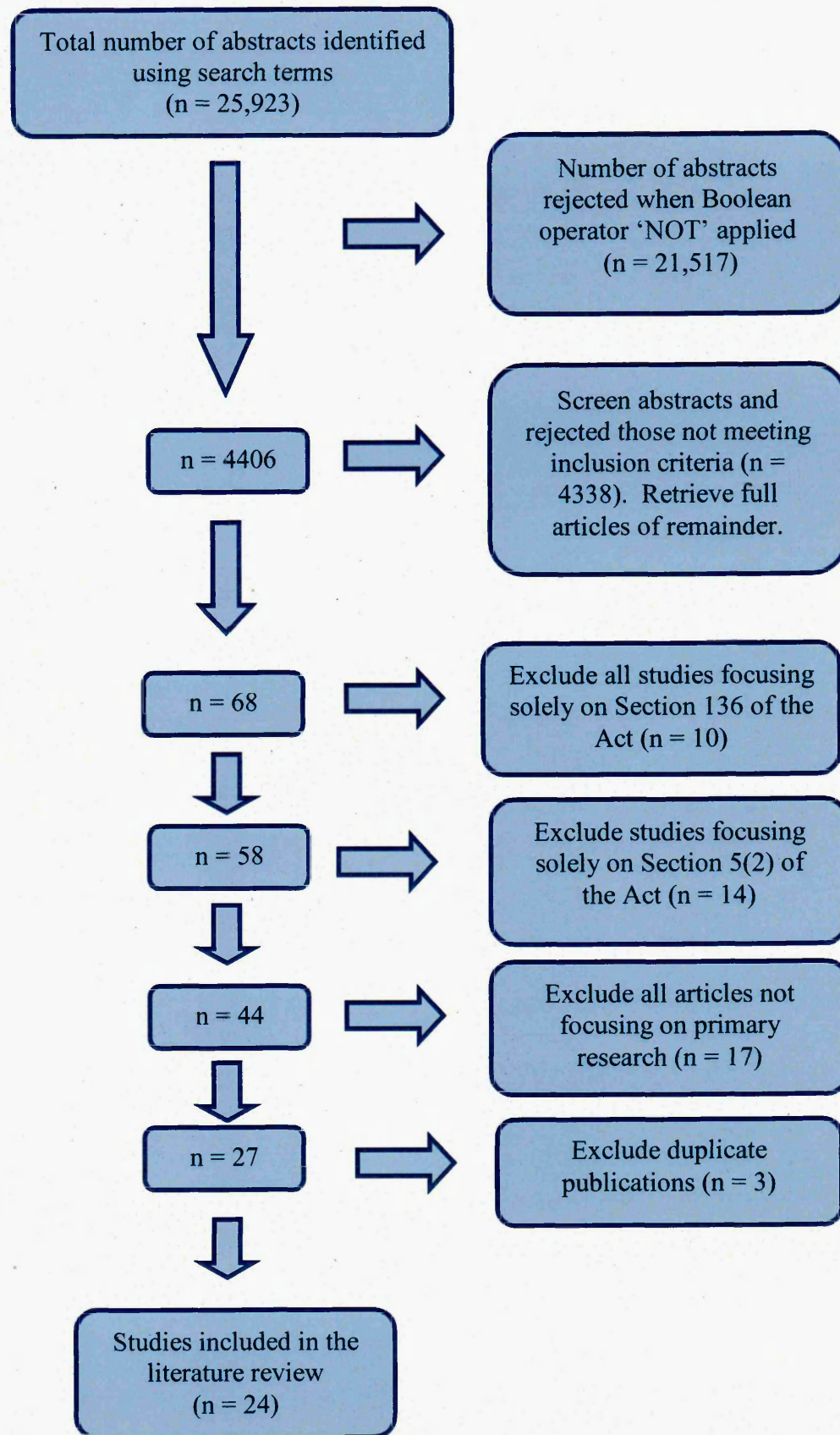
2.4.2.4 Step 4

Articles were then read in full resulting in a number being excluded as they did not meet the review's inclusion criteria. This step also identified a small number of articles through citation referencing that were then obtained and assessed for relevance to the review, some of which existed within the 'grey literature' (non-databased and unpublished reports) and had to be obtained by communicating directly with the author (Figure 3).

2.4.2.5 Step 5

The articles included in the review were then read several times to gain an understanding of the material they contained. Matrices were also produced in order to create an 'at a glance' access to different aspects of the information contained in the articles. These two methods enabled the articles to be compared and contrasted in order to identify the main themes contained within the research. The themes were then summarised and structured into the findings of the review reported below.

Figure 3 Flow chart of search strategy



2.4.3 Findings

A total of 68 papers were identified during Step 3. Twenty-four papers were then excluded as they referred exclusively to other emergency sections of the Act but not Section 5(4). Seventeen papers were excluded as they did not focus on primary research. These papers outlined the introduction of Section 5(4) (Sumner, 1983; Killen, 1983; Brooking, 1984; Smith, 1984; Leopoldt, 1985; Finch, 1986), described the administrative process that followed the application of the section (Dimond, 1983; Cooke, 1984; Finch, 1984), and discussed the implications for both nurses and patients of the decision to use or not to use Section 5(4) (Shanley, 1983; Ashmore and Carver, 2000a; Cutcliffe et al., 2000; Rogers and Topping Morris, 2000). Two papers discussed the reforms of the 1983 Act (Ashmore and Carver, 2000b; Ashmore and Carver, 2000c). Three articles (Ashmore, 1991; Ashmore, 1993; Ashmore, 1998a) were excluded as they reported preliminary findings that were incorporated in later publications (Ashmore, 1992a; Ashmore, 1995; Ashmore, 1998b). Therefore, the earlier publications were summarised as part of the review of the later reports. A total of 24 articles were included in the final review. As so few articles met the inclusion criteria a decision was made to include two pieces of research that did not appear in peer review journals (Goldstrom, 1993; Ajetunmobi, 2001c).

2.4.3.1 Aims

Two studies explored mental health nurses' attitudes to the introduction of the holding power (Hussain and Varadaraj, 1983; Dimond, 1989) and a further two investigated how nurses' perceptions of Section 5(4) impacted on their willingness to implement it (Allen and Johnson, 1992; Carver and Ashmore, 2000). Four studies investigated nurses' knowledge of Section 5(4) (Ward, 1991; Ashmore, 1992a; Goldstrom, 1993; Ashmore, 1998b). Six papers sought to identify the factors associated with the implementation of Section 5(4) (Ashmore, 1992b; Bowler and Cooper, 1993; Ashmore, 1998c; Lovell et al., 1998; Ajetunmobi, 2001a; Shivram, 2006). Two papers explored the factors that influenced doctors' response time to Section 5(4) (Ashmore, 1995; Ajetunmobi, 2001b). Three papers examined the use of Section 5(4) and its effect on the rate of conversion of Section 5(2) to other sections of the Act (Salib, 1998; Pym et al., 1999; Ajetunmobi, 2001c). Five papers aimed to identify the factors associated with the implementation of Section 5(2), including whether or not it had been preceded by

the application of Section 5(4) (Salib and Iparragaire, 1998; Brown et al., 2000; Ebrahim and Botha, 2000; Salib et al., 2000; Dearman and Waheed, 2003).

2.4.3.2 Design and methods

All studies in this review were descriptive and with the exception of Carver and Ashmore (2000) had a retrospective design. Six studies reported questionnaire surveys. The majority of these studies used forced-choice instruments. Only one paper indicated that 'some attempts were made towards ensuring reliability and validity' (Ashmore, 1998: 12), but no other details were given as to what this consisted of. Nineteen studies reported audits of case notes or Mental Health Act documentation.

2.4.3.3 Setting, sample, and analytical techniques

The majority of findings reported on data generated from single settings, mainly NHS Trusts. Two studies generated data from single academic institutions (Ashmore, 1992a; 1998b). The exception to this was the study undertaken by Carver and Ashmore (2000) where the authors published a questionnaire in the journal *Mental Health Practice*. The readership was asked to complete and return the questionnaire.

All data were generated from convenience samples with the exception of Ashmore (1998b) who identified his as a purposive sample. Sample sizes ranged from 25 to 571 and the period over which the data were collected ranged from one to 16 years (Ashmore, 1992b; Lovell et al., 1998; Ajetunmobi, 2001a; Shivram, 2006). Response rates ranged from 33.7%-100% (Allen and Johnson, 1992; Ashmore, 1998b). Most studies (n = 17) did not described their analytical strategies. All studies presented their findings in the form of descriptive statistics and eight also provided inferential statistics.

2.4.3.4 Nurses' opinions of Section 5(4)

Five studies elicited nurses' views of Section 5(4). Most nurses appear to hold positive attitudes towards the section, with up to 90% of respondents in the surveys being in favour of nurses having legal powers of detention under the Act (Hussain and Varadaraj, 1983; Dimond, 1989; Ward, 1991; Goldstrom, 1993; Carver and Ashmore, 2000). Carver and Ashmore (2000) reported that most nurses (89%) who had used Section 5(4) felt confident in their ability to implement it compared to 58% of respondents who had never used it.

Hussain and Varadaraj (1983) reported that 40% of respondents believed that six hours was the correct length of Section 5(4) while a further 40% indicated that it should be no longer than four hours. Carver and Ashmore (2000) found that some nurses (44%) felt that 24 hours was an appropriate length for the section, with a small number (9.8%) suggesting times of up to 72 hours. Approximately 4% felt the length of time should be less than six hours. Dimond (1989) reported that some nurses expressed concerns that doctors would abuse Section 5(4) and not arrive on the ward until close to the end of the six hour deadline.

2.4.3.5 Nurses' knowledge of Section 5(4)

Four studies have explored whether or not both student and qualified mental health nurses had what the authors believed to be 'sufficient' knowledge of Section 5(4) (Ward, 1991; Ashmore, 1992a; Goldstrom, 1993; Ashmore, 1998b). Sufficient knowledge was defined in one study as 'the ability to identify correctly the conditions specified in the Mental Health Act for the legal detention and care of the patient under section 5(4)' (Ashmore, 1998b: 9). Overall, these studies reported that both qualified and student mental health nurses had gaps in their knowledge of Section 5(4) that may impede their ability to implement the holding power in practice.

The majority of respondents were aware that for the patient to be detained under Section 5(4) they must be assessed to be a danger to themselves and/or others (range 83.3%-95%). In addition, respondents were also aware that for a person to be detained they must be an in-patient receiving treatment for a mental disorder (range 54%-83.3%), but some also believed that day and out-patients could be detained. A small number of students thought that visitors could be detained under the section (Ashmore, 1998b).

Most respondents (range 67%-70.8%) were aware that nurses could not be instructed to implement Section 5(4). However, others believed that psychiatrists and more senior nursing colleagues could instruct them to implement the section. A small number of qualified nurses believed that they could not apply Section 5(4) without a doctor telling them to do so (Ward, 1991).

The majority of respondents (range 81%-96%) knew that Section 5(4) lasted up to six hours. In one study (Ashmore, 1998b) some respondents (19%) believed the duration of Section 5(4) to be anything from two-12 hours in length. There also appears to be a common misconception about when Section 5(4) starts and finishes. While some were able to correctly identify the fact that Section 5(4) starts with the completion of Form 13 (range 16.7%-60.6%) up to 65% (Ashmore, 1998b) believe that it commences when the patient is informed. Similarly, errors also existed in relation to when the section ends. While some respondents were able to state correctly that Section 5(4) ended with the arrival of the psychiatrist on the ward (25%-75%); others believed that it was once the medical assessment had been undertaken (63%) (Goldstrom, 1993; Ashmore, 1998b). In addition, some respondents were unaware that any time spent on Section 5(4) counted as part of any subsequent time on Section 5(2) (38%-70.8%).

One study (Ashmore, 1998b) explored whether students knew that a psychiatrist was required to assess the patient within four hours of Section 5(4) being applied. Ten per cent of respondents were aware of this, 39% believed it to be one-three hours, 28% six-eight hours, and 23% did not know. Nurses were also asked to indicate what they would do if the section lapsed before the psychiatrist arrived on the ward. The most common answer was that they would use common law to prevent the patient leaving (range 26%-29%). Other responses were that they would implement another Section 5(4) (range 16%-23.8%) or allow the patient to leave immediately (range 7.1%-11%). Only 12% were correctly able to identify that the Code of Practice (DH, 1999) states that the hospital manager is required to supervise the patient leaving (Ashmore, 1992a; Ashmore, 1998b).

Finally, the majority (range 83%-85%) of nurses knew that a patient detained under Section 5(4) could not be treated against their will, although a small number (4%) believed that they could and a further small number believed it was sometimes justifiable (7%). In the latter case no further information was offered on what 'sometimes' meant (Ashmore, 1998b).

2.4.3.6 Frequency of use

Twelve papers reported on the number of Section 5(4)s applied in NHS Trusts. While the annual use of Section 5(4) has increased significantly since its introduction (DH,

1995; Ashmore, 1998c; NHS ICHSC, 2011), there are wide variations in its implementation within individual mental health NHS Trusts. For example, Lovell et al. (1998) have reported an average of 1.8 applications per annum while both Ashmore (1992b) and Shivram (2006) report a figure of 75 per annum. Some of these variations in use may have been influenced by the period over which data were collected, for example Ashmore (1992b) and Shivram (2006) reported on a one-year period while Lovell et al.'s (1998) findings were based on statistics from a 14-year period.

Although no systematic attempts have been made to investigate why this wide variation in applications occurs a number of authors have speculated on the phenomenon. For example, Lovell et al. (1998) have suggested that such differences could be explained by nurses persuading the patient to stay to see a doctor, on-site teams responding to emergencies within a few minutes, the locking of the ward door or falsely telling the patient that they must be seen by a doctor before leaving the hospital.

2.4.3.7 Clinical area

Two researchers reported on the clinical services in which the section was applied (Ashmore, 1998c; Shivram, 2006). The majority (range 85.3%-94%) of Section 5(4)s were applied in acute adult in-patient services. Section 5(4) was also applied in smaller numbers in adolescent, older adult, enduring mental health, forensic settings, learning disabilities, liaison, forensic, and intensive care services.

2.4.3.8 Age, gender, and ethnicity of patients

Six studies reported on age and the implementation of Section 5(4) (Bowler and Cooper, 1993; Lovell et al., 1998; Salib, 1998; Pym et al., 1999; Ajetunmobi, 2001a; Shivram, 2006). Bowler and Cooper (1993) reported a mean age at implementation of 33 years (range 17-76 years), Salib (1998) and Pym et al. (1999) a mean age of 37 years (range 19-60 years), and Lovell et al. (1998) a mean age of 38 years (range 19-57 years). Ajetunmobi (2001a) reported that the highest number of applications of Section 5(4) were in the 20-24 and 25-29 years old age groups. Their combined total accounted for 40% of all Section 5(4)s implemented. Shivram (2006) reported that 62% of all males detained were aged 16-34 years old while 81% of all women detained were 35 years and over.

Eight studies reported on the gender of patients detained under Section 5(4). With the exception of Lovell et al. (1998), all studies (Ashmore, 1992b; Bowler and Cooper, 1993; Ashmore, 1995; Ashmore, 1998c; Pym et al., 1999; Shivram, 2006) reported that more female (range 53%-61.7%) than male (range 38.3%-47%) patients were detained under Section 5(4). Lovell et al. (1998) reported that male patients accounted for 56% of Section 5(4)s. Shivram (2006) has suggested that the reason more women are detained under Section 5(4) may be because female patients are perceived to pose a higher risk to themselves and/or others during hospital admission. However, he offers no evidence to substantiate his claim. Others (Ashmore, 1998c) have suggested that this simply reflects the fact that at the time of the study there were more female than male admissions.

One study (Ashmore, 1998c) reported on the gender of the nurse implementing Section 5(4) and found that the majority (58.7%) were applied by males. Male nurses detained 55.9% of all female patients and 64.2% of all male patients. It is unclear whether this is a significant finding as one only study (Ashmore, 1992b) has reported on the number of male (47.2%) and female (52.8%) mental health nurses working in the NHS Trust during the data generation period.

Lovell et al. (1998) reported that 12 patients (48%) detained under Section 5(4) were white, and five (20%) were Afro-Caribbean - data were not reported for eight patients (32%). No other study has reported on the ethnicity of patients detained under Section 5(4).

2.4.3.9 Diagnosis

Five papers provided details of the diagnosis of patients detained under Section 5(4) (Bowler and Cooper, 1993; Salib, 1998; Pym et al., 1999; Ajetunmobi, 2001; Shivram, 2006). Bipolar disorder (range 15%-55.6%), schizophrenia (range 19%-30.3%), depressive disorders (range 18%-30%), alcohol dependency (range 1%-28%), and personality disorder (range 5.1%-18%) were the most common diagnoses of people detained under Section 5(4). Other diagnoses reported were: organic confusional state (7%); learning disabilities; paranoid states (4.1%); dementia (range 1%-3%); puerperal psychosis (2%); adjustment reaction (1%); anxiety state (1%); anorexia nervosa (1%).

Shivram (2006: 35) states that 'progression of Section 5(4) to Section 5(2) and Section 2 or 3 of the Act appeared to be influenced by the working diagnosis.' He reported that those patients with a diagnosis of schizophrenia, depression (moderate to severe) and mania were more likely to progress from Section 5(4) to Section 2 or 3 than a patient with a diagnosis of personality disorder, drug-induced psychosis or alcohol dependency. However, statistical analysis undertaken in the studies reported by Salib (1998) and Pym et al. (1999) did not support Shivram's (2006) claim.

2.4.3.10 Season, month and day of the week

Six papers provided information on the relationship between season, month, and day of the week and the application of Section 5(4) (Dimond, 1989; Ashmore, 1992b; Ashmore, 1998c; Lovell et al., 1998; Ajetunmobi, 2001a; Shivram, 2006). There were no significant seasonal or monthly variations in the use of Section 5(4) (Ashmore, 1992b; Ashmore, 1998c; Ajetunmobi, 2001a)

In relation to day of the week, again there was no significant variation in the application of the section. Three papers reported that the least number of sections were applied on a Friday (Ashmore, 1998c; Lovell et al., 1998; Ajetunmobi, 2001a), but others have reported that most occurred on this day (Dimond, 1989; Shivram, 2006). Only one study (Ashmore, 1998c) reported that the most Section 5(4)s occurred on a weekend (Saturday) and one (Shivram, 2006) the least (Sunday). Therefore, the expectation that the likelihood that more Section 5(4)s would be applied at the weekend when less doctors are available to assess a patient does not seem to be supported by the research findings.

2.4.3.11 The application of Section 5(4) over a 24-hour period

Eight studies have reported that there were wide variations in the application of Section 5(4) over the 24-hour period. Four studies have reported that the likelihood of Section 5(4) being implemented during the day can be divided into three periods (Ashmore, 1992b; Ashmore, 1998c; Lovell et al., 1998; Ajetunmobi, 2001a). The low period (midnight-8.00 a.m.) accounted for between 8% and 14% of all Section 5(4)s applied. The low use of Section 5(4) during this time frame has been attributed to this being a period when most patients would be expected to be asleep. In addition, it has been suggested that those patients still awake are likely to receive more input from nurses

(who have more time to talk to patients about their problems) and, although not explain how, this somehow addresses the factors that may lead to the need to apply the section (Ashmore, 1999b; Ashmore, 1998c; Lovell et al., 1998).

The medium period (8.00 a.m.-4.00 p.m.) accounted for between 32% and 40% of all Section 5(4)s applied. The higher number of Section 5(4)s applied during this period has been attributed to increased activity and noise on the ward, patients waking, fewer staff being available due to undertaking essential duties such as handover, medication rounds, and multi-disciplinary team meetings, all of which are seen as reducing the amount of time nurses are spending in direct patient contact.

The high period (4.00 p.m.-midnight) accounts for between 46% and 58% of all Section 5(4)s applied. Explanations for this high rate of application include the withdrawal of the doctors, that patients are at their most active, and levels of noise and clinical activities on the ward being at their highest.

Six studies reported that a high number (range 29.5%-76%) of Section 5(4)s were applied during doctors' office hours (Monday-Friday, 9.00 a.m.-5.00 p.m.) (Dimond, 1989; Ashmore, 1992b; Bowler and Cooper, 1993; Ashmore, 1998c; Lovell et al., 1998; Pym et al., 1999). Although, Dimond (1989: 542) notes that 'these findings seem odd because they do not accord with the assumption that the holding power would be used when the doctor was not normally available', none of the studies have explained adequately the high rate of usage during this period.

2.4.3.12 Reasons for implementing Section 5(4)

Four studies have reported on the reasons given by nurses for implementing Section 5(4) (Allen and Johnson, 1992; Bowler and Cooper, 1993; Salib, 1998; Pym et al., 1999). In summary, patients were detained because they refused to stay in hospital informally and it was believed that there was a risk that they would harm themselves or others. A diagnosis of active/severe psychosis, serious mental illness and dementia were also given as reasons for implementing the section. In addition, Bowler and Cooper (1993) reported that they found doctors had written in medical notes that named patients should not be allowed to leave the ward. Although the researchers did not

comment on the frequency of this practice the implication was that nurses' decisions to implement Section 5(4) may be influenced by it.

2.4.3.13 Length of admission and the use of Section 5(4)

Several authors have reported on the length of admission and the implementation of Section 5(4) (Bowler and Cooper, 1993; Salib, 1998; Pym et al., 1999; Ajetunmobi, 2001a; Shivram, 2006). Approximately 80% of all Section 5(4)s are applied within the first month of admission after which its use decreases significantly the longer the patient remains in hospital (Ajetunmobi, 2001a; Shivram, 2006). Between 24% and 35% of all Section 5(4)s are applied during the first 24 hours of admission (Bowler and Cooper, 1993; Pym et al., 1999; Ajetunmobi, 2001a). Salib (1998) reported that 6% of all Section 5(4)s occurred within the first 12 hours of admission. Up to 55% of applications occurred during the first week of admission (Ajetunmobi, 2001a; Shivram, 2006).

No research has been undertaken to explore why so many Section 5(4)s occur during the first week of admission. However, Shivram (2006) has speculated that ideally these patients should have been admitted under Section 2 or 3 although this may not have been clear at the time of the admission. Both Shivram (2006) and Ajetunmobi (2001a) have suggested that the first week of admission - particularly the first 48 hours - are unsettling for the patient. However, neither author offers any evidence to support their claims or speculates how admission unsettles patients.

2.4.3.14 Outcome of Section 5(4)

Information on the outcome of Section 5(4) has been reported in 13 papers. Consistent with national statistics (see for example NHS ICHSC, 2011), the majority of patients were placed on another section of the Act following the medical assessment (range 79.5%-96%). Section 5(4) was converted to Section 5(2) in most cases; however small numbers of patients went directly to Section 2 or 3 (Bowler and Cooper, 1993; Ashmore, 1995; Ashmore, 1998c). Of those Section 5(4)s not converted the reasons given were that: the patient had absconded; the crisis had been resolved and the patient required no further treatment; the section had lapsed before the arrival of the doctor; and the patient agreed to stay in hospital voluntarily. In one study it was reported that 4% of

patients had become informal again due to disagreement between doctors and nurses on the need for further detention (Ajetunmobi, 2001c). However, although this was a potentially interesting point, the author offered no further information on the issue. It has been proposed that the high conversion rate from Section 5(4) to other sections of the Act may reflect the accuracy of the nurses' assessments or that it may be explained by on-call doctors being unfamiliar with the patients and so agree with the nurses' decision in order to 'play it safe' (Ashmore, 1992b; Shivram, 2006).

Six studies reported on the likelihood of Section 5(2) (doctor's holding power) being converted to another section of the Act if it was preceded by Section 5(4) compared to those that were not (Salib, 1998; Salib and Iparragaire, 1998; Brown et al., 2000; Ebrahim and Botha, 2000; Salib et al., 2000; Dearman and Waheed, 2003). Salib (1998) reported that the rate of conversion to other sections of the Act was significantly higher when Section 5(2) was preceded by Section 5(4), compared to when the nurse's holding power was not applied - 80% compared to 53%. Similar findings have been reported by Salib and Iparragaire (1998), Brown et al. (2000) and Salib et al. (2000). However, Ebrahim and Botha (2000) and Dearman and Waheed (2003) could not replicate these findings.

2.4.3.15 Medical response time

Ashmore (1992b: 45) defines medical response time (MRT) as, 'the elapsed time...between the completion of Forms 13 and 16.' This is taken to be the time between the implementation of Section 5(4) and the arrival on the ward of the RMO to undertake their assessment of the patient. The 1990 Code of Practice (DH, 1990) stated that the MRT should not exceed five hours. This figure was reduced to four hours in the revised Code of 1993 (DH, 1993) and remained unaltered in the 1999 Code (DH, 1999).

MRT was examined in eight studies (Dimond, 1989; Ashmore, 1992b; Ashmore, 1995; Ashmore, 1998c; Lovell et al., 1998; Salib, 1998; Ajetunmobi, 2001b; Shivram, 2006). The reported mean MRT showed a wide variation from 72 minutes (Shivram, 2006) to 189 minutes (Ashmore, 1995). The range of time the patient remained on Section 5(4) was five to 400 minutes. Lovell et al. (1998) did report a mean MRT of 46 minutes, but this figure should be treated with a degree of caution as the authors appear to have excluded seven patients who remained on Section 5(4) for the full six hours from their

calculations. When their figures are adjusted to take this into account the mean MRT increases to 134 minutes.

Five studies have reported that between 62% and 95% of patients are assessed within the four hour period recommended in the Code of Practice (DH, 1999) (Ashmore, 1995; Ashmore, 1998c; Salib, 1998; Ajetunmobi 2001b; Shivram, 2006). One study reported that the annual mean MRT had decreased significantly over a 16-year period since its introduction in 1983 (Ajetunmobi, 2001b). However, five studies reported that between 5.4% and 29% of patients remained on Section 5(4) for the full six hours. Attempts to explain why some patients remain on the section for the full six hours include that the psychiatrist may be using Section 5(4) as a short-term detention order to determine the seriousness of the patient's crisis (Ashmore, 1995).

No significant differences were reported for mean MRT for day of the week. However, Ajetunmobi (2001) reported that the mean MRT for the weekend (Saturday and Sunday) was significantly shorter than weekdays (Monday-Friday) - 99 compared to 131 minutes. Three studies have reported that mean MRT increases during doctors' office hours compared to other time frames during the day (Ashmore, 1992b; Ashmore, 1995; Ashmore, 1998c). It has been suggested that during office hours psychiatrists may not be readily available to assess the patient because they are involved in other activities, for example out-patient clinics.

2.4.3.16 Alternatives to implementing Section 5(4)

Two studies (Allen and Johnson, 1992; Carver and Ashmore, 2000) have explored strategies deployed by mental health nurses to prevent patients considered at risk from leaving hospital without implementing Section 5(4). The most common intervention cited was persuasion and is consistent with the Code of Practice (DH, 1999). However, as Carver and Ashmore (2000: 22) note 'it...remains an open question as to how nurses 'persuade' patients to stay and whether these methods are legitimately persuasive.' Other interventions cited were: locking the ward door, giving medication, blocking the patient's path, distraction, and restraint. In the Allen and Johnson (1992) study nurses physically restrained some patients for more than one hour.

2.4.3.17 The effect on the nurse-patient relationship of the application of Section 5(4)

Some authors have suggested that the implementation of Section 5(4) will negatively affect the nurse-patient relationship (see for example Rogers and Topping Morris, 2000). Two papers addressed this issue (Dimond, 1989; Carver and Ashmore, 2000). Dimond (1989: 545) asked nurses who had used Section 5(4) if they had noticed 'any harmful effects on their relationship with the patient.' Respondents answered, 'none at all' (ibid). Another nurse commented that, 'there was no resentment from the patient' (ibid). Carver and Ashmore (2000: 22) reported that approximately 29% of their sample (n = 152) believed that implementing Section 5(4) 'negatively affected the nurse-patient relationship'. They made a further distinction between nurses who had implemented the section and those that had not. Thirty-two per cent of those who had implemented the section believed it affected the nurse-patient relationship compared to 45% of nurses who had never used the section.

In addition, nurses reported that the use of Section 5(4) led to the patient feeling 'protected' and 'that people do care and want them to be safe' (ibid). However, some nurses in the study also reported that some patients following detention under Section 5(4) had 'disengaged from therapeutic work' or had become 'resistant to treatment' (ibid). However, it remains unclear whether these negative outcomes can be directly attributed to the use of Section 5(4) per se or whether they are an outcome of any subsequent periods of detention under the Act. On the whole, nurses agreed that the use of Section 5(4) to maintain the safety of the patient or others took precedence over the potential negative impact on the therapeutic relationship. Therefore, while the available research has provided accounts of nurses' opinions on the subject, there is no research that shows in what way, if at all, the implementation of Section 5(4) actually impacts on the therapeutic relationship.

2.4.3.18 Patients views on Section 5(4)

Only one study (Dimond, 1989) has reported on patients' opinions of Section 5(4) and in this case those views were obtained from nurses rather than directly from the patients. Nurses reported that patients responded with 'frank disbelief' (Dimond, 1989: 545) when told that a nurse could detain them. However, it was also reported that once informed of Section 5(4) patients seemed to accept the fact. Dimond (ibid) also

reported that one ward sister had stated that, 'the patient seemed pleased the matter was taken out of his hands'. Many patients were also reported to be 'too disturbed to appreciate the legal niceties of their situation' (ibid).

2.5 Conclusion

The first part of this chapter (sections 2.2-2.2.8) has provided a description of what Cavidino (1989: 71) has described as 'the law in the books'; that is what nurses can and cannot do under Section 5(4) of the 1983 Act. In addition, the relevant guidance offered by the Code of Practice (DH, 1999) to nurses on using Section 5(4) has also been described. However, while these documents provide important information about Section 5(4), there is an absence of literature reporting on how nurses interpret and use these documents to inform their practice when using the holding power; that is an account of the 'law in action' (Cavadino, ibid), for example, how nurses interpret the meaning of 'premises' or 'persuasion' mentioned in the Code (DH, 1999).

The second part of the chapter (sections 2.3-2.3.4) has provided an account of the origins of Section 5(4). It has been suggested that a number of factors contributed to the introduction of Section 5(4) in the 1983 Act. This section has also highlighted the tensions between those who believed that Section 5(4) was unnecessary, and a genuine concern among mental health nurses to resolve the uncertainty they faced when managing an informal patient who was considered a risk; sometimes with tragic consequences. Some believed that for mental health nursing as a profession the introduction of Section 5(4) was a retrograde step that could only impact negatively on their relationship with patients. It was also suggested that as Section 5(4) emphasised the coercive aspect of the nurse's role they were unlikely to use it.

The final part of this chapter (sections 2.4-2.4.3.18) has reported on a review of the empirical literature relating to the implementation of Section 5(4) of the Mental Health Act 1983. The majority of studies in this review employed retrospective designs to generate data in single study sites. On the whole, sample sizes were small and methods used to generate data were those commonly associated with the quantitative research tradition.

The literature has focused on three main areas. The first area reported on mental health nurses' opinions of Section 5(4) and it is clear that the majority believe that the nurse's holding power is a useful piece of legislation. The second area has focused on mental health nurses' (registered and final year students) knowledge of Section 5(4). These studies suggest that gaps exist in nurses' knowledge of Section 5(4) that may affect practitioners' ability to implement the section correctly, but no research has explored whether this is actually the case in practice.

The third main area of research has focused on the trends associated with the implementation of Section 5(4). In summary, the literature suggests that the person detained under Section 5(4) is likely to be female, aged in their thirties, a patient on an adult acute in-patient ward and have a diagnosis of schizophrenia, bipolar disorder, major depressive disorder, or alcohol dependency. In addition, they will be detained on a weekday by a male nurse between 9.00 a.m. and 5.00 p.m. during the first week of admission. Most patients are assessed by a psychiatrist within four hours of being detained and will be placed on at least Section 5(2) of the Act. The reasons given for implementing Section 5(4) were that the patient was a danger to themselves or others and was unwilling to remain in hospital.

In summary, the literature reviewed has provided valuable insights into nurses' attitudes and knowledge of Section 5(4). It has also provided consistent findings on the trends associated with the use of Section 5(4), although these would benefit from a large, multi-sited study to confirm them. However, the review has identified a number of issues that have not been addressed empirically, for example the high number of Section 5(4)s implemented during the Monday-Friday, 9.00 a.m. - 5.00 p.m. and how and why nurses implement their holding power. Some of these issues have potential implications for how mental health nurses practice and the quality of care received by those people who are detained under Section 5(4). The rationale for undertaking further research in this area will be addressed in the next chapter.

Chapter 3

Methodology

“‘Tell me one last thing,’ said Harry. ‘Is this real? Or has this been happening inside my head?’

Dumbledore beamed at him... ‘Of course it is happening inside your head, Harry, but why on earth should this mean that it is not real?’”

Rowling (2007: 579)

3.1 Introduction

This chapter focuses on the methodological aspects of the study. A rationale is offered for undertaking this study followed by the presentation of the study's aims. A distinction is made between qualitative and quantitative research and it is argued that the former constitutes the most appropriate approach for answering the questions posed in this study. The chapter then considers relevant philosophical issues and concludes by positioning the study within a relativist ontology and social constructionist epistemology. A justification is also offered for both; the choice of the case study as the research strategy employed in the research, and the methods used to generate data on the use of Section 5(4).

3.2 Rationale for the study

As described in the previous chapter Section 5(4) was introduced in an attempt to resolve the uncertainties encountered by nurses when managing informal patients who expressed a desire to leave hospital but were considered at risk. However, it is proposed that Section 5(4) has seemingly been perceived as no more than a footnote in history (Bean, 1986; Unsworth, 1987; Nolan, 1993). As a result of this the topic has been given little attention in contemporary mental health nursing texts (Parsons, 2003). Even when it has been considered in more depth the emphasis has been on the legal and administrative rather than the practical aspects of its implementation (Hanily, 1999; Fennell, 2004; Callaghan, 2006).

The introduction of Section 5(4) led Christopher Price (1982) to raise the following question in Parliament:

'I ask the Minister, if he can, to give an indication of the extent to which the practice will be monitored, so that Parliament does not have to wait 20 years but can reconsider the issue in a year or two to see how it is working.'³⁷

However, there is little evidence to suggest that the use of Section 5(4) had been monitored either at a local or a national level. While national statistics have been made available on its annual use (see for example NHS ICHSC, 2011), the implementation of Section 5(4) has been mainly ignored among organisations responsible for monitoring its use. For example, the now defunct Mental Health Act Commission (MHAC) in its biennial reports either ignored the use of Section 5(4) completely or only mentioned it in passing. However, the MHAC's (2005) eleventh report did recommend that, 'services audit their own use of holding powers' in order to, 'determine whether lessons for local practice can be learned' (MHAC, 2005, 4.26: 214). Although it is unclear if or how NHS Trusts responded to this recommendation, it would appear that the apparent lack of significance attributed to Section 5(4) has contributed to making 'invisible' a nursing intervention that has the potential to impact significantly on the patient's long-term legal status and also their medical and nursing care.

I have also interpreted Price's (1982) suggestion that the introduction of Section 5(4) should be monitored to mean that there was a need to undertake research to explore issues surrounding its application. However, the literature reviewed in Chapter 2 revealed that little research has been undertaken in relation to the practices surrounding the implementation of Section 5(4). In addition, the research has limited itself to surveys and audits investigating: nurses' opinions of Section 5(4) (Hussain and Varadaraj, 1983; Dimond, 1989; Carver and Ashmore, 2000); nurses' knowledge of Section 5(4) (Ward, 1991; Ashmore, 1992a; Goldstrom, 1993; Ashmore, 1998b); and trends associated with the implementation of Section 5(4) (for example Ashmore, 1992b; Ashmore, 1998c; Lovell et al., 1998). While this literature has provided some insights into the implementation of Section 5(4), it is clear that what is known about the use of the holding power is incomplete.

³⁷ Hansard HC Volume XI Column 386 (20th May 1982)

Despite the fact that the holding power has been part of mental health legislation for nearly 30 years there is still no understanding of the process by which the patient, who enters hospital informally, is detained under Section 5(4) from either a nursing or patient's perspective. For example, no attempts have been made to explore how nurses interpret the meaning of health, safety or protection or how this impacts on their decision to implement Section 5(4). Nor is there any understanding of how the events before, during and after the implementation of Section 5(4) are managed or what the consequences of being detained are for patients. Finally, the absence of the medical practitioner during the process would also seem worthy of further exploration. It is therefore argued that the process of implementing Section 5(4) is an important area of nursing practice that requires further investigation as it is likely to have legal, policy and practice implications for both nurses and patients. Therefore in view of the recent review of and proposed reforms of the Act it seemed timely to undertake a doctoral level study exploring these issues.

3.3 Aim

The overall aim of the study undertaken in this thesis was to; explore, describe and explain how and why Section 5(4) (nurses' holding power) of the Mental Health Act 1983 (DH, 1983) was implemented.

More specifically the study aimed to:

- Identify the reasons given for why Section 5(4) was implemented;
- Explore and describe from the perspective of both nurses and patients the events leading up to, the management of, and the consequences arising from the use of Section 5(4) - the process of detention.

3.4 Qualitative research

Silverman (2000: 1) has stated that 'the choice between different research methods should depend upon what you are trying to achieve'. As the main focus of this study was to gain an in-depth understanding of how and why Section 5(4) was implemented from both the nurse's and patient's perspective, it was decided that a qualitative rather

than a quantitative approach to research design was the more appropriate. Simply put, quantitative research is:

‘A formal, objective, systematic process to describe, test relationships, and examine cause and effect interactions among variable.’

(Crookes and Davies, 1998: 326)

In contrast qualitative research can be defined as:

‘A systematic, interactive, subjective approach used to describe life experiences and give them meaning.’

(Crookes and Davies, 1998: 326)

Qualitative research ‘seeks answers to questions that stress how social experience is created and given meaning’ (Denzin and Lincoln, 2000: 8) while quantitative research studies ‘emphasize the measurement and analysis of causal relationships between variables, not processes’ (Denzin and Lincoln, *ibid*). Denzin and Lincoln (2000: 8) state that:

‘Qualitative researchers stress the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry. They seek answers to questions that stress how social experience is created and given meaning.’

Furthermore, according to Streubert and Carpenter (1999: 15) qualitative researchers have emphasised six significant characteristics in their research:

‘(1) a belief in multiple realities, (2) a commitment to identifying an approach to understanding that supports the phenomenon studied, (3) a commitment to the participant’s viewpoint, (4) the conduct of inquiry in a way that limits disruption of the natural context of the phenomena of interest, (5) acknowledged participation of the researcher in the research, and (6) the conveyance of an understanding of phenomena by reporting in a literary style rich with participant commentaries.’

3.5 Philosophical basis of the study

Holloway (1997: 131) has observed that qualitative research 'is an inclusive and wide-ranging term' while Denzin and Lincoln (1998: 2) suggest that the term refers to a 'complex, interconnected family of terms, concepts, and assumptions'. It is an umbrella term that is used to refer to a collection of 'methodologies, philosophies, methods and procedures' (Holloway, 1997: 131) used in the study of the social world and are distinguished from one another by their ontology, epistemology, methodology and methods (Dey, 1993; Marshall and Rossman, 1995; Streubert and Carpenter, 1999; Crotty, 2003).

It is therefore important for all researchers proposing to undertake a qualitative research study to clarify for themselves and others the philosophical basis of their work and the implications it may have for the design, implementation and analysis of their research. Furthermore, Denzin and Lincoln (1998: 26) have proposed that the investigator's beliefs 'shape how the qualitative researcher sees the world and acts within it'. How the researcher sees the world has been termed a paradigm and is essentially a 'set of beliefs that guide action' (Denzin and Lincoln, *ibid*). It has been proposed that the researcher's basic belief systems (paradigm) about the social world they wish to study is a *net* containing their assumptions about:

- **The ontological question:** What is the form and nature of reality and, therefore, what is there that can be known about it?
- **The epistemological question:** What is the nature of the relationship between the inquirer and the known? Therefore what can we know about what exists?
- **The methodological question:** How do we know the world or gain knowledge of it?

(Guba and Lincoln, 1998: 201)

3.5.1 The ontological question: the form and nature of reality

The answer to the ontological question - that is what the researcher believes to be the form and nature of reality - is an important one for the researcher as it will determine

how the project will progress. The review of the literature outlined in Chapter 2 identified that research undertaken in relation to Section 5(4) has reported findings from surveys using questionnaires (Hussain and Varadaraj, 1983; Dimond, 1989; Ashmore, 1998b; Carver and Ashmore, 2000;) or patterns of use based on locally collected statistics (Ashmore, 1998b; Lovell et al., 1998). Although these studies do not discuss the ontological question it would seem reasonable to suggest that they sit within a positivist/post-positivist paradigm; that is, they assumed that there is a real world and that it can be captured by researchers. While this realist or 'camera theory' of research (Arksey and Knight, 1999: 15) has provided some valuable insights into the use of Section 5(4) (Ashmore, 1998c; Lovell et al., 1998) it has left numerous unanswered questions in relation to how and why the holding power is used. In addition, it is argued that the methods of data collection associated with the positivist/post-positivist paradigm - for example, structured interviews or the completion of questionnaires with a number of fixed responses - are not appropriate in answering the research questions. Therefore, given the study's stated intention to address these questions by exploring nurses' and patients' experiences of the use of Section 5(4), it seems appropriate to adopt an ontological position based on a constructionist definition of reality.

The constructionist views reality from a relativist perspective; that is there is not one 'real' world to be revealed but multiple realities that are mentally constructed from social interactions. 'Reality' is therefore created in context and specific to local settings, and therefore is 'dependent for their form and content on the individual persons or groups holding the constructions' (Guba and Lincoln, 1998: 206). Taking this position on the nature of reality had implications for the study undertaken in this thesis. In relation to any application of Section 5(4) explored within the study it was reasoned that the circumstances surrounding the decision to implement the holding power had been constructed from the interactions between nurses, patients and significant others during events occurring on individual wards. Taken to its logical conclusion this may imply that no two applications of Section 5(4) could be compared in any way; however it is argued that this was not the case. It is proposed that within the Trust (see section 4.2.2) comprising the study site individual nurses and wards shared sufficient common factors in the form of policies and practices, to ensure comparisons of both similarities and differences in the implementation of Section 5(4) to be meaningful.

Burr (2003: 7) has suggested that knowledge production is 'historically and culturally specific.' Therefore, it is argued that any findings emerging from this study are 'time- and culture-bound and cannot be taken as once-and-for-all descriptions' (Burr, *ibid*) of using the holding power. This may imply that no claims about how and why Section 5(4) is used by other nurses in NHS Trusts can be made. However, it is argued that the fullness of the descriptions of the participants, settings and Section 5(4)s presented in this thesis will provide those that follow the opportunity to replicate the findings with different participants, at different times and in different NHS Trusts.

3.5.2 The epistemological question: social constructionism and the relationship between the inquirer and what can be known

The epistemological question asks the researcher to consider what is the nature of the relationship between the inquirer and the known. That is, what is the nature of knowledge and what are the grounds of that knowledge? Guba and Lincoln (1998: 201) suggest that the researcher's answer to the epistemological question is 'constrained by the answer already given to the ontological question; that is, not just *any* relationship can now be postulated.' In acknowledgement of Guba and Lincoln's (1998) comments and the arguments presented in the previous section, the answer to the question presented in this section is that a social constructionist epistemology was adopted in the study.

A social constructionist epistemology begins with the belief that our knowledge of the social world is not discovered, imprinted on the mind or interpreted, but is constructed. Knowledge of the social world arises from our attempts to make sense of our experiences through inventing concepts and models which are modified in the light of new experiences (Schwandt, 2000). Furthermore, any construction is 'historically and culturally specific' (Burr, 2003: 3). Therefore, constructionism rejects 'an out-and-out subjectivism' (Crotty, 2003: 43); that is we do not create meaning but construct it. As Crotty (2003: 44) observes, 'we have something to work with. What we have to work with is the world and objects in the world.' This means that we do not make constructions in isolation but by referring to our shared understandings, practices and language that are the products of the culture and historical period in which they are created - that is historical and cultural relativism.

3.5.3 The methodological question: how do we know the social world or gain knowledge of it?

The methodological question asks the researcher to outline how they intend to find out what they believe can be known and also to clarify the relationship between the inquiry and those (participants) who can provide knowledge of the social world. Once again, how this question is answered is *constrained* by the previous two questions; that is 'not just *any* methodology is appropriate' (Guba and Lincoln, 1998: 201). Therefore the challenge for the researcher is to develop a methodology that uses methods of data generation and analysis that are consistent with the adoption of a relativist ontology and constructionist epistemology.

The methodology of any research study has two components: the strategy of inquiry and the research design (Denzin and Lincoln, 1998). A strategy of inquiry is said to consist of:

'...a bundle of skills, assumptions, and practices that researchers employ as they move from their paradigm to the empirical world...put paradigms of interpretation into motion...[and] connect the researcher to specific methods of collecting and analysing empirical materials.'

(Denzin and Lincoln, 1998: 29)

While the research design has been defined as:

'a flexible set of guidelines that connects theoretical paradigms to strategies of inquiry and methods for collecting empirical material. A research design situates researchers in the empirical world and connects them to specific sites, persons, groups, institutions, and bodies of relevant interpretative material, including documents and archives.'

(Denzin and Lincoln, 1998: 28-29)

The research design begins by focusing on the study's research question, aims and its purpose and asks the researcher to consider the question, 'what information most appropriately will answer specific research questions, and which strategies are most effective for obtaining it' (LeCompte and Preissle, 1993: 30). Furthermore, in designing the strategy of inquiry Marshall and Rossman (1995) have argued that the

researcher needs to consider the *informational adequacy* of their design, that is, will it provide the information that is required in order answer the research questions ‘thoroughly and thoughtfully?’ (Marshall and Rossman, 1995: 42). Therefore, in relation to the methodological question, I recognised that there was a need to consider which qualitative strategy and design would enable me to answer the question, how can I gain knowledge of how and why was Section 5(4) implemented?

3.5.3.1 Choosing an approach

In section 3.4 it was noted that qualitative research is an umbrella term that Smith et al. (2011: 41) have suggested ‘refers to groups of methods and ways of collecting and analysing data’. Furthermore, Smith et al. (2011) have suggested that there are over 40 methods available for researchers to choose from, which can be classified into three main groups: (1) those exploring the use and meaning of language, for example discourse (Potter and Wetherell, 1987) and conversational analysis (Schegloff, 2007); (2) those exploring, describing and interpreting participants’ perceptions, for example phenomenology (Todres and Holloway, 2010); and (3) those focusing on theory development, for example grounded theory (Glaser and Strauss, 1967; Charmaz, 2000).

In nursing, qualitative researchers have commonly used ethnography, grounded theory or phenomenology to inform their studies. As a starting point for developing the strategy of inquiry utilised in this thesis, the adequacy of these three approaches was considered in relation to providing answers to the questions posed in this study. However, none were considered appropriate. For example, phenomenology was considered and rejected on the grounds that gaining an understanding of the lived experiences of the implementation of Section 5(4) was not the focus of the study. Although it seemed inevitable that details of participants’ experiences would emerge during the course of the study the primary focus of the research was concerned with understanding the how and why of the detention process.

Ethnography (Hammersley and Atkinson, 1995; Wolf, 2010) was also considered and rejected, but in this case for practical reasons. In ethnographic research data generation requires the researcher to immerse themselves in the cultural system and observe the phenomenon of interest in order to provide answers to questions. Whilst it would have been advantageous to observe the events before, during and after the implementation of

the Section 5(4) this was considered an unrealistic approach to data generation. It was reasoned that as Section 5(4) is an unpredictable, real-world event situated within the social world of psychiatric care, an ethnographic approach would have required me to spend long periods of time in clinical environments without any guaranteed likelihood of observing the section being used.

Grounded theory is concerned with explaining the 'social processes that occur in human interactions' (Smith et al., 2011: 45) and to generate a theory to explain them. Although no theory exists to explain the implementation of Section 5(4), the purpose of this study was not theory generation and therefore this approach was also rejected. More importantly, the approach's use of the simultaneous collection and analysis of data was considered restrictive in relation to this study. As noted earlier, the use of the section cannot be predicted and therefore the need to complete the analysis of one set of data before undertaking further field work may have resulted in the rejection of an already potentially limited supply of available data.

After further reading and consideration of the available qualitative approaches a case study approach was chosen as the strategy of inquiry best suited to answering the research questions posed in this thesis.

3.6 Case studies

Case study research has its origins in social anthropology/ethnography and draws upon the principles of naturalistic inquiry (Lincoln and Guba, 1986; Denscombe, 2003). It has subsequently been used by a number of academic disciplines, for example sociology (Shaw, 1930; Whyte, 1955; Becker et al., 1961; White, 1975), education (Simons, 1980), social work (Urek, 2005; Bennett and Elman, 2006), psychology (Robson, 2002) and counselling/psychotherapy (Yalom, 1989; McLéod and Balamoutsou, 1996). Furthermore, in recent years it has appeared with increasing frequency in nursing research, for example Bergen (1992), Dale (1995), Hellzen et al. (1998), Repper (1998a), Bergen and While (2000), Duffy (2003), Hamilton et al. (2004), Ellis and Nolan (2005), Lovell (2006), and Payne et al. (2007).

Although numerous definitions of the term case study research exist (Woods and Catanzaro, 1988; Hammersley and Gomm, 2000; Scholz and Tietje, 2002;) the two

most commonly cited are those of Stake (1995) and Yin (1994, 2003a). Stake (1998: 87) states that a case study is, 'both the process of learning about the case and the product of our learning.' While Yin (2003a: 13-14) defines a case study as:

'an empirical enquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident... [and] ...relies on multiple sources of evidence...'

Yin (1994, 2003a) believes a case study approach is appropriate when the researcher wishes to explore, describe and explain a phenomenon and is the research strategy of choice when:

'... 'how' or 'why' questions are being posed, when the investigator has little control over events, and when the focus is on a contemporary phenomenon within some real life context.'

(Yin, 1994: 1)

Therefore it was reasoned that the adoption of a case study approach as the strategy of inquiry in this study was wholly appropriate for the following reasons:

- It was not possible to control the who, where and when of implementing Section 5(4);
- The literature review led to 'how' and 'why' questions being posed in this study that are appropriate to further clarification and understanding using a case study approach;
- As there was little known about the use of Section 5(4) it was reasoned that the case study approach provided the means to develop a greater understanding of how and why the section was implemented. Furthermore, the case study approach allows for the study of a phenomenon within a natural setting. It is argued that as the use of Section 5(4) occurred within the natural setting of the four wards within the Trust the case study approach had the potential to explore the situational factors (for

example, the presence or absence of a doctor) that may influence the decision to apply the holding power;

- Finally, it was reasoned that the ‘thick description’ (Geertz, 1973) arising from each case would allow for an in-depth understanding of how and why each Section 5(4) was used.

3.6.1 Defining the case

Central to undertaking case study research is the need to have an understanding of what the *case* or the unit of analysis is in the study. Miles and Huberman (1994: 25) define a case as:

‘...a phenomenon of some sort occurring in a bounded context. The case is, in effect, your unit of analysis. Studies may be of just one case or of several.’

The case, argue Miles and Huberman (1994: 25), has a focus or a *heart*, and ‘a somewhat indeterminate boundary defines the edge of the case: what will not be studied.’ The case refers to what is studied (Clarke and Reed, 2010; Hentz, 2010). Miles and Huberman (1994) propose that a case can be an individual, a role, a small group, an organisation, an event, an encounter, a state, or a nation. Furthermore, Gangeness and Yurkovich (2006: 11) suggest that regardless of how the researcher defines the case there is a need to ‘state who is included, context, phenomenon and time-period studied.’

In this thesis the case study was undertaken within the bounded context of four acute in-patient wards in one NHS Trust (see section 4.2.2). The phenomenon to be studied was defined as an event; specifically the implementation of Section 5(4) and the ‘focus or heart’ (Miles and Huberman, 1994: 25) of the case was concerned with how and why that event occurred. The time period of the study was bounded by placing a limit of one year on the main data generation period. This period was selected in recognition of the fact that the use of Section 5(4) is an unpredictable event and therefore it could not clearly be specified in advance when data could be generated and thus how long it would take to conclude this phase of the study. It was also recognised that because of the aforementioned issues this defined time period needed to be flexible in order to

allow for exploration of further issues that emerged during data generation. It was also reasoned that this period of time would ensure that I was able to gain an in-depth understanding of the phenomenon being studied.

Although some (Yin, 1994; Yin, 2003a; Gangeness and Yurkovich, 2006) have argued that 'a tight definition of the case/unit' (Gangeness and Yurkovich, 2006: 11) should be determined before starting a study, others advocate a more flexible approach to case definition. For example, Stuart Wells et al. (2002: 339) reject the realist view of the unit of analysis, that is that 'cases pre-exist as empirical units out there waiting to be studied' in favour of a constructionist approach in which 'cases do not exist until researchers construct them, or co-construct them with their respondents'. Howard Becker believes a strict definition of what constitutes the case may be counterproductive, noting that:

'Researchers will probably not know what their cases are until the research, including the task of writing up the results, is virtually completed. What it is a case of will coalesce gradually, sometimes catalytically, and the final realization of the case's nature may be the most important part of the interaction between ideas and evidence.'

(Cited in Ragin, 1992: 6)

Therefore the definition of the case was seen as an iterative process developed through the generation of data and not finalised until the analysis and write up of the research was finished. This means that the definition of what constituted a case in this study (see above) was seen as the starting point for understanding how and why Section 5(4) was implemented. Therefore, the final bounding of each case was based on an iterative process and was dependent on the outcome of the exploration of the events before, during and after the application of Section 5(4).

3.6.2 Choosing a case study design

Different types of case study design have been proposed in the literature (Yin, 1994; Stake, 1995; Yin, 2003a). A major distinction is made between single and multiple case study designs. The multiple case study design is favoured when the investigator intends to explore the same phenomenon in a range of situations. Yin (1994, 2003a) believes the multiple case study design is the preferred choice where the phenomenon under

investigation would produce different results but for predictable reasons. While this study made no predictions about how and why Section 5(4) would be implemented it was considered important to explore its use in a diverse range of circumstances. It was reasoned that a single case study would not produce this information; therefore it was decided to use a multiple case study design.

Stake (1994, 2000) distinguishes between intrinsic, instrumental and collective case study designs. An intrinsic case study is undertaken, first and foremost because 'a researcher wishes to seek clarity and understanding about a particular case' (Appleton, 2002: 86) because the 'case itself is of interest' (Stake, 2000: 437). The instrumental case study is the design of choice if 'a particular case is examined mainly to provide insight into an issue' (ibid). When an instrumental investigation is extended to a study of a number of cases Stake (1994, 2000) calls this a collective case study. A collective case study is undertaken when it is reasoned that a single or instrumental case study will only provide a partial understanding of the phenomenon under study while the collective case study is chosen to provide more in-depth knowledge of a study's focus. Although using different terminology, both Stake and Yin's approaches to case study design are very similar. However it was decided to adopt the definitions offered by the former within this study. This decision was made because Stake's view of the case study is consistent with the ontological and epistemological position taken in the study while Yin's approach takes a more positivistic stance. Therefore, this study was defined as both instrumental and collective in design. Instrumental because the intention of the study was 'to provide insight into an issue' (Stake, 2000: 437), that is how and why Section 5(4) was implemented rather than the actions of individuals in each case. The study was collective because it was extended to more than one case.

3.6.3 Determining the number of cases

At the start of a collective (multiple) case study it is not possible to specify the exact number of cases that will need to be undertaken to answer the research questions. As Stake (1995: 4) has noted, 'case study research is not sampling research.' Initially a case is chosen to 'understand this one case' and to 'maximize what we can learn' (ibid) about it. In keeping with this view several authors have noted that the number of cases in a study will be small (Miles and Huberman, 1994; Yin, 1994; Stake, 1995; Appleton, 2002; Hammersley and Gomm, 2004; Payne et al., 2007). This suggestion is reflected

in reported case studies (Bergen, 1992; Woods, 1997; McDonnell et al., 2000). For example, Woods (1997) reported a study of five cases while Duffy's (2003) research on suicide risk and the therapeutic relationship consisted of six cases. However, other researchers have reported research involving larger numbers, for example Bury (1988) used a case study approach of 30 people living with arthritis and Yin (2003b) reported the findings of a multiple case study of how 20 universities prepared and submitted research proposals.

In an attempt to make sense of the two extremes Casey and Houghton (2010: 44), drawing on the work of Stake (2006), stated that the benefits of case study research 'may be limited if there are fewer than four cases or more than ten to 15 because the researcher could be overwhelmed by the data.' However, there appears to be no agreement on what constitutes a preferred number of cases and the final decision is that of the researcher and is more likely to be determined by the size and complexity of the case under study. At the start of this study the number of cases was not specified. However, a decision was made to generate data until no new themes or concepts emerged. Alternatively, if data generation reached the specified bounded period of one year the data would be reviewed to determine whether there was sufficient evidence to answer the research questions adequately.

3.6.4 Selecting cases

The selection of cases in the study was purposive (Parahoo, 1997) and therefore they were chosen in order to provide answers to the questions asked in the research. The rationale for choosing the first case in the study was simply that I followed the advice given by Appleton (2002: 93) who states that, 'a case is initially selected because of its relevance to the phenomenon under investigation.' Therefore, I simply selected and investigated the first Section 5(4) implemented following the start of the study. Further cases were selected based on their availability but more importantly because of their potential to provide answers as to how and why the holding power was implemented, that is because they were 'information rich cases' (Patton, 1990: 169).

3.7 Methods

Researchers undertaking case study research advocate using multiple sources of data (Yin, 1994; Stake, 1995; Woods, 1997; Yin, 2003a; Yin, 2003b; Gangenness and Yurkovich, 2006). Using multiple data sources is seen as one of the strengths of case study research as it is suggested that this is likely to provide a more complete understanding of the phenomenon under study (Yin, 1994; Yin, 2003a). Yin (1994, 2003a) has identified six sources of evidence available to the researcher employing this research strategy: documentation, archival records, interviews, direct observations, participant observation, and physical artefacts. Three of these methods of data generation were chosen as appropriate for providing answers to the questions identified in this study: archival records, documentation, and interviews.

3.7.1 Archival records

Archival records include: service records, personal records, survey data, and personal records (Yin, 1994; Yin, 2003a). The archival records utilised in this study was statistical data routinely collected by the Trust on the use of Section 5(4). I chose to collect this type of data in the belief that it had the potential to provide important background information on how the section was used in the Trust (Payne et al., 2007). Furthermore, it was reasoned that the identification of trends within this data could lead to potentially important areas worthy of exploration during interviews with nurses and patients (section 3.7.2). For example, comparing and contrasting the implementation of Section 5(4) at different times of the day could lead to the exploration of the availability or non-availability of medical staff and its impact on nurses' decisions to apply Section 5(4). It also provided an opportunity to update previous research in this area (see for example, Ashmore, 1998c) to ensure that any observed patterns to be explored reflected the most contemporary data both in the Trust and available literature.

Based on the review of the literature, the study's aims, and the above discussion it was decided to collect the statistical data in two parts:

1. A retrospective part in which statistical information would be generated on the following variables for the period 30th September 1983³⁸ until midnight 31st

³⁸ The date the Mental Health Act 1983 was introduced.

December 2003³⁹: date and time of application; arrival time of doctor; patient's gender; nurse's gender; and outcome of the medical assessment.

2. A prospective phase in which statistical information would be collected on all Section 5(4)s implemented in the Trust for the period 1st January 2004 until midnight 31st January 2006. Three years was chosen as it was reasoned - based on previous research (Ashmore, 1998c) - that this period of time would be required to produce significant numbers for any patterns established to be meaningful. It was decided that the data generated in this phase should replicate the retrospective stage supplemented by additional information consisting of: date of admission; and the patient's Mental Health Act history, ethnicity and age. The Mental Health Act Records Department (MHARD) was unable to provide this additional information for the retrospective data.

3.7.2 Documentation

Yin (1994: 81) believes that 'documentary information is likely to be relevant to every case study topic' while Burgess (1984) believes documents are a valuable source of data when investigating events in social settings. The advantages of documents include that, they contain permanent accounts of events (Miller and Alvarado, 2005), potentially 'speak in the absence of speakers' (Smith, 1984: 60), and as public documents they can be accessed by researchers. In the social sciences in general (Prior, 2003) and in medicine and nursing specifically, documents are valued as a source of learning and as a method for generating data (Barrett, 1988; Reiser, 1991a; Reiser, 1991b; Berg, 1996; Heartfield, 1996; Hale et al., 1997; Briggs and Dean, 1998; Iverson and Hughes, 2000; Horsfall and Cleary, 2000; Kim and Park, 2005; Friberg et al., 2006; Ziegert et al., 2007).

It was also recognised that 'the psychiatric hospital is an information system' (Erik and Gilbertson, 1969: 392) and as such generates data on patients from a number of perspectives from the point of admission to discharge. Therefore, it was decided that all documentation considered of relevance to understanding how and why Section 5(4) was implemented would be collected following each application of the holding power. As

³⁹ The date before the commencement of this study.

noted in Chapter 2 nurses are required to record their reasons for detaining the patient in writing by completing the relevant Mental Health Act documentation, that is Forms 13 and 16 (Appendix 1 and Appendix 3) along with a local incident form (Appendix 2). It was reasoned that this documentation had the potential to offer insights into nurses' reasons for making the decision to implement Section 5(4). Nursing notes, care plans and risk assessments were also sampled. Again, it was reasoned that these sources of data had the potential to provide insights into the process of detention as nurses are likely to have recorded the natural history of the events before, during and after the implementation of the holding power. Medical notes and relevant Mental Health Act documentation completed by doctors were also sampled in order to explore significant events before, during and after the patient's detention in order to gain a rich understanding of the use of Section 5(4).

In addition, where available, policies and protocols were collected in order to gain an understanding of how managers and clinicians have interpreted national policy documents and statute, for example the Mental Health Act (DH, 1983) and Mental Health Act Code of Practice (DH, 1999a). Specific policies considered of potential importance were those available to both nurses and doctors that could impact on the patient's decision to leave hospital. Examples of policies considered of relevance were those relating to risk assessment, locking ward doors, observation, and Section 5(4).

The use of documents in research is not without problems (Garfinkel, 1967; Wheeler, 1969; Denscombe, 1998). The documents used in this study are legal documents and therefore are official accounts of events written for a particular audience, in this case other health care professions (Health, 1982) and can be used to hold individuals accountable for their actions. Due to this issue of accountability, medical and nursing notes may provide researchers with only a partial and selective account of the events they represent (Berg, 1996). Mercurio (2002: 67) describes this phenomenon as 'buff[ing] the notes', in other words official documents 'may be subtly edited to exclude things that might render people vulnerable to criticisms' (Denscombe, 1998: 162). Therefore, as official accounts represented in documents may not give a full and in-depth account of the events before, during and after the implementation of Section 5(4) it was decided to undertake interviews with the main stakeholders in order to overcome these limitations.

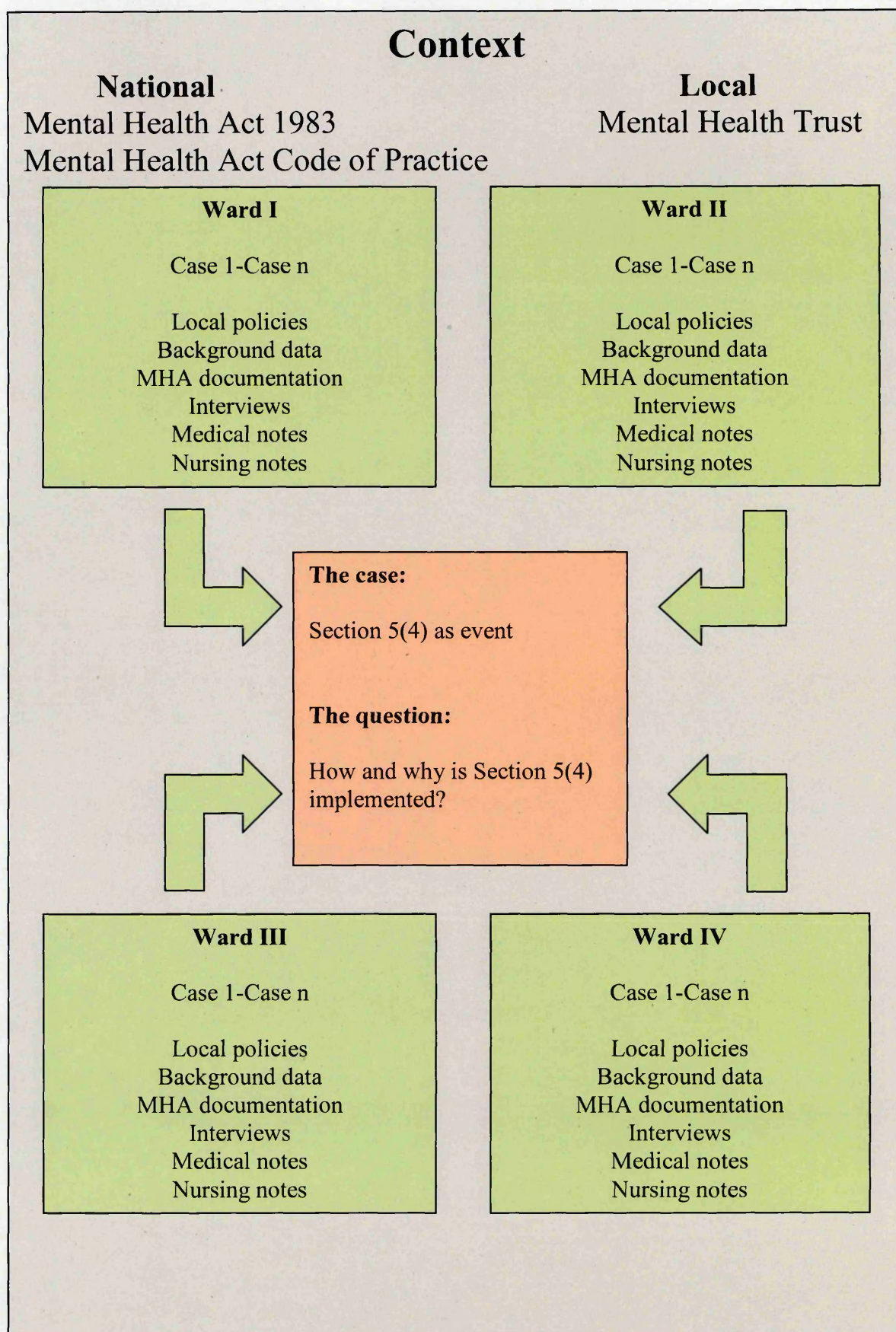
3.7.3 Interviews

Interviews were used extensively in this study to explore the implementation of Section 5(4) from both the perspective of the nurse implementing the section and the detained patient. The interview in its many forms (structured, semi-structured and unstructured) is a commonly used method for generating data in qualitative research (Fontana and Frey, 2000). Interviews allow the researcher to: explore events that cannot be directly observed; to gain a deeper understanding of events; and clarify meaning (Arksey and Knight, 1999). In relation to patients, interviews were considered the most appropriate method for exploring and producing an in-depth account of their experience of being detained. It is argued that none of the other sources of evidence described by Yin (1994, 2003a) would have enabled an account of the patient's experience to be produced from their perspective. For example, all documentation relating to the implementation of Section 5(4) are completed by nurses and do not require them to consult the patient.

The documentation completed by nurses following their decision to apply Section 5(4) offered an opportunity to gain insights into the detention process. However, due to the potential limitation of documents as a data source (see section 3.7.2) it was reasoned that by themselves they would not provide a full account of nurses' actions. Secondly, personal experience of Mental Health Act documentation suggested that nurses' written responses are often brief and raise more questions than they answer. Therefore interviews were undertaken with nurses and were seen as an opportunity to explore their actions in depth and also to clarify any issues identified in official documentation. Further issues are discussed in relation to undertaking the interviews conducted in the thesis in Chapter 4.

Therefore, at the start of this research the intention was that for each case all three types of data would be collected in order to gain a comprehensive understanding of each application of Section 5(4); the case under study. However, it was also recognised that as the study progressed there might be a need to be flexible and accept that problems encountered during the realities of field work may mean that it would not be possible to collect all types of data for each case. Figure 4 provides a summary of the study design.

Figure 4 The case, context and data collection methods



3.8 Conclusion

This chapter has offered a rationale for the study undertaken in this thesis and stated the question that the research intended to answer. The chapter has also considered the ontological, epistemological and methodological aspects of the thesis. The study has located the research in a constructionist and relativist paradigm under the umbrella term of 'qualitative research'. A number of qualitative approaches were considered in deciding upon the best approach to providing answers to the research question including ethnography, grounded theory and phenomenology. After much consideration it was decided that the case study approach was best suited to provide the answers sought in the study. Issues concerning types of case study and defining the case have been identified and reviewed. The chapter has also identified the six types of potential data generation methods commonly used in case study research and a rationale offered for the three (archival records, documentation and interviews) used in this thesis. The next chapter will describe in detail how the strategy of inquiry was implemented and how the issues encountered during this process were managed.

Chapter 4

Methods

'Many methodological accounts that appear in scholarly works convey nuts and bolts of the research process - how the sample was drawn, data were coded and interpreted, and problems of reliability and validity were addressed. Although dilemmas may be implied, a reader gets the overall impression that the researcher knows her craft and the process runs relatively smoothly. Less common are accounts that indicate the messiness and false starts in the research, the learning about self.'

(Hyde, 1992: 169)

4.1 Introduction

This chapter describes in detail how the research design described in Chapter 3 was implemented. The chapter is divided into three main sections. The first section, 'getting in', focuses on how access to the mental health NHS Trust and the four acute wards used for data generation was negotiated. The second section, 'getting permission', describes the process of obtaining formal NHS Local Research Ethics approval (NHS LREC) and meeting the Trust's research governance requirements in order to gain entry to the study site. The final section, 'getting on', describes how data were generated in the study.

4.2 'Getting in'

4.2.1 Choosing the study setting

As stated in the previous chapter this study sought to examine how and why Section 5(4) was implemented; therefore the success of the research relied upon gaining access to a setting where the holding power might be applied. Although Section 5(4) can be applied in any in-patient service where patients are receiving treatment for a mental disorder, it was decided to seek access to an acute psychiatric in-patient setting.⁴⁰ Previous research (Ashmore, 1998c) has reported that Section 5(4) is implemented more frequently in this type of setting. This may be due to the fact that patients admitted to acute services are more likely to be; experiencing a severe mental disorder, require medical treatment, and present a risk to themselves and/or others (Bowers et al., 2005a).

⁴⁰ As noted in Chapter 1 acute psychiatric in-patient wards provide care for patients between the age of 18 and 65 years, although the upper age limit may vary between NHS Trusts.

Having identified the most appropriate setting for the study, the next step was to approach a mental health NHS Trust that could provide access to this type of environment. I decided to approach a local NHS Trust as the potential study setting. This decision was, in part, based on the need to identify a setting where the implementation of Section 5(4) was sufficiently likely to enable the generation of sufficient data to complete the study. Whilst acknowledging that Section 5(4) could potentially be implemented on any acute psychiatric in-patient ward, in reality its use varies considerably from one NHS Trust to another on an annual basis. The most recent Department of Health (DH, 2003a)⁴¹ annual Mental Health Act statistics showed that Section 5(4) had been implemented 37 times during the previous years in the Trust under consideration. Previous research (Ashmore, 1998c) also confirmed that the section had been consistently used within the Trust since its introduction in 1983.

Consideration was also given to whether it was appropriate to approach a local NHS Trust where I was known or to consider one where no previous relationships existed. Within all NHS Trusts within the region - but more so in the local Trust - I was known to a significant number of clinical staff as a practitioner, lecturer and in one case the educational link between the service and the university. I reasoned that approaching the local Trust afforded me a number of benefits as an 'insider' (Bonner and Tolhurst, 2002). I was a mental health nurse with previous experience of implementing Section 5(4) while working in the Trust. It was reasoned that this gave me a potential insight into the processes leading to the use of Section 5(4) (Bonner and Tolhurst, 2002). In addition, others have suggested that being an 'insider' can help the researcher to: gain access to an organisation (Kidd, 1992; Pugh et al., 2000); establish rapport with participants (Gerrish, 1997; Platzer and James, 1997; Kennedy, 1999); and deal with ethical concerns (Ryan, 1993; Platzer and James, 1997). Certainly, my existing relationships with those in the Trust afforded me advantages in negotiating access to the four acute wards identified in the study. However, I also recognised that there were also potential disadvantages. For example, I was aware that there was a potential for both practitioners and myself to experience role conflict (Bonner and Tolhurst, 2002) or that

⁴¹ This document was the most recent publication available at the time the study setting was chosen.

nurses may feel socially obliged to participate in the research because of previous or existing relationships.

A further factor in making the decision to approach a local NHS Trust was a practical one. The nearest Trust where I was not known to practitioners was outside the boundary of the Regional Health Authority and would require me to undertake an 80 mile round trip. Given factors such as time, work commitments, funding and travel I decided that gaining access to a local Trust would increase the likelihood of the successful completion of the project, particularly as the intention was to undertake interviews as soon as possible after the implementation of the section along with the need to access nursing and medical notes over an extended period of time.

4.2.2 The setting

The study was situated in one mental health NHS Trust serving a large northern city (Population: 547,000). The Trust had four acute psychiatric wards providing 96 beds - 24 per ward - for patients requiring in-patient care. The Trust also had a number of specialist beds, including five substance misuse beds. Two wards were located in the north of the city (Houndkirk and Longshaw)⁴² and two in the south (Riverside and Blackamoor), each serving a geographically defined population. The Trust's stated aim of the acute psychiatric in-patient wards was to, 'offer assessment, provide treatment in a safe and therapeutic setting and prepare patients to be looked after in the community' (SHSC, 2011). Each of the wards had a staff group that included; nurses, psychiatrists (doctors), support workers, and occupational therapists. The nursing teams consisted of approximately equal numbers of male and female nurses and a range of clinical grades.

The decision to include all acute wards in the study was made in the belief that it would maximise the potential to recruit participants to the study when Section 5(4) was implemented. It was also reasoned that this would enhance the trustworthiness of the study by gaining a wide range of different perspectives on the subject from different participants on more than one ward on two different sites.

⁴² The names given to the four wards are pseudonyms in order to protect their anonymity.

4.2.3 Gaining access to the study setting

There was a need to obtain permission to undertake the research (see sections 4.3.1 and 4.3.2), and to negotiate access to the Trust and the four individual wards. A decision was made to undertake the two stages simultaneously in an attempt to reduce the amount of time required to complete these processes.

It is widely recognised that there are a number of key individuals who act as 'gatekeepers' within organisations (Burgess, 1991; Hammersley and Atkinson, 1993; Hammersley and Atkinson, 1995; Marshall and Rossman, 1995; Benton and Cormack, 2000; Denscombe, 2000; Roper and Shapira, 2000). McEvoy (2000: 241) suggests that in medieval times, 'the role of the gatekeeper was to keep watch at the town entrance and protect the town by stopping unauthorized persons from passing through.' In relation to research it is taken to mean, 'those individuals who could either facilitate or block access of the researcher in conducting the study' (Benton and Cormack, 2000: 130). In this study the 'gatekeepers' were identified as:

- Clinical Nurse Managers (CNMs);
- Ward Managers (WMs);
- Individual mental health nurses;
- Staff within the Mental Health Act Records Department (MHARD) and Patient Information Department (PID).

The next stage of the negotiation process was to organise a series of meetings with the above stakeholders in order to:

- provide verbal and written information about the research;
- identify any potential barriers to undertaking the project and explore possible solutions; and

- develop mechanisms to communicate information about the project to all members of the multi-disciplinary team (MDT) but specifically to nurses in the Trust.

4.2.4 Meetings with ‘gatekeepers’

My rationale for meeting with CNMs and the four WMs was that the former had overall responsibility for the wards and the latter had overall responsibility for the day-to-day management of the wards and the care of the patients admitted there. In addition, the WMs had the potential to: offer valuable insights into clinical activities on the ward; provide assistance with ‘selling’ the research to the nursing teams; and identify the means by which information could be adequately communicated.

Individual meetings were arranged with all WMs over a period of three weeks. In one case the WM invited the Deputy Ward Manager to the meeting and in another the CNM who had overall clinical responsibility for Houndkirk and Longshaw wards attended. Prior to these meetings a written summary of the research was sent to the WMs (Appendix 5). The decision to send a summary of the project rather than a copy of the full protocol was that the latter was approximately 8,000 words in length and it was reasoned that a document of this size was unlikely to be read by busy clinicians. In addition, it contained information that was irrelevant in making decisions regarding access to the wards. The full protocol was made available on request; no one asked for a copy. In addition to the written material, the project was also outlined verbally at the meetings.

All the WMs were supportive and enthusiastic about the research project taking place. Interestingly, some were keen to perceive my role as ‘expert’ who would be able to identify ‘problems’ and ‘solutions’ within the service (Hammersley and Atkinson, 1995). For example, one manager thought that the findings of the study could be used to support their own beliefs about the difficulties nurses faced in delivering acute care and the need for the allocation of more resources to the wards. Others provided helpful suggestions about the practicalities of ensuring the project ran smoothly. For example, one WM suggested that the rapid reporting of the implementation of the section to the

researcher could be improved if the initial contact was made by MHARD. One joked that, 'We'll have to arrange some five-fours for you.'

The managers also expressed concerns about the study in terms of resources, care delivery and the researcher as a 'critic' of nurses' practice (Hammersley and Atkinson, 1995; Scharer, 1996; Roach et al., 2009). Typical questions asked included:

- 'Why bother researching something that is rarely used and is twenty-years-old?'
- 'Who is funding the project?'
- 'Is the project instigated by the service as a way of monitoring nurses' practice?'
- 'Is it likely to affect nursing care or disrupt the running of the ward?'
- 'Will nurses be asked to justify their practice?'
- 'What will be the benefits to the wards and patients?'
- 'Will nurses be expected to be involved and therefore increase their already busy workloads?'

Such concerns are not untypical (see for example, Form, 1973). Nevertheless it was important to take these questions seriously as permission to access the wards depended on the answers I gave. In response to the concerns raised, I informed the managers that this was an independent study and not one initiated or sponsored by the Trust; nor would it impact on the management of the ward or the care of any patient. In addition, I emphasised the fact that the purpose of the project was not to be critical of wards or the practice of individual nurses. However, it would provide those individuals, who chose to participate in the study, an opportunity to tell their stories and reflect on their practices to gain a greater understanding of the issues involved. I also provided information on the use of the section both locally and nationally along with emphasising that, despite the holding power being over twenty-years-old, we still knew little about how and why it was used.

The attendance of one of the CNMs at one of the meetings was fortuitous as he had been supportive of previous research undertaken by myself in the past. He also offered

to 'sponsor' the research by speaking to his counterpart for Riverside and Blackamoor wards, and to the area manager who would have to give overall permission for me to undertake the research in the Trust. I also contacted the other clinical nurse manager as a matter of courtesy in order to provide information about the project and seek support. This process was made easier by the fact that the manager was an old colleague and friend. This is not an argument in support of occupational nepotism but to recognise that the 'relationships established with such people can have important consequences for the subsequent course of the research' (Hammersley and Atkinson, 1995: 74).

I also asked if I could attend a ward meeting or handover on each of the four wards in order to make a short presentation of the project to the team of nurses working there. In two cases the WM thought that this would not be possible due to the unavailability of an appropriate meeting or because of time constraints; however they offered to communicate the details of the study to all nurses and distribute any written information. In the other two cases the WM thought it was important to do this so that I could explain the study and answer any questions that may arise. However, in one case I arranged a meeting on two occasions but both times the manager cancelled without explanation. On the other ward two meetings were arranged but none of the nursing staff were able to attend due to clinical activity. No further attempts were made to arrange a meeting.

As an alternative to face-to-face meetings I was able to obtain a list of all qualified nurses on the four wards from the WMs and a personalised letter was sent out containing both a shortened version of the research protocol (Appendix 5) and an A4 summary of the study (Appendix 6). It was reasoned that as the nurses were busy going about their business of caring for patients they were more likely to read a brief account of the research that did not demand too much of their time. In addition, two colour laminated A4 posters were also delivered and displayed in each ward office. The first informed the reader that the project would be taking place and the second was a copy of the project summary (Appendix 6).

Collecting background statistics on the implementation of Section 5(4)s during the study period required access to data held by the Trust's MHARD and PID. Therefore, it was important to persuade the MHARD to act as my first point of contact for obtaining

information on the use of the section on a daily basis, and also that any information required could be extracted without compromising patient confidentiality.

Gaining access to these departments was an altogether different experience than that of gaining access to the wards. I had no contacts within these departments and did not know who to contact or where to contact them. I started by contacting the Trust's headquarters and acquired the telephone numbers for the relevant departments. This was followed by a 'cold call' to both departments. Following a number of false starts I was then put through to the relevant managers and explained the study to them and what I was requesting of their services. Initially both managers referred me to the other department but eventually we were able to agree who was best placed to provide which type of information. Individual meetings were arranged to provide a more in-depth account of the study and respond to any queries. Following individual and joint meetings with the two managers both agreed to support the project.

4.3 'Gaining permission'

4.3.1 Local Research Ethics Committee (LREC) approval

As the study intended to undertake research that involved access to routinely collected statistical data, patients, NHS staff and premises in one Trust there was a requirement to obtain permission from a NHS Local Research Ethics Committee (NHS LREC) before commencing data generation.

A research protocol was developed and the relevant documentation was obtained and completed. As requested 18 copies of the completed documentation along with, the Non Clinical Trial Insurance certificate and the written permission of all consultant psychiatrists ($n = 13$) who had clinical responsibility for all patients on the four wards was submitted to the committee. Consideration of my application by the committee was delayed for eight weeks as there was a quota system in place whereby only 12 submissions were considered per meeting; my submission was number 13.

I was invited to attend the next meeting of the committee and present a brief outline of the study and respond to any issues arising. Following the meeting a letter was issued by the committee offering a favourable opinion on the application subject to a number of minor amendments being made. These amendments were made and submitted with

some other changes which I believed improved the submission. However, whilst the requested amendments were approved I was asked to undo the changes that had not been requested. Finally ethical approval was granted 20 weeks after submitting the original application (Appendix 7).

4.3.2 Research Governance approval

Since the introduction of the Research Governance Framework (DH, 2001a) there have been further requirements imposed on researchers before a study can be undertaken within Primary Care Trusts and NHS Hospital Trusts. This is to ensure that all studies are undertaken to high scientific standards to protect those who participate in research. Before approval was given I was required to meet the requirements identified in Table 2.

Table 2 NHS Trust requirements for obtaining research governance approval

Requirements

- Written evidence of NHS LREC approval
 - Copy of University indemnity insurance certificate
 - Letter of support from PhD supervisor
 - Completion of Trust's research governance application form
 - Positive feedback from Trust's research governance scientific committee.
 - Letter of approval to undertake study in the Trust from the Area Research & Development Manager
 - Completion of occupational health questionnaire
 - CRB check
 - Evidence of support from the four ward managers
 - Evidence of support from the two clinical nurse managers
 - Evidence of support from the Medical Records Department
 - Evidence of support from the Patient Information Services Department
 - Issuing of an honorary contract or letter of authority
-

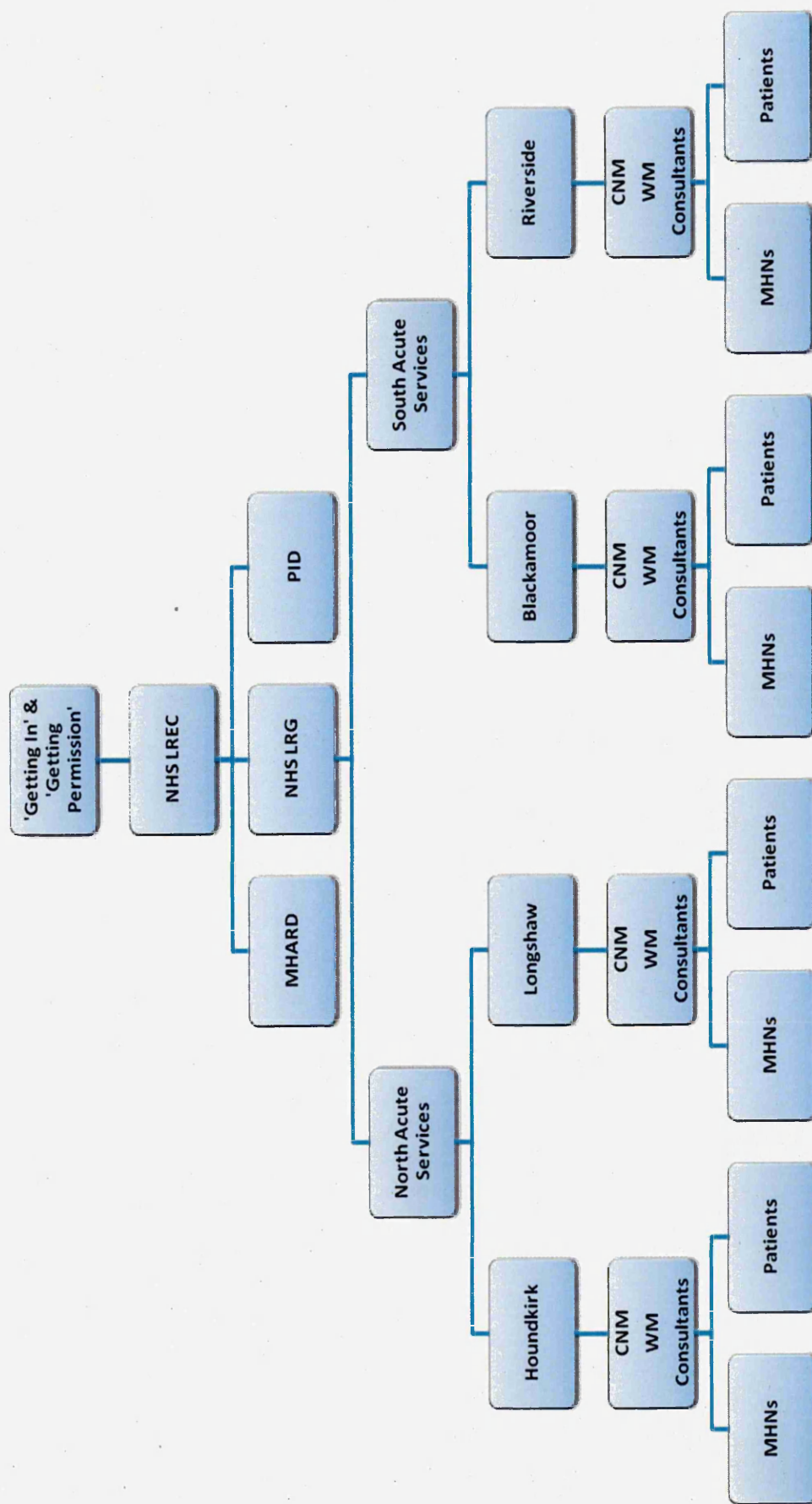
An application was submitted to the Trust's Research Governance Department (RGD). This resulted in a quick response from the scientific committee who approved the study. At this point I was confident that I would be able to start the study relatively quickly. However, in the end the governance process took a total of 32 weeks to complete.

While this was frustrating it is not unusual for researchers to experience a lengthy process or in some cases not to receive approval at all in seeking either ethical and/or governance approval (Hannigan and Allen, 2003; Hays et al., 2003; Byrne et al., 2005). In my case some of the reasons for this protracted process included:

- The misfiling of my application leading to the suspension of the process until new documentation was submitted;
- A lack of clarity surrounding the requirements that needed to be met and who was responsible for meeting them; and
- Being asked to meet further criteria surrounding confidentiality then, two weeks later, being informed that the request had been sent in error.

Further details of the events involved in gaining governance approval are outlined in Appendix 8. The process of 'getting in' and 'getting permission' are summarised in Figure 5.

Figure 5 The process of 'getting in' and 'getting permission'



4.4 Ethical issues

All researchers need to give considerable thought to the ethical aspects of the study they are intending to undertake (Robson, 1997). This section - guided by the ethical principles of autonomy, beneficence, non-maleficence and justice - describes the ethical issues identified in this study and how they were addressed in order to minimise the potential for exposing participants to discomfort, distress or harm. I also followed the NMC's (2004) Code for Professional Conduct and the RCN's (2004) research ethics guidance for nurses during the study.

As part of the general principle of respect for human dignity, the study recognised potential participants' right to self-determination. Participation in the study was based on a voluntary decision to do so free from any form of coercion or concerns that non-participation would result in any penalties or prejudicial treatment. This is of particular importance when the request to participate is made by a person in a position of authority, or where the researcher's access to the service is granted by a person in such a position (Burgess, 1984; Hammersley and Atkinson, 1995; Polit and Hungler, 1997). It was also made clear to potential participants that; they could withdraw from the study at any time without giving a reason, seek clarification regarding the purpose of the study or refuse to answer questions that they found distressing or uncomfortable.

In ensuring that the principle of voluntarism was met, participation in the study was based on an individual's ability to make an informed consent about whether to take part or not. Polit et al. (2001: 78) suggest that informed consent means that:

‘...participants have adequate information regarding the research; comprehend the information; and have the power of free choice, enabling them to consent voluntarily to participate in the research or decline participation’.

To this end, a full disclosure of information was made to all potential participants regarding what the study involved both in writing prior to undertaking any interviews (Appendix 9 and Appendix 10) and verbally at the time of data generation. Potential participants were also given the opportunity to ask questions about the study and what was expected of them should they choose to participate.

The informed consent process was documented by both the participant and researcher signing two copies of a consent form at the time of the interview (Appendix 11 and Appendix 12). The study also adhered to the concept of process consent (Munhall, 1988; Streubert and Carpenter, 1998). Process consent or 'consensual decision-making' (Ramos, 1989: 61) takes the view that consent is not a one-off event but is continually re-negotiated in response to events that occur during the research. Throughout the study there was a need for me to be aware of the need to re-negotiate consent as participants reacted and responded to questions. This allowed participants an active role in their decision to continue in the study and also served as a safeguard against any potential harm arising from their participation.

In relation to obtaining informed consent, I was aware that any patient participating in the study would be recruited from a potentially vulnerable group (Beauchamp and Childress, 1994; Behi and Nolan, 1995; Noble-Adams, 1998). However, the fact that a patient is experiencing a mental illness, detained under a section of the Act (DH, 1983) or undergoing a course of treatment (Stanley, 1982) does not necessarily mean that they lack the capacity to give informed consent to participate in a research study (Schafer, 1985). Indeed this group have been shown to perform as well in the consent process as non-mentally ill patients (Stanley et al., 1980; Stanley et al., 1981; Usher and Holmes, 1997). Therefore it was reasoned that it was appropriate to treat each case individually regardless of whether the patient was experience a mental illness or not (Brabbins et al., 1996). Indeed it has been argued that to exclude a patient from being given the opportunity to participate in a research study simply on the grounds of a mental illness may be paternalistic (Dyer and Bloch, 1987; Usher and Holmes, 1997; Koivisto et al., 2001) and disrespectful of their right to self-determination (Polit and Hungler, 1997).

The Mental Health Act Commission (1997: 2) defines the study undertaken in this thesis as a non-therapeutic piece of research; that is:

'where the principle intention or motive is for information gathering purposes, whereby the patient is treated as no more than a source of information.'

Furthermore they argue that a patient detained under a section of the Act (DH, 1983) should not be prevented from participating in research as long as the following three criteria are met:

- He/she has the capacity to consent and does consent,
- Such involvement does not conflict with any provision of the 1983 Act, or any provision or restriction imposed by law, and
- Such involvement is not otherwise inconsistent with the patient's status as a detained patient.

Similar to previous research involving the participation of individuals experiencing mental health problems (for example, Koivisto et al., 2001), before a patient was approached an opinion was sought from their key- or associate-nurse regarding their ability to give informed consent. The patient was then given information about the study and asked if they were willing to participate. Their capacity to give informed consent to participate in the study was determined by the guidance given in the literature (for example, Usher and Arthur, 1998; McKane and Tolson, 2000). Specifically, the assessment of the patient's capacity to give informed consent consisted of three mandatory elements (BMA/Law Society, 1995):

- The patient can retain and comprehend the information given to them, particularly that pertaining to the risks and benefits of participating in the research;
- The patient believes the information given to them, and
- The patient can make a decision having considered the information.

In addition, it was also recognised that any patient approached had the 'power of free choice, enabling them to consent voluntarily to participate in the research or decline participation' (Polit and Hungler, 1997: 134). Those patients who at any one time were

assessed as not meeting any of the above criteria were excluded from the study. It was also recognised that capacity could change over time within this vulnerable group. Therefore, as noted above, process consent was used in order to monitor any changes in capacity that occurred during the course of the study.

The interviews undertaken with both nurses and patients sought to gain an understanding of why and how Section 5(4) was implemented. Such interviews may offer benefits to the interviewees, for example an opportunity to clarify and resolve their thoughts and feelings surrounding the event through a debriefing process (May, 1991; Munhall, 1991; Dilonardo et al., 1993; Lee Murray, 2003). However, it was also recognised that interviews addressing sensitive topics have the potential to highlight 'recent untoward incidents or be instrumental in releasing distressing emotions surrounding these incidents' (Bonner et al., 2002: 467). In order to avoid any potential harm arising from this element of data generation, it was decided as a precaution that at the first sign of distress I would assess whether to temporarily suspend the interview or terminate it altogether. Should distress result from any part of the interview, a three-tiered approach to harm reduction would be implemented. Firstly, as a registered mental health nurse with relevant counselling and interviewing skills I felt able to react appropriately to minimise distress by offering support to the interviewee without entering into any formal counselling role. Secondly, the participant would be consulted as to their level of distress and what might be helpful in managing it, for example seeking support from ward staff in the case of the patient. Lastly, an offer would be made to put the interviewee in touch with appropriate support services, for example, a patient advocate or counsellor. In addition, when patients were interviewed the ward staff were made aware of the research procedures and the people interviewed.

In addition to preventing harm to participants, a number of authors have argued that researchers need to be aware of the potential risks to themselves while undertaking fieldwork (Cowles, 1988; Scharer, 1996; Lee-Treweek, 2000; Lee-Treweek and Linkogle, 2000; Johnson and Macleod Clarke, 2003; Lalor et al., 2006; Dickson-Swift et al., 2008). Potential harm for researchers include: risk of physical threat or abuse; risk of psychological trauma; and risk of being in a compromising situation in which there might be accusations of improper behaviour (Dickson-Swift et al., 2008). In anticipation that undertaking this study had the potential to expose me to a number of

these risks a five-point risk management plan was developed. One, I would inform nurses of my arrival and departure from the ward and how long I expected to be with the patient. Two, before undertaking any interviews with patients I would consult a nurse regarding their mental state and specifically any risks, if any, they posed to others. Three, when undertaking interviews an attempt would be made to avoid using rooms that were isolated from the main areas of the ward. Four, at the first sign of any aggressive responses to my questions I would end the interview. Lastly, should I experience any signs of psychological distress arising from undertaking the interviews I would seek support from my supervisors in the first instance and, if necessary, the university's counselling service.

The methods used in the study meant that information was generated from interviews that were recorded on audiotapes and then transcribed. There was also a need to make copies of both nursing and medical notes related to the patient's detention, the local incident form and other Mental Health Act documentation, for example Form 13. This information was gathered in accordance with the guidelines set out by the Department of Health's (2001) Research Governance Framework and NHS guidelines (Caldicott, 1997). Therefore, the participants' right to privacy was compromised as it was not possible to maintain anonymity during the face-to-face interviews or when accessing personal information contained within documentation (Walker, 2007). However, a promise of confidentiality was given to all participants. It must be recognised that participants were not asked whether they wished to be identified in reports of the study. Some authors (for example, Giordano et al., 2007) have argued that this decision may not respect participants' autonomy and that 'some individuals might even feel that they have a "right" to be identified if they so wish' (Giordano et al., 2007: 270).

All data were coded and modified to remove or change references to people, places and dates contained within data sources. Data were stored on a password protected computer or held and maintained in locked filing cabinets in a locked office within secure premises. All data, on completion of the study, will be destroyed in line with national and local guidelines. All data collection, handling and storage were therefore undertaken within the rules set out by the Data Protection Act (1998).

4.5 'Getting on'

In the previous chapter three methods of data generation were identified as appropriate for providing answers to the questions identified in this study: archival records, documentation, and interviews. The following sections describe how data were generated using each of the three methods.

4.5.1 Archival Records

Data generation consisted of two phases:

1. A retrospective phase in which the Mental Health Act Records Department (MHARD) forwarded an anonymised paper copy of their records of all Section 5(4)s implemented in the Trust for the period 30th September 1983⁴² until midnight 31st December 2003.⁴³ This data provided the following information: date and time of application; arrival time of doctor; patient's gender; nurse's gender; and outcome of the medical assessment.
2. A prospective phase in which statistical data was collected on all Section 5(4)s implemented in the Trust for the period 1st January 2004 until midnight 31st December 2006. The data generated in this phase replicated that of the retrospective stage but was supplemented by the following additional information: date of admission; and the patient's Mental Health Act history, ethnicity and age. This information was recorded on the pro forma developed specifically for the study (see Appendix 13 for an example of a completed pro forma) by a member of staff in the (MHARD). Completed forms were collected on a monthly basis.

4.5.2 Documentation

During visits to the four wards to undertake interviews the opportunity was taken to access both Mental Health Act documentation (for example Form 13, Form 16, and local incident forms) and medical and nursing notes. Mental Health Act documentation was stored in the patient's medical and nursing notes. Such documentation contained

⁴² The date the Mental Health Act 1983 was introduced.

⁴³ The day before the study commenced.

written accounts of nurses' reasons for implementing Section 5(4) along with information on any subsequent sections applied by doctors who had assessed the patient. Similarly, medical and nursing notes also provided information on the patient's care before, during and after the implementation of Section 5(4). Sometimes several visits were required to identify relevant information pertinent to the case. Mental Health Act documentation and sections of medical and nursing notes considered of relevance to the study were photocopied and taken away from the wards in line with the conditions specified by the NHS LREC and Trust's RGD.

4.5.3 Interviews

Interviews were conducted in two stages. Stage 1 preceded the main study and consisted of interviews with mental health nurses with experience of using or being involved in the implementation of Section 5(4) within the Trust. Stage 2 was undertaken over a period of one year and consisted of interviews with nurses and patients involved in the implementation of Section 5(4) during this time frame. The sampling strategy used in both stages can be described as purposive (Parahoo, 1997); that is I chose potential participants whom I believed were best placed to provide the necessary data to answer the questions posed in the study.

4.5.3.1 Stage 1 - Recruiting and interviewing mental health nurses

Interviews were undertaken with four mental health nurses, one from each of the four wards. The purpose of these interviews was to gain an understanding of the implementation of Section 5(4) by individual nurses and also to gain an overview of issues relating to its use in the Trust in general. In addition, the material obtained from these interviews also contributed to the development of the interview guide used in Stage 2. Participants were selected because they were known to have opinions on the subject, were willing to participate in the interviews following informed consent and between them had considerable experience of the use of mental health legislation (a total of 99 years).

4.5.3.2 Stage 2 - Recruiting participants: mental health nurses

The process of obtaining a sample of mental health nurses began with a telephone call from the MHARD to inform me that a Section 5(4) had been implemented in the Trust. I typically received notification of the section's use within 24-48 hours depending on

when it was implemented. For example, I would be telephoned on a Monday to inform me that Section 5(4) had been implemented the previous Friday.

The telephone call from the MHARD provided me with the following basic information on the section: name of the nurse implementing Section 5(4), the ward where it had been applied, the date and time of use, the patient's gender, and the outcome where it was known. This information was the starting point for the more in-depth investigation of why and how Section 5(4) was implemented and could be typically summarised in the following format:

On Saturday 12th February 2004 a male patient was detained at 12.40 pm on Longshaw Ward by Mark Pullman. The Section 5(4) was converted to Section 5(2) at 13.40 hours and a first recommendation was completed for a Section 2.

Once the nurse had been identified they were contacted by telephone and, following a brief explanation of why I was calling, a meeting was arranged with willing nurses at a mutually agreed date and time. Although occasionally contact was made with nurses immediately, more often several attempts had to be made to arrange a meeting as the nurse was often on another shift or on days off, night duty or annual leave. In such cases a meeting was arranged as soon after the implementation as possible.

In addition to any information they has previously received (section 3.2.4), all potential participants were sent a copy of the information sheet about the study (Appendix 9) prior to the meeting. At the time of the meeting a verbal explanation of the study was given to potential participants and the nurse was given an opportunity to ask any questions they had about the project. Following this they were asked whether they would be willing to participate in the study. If they agreed an appointment was made to undertake the interview at a mutually agreed date and time. This was usually a period of approximately seven days. This served as a 'cooling off' period in which the participant could reflect on their decision and withdraw from the interview - none of those approached chose to do this.

In some cases a mutually agreed date and time meant conducting the interviews at weekends or in two cases between midnight and 1.30 a.m. Others asked to undertake the interview there-and-then; for some this was simply because they had set aside time to meet with me with a view to participating in the study and they felt it was easier than arranging a further appointment. Others wanted to talk about their experiences as soon as possible as they had not been given the opportunity to 'debrief' following the implementation of the holding power. In these cases it was reasoned that they were autonomous individuals who had the right to determine where and when they gave an account of their experiences.

The recruitment of nurses to the study was a complete success with none of those approached declining the invitation to participate. However, a decision was made to exclude 10 cases from the study for the following reasons:

- In one case Section 5(4) was implemented before the study had received governance approval from the Trust.
- In one case the age of the detainee was 17 and therefore outside the study's inclusion criteria that all patients would be aged 18-65 years as approved by NHS LREC and Trust's research governance department.
- In four cases the nurse was excluded because they had previously been interviewed in relation to the implementation of another Section 5(4). This decision was taken in order to minimise any potential psychological risks that might occur as a result of asking to them to talk about sensitive issues on more than one occasion. In addition, it was reasoned that this would minimise any potential disruption to both the nurse and clinical functioning of the ward.
- Four cases were excluded for practical reasons, namely that a substantial amount of time had passed between the application of Section 5(4) and the opportunity to make contact with the nurse using it. This was due to the fact that I had taken an extended period of annual leave (four weeks).

4.5.3.3 Stage 2 - Recruiting participants: patients

At the time of recruiting nurses to the study the patient who had been detained was identified and their key-worker (or in their absence an associate-worker) was contacted and asked to make an assessment of the patient's capacity to make an informed decision about participating in the research (Lawton, 2001). If they agreed that the patient had capacity they were asked to approach them and enquire whether they would be willing to meet with me so that I could explain the study to them and determine whether they would be willing to participate in the research. Those who agreed were sent a copy of the patient's information sheet (Appendix 10) in advance of the mutually agreed meeting. At the meeting the structure followed that of the ones undertaken with nurses; the study was explained verbally and any questions answered. A date was arranged for the interview with those consenting to take part in the study. Patients were also given my contact details should they wish to change their mind as was their key-worker should they need to advocate on their behalf.

Twenty-one patients were excluded from the study for the following reasons (Figure 6):

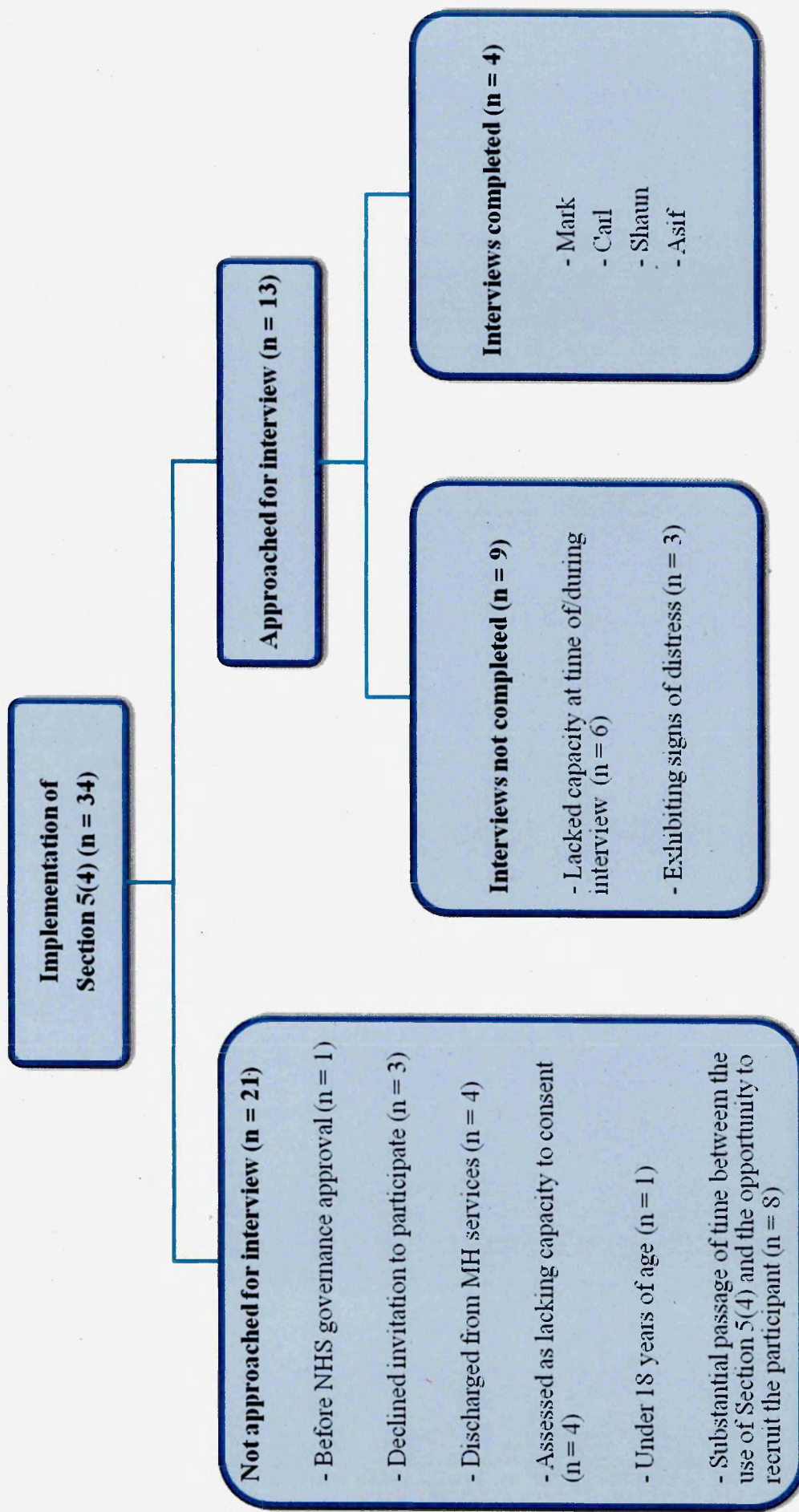
- In one case the section was implemented before the study had received governance approval from the Trust.
- In one case the detainee did not meet the age requirement of being between 18-65 years.
- In three cases the patient declined to participate in the study.
- Four cases were excluded on the grounds that the patient had been discharged from hospital.
- On four occasions the patient was assessed by their key-nurse to lack the capacity to give informed consent.

- In eight cases patients were excluded because a considerable amount of time had lapsed between the section being implemented and the opportunity arising to make contact with the person.

Therefore, due to the problems outlined above only four patient interviews were completed. While this was unavoidable it was also unfortunate as more patients' accounts of the implementation of Section 5(4) had the potential to enrich the study further. However, it is argued that this fact did not detract from the trustworthiness of the findings presented later in this thesis as each story provided an in-depth account of the detention from the patient's perspective. In this study it was not the case itself that was of central importance but the 'phenomenon... of which it facilitates understanding' (Woods, 1997: 52), that is how and why Section 5(4) was implemented (also see Quirk et al., 2003). Furthermore, each case in this study was not defined by the number of pieces of evidence present, but its ability to provide answers to the questions posed in the study. Others authors have followed a similar approach. For example, Duffy (2003) was only able to collect one out of several sources of data in two out of six of his case studies. Similarly, Woods (1997) was unable to complete participant observation of his sample in two out of five case studies.

However, the number of patients interviewed did impact on how the findings were presented. For example, one option that was considered was to present an in-depth and integrated account of each case from the nurse's and patient's perspective. However, as it was not possible to match each nurse and patient for each case, and also because of a need to account for all the data generated in this study this was rejected in favour of the analytical approach and style of presentation outlined in the chapters that follow.

Figure 6 Recruiting the patient sample



4.5.3.4 Stage 2 - Conducting the interviews

I aimed to undertake the interviews as near to the implementation of Section 5(4) as possible, and ideally within seven days. The rationale for this was the belief that this would allow me to access nurses' and patients' recent memories of the event, therefore providing a more detailed account of what had taken place and decreasing the 'possibility of memory deficits' (Fletcher, 1999: 13) associated with undertaking retrospective interviews. Gray (1994: 68) also believes that 'memory decay' is more likely to occur the further the interview is from the event and notes that, 'the respondent may get mixed-up about what events occurred and which occurred first, second and so on.' Similarly, Jones et al. (2000) and Bonner et al. (2003) point to the advantages of undertaking interviews within five days of events such as close observation and physical restraint of patients within psychiatric settings.

However, the ideal target of undertaking the interviews within seven days of the event proved unrealistic as at times it was difficult to arrange an interview due to, for example, nurses being on annual leave or patients undertaking therapeutic activities or being away from the wards. In reality participants were interviewed an average of 16.2 days following the implementation of Section 5(4) (range 6-46 days). There were certainly examples of 'memory decay'. In some of the interviews with nurses they would typically state; 'I can't remember precisely the order of things you would have to check the notes', while other nurses would bring along the patient's notes as an aide-memoire.

Gray (1994) suggests that attention be given to the environment in which the interviews are conducted. All interviews (nurses and patients) were undertaken on the wards. Ideally I would have preferred an environment away from the ward that was comfortable and free from disruptions (Walls et al., 2010). This was not possible as the nurses felt the need to stay on the ward in case they were required to return to clinical activities. This is not uncommon in this type of setting, because as Roach et al. (2009: 70) note, 'acute wards are unpredictable environments and there are instances where staff are needed first and foremost in a clinical capacity.' However, most of the nurses had the foresight to book a room in advance that was relatively free from disruption and noise but at other times we simply used the first available room. On a small number of occasions this resulted in interruptions when a member of staff or a patient would enter

the room resulting in a pause in the proceedings whilst the interruption was dealt with. For patients, the ward was the only place available to undertake the interviews as no other facilities were available, and, for at least some, their legal status limited their movement within the hospital.

Most participants would offer refreshments on my arrival for the interview; I would always accept this gesture as it provided an ideal 'ice breaker' and begin the process of building rapport (Clarke, 2006; Dickson-Swift et al., 2007). It was an opportunity for me to reacquaint myself with old colleagues and students, or to get to know a little bit more about a participant whom I had not met before; this was particularly important when the participant was a patient. It was also an opportunity for me to assess the level of clinical activity on the ward. This was important because it gave me indications about the participant's emotional state following a busy shift or day on the ward and whether it had the potential to impact on their ability to focus on the interview. Occasionally, a mutual decision was made to rearrange the interview in response to this assessment.

Although all participants had already received written information about the study I gave an overview of the project, which allowed both nurses and patients to ask questions before the interviews were undertaken. At this point I also reassessed the patient's capacity to consent to participate in the study in recognition of their membership of a vulnerable group. All participants were then asked to sign two copies of the consent form (Appendix 11 and 12); one copy was given to the participant and the other retained for my records. In keeping with the concept of process consent (Usher and Holmes, 1997), participants were reminded that they could withdraw from the study at any time or refuse to answer any questions asked during the course of the interview.

At this point the audiotape recorder was introduced. Participants were informed that the microphone was of sufficient quality that they could sit comfortably and speak normally. McCann and Clark (2005: 14) have commented that, 'despite assurances about confidentiality and anonymity, some participants may be reluctant to consent to audio recording'. In acknowledgement of this I made all participants aware of what would happen to the recording, namely that it would be transcribed and then erased, and

that only a limited number of people (the researcher, transcriber, and possibly supervisors) would hear the recording. I also offered to provide participants with a copy of the audiotape of the interview; however no one accepted this offer. Only one participant - a nurse - declined consent to the interview being audiotaped, commenting that; 'I can't be certain it won't be used against me'; however this is not an uncommon event in research focusing on potentially sensitive topics (Herdman, 2000). In this instance field notes were made in place of an audio-recording. Another nurse was happy to be recorded as long as she did not have to listen to her voice being played back to her.

The recording of the interviews was relatively unproblematic. Most of the rooms used to conduct the interviews in had access to mains electricity. As a backup the machine was fitted with batteries in the case of electricity failure or no supply being available. The batteries were checked before each interview and spares carried. In addition, an extension lead was taken to the interviews as some of the rooms were large and the seats situated some distance from the mains sockets. On the whole the recordings produced clear tapes, although a small number picked up surrounding noise from clinical activity on the wards which made some, but not many, sections of the audiotapes difficult to hear during transcription. Ninety minute (C90) audiotapes were used for recording purposes; this resulted in the minimum number of disruptions when having to change the tapes over as most interviews lasted between 40 and no more than 90 minutes.

The intention of all interviews was to encourage participants to give an in-depth account of their experiences of the implementation of Section 5(4) by asking the minimal number of questions. Initially, I took a semi-structured approach to the interviews that followed an interview schedule with a set of pre-determined questions developed from the Stage 1 interviews, the review of the Section 5(4) literature, and the aims of the study. However, it soon emerged that this format was too restrictive and prevented participants from telling their stories. In response to this, the interview schedule was replaced with aide-memoires that reminded me of the main issues but 'permitted flexibility in following the thoughts and ideas of the participants in telling their stories' (McCann and Clark, 2005: 12). Therefore interviews became unstructured in nature and consistent with a narrative enquiry with participants being encouraged to talk freely about their stories with minimal interruption from the researcher. Eventually the need

to refer to the aide-memoires became unnecessary as interviewees covered the events surrounding the implementation of Section 5(4) with my role reduced to providing minimal prompts or to asking questions in order to clarify the occasional issue.

All interviews began by asking 'easy-to-answer' questions, for example, 'Can you tell me how long you have been qualified?' The intention was to put the informant at ease before moving to the main focus of the interviews. The main section of the interviews with nurses was opened with a variation on the question:

'Tell me about the Section 5(4) you implemented on [Date].'

The interviews with nurses provided a number of 'thick descriptions' (Geertz, 1973) of their experiences of implementing Section 5(4). Many of the nurses welcomed the interview as it provided them with an opportunity to talk for the first time about their experiences of implementing Section 5(4), and as Lee Murray (2003: 234) has observed, 'by telling their stories, the participants took the first step in making sense of what happened to them'.

In some interviews the 'insider-outsider' perspective raised issues that had to be managed to ensure the process progressed smoothly. For example, in one interview I was treated by an ex-colleague as an 'insider' when, while describing the events surrounding the use of Section 5(4), Andrea commented that:

'...but I don't need to go into that because you'll know all about that from your own days on acute wards.'

As I did not wish to presume that my own construction of such events was the same as that of other nurses, I would on such occasions respond by saying that:

'Whilst I had experience of those issues and hold an opinion on them, my experience was a long time ago and I would really value hearing your views on the subject.'

On other occasions I was treated as an 'outsider' and the nurses were unsure of my motives. For example, there were times when nurses appeared unwilling or reticent to talk about certain topics that they interpreted as implying criticism of themselves, other nurses or doctors. For example:

Russell: 'Do you think the doctor should have detained him earlier?'

Nurse: 'You'd have to ask the doctor about that. I couldn't possibly comment on that.'

At such times there was a need to handle the situation sensitively by reassuring participants that there was no assumption on my part that there was a right and wrong way of applying Section 5(4) just differences between practitioners (Sullivan, 1998). I also, when appropriate, gave examples of times when I had implemented Section 5(4) in order to build trust with the interviewee and reduce any tensions in the situation.

On one occasion the interviewee asked for the tape-recorder to be turned off because they wanted to make comments about how a medical colleague had managed the aftermath of a detention but was concerned they may be construed as being overly critical and simply 'doctor bashing'. Alty and Rodlam (1998: 279) have noted that this is not an uncommon event in qualitative research where the researcher 'uncovers knowledge and/or practice that may be unacceptable or clearly poses questions about the organisation or actors under scrutiny'. However, in this case, following my reassurance that what they said would be anonymised they were happy to have their comments recorded (Alty and Rodham, 1998).

At the end of the interview I would thank the interviewee for their contribution and switch off the tape-recorder. With a number of the nurses there followed what has been referred to as an 'informal post-interview' (Gray, 1994) in which respondents would offer further information about their use of Section 5(4), seek confirmation that they had 'done the right thing' or ask questions such as; 'Could I pick your brains for a minute?' At such times it appeared that in my role of researcher I was viewed as an 'expert' and an 'educator' on all things related to the subject of Section 5(4). This was a difficult issue to address as offering an opinion may imply a criticism of the nurse's actions and

could also potentially create a barrier to accessing other staff on the wards in the future. On the other hand, it seemed inappropriate not to respond in some way as this too could be construed negatively. At such times I chose to draw on skills acquired from my years as a mental health nurse, educationalist and clinical supervisor to encourage the participants to reflect on their experiences, offering appropriate self-disclosure and making suggestions to enable the nurses to reach their own conclusions.

I also believed that the informal post-interview was important to ensure that the stated ethical intention to do no psychological harm during the study was met (Ramos, 1989; Scharer, 1996; Alty and Rodham, 1998; Kavanaugh and Ayres, 1998; Lowes and Gill, 2006). As many of the participants told stories of aggression, personal assault and feelings of betrayal and frustration at other professionals it was recognised that talking about the events surrounding the use of Section 5(4) may lead to participants 're-living' the emotions experienced at the time. Therefore the informal post-interview provided an opportunity to debrief participants and ensure that they did not leave in a state of distress (Holloway and Wheeler, 1995; Koivisto et al., 2001).

Undertaking interviews with patients is not uncommon but presents the researcher with a different set of challenges when generating data (Owen et al., 1998; Repper, 1998b; Robertson, 2000; Owen, 2001; Moyle, 2002; O'Tool et al., 2004; McCann and Clark, 2005). This was the case in this study. However, it is important to undertake research with patients because 'clients with mental health problems deserve to have their experiences heard rather than their distress reduced to statistics' (Koivisto et al., 2003: 223). Specifically, within this study it was important to undertake interviews with patients in order to gain their perspectives on the use of Section 5(4).

Although 13 patients were recruited to Stage 2 interviews (Figure 6), six were excluded from taking any further part in the study since they were assessed as no longer having the capacity to consent. In one case this occurred during the interview when it was assessed that the patient appeared to be experiencing auditory and visual hallucinations. Although the patient showed no signs of distress the decision was made to terminate the interview as a precautionary measure in order to prevent any harm occurring. The patient's key-nurse was informed of my observations.

There was a need to recognise the potential impact of the patient's mental health problems on their cognitive and verbal functioning (Dworkin, 1999; McCann and Clark, 2005; Moyle, 2005). All had been given a diagnosis of either psychosis, a major depressive disorder or anxiety. In addition, all were taking anti-depressants, anxiolytics or anti-psychotic medication, and in some cases combinations of more than one. The former may impact on the processing of information and the ability to concentrate while one side-effect of taking medication is that it can have a sedating effect (Dworkin, 1999; Owen, 2001; McCann and Clark, 2005). For example, due to feeling anxious and agitated at times during the interview Mark found it difficult to sit in one place for too long and periodically would leave the room to get a drink - a side-effect of his medication - or to locate other patients or members of staff whom he thought could substantiate aspects of his story:

'I'll just go and look for Alison [Support Worker].'

(PT1. U2: 52)

'I'm dry; do you mind if I go and get a drink of water?'

(PT1. U3: 221)

At such times the interview was taken at the patient's pace to ensure that they do not become over burdened or put under pressure.

The interviews with patients, like those undertaken with nurses, started by asking 'easy-to-answer' questions before moving on to ask the main question:

'Can you tell me what happened when [Name of nurse] stopped you from leaving the ward?'

Like the nurses, patients welcomed the opportunity to talk about their experiences. While some patients were able to describe their experiences in detail and spontaneously with little encouragement this was not the case for all. For example, Mark found it difficult to respond with detailed answers:

Russell: 'How did you come to be in hospital?'

Mark: 'I don't know.'

Russell: 'What happened to you?'

Mark: 'Don't know.'

(PT1. U1: 1-4)

At such times there was a need to ask 'closed' rather than 'open' questions, which were concise and needed to be rephrased or repeated on occasions (McCann and Clark, 2005). At other times there was a need to take on the role of 'cerebral detective' (Miles and Huberman, 1994: 29) and use 'creative guesswork' (Booth and Booth, 1996: 64) in order to elicit stories. For example:

Russell: 'Did you go and see your doctor, your GP?'

Mark: 'My sister took me there.'

Russell: 'Why was that then?'

Mark: 'Don't know.'

Russell: 'Do you think she was concerned about you in any way?'

Mark: 'Yeah, she's a good sister. She loves me.'

(PT1. U1: 14-19)

However, a combination of strategies enabled the production of a number of informative accounts of patients' experiences of being held under Section 5(4).

Finally, three interviews (Figure 6) were terminated when the patient showed signs of emotional distress in order to prevent any harm occurring. In all cases it was not possible to predict that the line of questioning would lead to the patient's response; as Clarke (2006) observes, 'it is not always apparent where an unstructured interview is leading' (2006: 24). For example:

Russell: 'Can you tell me why you were admitted to hospital?'

Jane: 'Yes, they brought me to Redmires. I'd stopped taking my medication [because] I'd like a baby that much. I know because I'm forty now's probably my last chance [Becomes tearful].'

(PT5. U2: 75-78)

At such times the interview was stopped and emotional support offered to the person. Once the person had composed themselves a decision, in consultation with the patient, was made as to whether to continue with the interview. On all occasions, the patient's key-nurse was informed of what had occurred. This was followed up the next day by telephoning the ward to inquire about the person's well-being.

4.6 Conclusion

This chapter has described in detail how the methodology described in Chapter 3 was implemented. Issues concerning access, permissions, ethics and governance have been problematised and reviewed. The chapter has also described how data were generated from medical and nursing notes, Mental Health Act statistics and documentation, and from interviews with nurses and patients. The process of undertaking interviews was described in depth along with some of the problems encountered and how they were addressed. The next chapter will justify and describe the data analysis strategies employed in the study.

Chapter 5

Data Analysis

'It's a bit like assembling an IKEA wardrobe. At first it looks like a lot of bits of wood and screws and bolts and stuff, but if you persevere and study the diagram and you've got the right screwdriver...'

Townsend (2009: 241)

5.1 Introduction

The purpose of undertaking qualitative data analysis is to make sense of the often large amounts of raw material generated during field work. This involves reducing its volume, identifying significant patterns and transforming them into the reported findings (Patton, 2002). However, as Patton (2002: 432) notes, 'no formula exists for that transformation. Guidance, yes. But no recipe.'

Deciding how to undertake the analysis of the data generated in this study proved difficult at times due to the lack of clear guidance within the case study literature (Meyer, 2001). Indeed Yin (1994: 102) has commented that, 'the analysis of case study evidence is one of the least developed and most difficult aspects of doing case studies.' Within the case study literature, there is a tendency for authors to describe the principles of analysis in general and, at times, vague terms (Gangeness and Yurkovich, 2006; Clarke and Reed, 2010) while others do not address it at all (Hentz, 2010). Robson (2002: 473) has suggested that, 'the fact that a study is a case study does not, in itself, call for a particular approach to the analysis of the qualitative data which it produces.' He argues that researchers could take an ethnographic or grounded theory approach to analysing their data. Robson's point is supported by the case study literature. For example Payne et al. (2007) draw on strategies commonly used in grounded theory to explore their cases while Crossley (2003) presented a narrative analysis of a single case study. Still others have taken a more pragmatic approach and have proposed a range of strategies that the researcher can draw upon for conducting their analysis. Perhaps the best known example of this is Miles and Huberman's (1994) sourcebook of qualitative data analysis.

In relation to case study analysis specifically, Yin's (1994) more positivistic approach focuses on pattern-matching, explanation-building, time-series analysis and the use of logic models. Stake (1995), using an approach that is conducive with the ontological and epistemological foundations of this study, identifies four types of data analysis in case study research; direct interpretation, categorical aggregation, correspondence and patterns, and naturalistic generalisation. The analysis of data generated in this study drew on a number of strategies from different approaches in order to make sense of the case studies. Each strategy used was employed as a practical solution to addressing emerging issues in the data. A justification for each decision is given in the relevant sections below.

While recognising that, 'no ways exist of perfectly replicating the researcher's analytical thought processes' (Patton, 2002: 433) I share Patton's (2002: 434) view that, 'analysts have an obligation to monitor and report their own analytical procedures and processes as fully and truthfully as possible.' Therefore, this chapter provides a detailed account of the analytical strategies employed in an attempt to make sense of data generated in this study.

Three methods were used to generate information on the implementation of Section 5(4); archival, documentary, and interview data. The mechanisms for analysing each type of data are now described.

5.2. Archival data

Archival data consisted of both retrospective and prospective statistics on the use of Section 5(4) within the Trust. Data were entered into a database and analysed using SPSS 14 for Windows. Descriptive statistics were generated from the analysis that identified and summarised the main trends contained within the data. As there was no intention to make any predictive claims based on this data, it was reasoned that undertaking an inferential statistical analysis of the data set was inappropriate as it would not further the study's purpose.

5.3 Documentary data

The documentary evidence (Mental Health Act documentation and medical and nursing notes) generated in this study was 'secondary data', that is, 'existing data which were

originally collected for other purposes' (Glaser, 1963 cited in Reed, 1992: 877). Therefore, when reading this material it quickly became clear that not all information contained in the documents - particularly the medical and nursing notes - was relevant for understanding how and why a patient came to be detained. For example, entries in the nursing notes such as 'slept well' contributed little to answering the research question.

Therefore, I decided *not* to analyse the documentary evidence separately but to consider it in conjunction with the interview data. Therefore, the documentary evidence contributed to the overall analysis in two ways. Firstly, all documentation was read and re-read to gain an overall impression of the patient's 'journey' from home to detention by the nurse in hospital. During this process significant events were noted and a timeline developed for each case (see section 5.4.4). Secondly, particular extracts relevant to the patient's detention were identified and used as part of the process of developing the plot of individual stories described in Stage 6 of the analysis (Dey, 1993).

5.4 Interview data

The interviews undertaken in this study can be divided into three categories. Firstly, background interviews took place prior to starting the main study (Stage 1 interviews). Secondly, interviews were undertaken with nurses implementing Section 5(4) (Stage 2 interviews). Finally, interviews were undertaken with patients who had been detained under Section 5(4). The interviews (along with selected documentary evidence) were analysed using the procedures outlined below. The stages of this analysis are summarised in Table 3. Patient interviews were analysed using Stages 1-7. Stage 1 nursing interviews were analysed using Stages 1-3, and Stage 9. Stage 2 nursing interviews were analysed using all nine stages.

Table 3 Procedures used in the analysis of narrative and non-narrative data

Phase I

- | | |
|----------------|---|
| Stage 1 | Transcribing the interviews |
| Stage 2 | Reading and immersion in the data |
| Stage 3 | Identifying stories from non-narrative text |

Phase II

- | | |
|----------------|--|
| Stage 4 | Ordering the events chronologically |
| Stage 5 | Constructing a story vignette |
| Stage 6 | Establishing the plot to explain the main outcome of the story |
| Stage 7 | Writing the interpreted story |
| Stage 8 | Developing a typology of the implementation of Section 5(4) |

Phase III

- | | |
|----------------|-------------------------------|
| Stage 9 | Developing a collective story |
|----------------|-------------------------------|
-

5.4.1 Stage 1: Transcribing the interviews

All interviews undertaken in the study (see section 4.5.3) were recorded on an audiotape cassette recorder. A copy was made of each recording and the original stored in a locked draw in a locked building. The copies were sent to a professional secretarial service for transcribing. This service consisted of one individual who was experienced in transcribing research interviews undertaken in health care research. The transcriber had procedures in place to maintain the confidentiality of the data.

Each audiotape was transcribed verbatim and returned by electronic mail as a Word document. The document was stored on a password protected computer. The transcriber deleted their copy of the transcript once they received confirmation that I had been able to access the document. All audiotapes were returned by post and then erased.

Each transcript was compared to the original tape recording and corrections made where necessary. Where the transcriber had encountered areas of incomprehensibility, the appropriate section of the audiotape was played again and an attempt was made to fill

any gaps in the transcript. If this failed to produce a result a '[...]' was inserted into the text to denote missing data.

Once I was satisfied with the accuracy of each transcript it was converted into a table and each unit of text was given a number. Continuous line numbers were also inserted throughout the transcript. These two procedures ensured that any text used in the findings could be located in a transcript and in doing so establish the accuracy and trustworthiness of the study by creating an audit trail. An example of the outcome of this process is shown in Table 4.

Table 4 Section of transcript taken from the interview with Anna

Speaker	Unit	Line	Text
M14	2	26	I can't remember when the gentleman was admitted,
		27	possibly Tuesday or Wednesday umm... Very chaotic in
		28	behaviour and for some reason he was brought in
		29	informally to us. He was extremely thought disordered.
		30	He couldn't stand up properly, he was falling over umm...
		31	and he couldn't string a sentence together basically.
I		32	Umm
M14	3	33	Quite confused at times; going into his bedroom, other
		34	patients' bedrooms and I felt that he was trying to leave the
		35	ward through the fire exit. Had he left he would probably
		36	have got knocked down by a vehicle...

All the transcripts were completely anonymised to ensure that where a participant mentioned another person or location, this was replaced with a pseudonym. The identity of each participant and/or clinical location was protected by using a coding system. In this system each participant's transcript was coded to denote whether it was a Stage 1 (S1) or Stage 2 (S2) interview. In addition, each transcript (T) was given a sequential number that denoted the chronological order in which the interviews were conducted. This coding system ascribed each participant a unique identifier on a computer password protected master list. This enabled me to identify the participant and the ward should I have wished to follow up any issues, although there was no need to do this. Each participant's unique contribution to the study was retained by giving them a pseudonym which was used when quoting from their transcript. Therefore, the code S1T1 corresponds to the first Stage 1 interview undertaken with 'Malc' the

manager on Longshaw ward. Similarly, all interviews with patients were coded to protect their anonymity and each participant given a pseudonym. Patients' transcripts were coded with a 'P' and given a sequential number that corresponded to details on the master list that identified the participant and the ward.

5.4.2 Stage 2: Reading and immersion in the data

The next stage in analysing the interview data was to familiarise myself with the material contained within the transcripts. This involved listening to the audiotapes and the reading and re-reading of the transcripts. This process while labour intensive, provided me with a preliminary understanding of the material contained within the individual transcripts and in particular an overview of the emergent process of detention from both a nursing and patient perspective. During this stage I also remained aware of the need to focus my reading on providing answers to the main question posed in the study; that is how and why is Section 5(4) implemented?

For each transcript I also wrote preliminary notes of what I thought were the main topics contained within the text and possible explanations for events. In addition, any questions arising from the data were noted with the intention of exploring them in subsequent transcripts. This iterative process was similar to that employed during data generation where issues raised by one participant became questions or themes that were explored in subsequent interviews. Therefore, each transcript was read to gain an understanding of its unique qualities and also to develop or refute ideas emerging from previous transcripts.

McLeod and Balamoutsou (2000: 135) recommend that a period of 24 hours should be left between reading individual transcripts and undertaking analysis. On occasions this proved to be sound advice as this allowed me to distance myself from the data in order to separate the 'wood from the trees' and make sense of what was contained within the transcripts. On other occasions it was more important to pursue thoughts and make and record connections within and between individual transcripts there-and-then.

5.4.2.1 Narrative and non-narrative data

As I became more familiar with the information contained within the transcripts it soon became apparent that the data were not uniform in nature. Specifically, it was possible

to identify in all transcripts both narrative and non-narrative data. In relation to narrative data - and similar to other researchers (for example, Earthy and Cronin, 2008) - although the study did not start out with the intention to do so the participants constructed and told stories (narratives)⁴⁴ about how and why Section 5(4) was used to prevent the patient leaving the ward. The term narrative has been used with increasing frequency in the research literature in recent years to the point where it simply refers to 'any text that consists of complete sentences linked into a coherent and integrated statement' (Polkinghorne, 1995: 6). However, the popularity of the term 'narrative' in qualitative research has led to what Riessman (2008: 5) has called the 'tyranny of narrative'. That is, the term is in danger of losing its specific meaning because as she notes, 'all talk and text is not narrative' (Riessman, *ibid*).

Attempts to define the term narrative more precisely has also proved problematic as various academic disciplines have operationalized it differently (Riessman, 2008). For example, the discipline of social linguistics offers a very restrictive definition in which a narrative is identified in a text by identifying the presence of distinct characteristics (Labov and Waletzky, 1967); while narrative in biographical research can refer to an entire life story (Chamberlayne et al., 2000). While recognising that the term 'narrative' and 'story' may mean different things depending on the academic discipline, in this thesis I have chosen a definition that captures the main issues that have been identified by a number of authors (for example, Bleakley, 2005; Riessman, 2008):

'A "narrative" is a *story* that tells a sequence of events that are significant for the *narrator* and his or her *audience*. A narrative as a story has a plot, a beginning, a middle and an end. It has an internal logic that makes sense to the narrator. A narrative relates events in a temporal, casual sequence. Every narrative describes a sequence of events that have happened.'

(Denzin, 1989: 37)

The generation of narratives and narrative analysis have been used in a number of disciplines including nursing (Boykin and Schoenhofer, 1991; Sandelowski, 1991; McCance et al., 2001; Bailey and Tilley, 2002) to explore aspects of health in general

⁴⁴ Like others (for example, Sarbin, 1986; Denzin, 1989; McCance et al., 2001; Riessman, 2008) I am proposing that *narrative* is coterminous with *story* and therefore the words are used interchangeably within the text.

(Loewe et al., 1998; Charmaz, 1999) and mental health specifically (Crowe and Alavi, 1999; Casey and Long, 2002; Gray, 2007; Smith, 2010). Therefore, it was reasoned that the analysis of the narratives 'discovered' in the data was an appropriate method for understanding the how and why of implementing Section 5(4). In this study participants shared their experiences of the nurse's holding power through their stories and also afforded me the opportunity to understand the practice of implementing Section 5(4) (Kelly and Howie, 2007).

The transcripts also contained non-narrative data, that is, where participants commented on aspects of the use of Section 5(4) without using the story format as defined by Denzin (1989). This material provided me with a rich source of data on specific topics relating to Section 5(4) and on general issues concerning related issues or specific topics. Non-narrative data often appeared in the form of question and answer sections of the text, for example:

Russell: 'And then a doctor came along?'

Adam: 'Yeah. I think it were about five o'clock when the doctor came.'

Russell: 'So, what did the SpR make of him?'

Adam: 'He said that he wasn't going to do a recommendation for a two because it was a first admission and because there wasn't a diagnosis as such in place he didn't want to go down that route... so, he just put him on to a five-two.'

Russell: 'I mean that's quite interesting that the SpR came along and did a five-two but not any further recommendations.'

Adam: 'I mean you'd have to ask him. But all he said was because there wasn't a diagnosis yet, he didn't want to do it...'

Russell: 'Was that SpR familiar with the ward?'

Adam: 'I'd never met him before.'

Adam (S2T11. U16-18: 144-160)

5.4.2.2 Narrative analysis

It is argued that the two broad types of data identified in the transcripts can be aligned with Bruner's (1985, 1990) belief that people engage in two main ways of knowing the

social world which he terms narrative cognition and paradigmatic cognition. Narrative cognition has been defined as, 'a storied way of knowing which combines elements of experience into an emplotted story' (Goodfellow, 1998:106) to create a unified whole. Therefore, the analysis of this narrative data focuses on making sense of human action. In relation to this study the purpose was to gain an understanding of why the characters in each story acted in the way they did and how that resulted in the implementation of Section 5(4). Therefore, the events outlined in participants' narratives are plotted sequentially by the researcher to produce a whole story and therefore greater understanding of the phenomenon being studied (Goodfellow, *ibid*).

In contrast, paradigmatic cognition is a logical/scientific mode of understanding the social world in which 'elements [of stories] are recognised as being members of a social category' (Goodfellow, *ibid*). With this in mind the storied data are explored and common themes identified, coded and grouped into categories. However, others have taken a different perspective on this process. For example, some authors (Richardson, 1985; Gould et al., 2005) have identified commonalities in stories and then used them to construct collective stories that represent the group rather than the individual. Therefore, this type of analysis would involve exploring the participants' stories with the aim of identifying commonalities in the detention process.

The next step was to explore the different approaches to undertaking narrative analysis and to make a decision as to which one was most appropriate for analysing the data contained within the transcripts. However, there is agreement among those working in the field of narrative research (for example, Emden, 1998; Priest et al., 2002a; Priest et al., 2002b; Elliot, 2005; Riessman, 2008) that there is 'no standard approach or list of procedures that is recognized as representing the narrative method of analysis' (Elliot 2005: 36). Mishler (1995: 88) goes further when he suggests that there is a, 'state of near anarchy in the field'. Some authors, for example Studs Terkel (1967, 1970), have presented their research interviews with little editing with the intention that texts should speak for themselves or at least that the reader will take their own meaning from the interview. More typically, the methods used by researchers to analyse narratives reflect their theoretical perspective. Riessman (2008) has attempted to bring some order to the field by identifying three main types of narrative analysis. Riessman (2008: 12) notes

that, 'each approach provides a different way of knowing a phenomenon, and each leads to unique insights.'

In thematic analysis the researcher focuses on *what* is said, that is the content of the narrative. Individual cases are explored and data are coded and organised into groups of themes. Lengthy quotes are used to support the emerging themes or in some cases (for example, Williams, 1984) individual stories are selected to illustrate general patterns and differences in and between stories. However, unlike approaches such as grounded theory, thematic narrative analysis focuses on generating and maintaining 'coherent stories' (Freshwater and Holloway, 2010: 189) rather than fracturing the text (Riessman, 1993).

Structural analysis focuses on specific linguistic mechanisms and explores *how* narratives are told. Therefore, this approach focuses on how the 'teller' attempts to convince the listener that certain events happened in a particular way and for the reasons the 'teller' says they did (Riessman, 1990a). This approach - developed from the work of Labov and Waletzky (1967) - suggests that narratives have formal structures that can be identified and analysed to identify recurring patterns in the way individuals talk about a phenomenon in the stories they tell.

Dialogic/performance analysis focuses on the interactive nature of speech. Stories are seen as co-constructions arising from the interaction of the investigator and participant in the context of the research situation. This approach is less concerned with the *what* and *how* of narratives but asks, "who" an utterance may be directed to, "when," and "why," that is, for what purpose?" (Riessman, 2008: 105). Analysis is interpretative and attempts to position the phenomenon under investigation in the context of wider issues, for example race and gender. For example, Riessman (2003: 338) attempted to illustrate how 'gender defines women by their marital and child-bearing status,' by presenting an in-depth analysis of Gita, a married woman from South India.

While all researchers draw on the main types of narrative analysis to some extent, there appears to be no standard approach to how they are applied to research data. Some authors, in an attempt to overcome the limitations of individual approaches, have combined different methods in their studies. For example, Riessman (1990b) and

Bailey and Jackson (2003) combined structural analysis with grounded theory to produce in-depth accounts of their data. Others have developed their own methods to make sense of narratives (Emden, 1998; Goodfellow, 1998; McLeod and Balamoutsou, 2000).

Although I was influenced by a number of approaches to narrative analysis, no one method was considered appropriate for making sense of the data in this study. Therefore, in analysing the transcript data I followed the nine stages summarised in Table 3; this method was influenced by a number of approaches to narrative analysis (for example, Richardson, 1985; Richardson, 1990; Riessman, 1993; Frank, 1995; Polkinghorne, 1995; Emden, 1998; Goodfellow, 1998; McLeod and Balamoutsou, 2000; Riessman, 2002; Molineux and Rickard, 2003; Kelly and Howie, 2007). However, the overall strategy to analysing the narratives was guided by the types of data identified in the transcripts and Polkinghorne's (1995) advice on how to analyse them. Polkinghorne (1995) has aligned Bruner's (1985) two types of cognition (narrative and paradigmatic) with two methods of analysis; analysis of narratives and narrative analysis. Narrative analysis involves the re-configuration of elements contained within the data to produce an emplotted story that attempts to explain its outcome (Polkinghorne, 1995). Narrative analysis may combine more than one data source, for example interviews and documents (Goodfellow, 1998). In contrast, analysis of narratives (paradigmatic analysis) involves a within- and an across-case examination of stories in which common elements and patterns are identified to produce an integrated perspective on the phenomena explored through narrative (Ayres et al., 2003). Both types of analysis were incorporated into the steps outlined below to produce individual stories of how and why Section 5(4) was implemented as well as a collective account of the detention process.

5.4.3 Stage 3: Identifying stories from non-narrative text

In keeping with the discussion presented above, this stage of the analysis focused on McCormack's (2004) suggestion that the researcher needs to identify stories from other forms of data contained within the transcripts. McCormack (2004: 223) notes that:

'Initially, the researcher locates the stories [from] the parts of the interview text not represented as stories.'

However, what constitutes a story has been the subject of much debate within the literature and reflects each author's theoretical persuasion (Stein, 1982; Stein and Policastro, 1984; Sarbin, 1986; Polkinghorne, 1988; Bruner, 1990; Viney and Bousfield, 1991; Holloway and Freshwater, 2007; Riessman, 2008). For example, Labov and Waletzky (1967) argue that a fully formed story consists of six elements: an *abstract*, that provides a brief summary of the story; an *orientation*, that introduces the people and the context or setting in which the story takes place; a *complicating action*, explaining what happened next; a *resolution*, that explains what finally happened; an *evaluation*, where the narrator indicates the main point or points of their story; and a *coda*, where the story brings the narrator and the audience back to the present. Others take a more general approach; where stories provide an account of human actions and have a beginning, middle, and an end. Stories also contain a series of events that are arranged chronologically and explained by a plot that links events in a sequential relationship (Sarbin, 1986; Young, 1989; Polkinghorne, 1995).

While all definitions of what constitutes a narrative were valuable, no one single approach was considered of practical use for identifying stories in the transcripts. However, I was able to draw on parts of different approaches in order to construct stories contained within the transcripts, for example Polkinghorne (1995), Banks-Wallace (2002), Riessman (2002, 2003). My starting point for Stage 3 of the analysis was to recognise that, consistent with the ontological and epistemological position taken in the study, any stories identified in the text were social constructions. That is, any stories told in the study were first of all constructed by the nurse or patient in order to make sense of their experiences of the events leading to the implementation of Section 5(4). Secondly, the stories captured in the transcripts were co-constructions created between myself and the interviewee during the interview. Lastly, the stories identified for analysis were further constructions, generated by myself as researcher as part of my attempts to make sense of the transcripts. Therefore, I would argue that the stories did not pre-exist in the transcripts waiting for me to discover them but were created as I began to take the data apart and 'give meaning to first impressions' (Stake, 1995: 71). Therefore, the overall approach to analysis was to move from *received* stories to *interpreted* stories (Goodfellow, 1998: 107). Received stories are those generated

during the interviews while interpreted stories are those created during the course of my analysis.

Taking each transcript I began to construct and separate the received story from other material contained within the text. The process of achieving this started by following McCormack's (2004: 223) suggestion that, 'stories are differentiated from surrounding text by recognisable boundaries.' One strategy I used to define the start or opening boundary of the received story was to identify any variation on my opening question to the participant and their response to it, that is; 'Tell me about the Section 5(4) you implemented on [Date]'. Therefore the story of the implementation of each Section 5(4) was taken as what the participants chose to tell me. Although I tried to keep my role in the creation of the story to that of audience, offering only encouraging minimal prompts, I recognise that my attempts to clarify issues may have affected how the participant told their story or even altered its direction.

The time period covered in each story varied according to what individual participants considered was important for explaining their actions. For example, some participants began their story immediately before the use of Section 5(4) and finished it at the point when the doctor arrived to make their assessment. Others began with the events leading up to the patient's admission to hospital and finished by bringing me up-to-date with how the patient was at the time of the interview.

Another strategy used to determine where a story began and ended was to examine the transcript for any *entrance* and *exit* talk used by participants (Jefferson, 1979; Riessman, 2002). For example, one participant indicated the beginning of their story with, 'I'll start at the beginning' and signalled the end by stating, 'That's about it really'. However, the boundaries of where a story ended was not always made clear by the participant; in such case there was a need for me to determine the end of the narrative. In such cases I would examine the transcripts for indications of when the conversation moved from the story of the detention to more general issues (Fraser, 2004). For example, during the interview conducted with Sharon I took the following comment as the story boundary:

Russell: 'Okay then... Just moving on from that, does the ward use any standardised assessment tools for risk?'

(S2T8. U17: 191-193)

It was reasoned that such questions required participants to move from the narrative reasoning of storytelling to the paradigmatic reasoning required to answer these specific questions (Bruner, 1990). However, it was not presumed that this denoted the end of the participant's storytelling; therefore the whole transcript was read for examples of where, if at all, the text returned to material that referred to the story of how and why Section 5(4) was applied.

5.4.4 Stage 4: Ordering the events chronologically

In some transcripts the participants from the start presented the events of their stories in a temporally ordered sequence with a beginning, middle, and end. However, this was not the case for many of the participants. In reality participants presented a more fragmented account in which some events were initially omitted or told out of sequence. Therefore, during the interviews I would find myself having to ask participants to explain some parts of their stories again. This enabled me to clarify my own understanding of what events had happened when and why. While this filled the gaps in individual stories it would, at times, disrupt the interviewee's storytelling. At such times the participants often responded 'thematically...rather than chronologically' (Molineux and Rickard, 2003: 56). Therefore, in order to gain a better understanding of how and why each section was implemented there was a need to reconfigure the data elements contained within the transcripts chronologically; a process common in many studies of narrative analysis (Polkinghorne, 1995; Creswell, 1998; Jackson, 1998; Wengraf, 2000; Molineux and Rickard, 2003; Kelly and Howie, 2007).

In this study, the process of configuring the data began, as noted above (section 5.4.2), with me immersing myself in the data by listening to the audiotapes and reading and re-reading the transcripts in order to gain a sense of what events occurred when and how they might relate to one another. Events were numbered chronologically on the transcripts. The relevant segments were then cut and pasted electronically to produce a new document so that the events of the detention could be read sequentially.

In addition, I constructed timelines of the events contained in each story from both the transcripts and documentary data (Berends, 2011). I considered this to be a significant part of gaining an understanding of the process of detention and the impact individual events had on one another. The outcome of the timeline constructed for Shaun is presented as an example of this process (Appendix 14). It is worth noting that although the process of analysis is presented sequentially many of the stages occurred concurrently. For example, this stage and the one that preceded it were undertaken in parallel.

5.4.5 Stage 5: Constructing a story vignette

On completing Stage 4 of the analysis I - like a number of other researchers (for example see Nyström et al., 2002; Stickley, 2007) - constructed a vignette of 200-600 words for each story. Erickson (1986: 149-150) suggests a vignette is a:

‘vivid portrayal of the conduct of an event of everyday life, in which the sights and sounds of what was being said and done are described in the natural sequence of their occurrence in real time.’

The purpose of constructing the vignettes was an attempt to summarise the; who, what, where, when and to some extent the why of the events as they unfolded chronologically and prepare the way for the next stage of the analysis. Examples of the vignettes constructed during this stage are given in Appendix 15.

5.4.6 Stage 6: Establishing the plot to explain the main outcome of the story

The construction of a vignette for each received story provided me with a preliminary understanding of the events leading to the implementation of Section 5(4). It also served as the starting point for the next stage of the analysis which aimed to produce an explanation or plot for how and why the section had been implemented. Holloway and Freshwater (2007: 10) suggest that the plot explains how events in a story are linked together in a ‘chain of causation’. Similarly, Polkinghorne (1995: 16) has proposed that the purpose of narrative analysis is to construct a plot (explanation) that links ‘past events together to account for how a final outcome might have come about’. Finally, Emden (1998: 35) has suggested that the term ‘plot’ is used:

‘interchangeably with ‘theme’ or ‘main point’, that is, a story usually (but not always) has a theme or main point to it (or more than one).’

Therefore, the plot attempts to make sense of events and the ways in which they are connected (Czarniawska, 2004; Holloway and Freshwater, 2007). The emplotment of stories has been used successfully in recent years to interpret health care phenomena, for example McCance et al. (2001), Casey and Long (2002), and Crossley (2003). In this study, the purpose of this analysis was to take Section 5(4) - the outcome - and explain how and why the identified events led to it. The plot is therefore constructed not found (White, 1973; Holloway and Freshwater, 2007).

As suggested by McCormack (2004: 223), the starting point for the emplotment of individual stories within this study was to establish, ‘how they (the teller) want to be understood’, that is what the main point of the story was. McCormack (2004), drawing on the work of Labov (1972), suggests that in this stage of the analysis the researcher reads the transcripts and identifies any evaluative statements used by the teller. Viney and Bousfield (1991: 758) describe evaluation statements as:

‘those parts of the story where the narrator indicates what he or she is getting at by telling this story.’

All the transcripts involved in this stage of the analysis⁴⁵ were read and any evaluative comments identified. When more than one evaluative comment was identified they were compared until only one main point remained. The main point was used as a working title for the story (McCormack, 2004: 223). For example, the following main points were identified and used as titles (see Appendix 16 for all working titles):

‘If I’d known Sarah I probably wouldn’t have five-foured her.’

Richard

‘I wasn’t sure how much you can do under common law.’

Ray

⁴⁵ Patient and nursing Stage 2 interviews.

‘A bit of a battle between myself and the on-call consultant.’

Simon

It’s a silly reason really but the morning staff were really reluctant to five-four her because it was her birthday.’

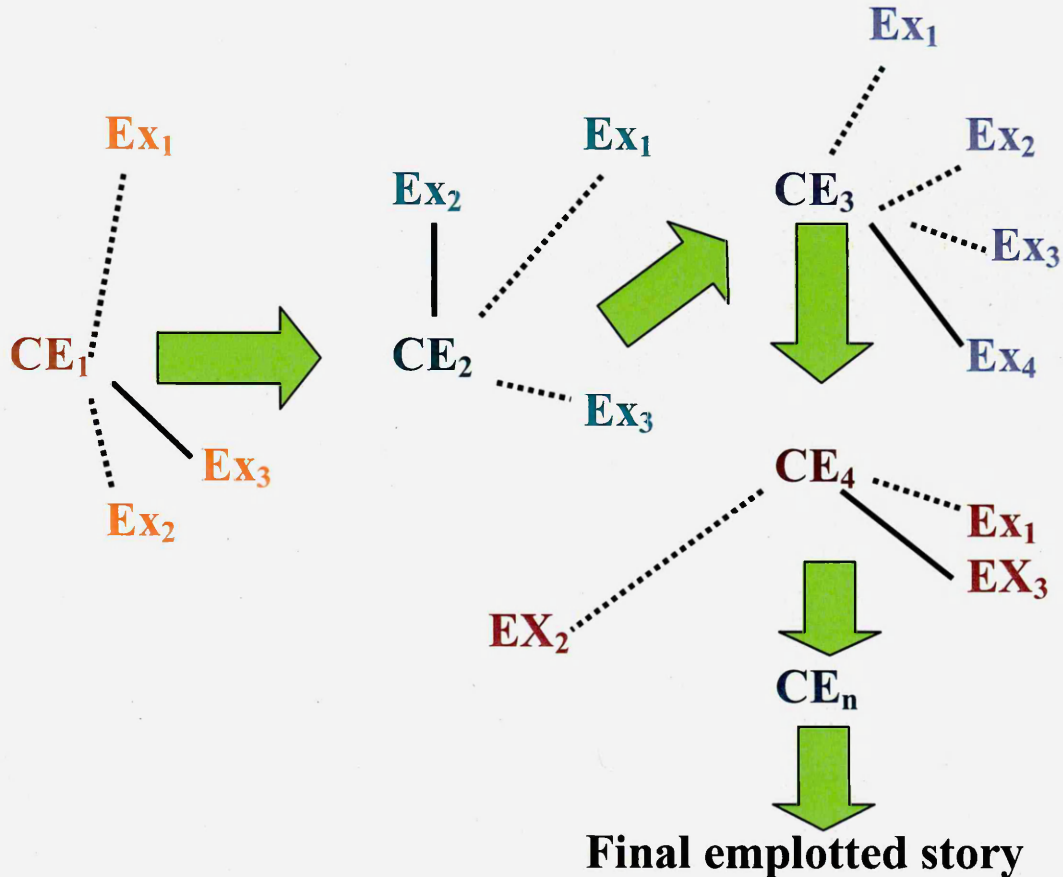
Joy

Once the main point of the story and its outcome had been determined the events identified in the timeline for each story were analysed sequentially. At each step in the process possible reasons were generated to explain why that event had occurred and how it had led to the next one in the sequence. The explanations were then compared with the transcript to ‘test’ out whether they were supported by the participant’s own account. At times, this led to the rejection of the initial explanation and the formulation of a new one. Explanations were also compared to written accounts of the events contained within the documentary data. As each new event and explanation was added to the sequence previous explanations were checked again to ensure that what had gone before was consistent with what followed it. This process continued until a plot had been generated that explained how and why each section had been implemented. This process is represented diagrammatically in Figure 7; dotted lines are rejected explanations and solid bold lines represent the explanation taken forward to develop the plot.

As the analysis progressed it became evident that not all events or characters mentioned in the received stories were relevant to the development of the interpreted story. Therefore, any information that did not contradict the plot but was not relevant to its development was excluded from the final story (Polkinghorne, 1995). Spence (1986, 1987) has termed this process ‘narrative smoothing’.⁴⁶

⁴⁶ Here narrative smoothing is used as an analytic tool that contributes to the construction of a plot in an interpreted story. However, in Spence’s (1986) original conception he viewed it as a potentially negative device for selective reporting of clinical data in psychoanalysis in order to support a preferred argument that ‘runs the risk of telling a story that is quite different from the original experience’ (Spence, 1986: 213).

Figure 7 The process of developing an emplotted story



Key

CE: Chronological Event

EX: Explanation

Modified from Wengraf (2000)

5.4.7 Stage 7: Writing the interpreted story

Finally, the product of the analysis was written up as a 2000-5000 word account of the interpreted story that aimed to provide an understanding of how and why Section 5(4) had been implemented in each case (McLeod and Balamoutsou, 2000). Quotes from the participants were integrated into the stories to support the interpretations. Examples of the end product of this approach to data analysis can be found widely in the literature, for example Kiesinger (1998), Crepeau (2000), Dalli (2000), Edmands and Marcellino-Boisvert (2002), and Finlay (2004).

5.4.8 Stage 8: Developing a typology of the implementation of Section 5(4)

The next stage of analysis was to develop a typology of Section 5(4) implementation. The rationale for this was two-fold. Firstly, the previous stages of analysis had produced a series of stories that gave detailed accounts of the application of the section. While the stories significantly contributed to answering the research questions it was not possible to present all of them in their entirety because of the word limit associated with the submission of this doctoral thesis.

Secondly, and more importantly, while the analysis of individual cases produced detailed accounts of the implementation of the section, it had not clarified the differences and similarities between the stories (Neusüss and Maedje, 2000). Therefore, it was reasoned that the development of a typology would produce a greater understanding of how and why Section 5(4) had been implemented.

Developing a typology in order to gain a greater understanding of a phenomenon has appeared with increasing frequency in nursing and health related disciplines in recent years (Nolan et al., 1995; Hart and Bond, 1996; Adams et al., 1998; Ayres, 2000; Cowley et al., 2000; Brody, 2003; Kennedy, 2004; Macduff, 2006; Robichaux and Clark, 2006). Patton (2002: 457) defines typologies as:

‘...classification systems made up of categories that divide some aspect of the world into parts along a continuum. They differ from *taxonomies*, which completely classify a phenomenon through mutually exclusive and exhaustive categories, like the biological system for classifying species. Typologies, in contrast, are built on ideal-types or illustrative endpoints rather than a complete and discrete set of categories.’

Therefore typologies attempt to describe and explain how phenomena ‘can be characterised or differentiated’ (Macduff, 2007: 41) in some way. Furthermore, as suggested in Patton’s (2002) definition, some typologies (for example, Nolan et al., 1995) suggest an internal order while others (for example, Robichaux and Clark, 2006) simply list and described the types (Macduff, 2007). The intention in this study was to examine the individual stories with the purpose of identifying and describing different types of Section 5(4)s.

The first step in developing the typology was to return to the interpreted stories generated in Stage 7 and to re-read them several times. This process, similar to the biographical life course study of single mothers living in Berlin undertaken by Neusüss and Maedje (2000), led to the identification of a number - initially five stories - of 'particularly striking single cases' (ibid: 292). A striking case was simply one that 'grabbed my attention' and offered significant insights into the implementation of Section 5(4). Each 'striking case' was then examined in depth using the story's main point and plot identified in Stage 6 as a starting point. Each 'striking' story was then named as a type and a short definition generated to describe it (Appendix 17). All 'striking cases' were then compared to one another and similarities and differences noted in plot structures. Eventually this process of constant comparison led to the generation of further story types and each story was placed in one of them based on recurring plots. A second stage of between-case analysis was undertaken that involved moving back and forth between individual aspects of the plot structures and the whole stories (Robichaux and Clark, 2006). This led to further refinements and the reduction of the number of stories contained within the final typology.

In establishing the typology of stories the intention was not to deny that 'people tell their own unique story' (Frank, 1995: 75) but to suggest that in doing so it was possible to configure them into a smaller number of types. The development of the typology was guided by Frank's (1995: 75) definition of what constitutes a story or narrative type; he states that:

'A narrative type is the most general storyline that can be recognised underlying the plot and tensions of particular stories.'

Therefore, this stage of the analysis moved from 'illuminating indigenous typologies' (Patton, 2002: 457) to 'analyst-constructed typologies' (Patton, 2002: 458). In the former the stories were explored with the intention of identifying ways in which participants characterised and distinguished between the Section 5(4)s they implemented. In the latter I inductively examined the stories to identify and make 'explicit patterns that appear to exist but remain unperceived by the people studied' (Patton, 2002: 459). However, Patton (2002: 459-460) has cautioned researchers to be

aware of imposing 'a world of meaning on the participants that better reflects the observer's world than the world under study'. Mindful of Patton's (2002) caution the final typology was presented to nurses both in the Trust and at an international conference (Ashmore, 2010) as a way of checking out whether the constructions made sense to them. The feedback and discussions that followed the presentations suggested that mental health nurses both locally and nationally did recognise their experiences of implementing Section 5(4) in the different story types.

In presenting the final typology it may appear that each story could easily be allocated to one type or another; however in reality this was not the case. During the analysis it was quite clear in some cases which type a story belonged to. However, in other cases it was more difficult allocating a story to a type because the plot structure shared some common elements with other stories. This was resolved by asking, 'What aspect of the plot (the main point of the story) does the teller keep returning to above all others?' This enabled me to distinguish between the main plot and subplots contained in a story and how they contributed to its final outcome. This process enabled me to determine where best to place stories sharing common elements in the final typology (Hickey and Kipping, 1996). For example, in Andrea's story the main point was medical inaction and all parts of the plot were used in an attempt to convince the audience of this conclusion. However, in Simon's story medical inaction appeared as a subplot that served to advance the narrative to its final outcome of implementing the section as an act of self-protection. Therefore, it was possible to place stories in the most appropriate category because 'their coherence was usually based on one dominant storyline or type' (Hänninen and Koski-Jännes, 1999: 1840).

Finally, it is proposed that the final typology is 'inclusive' (Pawson et al., 2004) in that it is argued that each story can be placed in one of the emergent types. It is also argued that although a story may contain some elements of other types they are not represented sufficiently for an individual story to be classified in more than one type, therefore it is suggested that the types are 'mutually exclusive' (Pawson et al., 2004: 13).

5.4.9 Stage 9: Developing a collective story

The previous stages of analysis led to the development of individual stories and the construction of a typology that provided an in-depth understanding of how and why

Section 5(4) was implemented. However, in relation to the nurses' transcripts (Stage 1 and Stage 2 interviews) this had led to the exclusion of some data that had the potential to illuminate the detention process further. For example, the non-narrative data identified in Stage 3 and some other material that had been excluded during the development of individual stories. Therefore, it was decided that there was a need to undertake further analysis to account for this data. However, in keeping with the narrative approach taken in this thesis it was reasoned that in order to do this there was a need to examine all parts (narrative and non-narrative data) of the nursing transcripts (Stage 1 and Stage 2). It is argued that for this stage of the analysis to examine the non-narrative data in isolation from the transcripts as a whole would fragment the material and be engaging in "anti-narrative" strategies that separate authors from their text' (Sandelowski, 1991: 161). In addition, to do so had the potential to obscure rather than further illuminate the detention process.

The intention of this stage of the analysis was to move away from the many individual stories told by the nurses to one integrated narrative. It aimed to compare and contrast all the nursing transcripts with the purpose of identifying common elements that would be then presented as a coherent whole. Richardson (1990: 25) refers to the product of this process - in which the common experiences of a group of people are represented - as a 'collective story'. Richardson (1990: 26) suggests that:

'...the individual response to the well-told collective story is, "That's *my* story. I am not alone."

However, while a number of collective stories have been reported in the literature (for example, Bertaux and Bertaux-Wiame, 1981; Ruth and Öberg, 1992; Gould et al., 2005; Pringle, 2008) guidance on their construction is less well documented (Elliott, 2005). For example, Richardson (1985) has produced a comprehensive account of a collective story in her book *The New Other Women*; however she provides no details on how she constructed the story. However, in a later publication Richardson (1990) does suggest that events in the collective story should be examined chronologically and the final product should be emplotted with a beginning, middle and end to explain the phenomenon being studied. Others, for example Pringle (2008), provide only a brief and incomplete account of the analytical strategies deployed in their studies. Still others

(for example, Ruth and Öberg, 1992; Gould et al., 2005) have used a constant comparative method of analysis (Glaser and Strauss, 1967) before producing a collective story, although once again the authors do not clearly articulate how they evolved their collective story from their initial analysis. Therefore, the procedures for constructing collective stories appear to be poorly articulated in the literature. What follows are the details of how I developed the collective story presented in Chapter 9.

The development of the collective story started by returning to the Stage 2 transcripts and reading through them again in chronological order from the first to the last section implemented over the data generation period. Each transcript was read as a whole and also unit by unit, enabling a list of topics to be generated from the interview material. A topic was defined as, 'the area of *content* of the discourse, or what the participants are talking *about*' (McLeod and Balamoutsou, 2000: 137). Each of the units was assigned one or more topics depending on the material it contained. A list of topics generated from the interview with Beth is offered as an example of this process (Table 5).

Table 5 Topics identified in Beth's transcript

Buffer period
De facto detention
Leaving
Risks
Team decision
Therapeutic relationship
Reluctance to use holding power
Therapeutic risk-taking
Doctors

The process of identifying topics proceeded from an initially broad, immediate, and impressionistic understanding of what the participant was talking about to a more fine grain analysis of the topics contained within each unit. Each topic was given a working definition in order to facilitate the identification of similar material in other transcripts (Dey, 1993; Braun and Clarke, 2006). Examples of these definitions are given in Table 6.

Table 6 Examples of topic definitions

Topic	Definition
Leaving	This topic refers to the patient's attempts to leave the ward and/or the nurse's attempts to prevent them from doing so.
Therapeutic relationships	This topic refers to the impact of implementing Section 5(4) on the nurse-patient relationship.
Making the decision	This topic refers to any discussion of the nurse's decision making processes surrounding the implementation of Section 5(4).

As each subsequent transcript was read new topics were generated and defined. As each interview was analysed topics were compared with those that had been generated in other transcripts. This led to some topics being renamed and in other cases definitions were modified. This process continued until all the topics contained in the transcripts generated during Stage 2 interviews had been identified. The process was then repeated with Stage 1 interviews. Units with the same topic title were copied from individual transcripts and placed together in a word file - one per topic.

The next stage involved comparing and contrasting individual data units for each topic. This fine grain analysis led to a greater understanding of individual topics. For example, an analysis of the topic 'making the decision' identified that the decision to implement Section 5(4) consisted of the following elements: 'avoiding the decision', 'making the decision', 'informing the patient of the decision', 'implementing the decision', 'enforcing the decision', and 'managing the aftermath of the decision'.

Once the analysis of individual topics had been completed they were compared and contrasted with the other topics; this process enabled me to gain an understanding of their relationship with one another. The next step was to configure the material chronologically, drawing on some of the procedures outlined in Stage 4 of the analysis. The final step in the development of the collective story was to develop a plot that explained how and why Section 5(4) was implemented from a collective rather than

individual perspective. This stage drew on the techniques described in Stage 6 of the analysis.

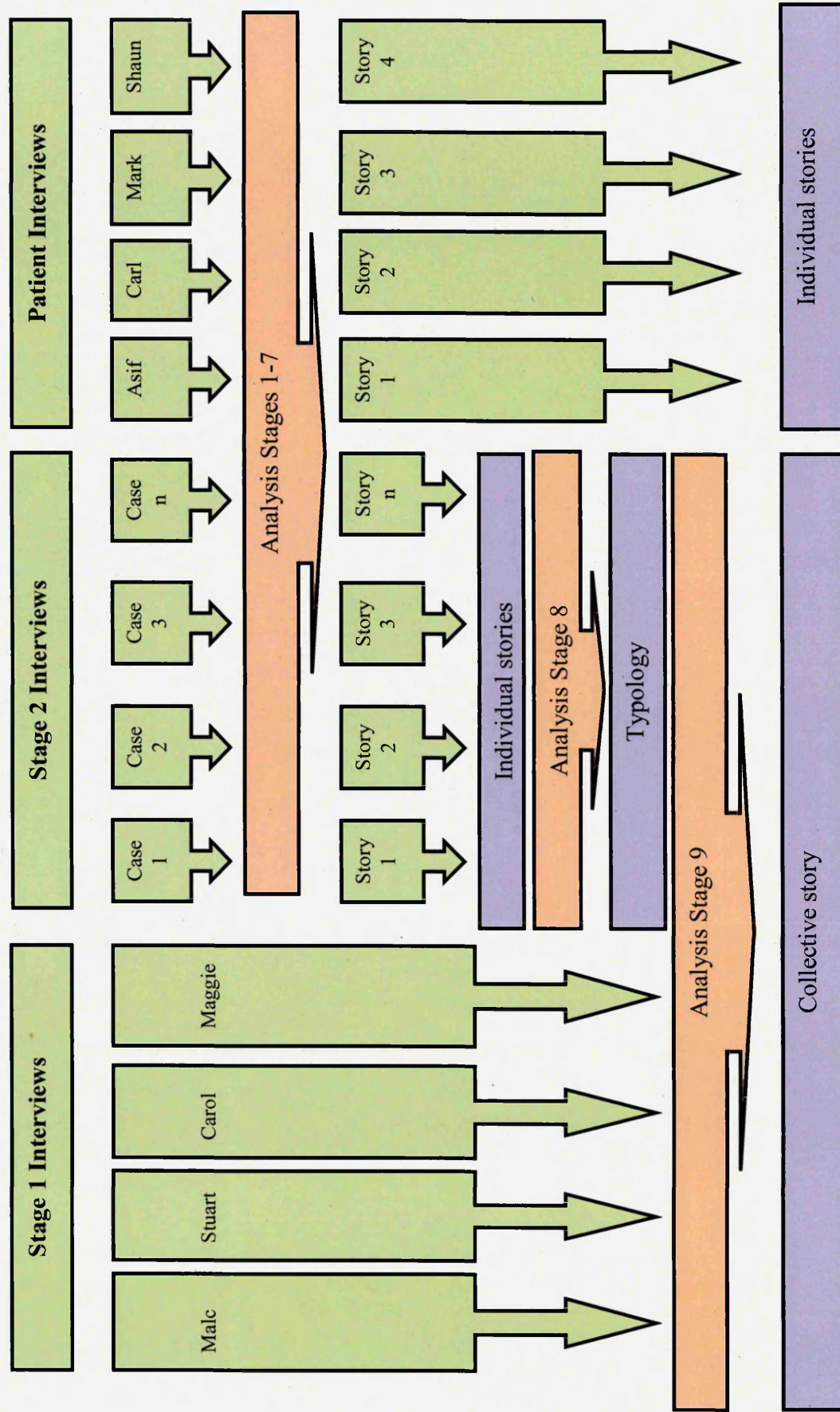
The stages of analysis undertaken on each type of interview data (nurses' Stage 1 and Stage 2 and patients) are summarised in Figure 8.

5.5 Conclusion

This chapter has offered a rationale for the analysis of the data generated in this thesis and outlined in detail the stages and procedures involved in this process. Specifically, consideration has been given to the analytic strategies used to explore data generated during case study research. While researchers undertaking case studies have deployed a wide range of methods from a number of perspectives in order to make sense of their data, for example ethnography and grounded theory, no consensus exists as to what constitutes the preferred method. Following a preliminary examination of the data it was decided that a narrative approach to data analysis was the method most suited to providing the answers to the questions posed in this study. A rationale was presented for this decision. The main approaches to narrative analysis were also discussed and then my own nine stage approach to analysis was presented as the preferred method for gaining an understanding of the data generated in this study.

In the next four chapters (six-nine) the findings generated from the different stages of the analysis are presented. Each chapter contributes to providing answers to how and why Section 5(4) was implemented within the Trust.

Figure 8 Summary of the analysis undertaken on the interview data generated in the study



Chapter 6

Data set and trends associated with the implementation of Section 5(4)

6.1 Introduction

This chapter presents the findings of the background data (both retrospective and prospective) generated on the implementation of Section 5(4) in the Trust (section 4.5.1). The findings are presented in two parts. In the first part, findings arising from the data generated on the: date and time of application; arrival time of doctor; patient's gender; nurse's gender; and outcome of the medical assessment are presented collectively for the period 1983-2006. In the second part, findings arising from the additional information (number of admissions to the Trust, date of admission; ethnicity; age; and the patient's Mental Health Act history) generated for the period 2004-2006 are presented separately. This chapter also presents the data set for the interviews conducted in this study.

The findings presented below should be read with a degree of caution as they are based on official statistics provided by the organisation in which the study was conducted. Therefore, the findings are based on data that represent the interests of the host organisation and those who collate information on the implementation of the Act, for example the National Health Service Information Centre for Health and Social Care. One disadvantage of official statistics provided to researchers is that they may be incomplete and therefore not represent the true extent of a phenomenon. Certainly in this study there were examples of missing items for some variables. In addition, at least one Section 5(4) implemented by a nurse in the study did not appear on the Trust's official statistics, although it was unclear why this had occurred.

6.2 Trends associated with the implementation of Section 5(4) 1983-2006

6.2.1 Incidence

During the period 30th September 1983 until 31st December 2006 Section 5(4) was applied on 803 occasions, an average of 33.4 times per annum. It was used least frequently in 1983 and 1998 (n = 5) and most frequently during 1990 (n = 76) (Figure 9). The majority (93.4%, n = 750) of sections were applied in acute in-patient wards; the remaining 53 (6.6%) were distributed across a range of clinical services (Table 7).

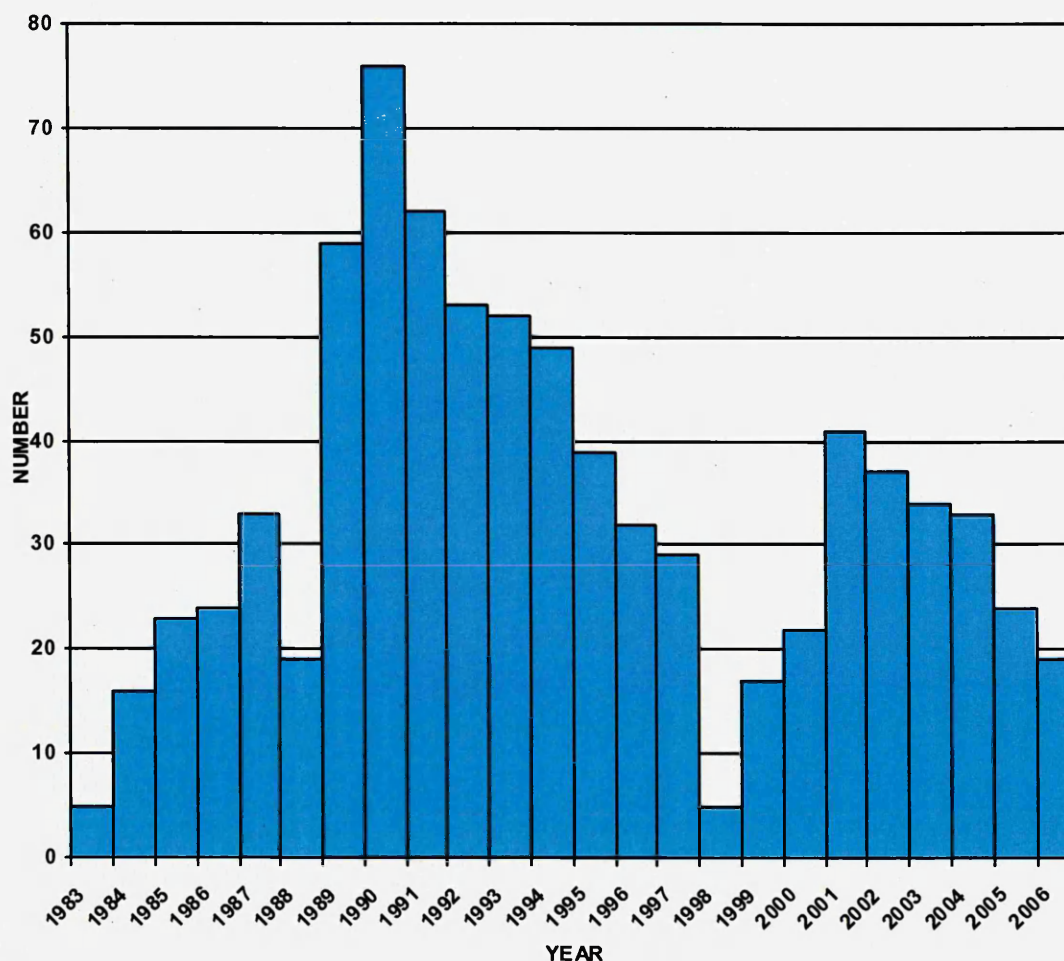
6.2.2 Outcome of the medical assessment

Section 5(4) was regraded to another section of the Act on 664 (82.7%) occasions; the majority of patients were placed on Section 5(2) (79.1%, n = 635). In 17.3% (n = 139) of cases the patient was regraded as informal (Table 7).

6.2.3 Gender

Section 5(4) was applied to 469 (58.4%) female patients and 334 (41.6%) male patients. The section was applied by a male nurse on 441 (54.9%) occasions and by a female nurse on 344 (42.8%) occasions (missing items⁴⁷ = 2.2%, n = 18). Male nurses detained 51.4% (n = 241) of female patients and 60.5% (n = 202) of male patients.

Figure 9 The use of Section 5(4) by year



⁴⁷ Hereafter, MI

Table 7 Sample characteristics

Characteristic	n	%
Gender		
Female	469	58.4
Male	334	41.6
Clinical service		
Adult	750	93.4
Older Adult (acute care)	31	3.9
Older adult (cognitive impairment)	8	1.0
Children and young adult	6	0.8
Enduring	5	0.6
Forensic	2	0.2
MI	1	0.1
Medical response time		
00:00 - 00:59	162	20.2
01:00 - 01:59	279	34.8
02:00 - 02:59	135	16.8
03:00 - 03:59	71	8.8
04:00 - 4:59	40	5.0
05:00 - 5:59	32	4.0
06:00>	67	8.3
MI	17	2.1
Outcome of the medical assessment		
Informal	139	17.3
Section 5(2)	635	79.1
Section 2	5	0.6
Section 3	2	0.3
MI	22	2.7
Day of week		
Monday	114	14.19
Tuesday	121	15.06
Wednesday	111	13.82
Thursday	116	14.44
Friday	111	13.82
Saturday	110	13.69
Sunday	116	14.44
MI	4	0.49
Month of year		
January	60	7.47
February	57	7.09
March	85	10.58
April	63	7.84
May	66	8.21
June	56	6.97
July	60	7.47
August	90	11.20
September	55	6.84
October	70	8.71
November	82	10.21
December	55	6.84
MI	4	0.49

MI, missing items

6.2.4 Temporal patterns

6.2.4.1 Season, month, and day of the week

In relation to season, Section 5(4) was implemented: 172 (21.4%) times in winter; 214 (26.7%) times in spring, 206 (25.7%) times in summer; and 207 (25.8%) times in autumn. For month of the year and day of the week, most detentions were implemented during August (11.2%, n = 90) and on a Tuesday (15.01%, n = 121). The least were implemented in September and December (6.84%, n = 55), and on a Saturday (13.69%, n = 110) (Table 7).

6.2.4.2 Time of day

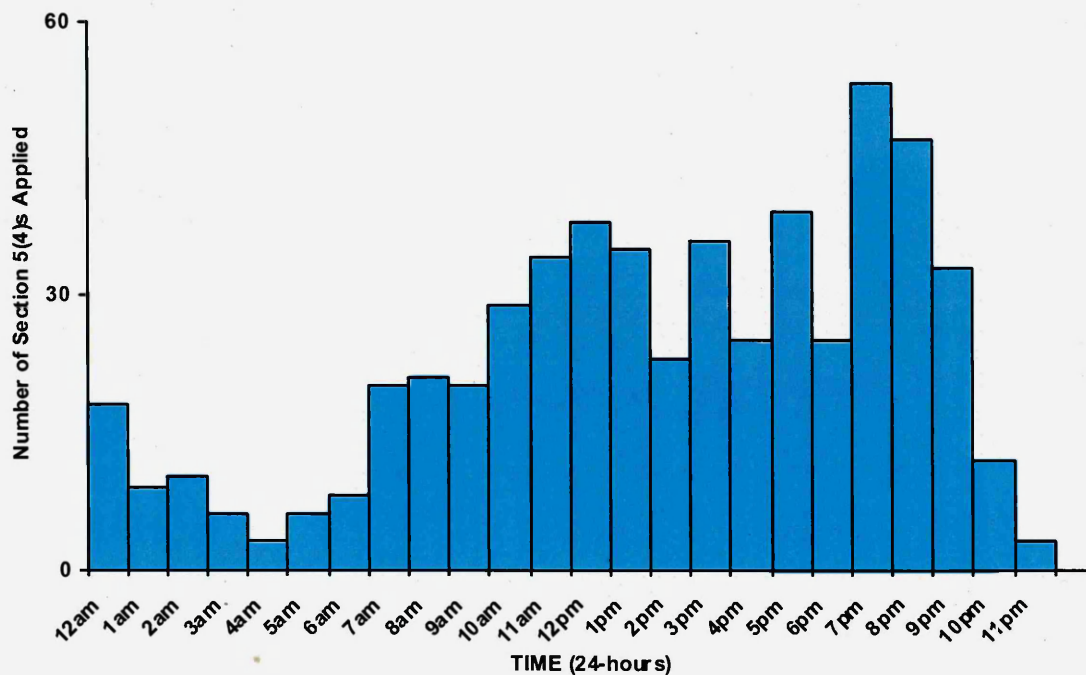
Differences were observed in the use of Section 5(4) over the 24-hour period of the day (Figure 10). In keeping with previous research (Ashmore, 1992b; Ashmore, 1995; Ashmore, 1998c; Ajetunmobi, 2001; Shivram, 2006) the 24-hour period was explored in more detail by identifying four eight-hour periods:

- Period 1 (midnight-8.00 a.m.),
- Period 2 (8.00 a.m.-4.00 p.m.),
- Period 3 (4.00 p.m.-midnight), and
- Period 4 doctors' working hours (Monday-Friday, 9.00 a.m.-5.00 p.m.).

Analysis of these four periods revealed that 102 (12.7%) sections were applied during Period 1, 340 (42.3%) sections during Period 2, 344 (42.8%) sections during Period 3 (MI = 2.1%, n = 17), and 349 (43.5%) during Period 4.

The fact that most applications of Section 5(4)s were implemented during 'out-of-hours' working - when a doctor is not usually readily available to assess the patient - would support the rationale for the introduction of Section 5(4) in the 1983 Act. However, of more concern was the fact that 43.5% of all sections were applied during doctors' working hours as it raises questions about the lack of availability of appropriately qualified medical staff to undertake assessments of the patient during this period. Although it is unclear why this occurred it is an issue worthy of further investigation as it impacts on the need to implement Section 5(4) and the subsequent care of the patient.

Figure 10 The implementation of Section 5(4) over the 24-hour period



6.2.5 Medical response time

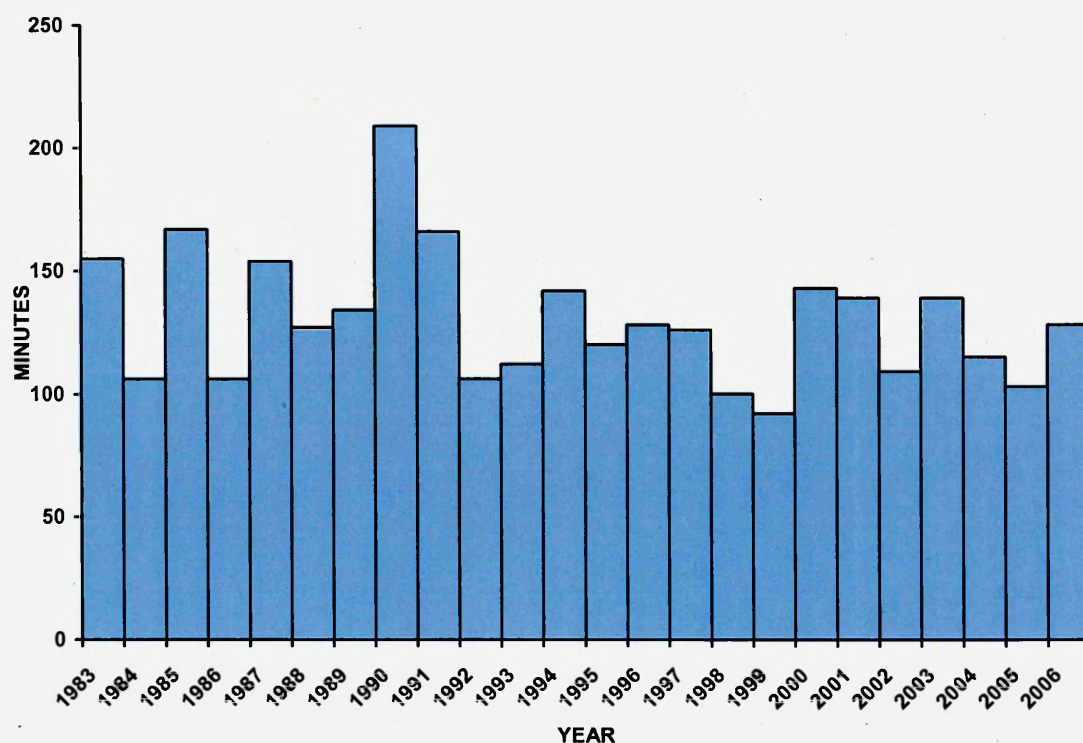
6.2.5.1 Overall patterns of medical response time

The annual mean medical response time⁴⁸ (MRT) for the period 1983-2006 is shown in Figure 11. The overall mean MRT for this period was 140 minutes (range 3-555 minutes); the female subgroup had a mean MRT of 144 minutes and the male subgroup 156 minutes. The MRT in the majority of cases (34.8%, n = 279) fell between one and two hours and 80.6% (n = 647) of patients were seen within the four hour period specified in the Code of Practice (DH, 1999a). In the period (1994-2006) following the introduction of the four hour period⁴⁹ there was a reduction in the mean MRT (122 minutes) when compared to the mean MRT (143 minutes) for the period preceding it (1983-1993). Sixty-seven patients (8.3%) had a MRT of six hours or more (Table 7).

⁴⁸ Medical response time has been defined as the elapsed time between the nurse implementing Section 5(4) as recorded on Form 13 and the arrival time of the doctor on the ward to undertake the medical assessment as recorded on Form 16 (Ashmore, 1992b).

⁴⁹ The 1990 Mental Health Act Code of Practice (DH, 1990) recommendation that all patients be assessed by a doctor within five hours of Section 5(4) being implemented. In the 1993 Code of Practice (DH, 1993) this period of time was reduced to four hours.

Figure 11 Annual medical response time 1983-2006



6.2.5.2 Day of the week and time of day

From Monday to Sunday the mean MRT was 146, 95, 129, 150, 148, 129 and 136 minutes. MRT over the 24-hour period was examined by comparing the four eight-hour periods identified in section 6.2.4.2. The mean MRT for the four periods were:

- Period 1: 137 minutes;
- Period 2: 168 minutes;
- Period 3: 106 minutes; and
- Period 4: 153 minutes.

6.2.5.3 The six hour sections

Sixty-seven (8.3%) sections remained in place for the maximum period of time (360 minutes); nine (1.1%) of which exceeded the six hour maximum by an average of 47 minutes (range 365-555 minutes). Of the 67 sections, 12 were applied during Period 4, including three of over 360 minutes (365, 390 and 420 minutes); and seven were applied before 9.00 a.m. but the patient spent an average of 277 minutes (range 165-345

minutes) in the 'working hours' period, five of which exceeded 300 minutes. A further 10 patients spent the full six hours detained in the 9.00 a.m.-5.00 p.m. period at the weekend.

At the end of the six hour period 34 patients were regraded as informal: two absconded before being assessed by a doctor; four were assessed as requiring no further detention and discharged from hospital; seven sections expired before the doctor arrived and the patients discharged themselves, in one of these cases the doctor was unable to attend due to heavy snow fall and in another the doctor was not contacted by the nursing staff; and 21 patients - following assessment - agreed to remain in hospital informally. The remaining 33 patients in this group were, following assessment, detained under Section 5(2) including four patients who exceeded the maximum of 360 minutes (365, 390, 400, and 555 minutes).

6.3 Additional factors associated with the application of Section 5(4) 2004-2006

6.3.1 Admissions to hospital

A total of 2583 patients were admitted to the four acute wards during the period 2004-2006: 765 (29.6%) to Blackamoor; 619 (24.0%) to Houndkirk; 395 (15.3%) to Longshaw; and 804 (31.1%) to Riverside.

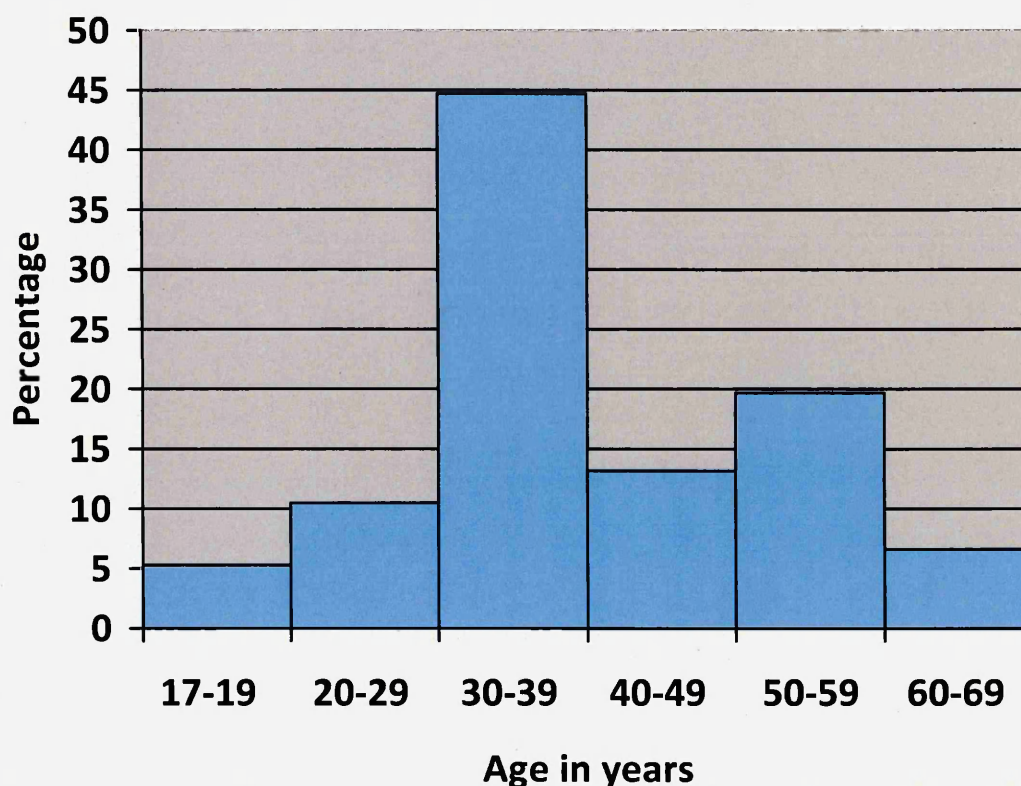
6.3.2 Mental Health Act

A total of 1934 (74.9%) patients were admitted under a section of the Act, the remaining 649 (25.1%) informally. Seventy-six informal patients were subsequently detained under Section 5(4). This accounted for 2.9% of the total number of admissions and 11.7% of all informal admissions. Approximately equal numbers of Section 5(4) were implemented across the four wards: 22 (28.9%) on Blackamoor; 18 (23.7%) on Houndkirk; 17 (22.4%) on Longshaw; and 18 (23.7%) on Riverside. There was one (1.3%) MI. For the majority of patients (51.3%, n = 39) the use of Section 5(4) constituted their first detention under the Act. The remaining 37 (48.7%) patients had been detained on at least one other occasion.

6.3.3 Gender, ethnicity and age

For the period 2004-2006, female patients accounted for 52.6% (n = 40) of all Section 5(4)s implemented and male patients 47.4% (n = 36). The majority (78.9%, n = 60) of patients were of white British origin; the ethnicity of the remaining 16 patients was: Asian British Pakistani (10.5%, n = 8); Asian other (3.9%, n = 3); Somali (2.6%, n = 2); black British Caribbean (1.3%, n = 1), mixed race white and black Caribbean (1.3%, n = 1); and Yemen (1.3%, n = 1). The highest number of Section 5(4)s were applied in the 30-39 (n = 34) and 50-59 (n = 15) age groups. Their combined total of 49 accounted for 69.7% of the total number of Section 5(4)s applied in this period (Figure 12).

Figure 12 Age and application of Section 5(4)

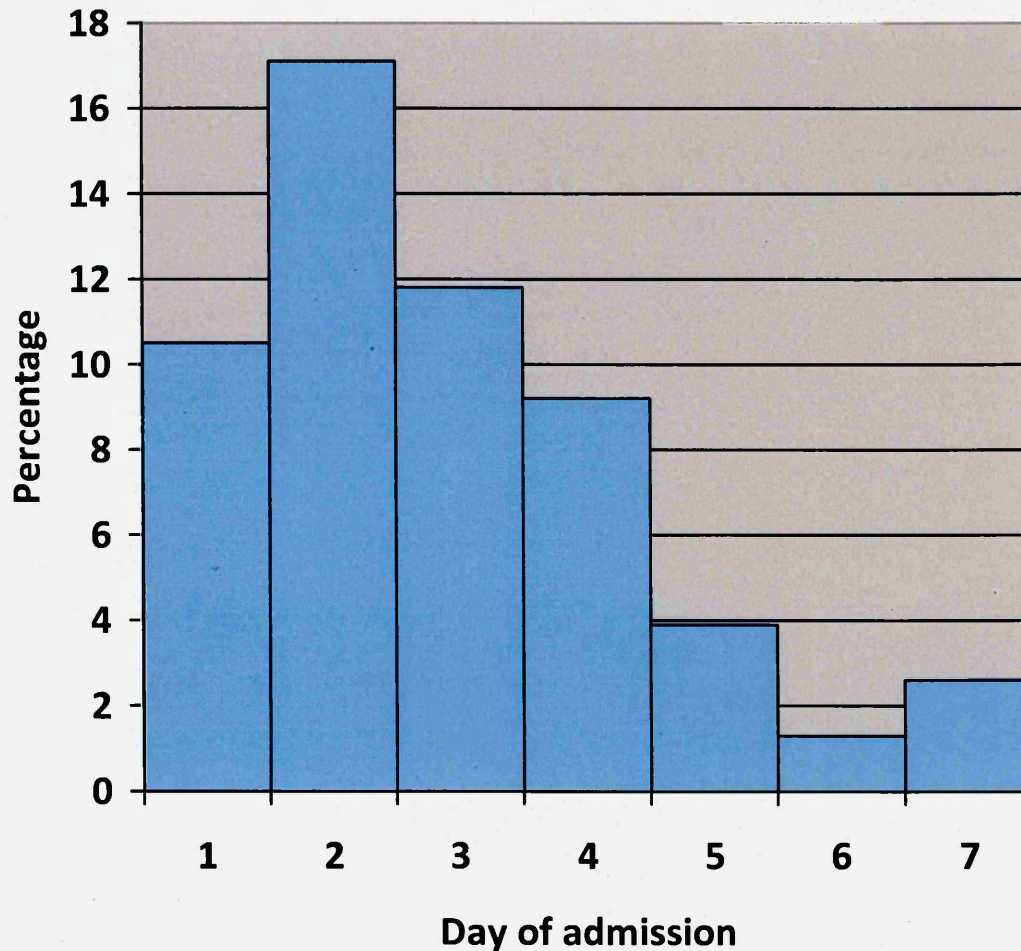


6.3.4 Length of admission and the use of Section 5(4)

For the period 2004-2006, 63 (82.9%) applications of Section 5(4) were implemented during the first month of admission, of which 43 (56.6%) occurred during the first week of admission. Fifty-four (71%) occurred during the first two weeks of admission. Eight (10.5%) were applied on the first day of admission, 13 (17.1%) on day two, 9 (11.8%)

on day three, and 7 (9.2%) on day four. Therefore the first four days of admission accounted for 48.7% (n = 37) of all Section 5(4)s applied (Figure 13).

Figure 13 The use of Section 5(4) within the first week of admission



6.4 Summary of interview data

This section summarises the data from the interviews undertaken with nurses and patients in the study.

6.4.1 Interviews with nurses

A total of 30 interviews were undertaken over a period of one year; four in Stage 1 of the study and 26 in Stage 2. All interviews were included in the development of the collective story while only Stage 2 interviews were used to develop the typology presented in Chapter 7. Stage 1 interviews consisted of two females and two males.

Two were grade 'G', one grade 'F' and one grade 'E'. They had a total of 99 years clinical experience with a mean of 24.75 years (range 15-39 years).

Of the 26 interviews undertaken in Stage 2, 10 nurses were female and 16 male. Four nurses were grade 'D',⁵⁰ 18 nurses were grade 'E', and four grade 'F'. Eight of the nurses interviewed worked on Houndkirk ward, seven on Blackamoor, seven on Longshaw and four on Riverside. The nurses had a mean of 6.7 years post-qualifying experience (range 0.6-39 years). Five nurses had never used Section 5(4) before. The remaining 21 nurses had used Section 5(4) on a total of 93 occasions, with a mean of 4.4 times per person (range 2-16 occasions). There was one MI.

6.4.2 Interviews with patients

A total of four patients were interviewed. All were male and had a mean age of 35 years (range 18-47 years). Two patients had previous admissions to hospital and both had been previously detained under the Act. Two patients were admitted to Blackamoor ward, one to Longshaw ward and one to Riverside ward. They were placed on Section 5(4) an average of 21.75 days after admission to hospital (range 12-34 days).

6.5 Conclusion

This chapter has reported findings on the trends associated with the implementation of Section 5(4) in the Trust over the period 1983-2006 by exploring a number of variables. Consistent with the literature reviewed in Chapter 2 the trends reported suggest that the person detained under Section 5(4) is likely to be female, aged in their thirties, and a patient on an adult acute in-patient ward. In addition, they are more likely to be detained on a weekday by a male nurse between 9.00 a.m. and 5.00 p.m. during the first week of admission. Most patients will be assessed by a psychiatrist within four hours of being detained and will be placed on at least Section 5(2) of the Act.

In addition to providing contextual information on the implementation of Section 5(4), the trends also proved useful for identifying a number of issues relating to the application of the holding power. For example, similar to previous research (for

⁵⁰ From the 1st April, 2006 clinical grades were replaced by bands (DH, 2004a). Grades 'D' and 'E' were integrated into the single Band 5, grades 'F' and 'G' into Band 6, and grade 'I' into Band 7.

example Ajetunmobi, 2001a; Shivram, 2006), a high percentage of Section 5(4)s were implemented in the first week of admission yet it was unclear from the statistical data why this was the case. Another issue was the fact that nearly 20 per cent of patients had to wait more than four hours before being assessed by a psychiatrist. Although this finding is not uncommon (for example see Ashmore, 1998c; Shivram, 2006) the reasons why it occurs have not been adequately explained. This issue - along with others - have the potential to impact both on patients who are uncertain about their future care, and nursing staff involved in managing the situation. Therefore the trends led to the identification of potential topics that were worthy of further exploration in order to understand how and why Section 5(4) was implemented. Some of these issues were taken forward and examined in the interviews with both nurses and patients.

Chapter 7

Nurses' stories of using Section 5(4): a six-part typology

7.1 Introduction

This chapter presents the six-part typology of Section 5(4) stories developed from the analysis of the Stage 2 interviews (n = 26).

The initial analysis generated 14 story types of Section 5(4) as:

- 1) health, safety or protection;
- 2) a response to an inappropriate informal admission;
- 3) a lack of clinical knowledge about the patient;
- 4) arising from situational factors;
- 5) a catalyst;
- 6) a response to medical inaction;
- 7) self-protection;
- 8) manipulation;
- 9) a negative experience for the patient;
- 10) a negative experience for the nurse;
- 11) a last resort;
- 12) a short-term intervention;
- 13) a response to the limitations of common law;
- 14) a justification for implementing containment interventions.

Further analysis resulted in the initial 14 stories being reduced to a final typology of six:

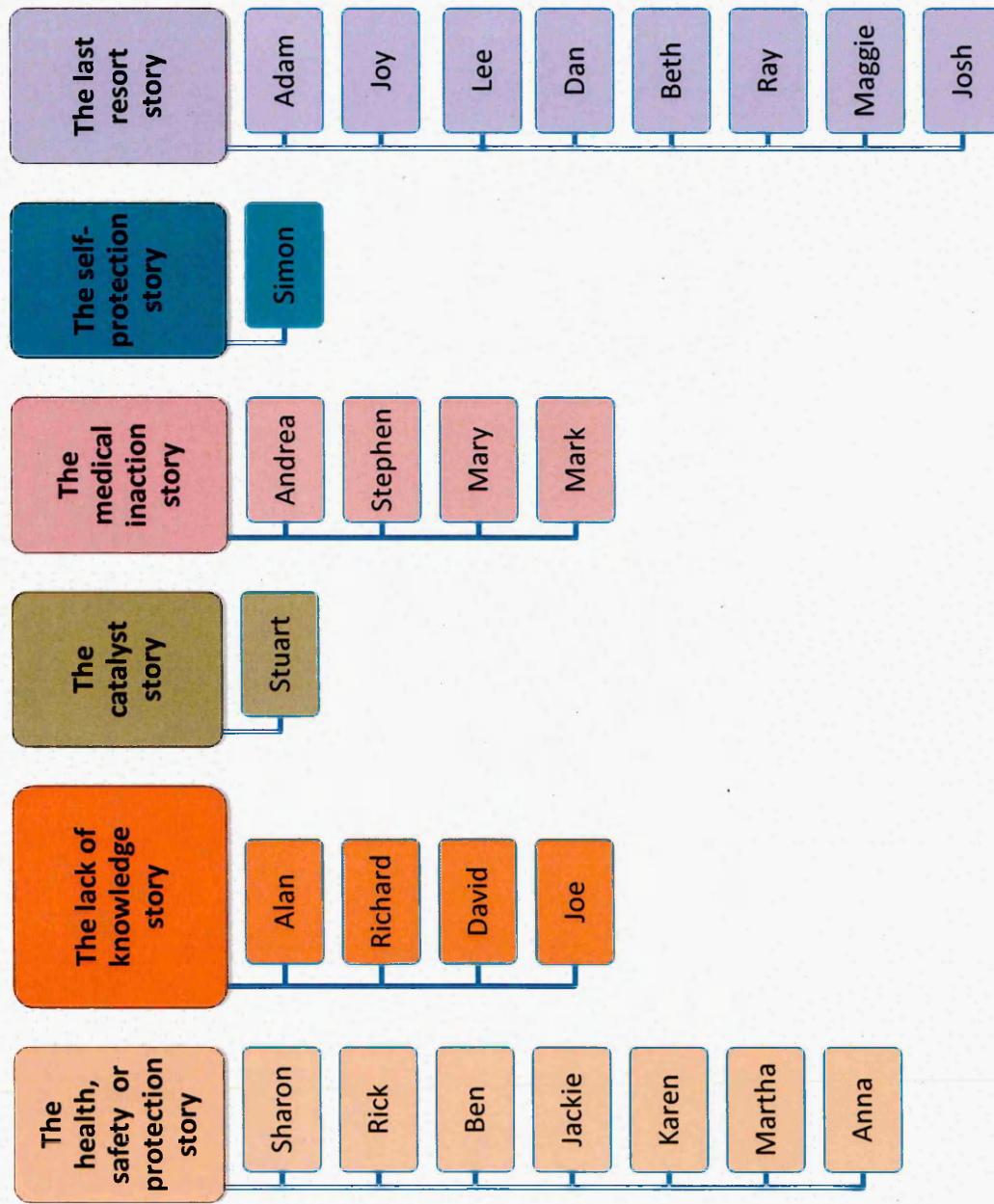
1. The health, safety or protection story;
2. The lack of knowledge story;
3. The catalyst story;
4. The medical inaction story;
5. The self-protection story;
6. The last resort story.

Figure 14 shows how the initial 14 stories were reduced to the final six. Figure 15 shows which nurse told each type of story. One example of each story type is now presented.

Figure 14 Nurses' stories of using Section 5(4): a six-part typology



Figure 15 Nurses telling each type of story



7.2 The health, safety or protection story

This type of story was the one that most closely resembled the use of Section 5(4) as described in the Act; that is the section was applied by the nurse to legally prevent an informal patient from leaving hospital when it seems that:

- the patient was experiencing a mental disorder to such a degree that it was necessary for their health or safety or for the protection of others for him or her to be immediately restrained from leaving hospital; and
- it was not practical to secure the immediate attention of a practitioner for the purpose of furnishing a report under subsection 2.

This type of story focused on the patient's risk either to themselves or others, their wish to leave hospital and the nurse's failure to persuade them to stay on the ward until they could be assessed by a doctor.

7.2.1 Background

Rose was a 61-year-old woman with a 20-year history of depression. Rose was found at home by a neighbour complaining of breathing problems. She was taken by ambulance to the Accident and Emergency (A&E) department. On arriving she stood for six hours without moving and would not answer any questions put to her. She was then transferred to Blackamoor ward. Jackie was an 'E' grade staff nurse who had been qualified for 18 months. She had no previous experience of using Section 5(4).

7.2.2 A risk to self and/or others

Central to this type of story was the nurse's presentation of the patient as someone who was either a risk to themselves (health and safety) or others (protection). Jackie's story began by describing how little was known about Rose on admission and the concerns the nurses had about her safety:

'We had a lady admitted about seven in the morning at handover time. She had come from A&E and the doctor [there] had got virtually no information from her. The patient was saying, "I need an injection and I can't breathe" and that's what this patient kept repeating over and over again. The doctor hadn't done a...complete assessment...but felt that she needed an admission and she was brought here by ambulance. After handover I went to do the nursing admission while we were waiting for a medic to arrive to do the

rest...and it was very difficult to get any information from her. She kept saying, "I need an injection. I can't breathe." I couldn't find out any information as to...what her address was, whether she had any family. She couldn't give me basic information about her history, and in terms of her mental health an assessment was made purely by observation. But she was very emaciated. She'd clearly not bathed for a long, long time; clothes were in rags and hanging off her and she was an elderly lady as well. I think she was 61, but she looked a lot older. She was clearly very fragile. She...was very confused and disorientated. She didn't know where she was, she didn't know how she'd got here, but she said she'd been depressed for 20 years [but] couldn't elaborate on that. We asked her simple questions like, "When was the last time you had some food?" "When was the last time you had a drink?" She was unable to answer that.'

Jackie (S2T16. U1: 6-27)

7.2.3 Leaving and persuasion

While nurses' concerns were at the heart of the health, safety or protection (HSP) story it was the patient's attempts or expressed desire to leave that initiated the process that ended in their detention. For example, Jackie recalls that:

'I got as much information as I could from her initial assessment and she was shown to her room and at that point she started to say, "I don't want to stay here. I want to go home. I don't need to be here."'

Jackie (S2T16. U1: 29-31)

However, the Code of Practice (DH, 1999a: 40) states that, 'most patients who express a wish to leave hospital can be persuaded to wait until a doctor arrives to discuss it further.' In the HSP and other types of stories told in this study there were clear examples of nurses' attempts to persuade the patient to stay on the ward. Jackie provided insights into her own attempts at persuading:

'And probably about half an hour was spent just talking to her, trying to reassure her, just asking her to stay until the doctor arrived in order to discuss [things]. And she seemed to take it on board. I still don't think she really understood what was happening to her, but she didn't attempt to leave or anything.'

Jackie (S2T16. U1: 31-35)

The HSP story also illustrated how nurses needed, at times, to use containment interventions - for example, locking the ward doors - to ensure the patient remained on the ward for their own and others' safety:

'So she was put onto observations initially more for her reassurance to have somebody with her and also because there were a lot of ill patients on the ward and we didn't want them to be a target.'

Jackie (S2T16. U1: 36-38)

However, despite Jackie's attempts to convince Rose to remain on the ward it was not long before she again stated a desire to leave. While this potentially illustrates the fluctuating mental state of a patient at the time of a crisis, Jackie's comments also provide an insight into the amount of time nurses are willing to invest in their attempts to persuade a patient to stay informally on the ward:

'About ten minutes after that last conversation she started raising her voice saying, "I need to get out of here! I want to go!" So I went over and spent about twenty minutes to half an hour talking to her, explaining to her why she was here, that we felt she was poorly and that she needed to stay and see a doctor.'

Jackie (S2T16. U1: 37-40)

7.2.4 Implementing Section 5(4)

However, in the HSP story nurses' attempts to persuade the patient to stay were ultimately unsuccessful. This was indicated by examples of further deterioration in the patient's mental health and/or a more determined attempt (verbally and/or physically) to leave the ward:

'She became more and more agitated shouting on the corridor saying, "I'm going. I want to go! I want you to ring me a taxi." We said we couldn't phone her a taxi. We wanted her to wait and see the doctor. She became more agitated, started shouting and swearing, demanding that we call a taxi. When that was denied, she said, "I'm going!" and pushed some of the staff out of the way to try and leave. Fortunately, she wasn't that clear on where the exit was. She was kind of looking for the doors.'

Jackie (S2T16. U1: 41-47)

Nurses inevitably reached a point where they recognised that their attempts at persuasion were unsuccessful and that they had to make a decision about whether to implement Section 5(4). In some cases this required an immediate decision as the patient was already exiting the ward; however Jackie had sufficient time to consult with her colleague:

‘So I called the ‘F’ grade and said, “I think this lady is suitable for a five-four, what do you think?” So the ‘F’ grade went to speak to her and within a few minutes said, “I think that we’ve got no choice.”’

Jackie (S2T16. U1: 47-50)

Jackie’s conversation with her colleague supported her view that Rose should be prevented from leaving and Section 5(4) was implemented immediately. The decision and what it meant was explained to Rose:

‘So then I told this lady that I was going to put her on a five-four, explained what that was and said that she wasn’t allowed to leave the hospital until she’d been seen by a doctor.’

Jackie (S2T16. U1: 50-52)

7.2.5 The patient’s response to the decision

Rose’s response to her detention was one of distress; however she did appear to respond positively to the nurses’ interventions:

‘And she seemed to understand what I was saying. She said, “Don’t put me on a section I’m not a nutter” and similar phrases to that. And again we just tried to reassure her and help her see that what we wanted her to do was to stay for the doctor... She calmed down very quickly once she realised that we weren’t going to let her go out the door. She kind of resigned herself to the fact that she was going to stay. She went back into the lounge and she was quiet and amenable.’

Jackie (S2T16. U1: 52-55, 61-63)

7.2.6 Justifying the decision

Jackie justified her decision to implement Section 5(4) by explaining her concerns for Rose’s safety:

‘We felt the risks were she was disorientated, she didn’t know where she was, she couldn’t get home, she clearly wasn’t able to look after herself, she’d not eaten for days...and her mental state was [such that she] certainly wasn’t well enough for us to think she could cope on her own if she left the hospital... I think she would have wandered the streets trying to find a way home and would have just been very vulnerable...until the police found her.’

Jackie (S2T16. U1: 55-59. U2: 68-69, 78)

The official reasons given by Jackie for detaining Rose were:

‘Patient wanting to leave the ward, refusing to stay and see a doctor. Patient disorientated, confused, dishevelled, undernourished. Patient vulnerable and considered to be a danger to herself if allowed to leave. Requires further assessment.’

Form 13

7.2.7 Outcome

As dictated by the Code of Practice (DH, 1999a) Jackie informed a doctor of Rose’s detention. The Code (ibid) also requires a doctor to assess the patient within four hours of Section 5(4) being implemented; however in Rose’s case:

‘They arrived about 15 minutes before it lapsed.’

Jackie (S2T16. U23: 241)

Jackie attempted to explain this delay:

‘The reason for that was because we had no consultant cover. They were all on annual leave that week. So we had cover of a consultant not based here. So we had to wait for her to come over. So it took longer than normal... [Although] she gave me a time. She said, “I’ll be there between...one and half one” I think... She arrived a bit later [because] she was in A&E at the time...covering for some [of our] consultants...’

Jackie (S2T16. U23-26: 243-262)

Once the doctor arrived an assessment was made of Rose's mental and physical health. Jackie believed that the medical assessment endorsed her view that Rose was a risk to herself and needed to remain in hospital for her own safety:

'They felt that she was very confused and vulnerable and was clearly unwell, although they didn't know how why. They felt...that because she had attempted to leave and [was] so vocal about it, that could happen again and she clearly had some kind of mental disorder and so she was put on a five-two and then a Section 2.'

Jackie (S2T16. U10: 152-157)

Finally, Jackie concluded her story by providing an update on Rose's progress. This offered further support for the decision to detain Rose in order to maintain her safety:

'She's deteriorated and she's become increasingly more depressed. She didn't understand what was happening to her. I think she's going to have some scans of her brain. She's not well at all. They're querying some kind of agitated depression or psychotic depression or some organic cause. So she's still being assessed really.'

Jackie (S2T16. U11: 161-168)

7.2.8 Coda

At the time of the interview Rose was detained under Section 2 of the Act and remained a patient on the ward.

7.3 The lack of knowledge story

This story type demonstrated how a lack of information about a patient and/or a clinical situation encountered on the ward was an important determinant in the decision to implement Section 5(4).

7.3.1 Background

Sarah was a 41-year-old patient with a number of previous admissions to hospital for mental health care. She was admitted informally following a referral from her community psychiatric nurse. Her referral described her as displaying 'increasingly suspicious behaviour..., losing a lot of weight' and 'generally not being able to cope.'

Richard was an 'E' grade staff nurse who had been qualified for seven years. He had worked on Longshaw ward for six years and had implemented Section 5(4) on 15 previous occasions.

7.3.2 Returning to work

There was sufficient material in Richard's story to justify his use of Section 5(4) based on the criteria given in the Act (DH, 1983) and Code of Practice (DH, 1999a), for example Sarah's desire to leave the ward, her unwillingness to discuss her plans and her apparent distress. However, regardless of Sarah's perceived mental state or the official reasons given by Richard for detaining her it is argued that it was his lack of knowledge about her that was the determining factor in the decision to implement Section 5(4).

Richard recognised early in his story the importance of having knowledge of a patient's clinical history. He also provided an explanation as to why he did not have sufficient knowledge of Sarah's circumstances:

'I should explain the preamble to this. I had been off work three weeks. I'd returned and worked Sunday, Monday and Tuesday night. So then I was working a nine-to-five on Sunday. So, (a) I still had a bit to catch up with what was happening on the ward, and (b) I didn't know Sarah at all.'

Richard (S2T3. U1: 33-37)

Therefore, Richard was at a disadvantage when he met Sarah for the first time. Richard found her in a distressed state but knew little about Sarah's mental state or what her intentions were:

'While I had been doing...the two hourly checks, I'd noticed Sarah in her room in tears. I didn't know Sarah at all and my first...encounter with her was when I discovered her in her room in tears.'

Richard (S2T3. U1: 31-33)

However, it was not Richard's lack of knowledge about Sarah per se that resulted in her detention but his inability to obtain sufficient information to make an assessment of her safety. Richard explained how he spent time with Sarah in an attempt to gain an understanding of her distress. However, in recognition of his lack of success Richard

attempted to find someone who he thought would be more appropriate in offering Sarah support:

‘I tried to get her to talk to me, but she’s very guarded, very suspicious, although we did seem to get a little bit of a rapport in that she did answer. Although very briefly she did answer my question and I said, “Would you like to talk to a female member of staff?” and she didn’t answer, but she didn’t indicate that she wouldn’t. I felt that she would...benefit from a bit of TLC basically.’

Richard (S2T3. U1: 39-46)

7.3.3 Delays

The events leading to Sarah’s detention were played out against a backdrop of the clinical activities taking place on the ward:

‘Well, as usual it was rushed. I mean it was a very busy day. We’d got one person in seclusion, three people on one-to-ones, not enough staff and running round.’

Richard (S2T3. U1: 29-31)

It is argued that the need to manage the clinical activities competed with Richard’s desire to gain a greater insight into the nature of Sarah’s distress. In an attempt to learn more about the nature of Sarah’s distress, Richard asked a colleague to spend some time with her. However, once again events on the ward delayed this process:

‘So I came up to the office and the afternoon staff had just come in a little bit early and I’d asked one of them...if they would go and just speak to Sarah [to] offer some support and they said, “Yes, fine, but I’ll have to go and put my coat away,” and what have you. So it wasn’t straight away. I mean the time was probably about seven minutes or so and of course there were lots of other things happening in the office because to come in on a Sunday afternoon, which is supposed to be quiet, when we’ve got someone in seclusion, who you could actually hear him in the office shouting and banging, and we’d got three people on one-to-one. You know, people want to catch up and so there was a delay.’

Richard (S2T3. U1: 46-58)

During this delay Richard observed Sarah leaving the ward. He explained what happened next:

'It was then that I noticed Sarah walk past the office. Although the doors were locked at the time, a doctor was leaving and Sarah...just went straight out. So I went after her and I asked her if she would just stay and talk, [I] informed her that...if she was wanting to go out for a walk - fine, I'd no problems with that, but I just needed to talk to her to make sure that I felt that she was alright... [that] she was safe because not 10 minutes ago you were in tears. Sarah wouldn't talk to me. Then shortly afterwards the support worker came out as well and we were trying to...reassure her that...all we wanted her to do was just come back to the ward so that we could have a chat and...make sure that we felt that she was alright and that she was safe and effectively fine... She wouldn't talk, just saying, "I'm going for a walk." We said, "Well fine, but where are you going?" "How long are you going to be?" You know, "How are you at the moment? You need to tell us." And all she would say was, "I'm going for a walk. I'm going for a walk," and sort of made to go past. So I tried to block her way saying again "All I want to do is to talk to you." [She said,] "I'm going for a walk." And this process went on for about 20 yards. At this stage I felt well, we can go on until we get to the main road or we can cut it short now because we're not getting anywhere. There were no signs there was going to be any sort of interaction between us so I made the decision then that we would bring her back onto the ward under a five-four.'

Richard (S2T3. U1: 58-90)

Therefore, Richard did not simply attempt to ascertain where Sarah was going and for how long but sought information on her mental state; specifically whether she a danger to herself or others. For example, he mentioned that he wanted to know that she was 'alright', 'fine', and 'safe'. However, the opportunity for Richard to make this assessment was limited by the fact Sarah was walking away from the ward and seemingly unwilling to provide him with this information. These factors resulted in Richard applying Section 5(4) and returning Sarah to the ward.

7.3.4 Knowing Sarah

Richard made it very clear that it was his lack of knowledge of Sarah that was the main reason for his decision to implement Section 5(4):

'It was all very rushed and probably not ideal. If I'd have known Sarah I probably wouldn't have five-foured. I mean if the situation happened now, I wouldn't five-four, but it was purely because I didn't fully know Sarah at that time.'

Richard (S2T3. U2: 99-103)

Richard's story also illustrated how in the absence of firsthand knowledge of the patient nurses turn to the best sources of information available to them at the time of their decision to implement Section 5(4). In Richard's story - due to the activities on the ward - this was the information he had received during the nursing handover immediately preceding his first contact with Sarah.

'[I knew] very little. In an ideal world with any new patient you'd be able to sit down, look through the notes, look through everything, talk to them, but with what was happening with seclusion that didn't happen... From the handover I'd [been told] that she was very suspicious. There had been some history of self-harm [and] a lot of self neglect... One issue that probably influenced the decision [was] that she was refusing medication.'

Richard (S2T3. U2: 105-109. U3: 115-119; U9: 200-201)

Richard explained why - in the absence of any personal knowledge about Sarah - he implemented Section 5(4) based on the information he received from the handover:

'Because I didn't have enough information to make a judgement about risk. It's erring on the side of caution...and I didn't feel confident enough to say, "Oh fair enough, go for a walk."'

Richard (S2T3. U4: 126-127, 132-133)

Finally, Richard explained how events on the ward had impacted on his decision to implement Section 5(4) there-and-then rather than at a later time:

'We'd got three people that needed constant observation so that was three of the staff to cover the ward and we had one [patient] in seclusion. [So I thought], "Right, I've got to make the decision now. I've got to get this sorted out. I can't spend time out here." There were two other members of staff trying to stop her going and trying to persuade her to come back. So I had to make the decision. [I thought], "We've got to do this now" because... she was making attempts to go past. I mean if she'd been stood still I'd

have probably given a bit more time, but [she] was making attempts to go past and I had to make the decision now and there was three staff out there. Basically there were none on the ward! So we had to get it done. We had to get it sorted...So the outcome may have been different.'

Richard (S2T3. U6: 152-171, 175)

7.3.5 Coda

Following Roger's decision to implement Section 5(4) Sarah was assessed by the on-call SpR⁵¹ and placed on Section 5(2). Sarah made no further attempts to leave the ward and was compliant with her medication regime. At the time of the interview Roger's assessment of Sarah was that he would have been happy for her to leave the ward should she have wished. However, Sarah was assessed by the medical team and her Section 5(2) progressed to a Section 3. She was still a patient on the ward.

7.4 The catalyst story

Within this type of story Section 5(4) was used as a catalyst - that is 'a person or thing that causes a change' (Collins Dictionary and Thesaurus, 2004) - in order to benefit the patient who has been detained. It is recognised that all applications of Section 5(4) have a catalytic function, for example they result in a change in the patient's legal status. However, this type of story had a more specific purpose as it illustrated how nurses could manipulate the legislation in an attempt to achieve a preferred outcome. In this story type (also see section 7.6) the nurse's motivation for implementing Section 5(4) was not to protect the patient or others but to facilitate a process in which they attempted to achieve a positive outcome on the person's behalf. This outcome seemingly could not be achieved through more conventional means. This story type is illustrated in Stuart's narrative.

7.4.1 Background

Dean was a 37-year-old man admitted to hospital as an informal patient and he had been a patient on Blackamoor ward for four months at the time of his detention under Section

⁵¹ A Specialist Registrar or SpR is a doctor in the United Kingdom and Republic of Ireland who is receiving advanced training in a specialist field of medicine in order eventually to become a consultant.

5(4). He was admitted following deterioration in his mental health precipitated by the breakdown of a long-term relationship and issues relating to access to his daughter. On admission he was described as agitated, occasionally aggressive, suspicious and noted to be experiencing auditory hallucinations. Stuart was a 'F' grade deputy ward manager on the ward. He had been qualified for 17 years and working on the ward for approximately four years. He had used Section 5(4) on eight previous occasions.

Stuart's decision to use Section 5(4) was not one arising out of his concerns for Dean's or others' safety, although there were sufficient indicators to justify its implementation. It was in fact a story in which Stuart moulded events to justify using Section 5(4) in order to initiate a major review of Dean's care by the multi-disciplinary team (MDT). Stuart's catalyst story began with a detailed but concise history of Dean:

'[Dean's] a gentleman with a diagnosis of schizophrenia. Having said that he's got a fairly unique presentation. There were periods when he was extremely problematic, but he's also had long, long spells when he wasn't. Although he'd been on the ward for a while...he'd never actually been sectioned, even though for long spells of time we had him on one-to-one observation. He could be inappropriate in his approaches to females and I would say over-friendly rather than sexually threatening or predatory. He also seemed to target specific individuals and...bully [them]. He was compliant with his medication. Generally compliant as far as staff were concerned. He could be quite loud...but it never manifested itself in physical violence towards staff when...being confronted. He did on occasions assault other people, but they weren't assaults that engendered any long-term damage or injury to the people concerned; a slap on the head...a sneaky kick now-and-then. He was initially admitted following some friction with his neighbours and I think he'd actually been arrested on a charge of criminal damage. Quite loud at night, quite chaotic, quite disturbed following the breakdown of a long-term relationship. I think there are other stresses involved: there's the custody of a child, all sorts of things like this.'

Stuart (S2T12. U1: 1-22)

Stuart's account of Dean provided both background information on the patient and also a partial insight into the circumstances leading to his decision to implement Section 5(4). Stuart's account of Dean's 'unique presentation' created an unclear clinical account of the patient, for example he had been 'problematic' but there [had] been 'long

spells [when] he wasn't.' He's been 'on the ward for a while', he'd 'never...been sectioned' but he'd had 'long spells...on one-to-one observations.'

7.4.2 An opportunity for detention

Stuart explained the circumstances leading up to his decision to implement Section 5(4):

'Right, the afternoon...there'd been an incident with another patient and again Dean was the antagonist. He'd been threatening someone. There hadn't been any physical aggression. I confronted Dean and deflected his verbal barrage whereupon he insisted he was going to leave.'

Stuart (S2T12. U2: 31-32. U5: 85-86)

There appeared to be sufficient information in Stuart's account to justify his use of Section 5(4). However, he attempted to counter this view by explaining that there had been similar occasions in the past when concerns had been expressed about Dean's safety but he had not been prevented from leaving the ward:

'There had been some concerns about Dean spending time off the ward because of his inappropriate behaviour. I don't think there were any risks about road crossing and things like that, but certainly some of his comments could elicit some very negative responses from people, [for example] he'd accused other patients on the ward of raping him when he was younger...but the accusations he made were to people that he'd never met him... He'd not been prevented from leaving.'

Stuart (S2T12. U2: 35-41)

Returning to the main story Stuart informed the audience that Dean was, 'actively moving towards the door' and that he, 'did have to stand in front of him' to prevent him leaving. However, he did not have to seek assistance from other nurses in order to prevent Dean leaving:

'There were other staff members about [but] not within arm's reach, I don't think they were aware of what happened [but] certainly within sight and ear shot.'

Stuart (S2T12. U7: 112-115)

The Code of Practice (1999, 9.2: 40) states that, 'most patients who express a wish to leave hospital can be persuaded to wait until a doctor arrives to discuss it further.' Stuart recognised that Dean was usually open to persuasion; however he admitted he did not follow this course of action assertively:

'I have to say under normal circumstances Dean would probably have been dissuadable. [However] I didn't put as much time or effort as I would normally have done into this. As I say, Dean had been dissuadable in the past and I think if I'd have expended more time and effort he would have stayed... I would still have had to have been a physical presence initially between him and the door.'

Stuart (S2T12. U6: 107-110)

Stuart, turning to the main point of his story, explained why he made the decision to invest little time or effort in attempting to persuade Dean to stay on the ward:

'It was a fairly conscious decision to five-four him. I think that to some extent I'd probably already made my mind up beforehand, that if the situation arose where, however thinly, I would five-four him and concentrate our efforts on him.'

Stuart (S2T12. U5: 88-90)

Although Stuart made the decision to implement Section 5(4) this was not a result of any concerns he had about Dean:

'I have to say that I don't actually think that the risk element in him leaving the ward was immediate and probably not that great...he had been off the ward before and most of the time without incident. I'd no reason to think that this time would have been different.'

Stuart (S2T12. U5: 97-99. U2:42-44)

However, the official reasons given for Dean's detention suggest a situation completely different to the one described by Stuart:

'Mr Gordon was becoming increasingly threatening and intimidating towards a targeted member of staff. When confronted about his aggressiveness he insisted he was going to leave and discharge himself. This

is not in Mr Gordon's or others best interests. As he was making his way purposefully towards the exit and given his behaviour over the past 48 hours (He has been the perpetrator of two assaults while on the ward and has also presented at A&E for no good reason where he was described as bizarre and confused) I had no option but to place Mr Gordon upon a S5(4) of the MHA 1983.'

(Nursing Notes⁵²/Local Incident Form⁵³)

Seemingly in recognition of the contradiction between his stated and official accounts of Dean's risk status, Stuart offered a candid account of his motivation for implementing Section 5(4):

'I think if I'm perfectly honest, my main motivations for implementing the five-four was because Dean had been with us for so long [and I wanted] to bring things to a head. Because he was generally compliant...we seemed to be pottering along rather than...proactively [and] aggressively treating him and I must admit, I think it was part of my intention to force the medic's hand to actually have a closer look at Dean.... I thought that the section would actually bring people together and make them recognise that there was a problem that needed to be addressed.'

Stuart (S2T12. U2: 44-50. U3: 59-61)

7.4.3 Facilitating the multi-disciplinary team review

Therefore, Stuart's intention in applying Section 5(4) was to act as a catalyst and facilitate a MDT review of Dean's care plan. Although Stuart never made it clear why he believed that this was the only way to facilitate such a review, he did offer some insights into how the situation had developed. Firstly, Stuart argued that Dean's clinical presentation lacked consistency and this was reflected in his treatment plan:

'I think the nature of Dean's presentation wasn't consistent...he wasn't consistently problematic. There were long spells where he wasn't threatening to other people, where he wasn't attempting to bully you, where he wasn't being totally inappropriate in his verbal interactions with other people and I don't think anybody takes detention under the Mental Health Act lightly. He was compliant with his medication. He would generally go along with your requests. I think everybody thought it was really quite

⁵² Hereafter NN

⁵³ Hereafter LIF

awkward and... We didn't seem to be any further on as far as diagnostic picture and effective treatments than when he first came in.'

Stuart (S2T12. U3: 54-59, 63)

Secondly, Stuart believed that previous MDT meetings had focused too much on individual aspects of Dean's presentation rather than taking a more holistic approach to his assessment and treatment:

'We seemed to have got bogged down. It'd be his bullying one week, his inappropriate sexual conversations another week and his attempts to form relationships [another]. Was there a learning disability involved? Is there some organic stuff? Because as I say there didn't seem to be any depth of belief in any of the odd, bizarre things, we didn't know where they came from... There [were] all sorts of issues going on...his accommodation... the custody battle...and I just got a feeling things weren't being looked at as a whole and I don't think we were considering that anything other than psychiatric intervention might be an answer. I don't think we've got the answers to everything.'

Stuart (S2T12. U20: 230-235, 239-244)

Lastly, Stuart reported that the team had based their treatment plan on inaccurate information:

'We were being told from community sources that his presentation had changed from what it was previously... [However], his parents actually said that Dean's behaviour hadn't changed that much and yet we were...working on the basis that there'd been a significant change in presentation since the breakup of the relationship, but...two months or so down the line, it would appear that that wasn't the case. The change hadn't actually been as radical as we were led to believe. We were working from...an artificial base line and I think that's what was causing us problems because we didn't have a realistic goal...a realistic treatment output really.'

Stuart (S2T12. U4:70-80)

7.4.4 Outcomes

The application of Section 5(4) led to Dean being placed on Section 5(2) and precipitated a full multi-disciplinary team review of his care as Stuart had intended. An entry of six sides was made in Dean's medical notes and can be summarised as follows:

‘It was unanimously agreed that Dean’s mental health has deteriorated to an extent where all felt in his best interests he should be detained under Section 2 for further assessment. Increase Depixol to 50mgs weekly.’

(Medical Notes)⁵⁴

Therefore, Stuart’s detention of Dean seemed to have the catalytic effect he intended. Stuart concluded his story by evaluating his decision to implement Section 5(4) and its repercussions for Dean’s care:

‘I think to some extent...[there’s been] no radical changes in his medication. They’ve recently started him on a depot and they are still titrating the dose, but he remains much improved. You know he’s now informal. I do think it concentrated people’s minds. Encouraged them to take an overview rather than look and try and rationalise individual incidents or sequences of incidents. But I do think it served some purpose...[although] I don’t really think we’re any further forward to be quite honest.’

Stuart (S2T12. U15:199-204)

Reflecting on his decision to implement Section 5(4) Stuart commented that:

‘It just seemed...a misguided attempt at forcing the multi-disciplinary team’s hand to have a proper look at the situation as a whole rather than [at]...specific and changing behaviours... I do think it was the right thing to do and I think that even if it hadn’t moved us no further forward and I’m not sure it has. I think at least it was an attempt to make us as a team explore...it in a way that I wanted it explored rather than [how] the rest of the team were looking at it... Dean was a source of an awful lot of discussion amongst the nursing team and the multi-disciplinary team, but it didn’t seem to be leading to any action that was of benefit to Dean... I certainly felt that I was acting with Dean’s long-term interests at heart and I could justify it within the letter of the law...’

Stuart (S2T12. U19: 225-228. U21: 251-256. U22: 261-267)

7.4.5 Coda

Following the multi-disciplinary review of Dean’s care the doctor’s holding power progressed to Section 2. Some changes were made to his medication but all other

⁵⁴ Hereafter MN

aspects of his care remained the same. Dean was still a patient on Blackamoor ward at the time of the interview.

7.5 The medical inaction story

This story type presented the need to implement Section 5(4) as a failure on the behalf of a doctor to use their powers under the Act. Therefore, in these stories the use of Section 5(4) was presented as an avoidable act should the doctor have performed their role correctly and/or acted on the professional knowledge and opinions of nurses. However, nurses in this type of story did not suggest that the doctor should detain a patient simply because they said so. On the other hand, they did believe that their in-depth knowledge of working with a specific patient and/or experience of managing similar situations were ignored. The doctor's decision not to act on the information provided by nurses was seen as only deferring the patient's detention rather than avoiding it and ultimately being detrimental to the management of the care process. Andrea's account of her use of Section 5(4) provides an example of this story type.

7.5.1 Background

Tina was a 31-year-old woman admitted to Longshaw ward. At the time of admission she was reported as having a two-week history of exhibiting bizarre behaviour including, 'Karate type movements and dancing.' She was also described as being 'agitated', 'irritable', 'shouting frequently', 'disorientated', and 'labile in mood'. During this two-week period she had also gone missing from her flat and attacked her partner. Tina was admitted under Section 2 of the Act. However, her mental health improved quickly and approximately two weeks after being admitted she was regraded to informal. On the day of her detention under Section 5(4), Tina had been returned to the ward after she had made an attempt to jump in front of a car. Andrea was an 'F' grade deputy ward manager on Longshaw with 20-years experience. She has worked on the ward for one year and had used Section 5(4) on three occasions over an eight-year period.

7.5.2 Expecting the patient to be detained

It was clear from the opening lines of Andrea's story that she and other members of the nursing team believed that Tina should be detained for her health, or safety or the protection of others. Therefore, the nurses' expectation of the SpR was unambiguous:

'Prior to her being detained we'd asked Doctor [Name], our Specialist Registrar, to assess this lady with a view to detaining her.'

Andrea (S2T4. U1: 31-33)

Andrea and the SpR completed a joint assessment of Tina; the outcome of this was that she remained informal. Andrea began to construct a case for the main point of her story, namely her belief that the SpR had made a questionable decision in allowing Tina to remain informal simply because she had, 'said all the right things'. This she believed was in direct contradiction to the information she had provided about Tina's recent behaviour and mental state:

'It was half-past three...we did an assessment for about 45 minutes [and]... she said all the right things in that interview at the time. I mean it was clear she was really ill. It was clear she'd behaved quite dangerously. She'd been brought back at quarter-past two that afternoon by the police jumping in front of moving cars in the road.'

Andrea (S2T4. U1: 33-40)

Andrea challenged the doctor about his reasons for not detaining Tina. She contrasted her own detailed case for detaining Tina with what she saw as the SpR's inadequate reasoning. While Andrea acknowledged that it was reasonable to take account of Tina's stated willingness to remain in hospital, she believed her own contribution had been ignored:

'[He said], "Well, from that assessment she's not given me any grounds to detain her." I said, "Well, what about her previous history? Have you not taken that into account and the risk that she was to herself and others by jumping in front of cars and the fact that she is chaotic in her mental state? She's got schizophrenia and she clearly has little control over her behaviour at the current time." She agreed in the interview that she was not able to keep control over herself. She had partial insight into that so [she] said all the right things; "Yes, I'll stay in hospital for a week. I won't leave hospital

for a week. Yes, I'm happy with the changed increase in medication. I will accept treatment." So he felt unable to detain her at that time.'

Andrea (S2T4. U1: 50-63)

Andrea reinforced her position by offering a further example of the SpR's failure to acknowledge her knowledge and experience of mental health care in the Trust:

'He increased her medication following that interview at night. So there wasn't any kind of current medication to be administered following the interview and [he told] me that I could get an SHO⁵⁵ to detain this lady if I needed to because he was a gentleman who worked out of Sheffield and I said, you know, "I can't. It has to be a Specialist Registrar," [but] he wouldn't accept that....'

Andrea (S2T4. U1: 43-50)

7.5.3 Detaining Tina

Soon after the end of the assessment Andrea detained Tina. The fact that it occurred so soon after the SpR's assessment served to reinforce Andrea's view of the doctor's failure to act:

'Within less than half an hour, she wanted to leave the ward. She'd forgotten the interview and things she'd been saying in the interview and I kept reminding her of that when she was saying... She'd gone to the doors saying, "Just open these fucking doors. I want to leave" and so we put her under Section 5(4).'

Andrea (S2T4. U1: 64-68)

Once again Andrea supported the need for Tina's detention by pointing to the SpR's unwillingness to act on her superior knowledge of the patient's history:

'My picture was not just the immediate moment of the five-four...of what she would do if she went out of hospital or what she'd be doing in hospital. I was taking into consideration the previous 24 hours as well...this was informing my clinical judgement of whether to detain her... He'd never met

⁵⁵ A senior house officer (SHO) is a junior doctor undergoing training within a certain speciality. SHOs are supervised by consultants and specialist registrars, who oversee their training and are their designated clinical supervisors.

Tina before. He's new. I'd nursed her from her admission from being on Section 2 so I'd seen her progress and gradually deterioration following the changes in her medication.'

Andrea (S2T4. U4: 174-180, 185-191)

Andrea concluded her story by offering an evaluation of her experience:

'I suppose I think if you're asking a doctor to do an assessment [it's] in the best interests of the patient with a view to detention because of the concerns. He's heard the concerns, the report from the police when [they] brought her back that afternoon... Well, I felt let down by him as part of our team. I felt he hadn't taken into consideration the greater history. He hadn't taken into consideration my experience of her and my rationale that I've given him - our nursing concerns. Our feeling was that she did need to be in hospital and we knew we couldn't keep her informally at that point in hospital. We'd gone past that.'

Andrea (S2T4. U5: 198-203, 207-212)

7.5.4 Coda

Following the application of Section 5(4) Tina was assessed by another SpR and placed on Section 5(2) and then Section 2. At the time of completing Andrea's interview Tina remained on the ward receiving treatment.

7.6 The self-protection story

Another story type depicted the implementation of Section 5(4) as serving a self-protection function for the nurse using the holding power.. The Act provides legal protection to nurses to enable them to use reasonable force to prevent a patient assessed to be a risk from leaving hospital without them facing potential charges of assault and battery and/or false imprisonment. The self-protection story in this study focused on circumstances where the nurse felt compelled to use Section 5(4) to protect themselves and not the patient. Furthermore, in the self-protection story the patient may not even meet the criteria that are required to detain them under Section 5(4).

7.6.1 Background

Jim was a 56-year-old man admitted to Houndkirk ward following an assessment undertaken by the crisis team in the A&E department. Prior to the application of Section 5(4), Jim had never been detained under the Act. Simon was an 'E' grade staff nurse who had worked on Houndkirk ward since qualifying two years previously. He had implemented Section 5(4) on two previous occasions.

Simon's story began with him providing background information on Jim and the circumstances leading to his admission to the ward:

'He'd approached [the] crisis team [as an] emergency where he had a bottle of Methadone in his pocket and said that unless he was admitted to a hospital ward he [would] overdose, to which he was immediately admitted.'

Simon (S2T18. U2: 40-42)

Simon made it clear that since Jim's admission there was nothing to suggest that he was exhibited any signs of mental illness. Furthermore, he did not consider Jim to pose a risk to himself or others despite his past and recent history:

'[There was] no kind of objective signs of depression and certainly no thought disorder or psychotic symptoms. He seemed to be entirely in control of what he was doing, and no noted stressors precipitating a suicidal outlook. It was noted that the man did have a history of personality disorder [and had]...taken quite large overdoses [but]...no kind of suicidal reason.'

Simon (S2T18. U2: 43-46)

7.6.2 Risk assessment and formulating a plan

The process leading to Simon's decision to implement Section 5(4) for his own protection began with Jim absconding from the ward and taking an overdose of 32 Paracetamol tablets. Jim was then returned to the ward by the police. Although Jim's overdose could have been interpreted by some nurses as an indication that he was at risk, Simon's assessment of the patient remained the same; that is there was insufficient evidence to justify his detention using Section 5(4):

‘The chap had taken an overdose of Paracetamol and had been brought back to the ward by the police and it became quite clear that he wasn’t...suffering a formal mental health problem. He had [a] previous diagnosis of personality disorder and his responses to...my wishes for him to attend A&E to have his bloods taken were to refuse. He did seem very much problematic, but certainly he wasn’t in any way detainable and we were in no position to enforce treatment.’

Simon (S2T18. U1: 1-6)

Although Jim was unwilling to receive any form of medical intervention for his overdose Simon asked the SHO to undertake a medical assessment. Based on both the medical and nursing assessments an agreed action plan was formulated:

‘Myself and the SHO agreed about it and...I was quite happy to let the situation lie and just come up with a contingency plan about going to A&E [if needed].’

Simon (S2T18. U10: 140-142)

The plan was communicated to the ward’s SpR who, while not making an independent assessment of Jim, supported the decisions made. Simon interpreted this as an endorsement of the joint medical and nursing assessment of Jim:

‘I think the SpR was quite happy with what myself and the senior house officer had documented...we’d been quite comprehensive about it...that we weren’t in a position to enforce treatment and that being the case, the plan being that if this man suffered immediate physical problems he would be taken to A&E. The 16 hour period between taking Paracetamol and actively being administered treatment [had] truly lapsed by the time we got to that point.’

Simon (S2T18. U8: 100-101, 108-118)

7.6.3 A ‘bit of a battle’

Jim’s decision to refuse treatment was communicated to the on-call consultant as part of the standard procedures on the ward:

‘I ended up getting the SHO involved. The SHO in turn got the Specialist Registrar involved, who in turn got the on-call consultant involved.’

Simon (S2T18. U1: 7-9)

The involvement of the on-call consultant in Jim's treatment proved to be a turning point in Simon's decision to detain Jim for self-protection. During the shift Simon and the consultant engaged in a series of telephone conversations that focused on their conflicting views about how Jim's post-overdose care should be managed. Simon recognised that during his conversations with the consultant that there was a shift from a clinical debate to one of conflict:

'The [outcome was] a bit of [a] battle between myself and the on-call consultant about [his] wish that we, while this man was not detainable, would...try and take blood under common law. I told him that this was an absolute nonsensical idea that we would try and restrain somebody under common law to take IV bloods.'

Simon (S2T18. U1: 9-13)

The outcome of this developing conflict was a shift in Simon's focus from managing Jim's overdose to seeking support from his colleagues for his refusal to forcibly take intravenous blood from the patient as requested; a self-protection strategy:

'And this became quite an on-going thing for the rest of the shift. We were trying to contact the 'F' grade in charge on another ward and he agreed with my contention. I then contacted the service manager, who also agreed with my point.'

Simon (S2T18. U1: 14-16)

Simon also cited the SHO's conversation with the consultant as further support of his own position and his belief that what was being requested of him was unreasonable:

'[The SHO] spoke to the consultant who didn't see it and seemed to have very little idea about what to do about it other than [to say], "You will restrain this man under common law and take bloods from him," which the SHO was really quite worried about saying, "No, we can't do that and we're not even going to entertain the idea."'

Simon (S2T18. U7: 89-93)

Despite discussions lasting for over three hours the consultant continued to insist that the nurses forcibly take blood samples from Jim; although he was unwilling to undertake an independent assessment of the situation. Simon was critical of the consultant's refusal to attend the ward and in doing so he used it as further evidence to support his position and negate that of the doctor:

'I think the consultant was very much engaged in doing something else in a pub perhaps or something like that and just understandably wanted it to go through the right routes, but what he viewed as being the right routes being... "This man will have this done" was entirely bizarre. Why he didn't come out? I suppose, it's because he's an on-call consultant and he's got golf to play or something like that.'

Simon (S2T18. U8: 100-106)

Simon sought to strengthen his decision-making and therefore protect himself from future consequences when he commented that:

'It was really irritating. It was just really irritating. I fully recognise that consultants [are] knowledgeable people and know what [they're] on about, but this isn't really relevant to the situation. This is a situation managing a person who I'm actually here with him and you're not. You can't make a decision when you're not here.'

Simon (S2T18. U26: 386-389)

Eventually, Simon and the consultant agreed on a plan to resolve their differences about how to manage Jim's care:

'It got to the point where we agreed with the consultant that the best idea would be for the SpR to see this man and to officially note that [he] was competent to refuse treatment, and the SpR arranged to come.'

Simon (S2T18. U1: 16-19)

7.6.4 Defensive practice

However, before the SpR arrived to undertake the assessment Jim stated his intention to leave the ward. Based on the outcome of Simon's earlier assessment of Jim - his belief that he was neither a risk to himself or detainable under the Act - it could have been

assumed that he would be allowed to leave. However, Simon explained this was not the case:

‘Approximately 10 minutes before I was expecting the SpR to arrive, he demanded to leave the ward. I asked him why he wished to leave the ward and he became very angry and...said, “Mind your fucking business! I can come and go as I please. I’m an informal patient.” [To] which I said, “I really would prefer you to remain on the ward so we can just go through this and after that whatever you want to do you can do.” He continued to be aggressive and [said], “Let me off this fucking ward right now!” and against...well, not against my better judgement, but certainly against the better principles of five-four I did detain him on a very kind of mildly, defensive thing, but if I was going to keep him on the ward he should be detained and I certainly wasn’t going to allow him off the ward purely in terms of defensive practice, but if he did go off the ward I suspected he would take another overdose and if...this one were fatal or if...following on from this...anything else that had happened that was really bad, then there’d certainly be my butt on the line. So it was entirely defensive practice [because] I certainly didn’t think he was a danger to others or himself and if he was...it would be quite normal to him.’

Simon (S2T18. U1: 19-32)

Therefore, Simon had clearly chosen to implement Section 5(4) as a ‘defensive practice’ in order to protect himself. This decision was based on the belief that, as nurse-in-charge of the shift his ‘butt [was] on the line’ and he would be held responsible should anything happen to Jim. Although Simon was uncomfortable with his decision he was reassured that it would be dealt with quickly, and that the SpR’s assessment would resolve any issues with the consultant:

‘I did take into account that the SpR would be arriving soon and...my holding powers would end immediately. And I thought, “Well, you know, what’s 10 minutes really?” ...and the SpR can then make a judgement on risk and I’d inform the SpR of my opinion that I’m sure he wasn’t a risk but I thought that you could see this man and I don’t believe he has a formal mental health problem.’

Simon (S2T18. U1: 32-38)

‘[I thought] that I could at least get him seen by the Specialist Registrar who could then say, “This man is capable to refuse treatment and is not suffering from a mental health problem.” But, as I say, he wanted to discharge himself prior to seeing the SpR and I thought, “I’m not losing my bloody

job over this. I'm quite happy for you to be detained for 10-to-20 minutes until she arrives.”

Simon (S2T18. U7: 93-98)

Simon was also quite clear in his explanation as to why he decided to detain Jim, although he believed that there was no evidence to support his decision to do so:

‘I think it was largely dealing with consultant pressure and I think it’s something that everybody responds to at times... I was engaged in a quite heated debate over the phone with the consultant that we weren’t going to take bloods to which he said, “Well, it’s your neck, isn’t it mate, if you’re happy doing that.” Which is none too supportive, but certainly kind of struck the fear of God into me. I thought, “Bloody hell! Well, in that case he’s going to be seen to say this man’s capable of refusing treatment.” But before that I [thought that]...if he’d wanted to discharge himself or wanted to do anything...I certainly wouldn’t have five-foured him...’

Simom (S2T18. U9: 123-133)

Finally, Simon reflected on his experience of using Section 5(4):

‘I was quite gutted I’d done it. It was a case of, you know, basically all that effort to kind of try and keep somebody informal and not to abuse the mental health system and it’s not worked... I was of the opinion that I was detaining somebody who was mentally well and I was detaining him for my own good really. [I thought], “I’m not going to be struck off. I’m not going to go to a Coroner’s Court and have this shit thrust upon me because of you.”’

Simon (S2T18. U15: 214-216. U16: 221-225)

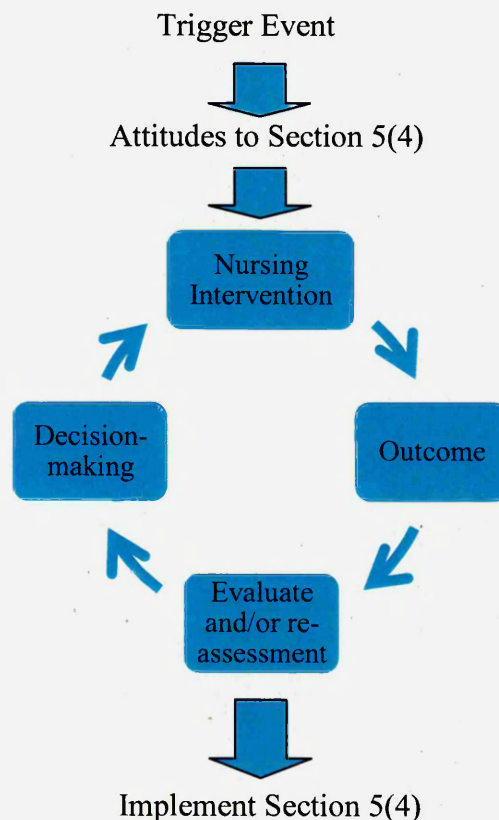
7.6.5 Coda

Jim was assessed by the SpR who decided that there no need for any further detention under the Act. Jim eventually agreed go to the A&E department to receive treatment for his overdose from where he was admitted to a medical ward. On completing his treatment he was discharged and went home. Jim did not return to Houndkirk ward and two days later he was discharged from psychiatric care.

7.7 The last resort story

The last resort story, as the title suggests, focused on how nurses attempted to avoid the use of Section 5(4) and their reasons for doing so. None of the nurses telling this type of story denied that the patient was at risk and needed to remain in hospital; however they were motivated to avoid using Section 5(4) because they believed that it would not be in the patient's or their own interests. While they believed that it was important to maintain the patient's informal status they were not prepared to allow them to leave hospital. Within this story type the nurse's actions - until they make the decision to detain the patient - were characterised by a cyclical process that consisted of an intervention, an outcome, an evaluation of the situation and/or a reassessment of the patient, and a decision to intervene again or not (Figure 16). Ray's tale provides one example of this story type.

Figure 16 Cycle of intervention in the last resort story



7.7.1 Background

George was a 54-year-old man who was taken to A&E after he was found wandering the streets. He was admitted informally to Houndkirk ward shortly afterwards. George

had a long history of mental health problems and on admission he was described as, 'uncooperative and uncommunicative', 'confused', 'easily agitated and verbally aggressive', and although there was 'no evidence of self-harm' he was considered a high risk of 'exploitation' from others. George remained informal for approximately three months before being detained. Ray was a 'D' grade staff nurse and had worked on Houndkirk ward since qualifying seven-and-an-half months earlier. This was his first application of Section 5(4).

7.7.2 Vulnerable and unpredictable

Like patients in a number of other stories George was presented as a person who was a potential risk to himself and others. Ray's opening descriptions presented George as both vulnerable and, at times, unpredictable:

'His mental health had deteriorated to the stage that they couldn't cope with him at his accommodation so [he came] into hospital on an informal basis.'

Ray (S2T9. U1: 4-5)

'His mental health was stabilising, but he kept getting these periods where his speech had become quite bizarre and...he'd talk about having magic spells cast upon him and at [these] time[s], if you tried to approach him, he could become quite hostile and aggressive.'

Ray (S2T9. U2: 11-16)

The assessment of George as vulnerable and unpredictable was used as justification by the nurses to provide him with an escort during leave from the ward:

'On the actual day...although he was informal...because he's seen as quite vulnerable in the community one of the support workers had taken him up to the local shop.'

Ray (S2T9. U2: 16-19)

7.7.3 Into the community

On the day of George's detention he had gone to the local shops accompanied by a support worker; however he was unwilling to return to the ward. Ray described how he

became involved in the events and also his attempts to persuade George to return to the ward:

‘That day I was shift coordinator and she came back to the ward about 40 minutes later saying that she were having trouble getting him back onto the ward and he was stuck to some railings actually outside the hospital grounds, but very near a busy road. So I went for a walk with the support worker and tried to coax him back...’

Ray (S2T9. U2: 19-225)

Up to this point there was nothing in Ray’s story to suggest that George was a risk to himself. However, his reference to George’s physical location, that is ‘near a busy road’, implied that he believed this to be the case. In addition, George’s unwillingness to return to the ward - which he was entitled to do as an informal patient - and his mental state at the time led Ray to the decision that he needed to intervene to maintain his safety. Ray gave an example of his mental state:

‘...his speech [was] bizarre. He [was] making reference to magic spells and “somebody could kill me.”’

Ray (S2T9. U2: 26-28)

Furthermore, although it appeared that Ray’s intention was to return George to the ward he did not consider the use of a legal intervention to do so. Perhaps this was because his initial attempt ‘to coax him back’ appeared successful:

‘He did actually set off walking towards the hospital at one point and then stopped again.’

Ray (S2T9. U2: 28-29)

However, this intervention did not bring about the desired effect as George, rather than returning to the ward, walked away from the hospital. Ray provided an evaluation of his intervention and its impact on persuading George to return to the ward:

'Then he let go...of the railings and proceeded to walk past the hospital towards the busier part of the road by which point we were joined by another staff nurse because we'd been missing probably 20 minutes at that point. And it [was] quite clear that he weren't coming back onto the ward, but we managed to persuade him to walk. We'd passed the main entrance and there's another entrance further down, you know, and we steered him away from the busy traffic further up onto the grounds of the [hospital].'

Ray (S2T9. U2: 29-38)

7.7.4 Common law

Although George walked away from the 'busy road' what followed suggested to the nurses that his behaviour was placing himself at further risk. Ray developed his story:

'...at which point he deteriorated again and he was swinging his bag round and being verbally abusive and kicking out and then he actually lay in the middle of the road. So we'd no choice really but to get him off the road with two members of staff. So under common law we passively walked him back to the hospital talking to him, by which point he'd settled and he came.'

Ray (S2T9. U2: 38-42)

At this point Ray's story contained sufficient evidence to justify his use of Section 5(4); however he decided to return George to the ward using common law. Ray explained his reason for this decision:

'I thought, "I'm going to get back on the ward and [he'll] settle down and it'll be over," but it wasn't quite like previous times and he didn't.'

Ray (S2T9. U5: 106-107)

On arriving back on the ward the situation changed again:

'...as soon as we came back onto the ward he made it clear that he [wasn't] going to [stay]... He started...lashing out again. He made it clear...that he want to go to his accommodation in Sheffield.'

Ray (S2T9. U3: 49-50. U4: 60-61)

George's stated intention to leave meant that Ray had to consider whether he should prevent him from doing this. At this point Ray suspended the action to offer an insight into the dilemma he faced:

'You see the problem was this was about the third time it had happened in about six weeks... Two weeks prior to that I'd had to fetch him back from another part of the hospital and I've seen this before - kicking out, swinging - but from a distance I managed to coax him back onto the ward and, like I say, within an hour, everything were forgotten...but on this occasion it didn't happen.'

Ray (S2T9. U4: 51-52, 57. U9: 154-159)

Although George was still an informal patient it is argued that as the nurses were preventing him from leaving this constituted a de facto detention. That is, an informal patient who is:

'...unwilling to...remain in hospital, but are nevertheless compelled to...stay without the imposition of formal legal detention.'

Cavadino (1989: 75-76).

This view is supported by the nurses' next intervention:

'So basically we walked him into a low stimulus environment and sat with him... We offered him oral medication, which had worked in the past, [but] he totally refused and he was still being hostile verbally to staff.'

Ray (S2T9. U4: 62-68)

7.7.5 From de facto to legal detention

Ray recognised that none of the nursing interventions used to manage George's behaviour had been successful. Furthermore, George's refusal to accept oral medication was the tipping point in Ray's story resulting in him considering and then implementing Section 5(4) as a last resort to resolve the situation:

'He'd been written up for IM medication...but on another occasion everything had been done under common law. And I wasn't sure how much you can do under common law so I spoke to a senior member of staff and I said, "Do you think it warrants a five-four?" And he went, "Why are you thinking like that?" I just said, "Well we brought him back under common law. He's in seclusion and we want to medicate him, but he's not happy to stay on the ward. He's not accepting his medication and I think he needs mental assessment." And then he said, "You know if something goes wrong, someone's going to say to you why didn't you take it one step further and secure his medical assessment." I knew that he was agreeing with what I were saying... So that was the decision... That was my reason that I five-foured him.'

Ray (S2T9. U4: 69-81)

However, Ray's decision to implement Section 5(4) did not occur until he had considered and then rejected other possible interventions to prevent George leaving the ward:

'Perhaps if we'd had staff in time, there would have been some other way. Perhaps we could have put him somewhere for an hour and he would have calmed down. Perhaps we could have detained him informally. Perhaps...we could have just locked the doors basically..., which is not fair. You know, it's not right, it's [not] ethical...'

Ray (S2T9. U10: 168-175)

However, it was clear that for Ray using Section 5(4) was a last resort and that this belief had motivated his earlier actions. Ray offered two examples that supported this view. Firstly, he recognised that he had used common law to manage George's behaviour in order to avoid using Section 5(4):

'I didn't mind bringing him back under common law because that was for his own well-being...and it meant I didn't have to use five-four.'

Ray (S2T9. U9: 160-161)

Secondly, his thoughts and feelings - although not expanded upon - about using Section 5(4) appeared to have influenced his reluctance to use the section:

‘Well, I felt bad...I wish it had been somebody else.’

Ray (S2T9. U9: 154, 165)

Although Ray was reassured that he had made the correct decision when the SpR placed him on Section 5(2):

‘The SpR interviewed him and...put him on Section 5(2) for 72 hours... Which, if I’m honest, made me feel a little bit better, although like I said I didn’t feel good about it...’

Ray (S2T9. U10: 182, 184, 187-188)

7.7.6 Coda

George was assessed by the consultant and placed on Section 3 of the Act. He was still a patient on the ward at the time of the interview with Ray.

7.8 Conclusion

This chapter has presented the implementation of Section 5(4) as a six-part typology. In the HSP story Section 5(4) was implemented when the nurse believed that the patient presented a risk to themselves or others and was not prepared to remain in hospital until a medical assessment could take place. This story also provided insights into the process leading to the implementation of Section 5(4), for example: how nurses attempted to persuade patients to remain on the ward; the dilemmas they faced when limited information was available on the patient’s mental state; and how they managed emergency situations in the absence of a doctor.

In the lack of knowledge story Section 5(4) was implemented when the nurse had insufficient information about the patient to make a full assessment of their risk status. In these circumstances the default position was to act with caution and prevent the patient from leaving. At such times the nurse would draw on any available source of information to help them make their decision, for example, the nurses’ handover. Subsequent information obtained by the nurse implementing the section sometimes led them to revise their opinion about the patient’s level of risk. However, for the patient in

this story type there was inevitably a consequence of the decision to implement Section 5(4), usually a further period of detention under the Act.

In the catalyst story Section 5(4) was implemented by the nurse in an attempt to facilitate a positive therapeutic change in the patient's care. Although the implementation of Section 5(4) was useful as a mechanism for initiating change it was recognised that the intended benefits may not be achieved. Although on official documentation a nurse was able to justify the decision to implement Section 5(4), in reality it was acknowledged that the patient did not meet the criteria for detention.

The medical inaction story type offered insights into the difficulties faced by nurses in managing clinical situations when a doctor is unwilling - albeit based on their own assessment of the situation - to detain a patient. From the nurse's perspective this was perceived not as a difference in clinical opinion but a disregard for their superior knowledge of the patient's clinical presentation and/or experience of similar situations. This perceived disregard was evaluated negatively and expressed emotionally as disappointment and anger. The decision not to detain the patient was seen as potentially affecting future working relationships with doctors. More importantly, nurses believed that in the aftermath of such decisions they were required to manage a difficult clinical situation involving an informal patient who wished to leave the ward but was still a risk to themselves and others. Inevitably Section 5(4) was implemented; however nurses believed that it could have been avoided.

The self-protection story was the result of nurses feeling that they had no alternative but to implement Section 5(4) in order to protect themselves from a threat. In Simon's story the threat came from a medical practitioner but in other cases the decision to use Section 5(4) could have easily been the result of an interaction with a patient. Importantly - and similar to the catalyst story - the patient who was detained was not thought to meet the criteria laid down in the Act (DH, 1983) and Code of Practice (DH, 1999a).

Finally, the last resort story explained how nurses attempted to avoid implementing Section 5(4). However, nurses acknowledged that they thought that the patient would constitute a risk should they be allowed to leave hospital. In recognition of this patients

were prevented from leaving without being legally detained, at least in the first instance. The decision not to implement Section 5(4) was based on the belief that detention would not be in the patient's best interest or, at times, their own. However, there was a recognition - both legally and ethically - that they could not prevent the patient leaving indefinitely without turning to the Act.

Chapter 8

Patients' stories of detention

8.1 Introduction

This chapter turns to the experiences of the detainees and presents the findings of my analysis of the interviews undertaken with Mark, Carl, Shaun and Asif.

8.2 Mark's Story: 'I didn't know what a section was'

8.2.1 Background

Mark was a 47-year-old man admitted to Blackamoor Ward following a referral from the Crisis Team. This was his first admission to hospital for mental health problems. Six weeks before Mark's admission he had received notification that his divorce had been finalised. Mark and his wife of 24 years had separated one year prior to his admission. During the six months leading up to his admission Mark's mental health was reported as having 'deteriorated'. Mark felt he had been abandoned by his family; particularly his son (he also has a daughter) whom he believed was siding with his ex-wife. He had financial problems and also found coping with living alone difficult. Mark was distressed by his perceived abandonment by his family and eventually he was taken by his sister to see his GP who prescribed him medication for depression and anxiety. Six weeks later he was sent home from work as his employers felt that he was unfit to continue. He was persuaded to return to his doctor and - showing no signs of improvement - was referred to the Crisis Team who arranged for him to be admitted to hospital.

On admission he was described in the nursing assessment as:

'...suffering from anxiety and depressive type symptoms and expressing passive suicidal ideation [having] said to his brother-in-law that he would take tablets "as a threat" but says he has no plans to do so... No risk to self or others.'

(NN)

Both Mark's medical and nursing assessments reported that he was; 'happy to stay in hospital and won't leave', a 'low risk of absconding', 'no risk to others' and a

‘moderate risk of harm to self’ based on him ‘threatening to talk pills but [he had] no plans to do so.’

8.2.2 Getting admitted

At the start of the interview Mark was asked to tell the story of his admission to hospital and the events leading to his detention under Section 5(4). However, he found this difficult and was unable to provide little in the way of detailed information surrounding these events:

Russell: ‘How did you come to be in hospital?’

Mark: ‘I don’t know.’

Russell: ‘What happened to you?’

Mark: ‘Don’t know.’

(PT1. U1: 1-4)

However, Mark was able to offer some insights into his current circumstances:

‘I was a bit depressed that’s all because no-one was coming to see me and my daughter wouldn’t come to see me and I was a little bit depressed.’

(PT1. U8: 436-438)

Mark’s comments shared some similarities with that of the admitting doctor’s assessment:

‘Depression with somatic syndrome. No psychotic features. Generalised anxiety. Plan: Trazodone. PRN Lorazepam if anxiety is persistent and unmanageable.’

(MN)

Although Mark was unable to provide a detailed story of his admission to hospital this did not appear to be an issue of memory as he was clearly able to recall how long he had been on the ward:

Russell: 'Can you remember coming in at all?'

Mark: 'Yeah.'

Russell: 'How long have you been here now?'

Mark: 'Four weeks on Monday.'

(PT1. U1: 5-9)

As Mark was finding it difficult providing anything but the briefest of information an attempt was made to elicit more of his story by using 'creative guesswork' (Booth and Booth, 1996: 64):

Russell: 'Did you go and see your doctor, your GP?'

Mark: 'My sister took me there.'

Russell: 'Why was that then?'

Mark: 'Don't know.'

Russell: 'Do you think she was concerned about you in anyway?'

Mark: 'Yeah, she's a good sister. She loves me.'

(PT1. U1: 14-19)

Although Mark provided little detail here, one interpretation of this information could be that his sister was sufficiently concerned about him to arrange an appointment with his GP and escorted him there. Similarly, although not explicitly stated, it would appear that the GP's assessment of Mark led him to conclude that he required an admission to hospital.

It is unclear whether Mark was aware of or agreed with the concerns others - that is his sister and GP - had about his health. However, one interpretation could be that they had sufficient influence over him to persuade him to be admitted to hospital. On the other hand, it could also be argued that he might have felt he had to agree to the admission in

order to maintain contact with his family. For example, Mark is quoted verbatim in his medical notes as being told by his son that:

‘...you are not well mentally. You need help and until you get it you can’t see your grandchild.’

As contact with his family was important to Mark, it is suggested that his son’s comments may have been sufficient to explain his willingness to be admitted to hospital:

‘I went into Longshaw for one night ‘cause me son said I was mad.’

(PT1. U2: 46-47)

Furthermore, as this was Mark’s first contact with the mental health services it is unclear what knowledge he had of how they operated or what his potential options were. As a lay person Mark’s response to being labelled ‘mad’ may have led him to believe that he had no other choice but to be admitted to hospital. Certainly his next comment would seem to question whether he was adequately informed of his options or that he could have refused to be admitted:

Mark: ‘I’m voluntary...I didn’t know this at first.’

Russell: ‘You didn’t know you were voluntary to start with?’

Mark: ‘No...I thought they had put me in here.’

Russell: ‘Didn’t anyone tell you that you were voluntary?’

Mark: ‘No not at first.’

(PT1. U2: 35, 37, 39, 42-44)

Mark turned the focus of his story to his experiences on the ward. He informed the audience that he believed his admission had been detrimental to his health:

'I was alright before I came in here. It's what's happened since I came in here.'

(PT1. U1: 29-30)

This Mark clearly attributed to his medication:

'They've stuffed me full of drugs... Every night, 10 o'clock, they give me tablets... I thought they were giving them to me to make me better.'

(PT1. U2: 29-30, 34, 37-38)

Furthermore, Mark noted that:

'I don't have to take them I'm voluntary... I didn't know this at first.'

(PT1. U2: 34-35, 37)

This comment may suggest that Mark - and possibly other patients - believed that when admitted to hospital there is no other choice but to comply with the requests of doctors and nurses. This compliance may include patients feeling compelled to take medication that they do not want. A second issue - not answered in the interview - is when and how Mark discovered that he was 'voluntary' and what this meant in relation to his right to refuse his medication should he choose to do so.

8.2.3 Getting detained

At one point in the interview Mark left the interview room to ask a healthcare support worker - Alison - to contribute to his story. Alison's initial contribution supported Mark's concerns about his relationship with his family and also confirmed that a medical approach to managing his mental health problems had been taken:

Mark: 'Tell him what's been going on.'

Alison: 'When you first came in here you were very paranoid about your family and what had happened out there...so these thoughts you were having...you were unwell and you were wrote up for medication. And at one point you were getting better.'

(PT1. U3: 54, 59, 61-62, 67-70)

This conversation was important as it introduced the subject of Mark's detention and offered an insight into Alison's thoughts on the events surrounding it:

Mark: 'I could have gone home on Sunday but Ben put me on a section.'

Alison: 'No, what happened that Sunday was the way you created, running off the ward. Ben five-foured you but the day after you were regraded because they knew you wouldn't need a section...didn't need to be on a section...'

(PT1. U3: 74-80)

Although Alison's comments tell us little about the implementation of Section 5(4), it is proposed that they can be interpreted as her believing that Mark brought on his own detention. In addition, that the nurses perceived the use of Section 5(4) as a short-term measure only. However, Alison did provide an account of the events leading to Mark's detention:

'On Mark's return [from leave he] refused to come back on the ward because his sister had challenged him about phoning members of his family late at night. Mark became very distressed by this and had ideas that no one cared about him. One-to-one nursing time given. Mark became so distressed he left the ward and was followed by nursing staff.'

(NN)

As with other parts of his story, Mark's account of his detention was pieced together from small fragments of conversation. It would appear from the following extract that prior to his detention Mark was unaware that a nurse could prevent him from leaving. Furthermore, it appears that he was uncertain what a section referred to; although he did seem to have acquired a basic working knowledge of it from somewhere:

Russell: 'Did you know before you came into hospital that nurses could put you on a section?'

Mark: 'No... What is a section?'

Russell: 'Have you heard of the Mental Health Act?'

Mark: 'Yeah.'

Russell: 'What do you think a section is?'

Mark: 'A section's were they keep you in hospital for just a couple of weeks.'

(PT1. U4: 294-300, 303-305)

As noted by Alison, Mark had been out for the afternoon with his sister and following a disagreement with her he decided to leave the ward. With further questioning it was possible to gradually build up his story of the events surrounding his detention:

Russell: 'So what happened?'

Mark: 'I had just been out to the garden centre...and I wanted to stay out [and go home].'

Russell: 'You were leaving the ward and then what happened?'

Mark: 'I had my coat on and was going off the ward... I was on the stairs and Ben and somebody else came [after me] and said we are going to detain you under Section 5(4) of the Mental Health Act.'

Russell: 'Did he tell you why?'

Mark: 'No.'

Russell: 'Not at all?'

Mark: 'Well he put me on a section...because he said, "You need your medication Mark; you need to take your medication."'

(PT1. U4: 225, 228-229, 248-255. U5: 329. U6: 343-346, 353-356)

Mark's view of why he was detained can be compared with the official reason given by Ben, as recorded on the local incident form:

'Became increasingly agitated following his sister leaving the ward, determined to go out and confront the rest of his family regarding possible persecutory ideas he has about them. Due to agitated state of mind, risk to self/family if acted on plans whilst out, felt no alternative other than to detain him.'

Although Mark was prevented from leaving he initially refused to accept this decision and challenged its legality:

‘I said, “I’m voluntary” but he said, “Things have changed, you’re on a section.” I don’t know why he put me on a section...I didn’t know what a section was.’

(PT1. U4: 263, 294-295)

He also physically resisted the nurses’ attempts to return him to the ward:

‘I tried not to let him keep me [in hospital]. I tried to push past and get myself down the stairs.’

(PT1. U8: 407-411)

In response to this the nurses attempted to persuade him to return to the ward by making him aware of the potential impact his actions were having on his sister who was present during the detention:

‘They [the nurses] said, “Come on Mark, come [back] in you are upsetting your sister.” I said, “Alright.”’

(PT1. U8: 413-414)

This seemed to have the desired effect and may have been the result of - as noted earlier - that Mark ‘loved his sister’. This potentially highlights the importance of involving family and carers in care decisions when appropriate:

‘I stopped pushing because my sister was there and I was upsetting her.’

(PT1. U8: 420)

However, Mark made it clear that he did not return of his own volition:

'They brought me in here... Made me come back in here.'

(PT1. U7: 248-256)

Mark described the aftermath of his detention:

Russell: 'What happened once they said they had detained you?'

Mark: 'They kept me in hospital and brought me back to the ward. He [the nurse] gave me a tablet. I went to my room...and the doctor took my blood pressure and asked me what was up with me.'

(PT1. U6: 357-358. U7: 379, 385)

Mark was uncertain what, if any, impact his detention had on his relationship with the nurses on the ward:

Russell: 'Do you think it affected your relationships with the nurses?'

Mark: 'I don't know. May have done...don't know... I can't remember it's a long time ago.'

(PT1. U7: 387. U8: 398)

Although Mark's story suggested that he was not clearly informed about why he was detained he was able to offer an insight into the immediate impact the holding power had on him:

Russell: 'How did you feel about that?'

Mark: 'I wanted to cry but I couldn't... It frightened me...I thought they were putting me away for good.'

(PT1. U5: 310. U6: 378)

Mark gave no more details about the aftermath of his detention but he did not attempt to leave the ward again that day. He was assessed by a doctor and placed on Section 5(2) with the following rationale:

‘Distressed, agitated, anxious and has a diagnosis of depression. Has fixed ideas about his family. Wanted to leave the ward. As an informal patient wouldn’t comply with request to stay on the ward and might pose danger to his health and safety as expressed suicidal ideas.’

(Section 5(2), Form 12)

However, the following day the Section 5(2) was rescinded and this decision was recorded in his medical notes as follows:

‘Continued agitation requiring PRN Lorazepam, however is remaining on the ward and accepting medication. Regrade to informal. More settled...if all goes well discharge on Thursday.’

8.2.4 Coda

At the close of the interview Mark was still an informal patient on Blackamoor Ward and continued to express similar concerns about his family as those leading up to his admission. However, from Mark’s perspective some progress had been made with his children as they had started to visit him on the ward; although the future nature of their relationship remains uncertain. Similarly, the progress of his care was uncertain in that many of Mark’s presenting symptoms were judged by him and by both the doctors and nurses involved in his care as showing little sign of improvement. Despite this Mark has been encouraged to take periods of leave and a discharge date set. However, as the interview came to a close he was seeking an extension to his time on the ward.

8.3 Carl’s story: ‘The pot of honey’

8.3.1 Getting to hospital

Carl was a 36-year-old man who prior to his admission had no previous history of contact with the mental health services. Over a three month period Carl, a church minister, had been subjected to physical and psychological harassment from a gang of local teenagers at both his home and place of work. The outcome of this was that he reported feeling low in mood and angry. In addition, as a result of a ‘crisis of faith’ Carl had been on a 10 week leave of absence from work at the time of his admission to

hospital. Carl was prescribed a course of anti-depressants by his GP; however the medication did not lead to the desired improvement in his mental health.

Carl's mental state deteriorated further to the point that on the day of his admission he visited his GP and informed her that he felt suicidal. The GP, concerned about his safety, referred him to the Crisis Team who arranged an emergency home visit. On their arrival Carl disclosed to them that he felt suicidal and unsafe at home, and had taken 10 paracetamol four hours earlier. Commenting on his mental state at the time of his admission, Carl recalled that:

'I had an overwhelmingly feeling of depression. I had been feeling bad for a few months. I was just taking Paracetamol, loads of them. Every day I was taking, I don't know, three or four times as many as I should have and stuff like that and I was feeling depressed and suicidal. So I went to my GP and she referred me to the Crisis Team... I think two nurses came up to see me the following day and...I just broke down and started crying and they suggested I came into hospital. I wasn't sleeping or eating properly and in particular I couldn't sleep. I couldn't sleep at all.'

(PT2. U1: 9-12, 40-43)

The Crisis Team believed that Carl was a risk to himself and arranged for him to be admitted informally to Blackamoor Ward. However, despite recognising that he was in need of help Carl was reluctant to be admitted:

'I didn't want to come into hospital. I wasn't sure what it would be like once I got through the door, but I needed to come in... [It was] the stigma of it basically and I wasn't sure what it would be like, what they were doing here.'

(PT2. U2: 47-48, 51-52)

Carl also commented on how his experiences of the care he received following his admission did not meet his expectations:

'I thought there'd be more chances to counsel me, to talk. The treatment isn't treatment as I see it. I don't know, [I thought there would be] counselling...[but] people have been unwilling to listen. They have put me on different drugs...I just thought...I would get more help... I just thought

the pain that I carry round would be taken away and it hasn't been taken away. It's still there. I'm still carrying the pain and the burden.'

(PT2. U2: 55-63)

8.3.2 The road to detention

8.3.2.1 Days one-three

The initial medical and nursing assessments of Carl were very similar in content. The medical assessment - undertaken by the senior house officer (SHO) - reported that he had been admitted informally and that he was, 'angry', '[felt] low about himself', 'has continued thoughts of DSH [deliberate self-harm] and had taken an overdose of 10 paracetamol.' The doctor also questioned whether Carl was experiencing pseudo-hallucinations or whether this was part of his spiritual belief system. Carl was given a differential diagnosis of 'severe depressive episode +/- psychotic symptoms.' The medical plan was to:

'Discuss with nursing staff 5 minute observations at nursing staff's discretion. To be reviewed in the morning.'

(MN)

Similarly, the nursing assessment noted that Carl was low in mood and had suicidal ideas; 'I want to kill myself' and that he had 'some form of pseudo-hallucinations'. Following his recent overdose Carl's risk of harming himself was assessed as 'medium/high.'

On day two Carl was seen by the specialist registrar (SpR) and the assessment focused on his 'pseudo-hallucinations'. The notes drew attention to the fact that Carl was a church minister and quoted him verbatim as stating that:

'I'm into exorcism...the spirits exorcised from my congregation have been attacking me...they've taken over my mind...they come into my room...they press down on my chest and say "you must die, Carl".'

(MN)

Following the above entry the SpR wrote one word; 'psychotic' and made explicit the diagnosis of 'psychotic depression'. In response to this Carl was prescribed anti-psychotic medication (Sulpride 200mgs). Of equal significance was the medical plan which stated:

'No leave at present. Obs [observations], assess for 5(2) if tries to leave.'

(MN)

Carl's first three days on the ward were characterised by a number of entries in his nursing notes that referred to him being 'anxious' or 'agitated'. For example, on day two he was described as 'feeling very agitated' and wanting 'to hit someone or something.' At these times the nurses responded by; informing Carl that his behaviour was unacceptable, offering him PRN medication, occasionally offering him 'one-to-one' time, or suggesting that he went for a walk in order to 'cool down'. These periods of unescorted leave for up to half an hour seemed to be in contradiction of the medical plan, that is he was on five minute observations and not to leave the ward.

On day three, although it had been recorded that Carl 'felt angry and had been cutting his wrists', the doctor terminated his observations and gave permission for him to take unescorted leave from the ward.

8.3.2.2 Days four-seven

During this period there were fewer entries in Carl's nursing notes that referred to his anxiety and/or agitation. However, there were an increasing number of references about him being 'isolated and 'quiet'. Perhaps of more significance were the references to Carl's 'deliberate self-harm'. For example:

'It has been reported that Carl has either re-opened previous wounds/cuts to his wrists or has lacerated again.'

(NN)

In response to this, Carl was offered support and 'education'. However no concerns were expressed by the nurses about his safety and in support of this Carl was allowed

periods of leave from the ward. For example, it was recorded in his nursing notes that he had, 'been out for a walk' and 'went off the ward'. However, on two occasions there had been incidents while he was on leave. On the first occasion Carl had presented himself at the local accident and emergency (A&E) department '...claiming to have taken 20 paracetamol...' and on his return to the ward he disclosed to the nursing staff that he had been, 'cutting his arms whilst out on day leave'. On another occasion (day six) Carl was picked up by the police who thought he was trying to damage their car but in fact he was 'picking up some broken glass with the intention of self-harming'.

Following the above incidents a joint medical and nursing assessment was undertaken (day seven). The nursing assessment concluded that Carl was not a sufficient risk to himself to be detained under Section 5(4) should he decide to leave the ward. Similarly, the medical assessment made no reference to the need for an assessment to be undertaken under the Act. As if to reinforce the outcome of this joint assessment Carl was allowed to take leave on the conclusion of this meeting for an unspecified period of time.

8.3.2.3 Days eight-eleven

The overarching theme of the content of Carl's nursing notes for this period was that he was, 'raising others [nurses] concerns'. There were also numerous references to his expressed desire to harm himself and/or reports of actual incidents of self-harm:

'He voiced that he is depressed and intends suicide, but not today because he doesn't have the tools or energy.'

'...threw a razor across the bedroom floor. On investigation no broken razors were found. Carl has not brought any injuries to staff's attention.'

(NN)

On day 10 it was reported that Carl 'appears troubled' and that 'he felt very low'. It was also reported that he 'asked for seclusion to be opened and started thumping the furniture.' More significantly, later in the day the following entry appeared:

‘...at 15.40, Jim Johnson [a patient] walked past Carl’s room and saw [him] with a bed sheet tied around his neck, standing on a chair with the bed sheet trapped at the top of the bathroom door...Jim went into the room, this was when Carl pushed the chair. Help was called, and Carl became angry, resisting staff’s attempts to remove the bed sheet. However when encouraged, he calmed down, and the sheet was removed and he sat in a chair.’

(NN)

Following this incident Carl disclosed that, ‘he [was] intent on killing himself’ and regretted the nurses’ intervention. However, following further discussion he informed the nurses that he regretted his actions and did not intend to make another attempt on his life. Approximately half an hour following the incident Carl requested and was granted unescorted leave off the ward to go out for a walk as ‘fresh air [would] help him to relax’. It was later recorded that ‘he did return as agreed’. On his return Carl agreed ‘...to stay [in hospital] and receive treatment...’ and ‘...seek help when feeling like hurting himself’. Despite the earlier incident it was noted that ‘his observations have remained as routine’.

In response to the above events Carl was assessed by a SpR the next day (day 11). The SpR was of the opinion that Carl was; ‘preoccupied with wanting to kill himself’, had ‘a desire to kill himself’, had ‘spirits telling him that he should kill himself’, and was ‘ambivalent regarding medical explanation for his behaviour’. Based on this assessment the following medical plan was formulated:

- ‘Not for leave on own - I would advise escorted leave home if wants to collect belongings;
- To be assessed for 5(2) if attempts to leave.’

(MN)

8.3.2.4 Day twelve

On day 12 an incident occurred on the ward that resulted in Carl’s detention under Section 5(4). The details of the incident were recorded as follows:

‘Carl demanded to take unescorted leave at 12.30 hrs. I advised against this due to SpR medical plan and Carl’s suicidal feelings, but I asked him to wait

to see Dr [Name] who was on his way up (by chance) - (the doctor was on call on another ward) Carl said "OK". However, I locked the ward due to suspicion that Carl would run away. Within 5 minutes Carl ran to the door only to find it locked. He came back onto the corridor. Dr. [Name] arrived at this point. Carl became angry. Dr [Name] attempted to negotiate with Carl who was now yelling "I want to fucking leave now, open the fucking door." Carl refused to allow risk assessment interview to take place, Carl refused to discuss with Dr [Name] and myself. Carl refused to contract not to engage in suicidal actions. He became agitated.

As he left the interview I had to detain him on Section 5(4) as Carl refused to stay informally until the SpR arrived to get authorisation for leave. At 12.40 hrs he was placed on Section 5(4) and leaflet and info given. At 13.15 Dr [Name] SpR attended as arranged. Carl told Dr [Name] that he "needed to kill himself". Carl then began demanding to leave - shouting and swearing. He again refused to enter into negotiation and contracting with Dr [Name] who subsequently placed him on Section 5(2) at 13.40 hrs. Given 1 mg Lorezepam at 13.15 hrs. Carl was given rights and information. He was angry but went to sit down. At 18.00 hrs became agitated, angry - pacing, yelling demanding to leave - given Lorezepam 2mgs at 18.00 hrs.'

(NN)

The official reasons for Carl's detention were recorded on the local incident form as:

'Carl asked to leave the premises without an escort and became agitated when asked to discuss it with SHO. I locked the ward doors as a precaution - soon after he bolted for the doors until I shouted after him. Recent suicidal actions (Hanging attempt Thurs) [day 10]. On discussion with SHO Carl refused to negotiate - Yelling out "Let me out now" - Prevented by locked doors.'

(LIF)

8.3.3 Going shopping

Carl's own story of his detention began by orientating the reader to the, who, what, where and why of the story. Carl's orientation also provided a guide for how he wanted the audience to interpret the plot of his story. He began his story by presenting himself as an everyday man (a layman) doing everyday things, a human being with agency who is helping another person (a patient):

'...somebody asked me if I'd go down the shop for them to get some honey and I said I would...'

However, Carl's account made it clear that the 'everyday world' of the layperson with the freedom to come-and-go at will coexisted with a psychiatric world that imposed restrictions on a person's liberty. Carl emphasised in his story the ease with which Mark - the nurse - was able to impose the restrictions of the psychiatric world on his liberty by locking the ward door and detaining him:

'...Mark Pullman...said, "I don't think that's a good idea." So I said, "You can't stop me. I'll go where I want to go", and then he locked the door. [But] he did stop me going. He said he was going to detain me and he locked the door. He said the doctor would be in to see me within six hours and that was it basically. It was that simple.'

(PT2. U3: 102-108)

Carl described both his immediate reaction and emotional response to his detention:

'Well, I tried to open the door and run out the door. I felt angry. I think I got into a bit of a state as well. I was shocked really. I was just shocked [because] the door had been locked and I couldn't get out... It was funny in a way. It was like unreal; as if I didn't think you could do that. So it was just unreal, you know, but the door was real enough though. I felt my freedom had been taken away unfairly and it was really unfair because all I was going to do was go down the shop. I wasn't going to do anything.'

(PT2. U5: 155-167)

Carl's account provided an insight into the emotional impact detention has on the patient. In addition, it may also suggest the need to provide patients with sufficient orientation to life on acute in-patient wards to overcome the differences between the lay and psychiatric world. While Carl may have felt that his experiences were 'unreal', there also appeared to be growing recognition that the psychiatric world had restrictions and that his taken-for-granted liberties associated with the everyday world may not exist during his time in hospital. For example, Carl's comment that, 'I wasn't going to do anything' perhaps indicated that his time on the ward had given him an insight into the types of behaviour that could impact on a patient's liberty. This comment also

suggested that Carl recognised that there was something about his behaviour that situated him within the psychiatric world and may have been of concern to others.

At this point in the story Carl suspended the action to reflect on the events in the days leading up to his detention. For example, he disclosed that, 'I wanted to kill myself'. Carl's disclosure suggested that during his time on the ward he had gained an understanding of some of the 'rules' of the psychiatric world. He also appears to have recognised that his actions had been interpreted as having broken the rules of safety; the consequences of which had resulted in his detention. However, Carl also questioned what 'safe' and 'unsafe' meant within the psychiatric setting and perhaps the lack of clarity around the issues from the patient's perspective:

'The doctor had said that he didn't think it was safe for me to go home. That's all he said. Nobody talked about unsafe to go out from the ward. No, he only felt it was unsafe for me to return home...I thought he meant going home and staying home and not, you know, physically going home for a couple of hours or something, and certainly it were nothing to do with going out to the shop. I mean I've been to the shop loads of times.'

(PT2. U3: 119-126)

Therefore, Carl's comments challenged the fine detail of what 'safe' and 'unsafe' meant within the multi-disciplinary team. In the above quote Carl draws attention to the distinction between safe to go home and safe to go out to the shops alone, and in support of the latter point he emphasises the fact that he had 'been to the shop loads of times'. Carl's frustrations are perhaps easy to understand as there were several entries in his nursing notes when he was not only encouraged to take time out from the ward but at other times *told* to do so. Perhaps more extraordinarily, on one occasion he was allowed to leave the ward less than half an hour following his hanging attempt. Once again, Carl's experiences encourage the reader to consider the lack of clarity in the rules of safety as exercised by both the nurses and doctors on the ward. It is proposed that this lack of clear guidance contributed to the implementation of Section 5(4) in Carl's story.

Carl returned to his story by recounting the aftermath of his detention. This provided insights into; the potential problems encountered by patients when trying to recall the

events surrounding their detention, the emotional impact of being detained, and - albeit a partial account - how the nurses and doctors managed the situation:

'It is hard to remember [what happened next]. Well, they locked the door and kept the door locked. I think I just wandered up and down. But at some point I started getting angry. I had some Haloperidol. All I can remember is soon after that I was just very sleepy and I just slept for a long time and they had trouble waking me at one point. All I remember is it was the weekend and some consultant guy came in, asked me how I was feeling. So I told him how I was feeling.'

(PT2. U7: 216-218, 234-2356)

Although Carl's story informed the audience that he saw 'some consultant guy' and that he told him how he 'was feeling', he provided no further account of what he told the doctor. However, he did provide an account of the reasons given to him by the consultant for his detention. This account once again contrasted his lay view of events with that of the psychiatric perspective:

'Yeah, the consultant told me why. He just said, "You've got depression and it's clouding your judgement, so we think you're a danger to yourself." He said he thought I [might] harm myself or others, but he didn't go into details about that. My understanding [of that] is you know; jump off a cliff...an immediate harm to yourself or immediate threat to others. Like I said, I was rational. I could have gone to the shop and done something, but there's no evidence of that. It's just supposition. I certainly had no intention [of] doing anything. No one asked why I wanted to leave the ward; they just said it wasn't a good idea to [leave] the ward. I think...they'd been told by somebody or warned if I did, they should use their powers to stop me. Well, that's what I think happened.'

(PT2. U8: 238-245, 258-259)

Therefore, Carl's account emphasised the point that once the doctor had made the decision that he was at risk he had little control of or role - other than patient - in the decisions that followed. He also offered a lay account of what he understood to be a danger to self and others and suggested that he did not meet the criteria. That is, in relation to the doctor's decision he believed that, 'there's no evidence... It's just supposition.'

Carl also offered an insight into his understanding as to what it meant to be admitted as an informal patient and the reality of this once he arrived on the ward. This may perhaps question whether patients are given sufficient information about informal admission to hospital and the conditional nature of being allowed to leave the ward again:

‘I was told I’d come in as a voluntary patient and I’d be here for a very short time by the crisis team [but] I’m still here five weeks later. I just assumed...if I went into hospital I could discharge myself whenever I wanted to and then when I did want to discharge myself I couldn’t. I said...I wanted to go and couldn’t go, so I tried to discharge myself and I couldn’t discharge myself.’

(PT2. U14: 397-405)

8.3.4 Aftermath

Carl moved his story on to the aftermath of his detention. Carl weaved together the post-detention events with his emotional experience of them to construct a negative view of the psychiatric care he received. During the interview his anger was evident and focused on the belief that he was not a danger to himself at the time of his detention - despite his earlier admission that he had tried to hang himself. Carl’s unwillingness to accept his detention led to further conflict between himself and the nursing staff:

‘I was still in disbelief at this stage. It was three hours later. It was just like it was a joke and it was hard to fathom it could be real because I thought; “I’m not going to do anything. There isn’t an immediate threat. How can two people just suddenly lock me in a room?” This is what they did, locked me in this big, square room called a ward. I wanted to leave and they said I couldn’t leave. They threatened me with seclusion as well...as if I’m a school boy. Yeah, their words were, “If you don’t behave, you’ll spend a night in seclusion.” You know, “If you don’t behave, you’ll spend a night in seclusion. Bottom line. I hadn’t even been shouting. Okay I might [have] raised my voice. I may have sworn. I can’t remember. I really can’t remember... But I hadn’t done anything. I mean I hadn’t slammed doors or ran up and down the corridors or screamed.’

(PT2. U9: 263-285)

The management of Carl’s emotional responses by the nurses might once again be viewed as a conflict between the lay and psychiatric world. On the one hand, Carl

perceived his emotions as 'natural' under the circumstances while on the other he believed that the nurses wrongly interpreted his behaviour as an indication of psychiatric symptoms. He clearly believed that once a psychiatric interpretation had been made then the next step was to manage it through controlling his behaviour; in this instance through the administration of medication:

'It didn't calm down the next day, but I was calmed down the next day. They gave me Haloperidol or something...and it just knocked me for six. Aye, it just zonked me out. You know, I think the idea was I was agitated [but] I was pissed off for being locked up. I can't see how they could possibly be thinking that... I can't see how they can say that now because obviously if you lock somebody up, they're going to be naturally pissed off or angry. So the only reason I can see is that they purely gave the medication to calm me down. You know, how can they look at me and say "Somebody's just been locked up. Oh, symptom of psychiatric illness. Give medication." I mean I can't understand that. Maybe my layman's perspective is daft, but I just don't understand how they can see that.'

(PT2. U10: 292-318)

There were both short- and long-term implications of Carl's detention:

'I went on close observation, that's because I tried to hang myself but they increased that and...they put me on more medication after I was sectioned.'

(PT2. U15: 404-420)

In addition, Carl was placed on Section 5(2) and then Section 2; this resulted in him not being allowed to leave the ward for five days. After this time he started leaving again without anyone challenging him. Carl was confused as to how it had been established that he was safe to leave the ward again as he felt no different to when he had been detained. Nor had he been consulted prior to the decision being made:

'I didn't feel any less like harming yourself. I felt just the same. I didn't feel any different. I've got no idea how they decided I was safe to go out. I assumed the doctors had discussed it and decided. Nobody asked me.'

(PT2. U16: 431-435)

Carl concluded his story by commenting on: his disillusionment with the whole process relating to the use of the Act specifically; and his sense of disempowerment generally during his admission to hospital. He illustrated this by referring to the decision to rescind Section 2, his lack of involvement in the process, and how the decision was communicated to him:

'I feel alienated from the whole process... Nobody [formally] told me when the section stopped... I waited around all day to see the consultant but I didn't speak to him. One of the nurses...came up to me and said, "How do you like about your new found freedom? You've been regraded." ...So these decisions are being made without me even seeing a [doctor]. ...I mean it's surely good practice that says that [I] should [see one]... It's a system and I'm in it and going through it. It's crap. It's dehumanising, depersonalising and it just takes away any self-esteem that you might have left, which is not a great deal when you're in here. There's no sense of empowering me to make my decisions. My decisions revolve around vegetarian or meat for dinner. That's about it.'

(PT2. U16: 446-482)

8.3.5 Coda

Carl was still in hospital at the close of our meeting. He had not been given a discharge date although he did not wish to remain on the ward any longer as he felt, as a result of his detention, that he could not work constructively with the nursing and medical staff. He was also uncertain as to what his future might hold for him as his 'crisis in faith' continued.

8.4 Shaun's Story: 'It's the best thing they could have done all round, but I didn't think so at the time.'

8.4.1 Background

Shaun was a 37-year-old man admitted to Longshaw Ward following two recent incidents in the community. The first incident occurred a week before Shaun's admission; a neighbour recognised the smell of gas and contacted the police who broke down his door and referred him to hospital. The second incident occurred when Shaun telephoned a friend and informed him that he had taken an overdose and turned the gas on in the kitchen with the intention of killing himself. On this occasion the fire brigade

forced an entry into his flat and Shaun was taken to the A&E department where he was assessed by the Crisis Team and subsequently admitted to hospital. Shaun reported that the first incident was an impulsive act while the second was a planned suicide attempt. Shaun's nursing assessment noted that he had, 'a history of self-harming behaviour, a forensic history and has assaulted others when under the influence of alcohol.' His medical assessment stated that his admission was due to 'a relapse of major depression.' Shaun had been sectioned a number of times on previous admissions.

Shaun's story is an account of how he was detained twice under Section 5(4) over a five day period. The story was constructed from Shaun's tale of his experiences along with information obtained from his medical and nursing notes, and Mental Health Act documentation.

8.4.2 Getting to hospital and getting detained

Shaun began his story by providing the audience with a clear and concise account of the circumstances leading to his admission and subsequent detention. Shaun recognised that he needed help and was willing to accept an admission to hospital. He also seemed to have an awareness of the fact that there is more than one way a patient can be admitted to hospital; that is either informally or formally:

'After three years running a pharmacist I was taking a lot of work on for different organisations and all that and things just broke down, so I took an overdose and tried gassing myself. So that's how I came to be on here. I got assessed by the team and I just said, "Well, I think I need help like" and then I was admitted informally...about two months [ago].'

(PT3. U1: 6-10, 12)

Shaun's story then moved on to the details of his detention. Superficially, Shaun's story appears to be a simple tale in which he did not contest the need for the use of Section 5(4) or the nurse's actions in implementing it. Shaun also seemed to be well informed about Section 5(4) and his rights as an informal patient to leave the ward; this he attributed to having been previously employed as a mental health support worker:

‘There were a lot of shit going off in me head like worrying about family and ...a lot of other issues going on that I’m not going to discuss with you. I was informal [so]...I went home... I couldn’t cope and I asked if I could come back. I’d picked a drink up after being abstinent [for] two years, I took all my tablets and that is how I came to be in the state that I [was in] and then I tried hanging myself. I started creating. I wanted to leave. They thought I was going to harm myself, so they held me under the nurses’ holding power, which is a five-four. It’s as simple as that. I’m not going to make it any more complicated than it is. That was it.’

(PT3. U2: 20-26. U4: 57-61. U9: 97-102)

However, although presented as a concise and simplistic tale, Shaun’s story is in fact more complex, as indicated when he notes that, ‘a lot of issues were going on that I’m not going to discuss with you.’ Although it was unclear why Shaun did not want to discuss them further it was possible to identify some of the issues and events that may have contributed to his detention from his medical and nursing notes (hereafter MNN).

With the exception of the theft of an expensive top, Shaun’s first 17 days on the ward were uneventful. However, from that point forward until the first application of Section 5(4) (day 34) it is argued that a number of events occurred that contributed to his detention. Firstly, a number of changes were made to his medication which resulted in Shaun experiencing both physical and psychological side-effects. Shaun reported these to both the nursing and medical staff and they were recorded as follows:

‘Feels “dazed, disorientated and confused”, unable to remember some day to day events, “head his spinning” and feels “low in mood”.’

(PT3. MNN, Day 21)

‘Feels “low in mood” and reports poor sleep due to reductions in Diazepam and new anti-depressant regime.’

(PT3. MNN, Day 25)

‘Reports dizziness due to medication...’

(PT3. MNN, Day 30)

Secondly, Shaun complained on several occasions that he had been subjected to sexually inappropriate advances from a male patient on the ward:

‘Has made compliant of ‘sexual contact’ from male patient.’

(PT3. MNN, Day 20)

‘Reports inappropriate sexual contact that [has] triggered thoughts of incidents that have happened in his past regarding sexual abuse.’

(PT3. MNN, Day 21)

Thirdly, there were several references to Shaun’s dissatisfaction with how the nurses had responded to his complaints of sexual harassment. In addition, he also believed that not enough had been done to protect him from the other patient, for example:

‘Shaun is dissatisfied’ with how nurses [are] managing situation with fellow patient.’

‘Shaun is angry and felt staff were not taking him seriously enough, re-iterating his right to be safe on the ward and not suffer any problem.’

(PT3. MNN, Day 25)

Although it was unclear from the available evidence how this situation was managed by the nursing staff, the following example offers an insight into what one nurse thought about some of Shaun’s claims:

‘Shaun is manipulative and demanding. He is exaggerating the incident that happened with fellow patient who was sexually inappropriate towards him. He is reverting back to behaviour previously exhibited in the past, which culminated in his discharge from the ward.’

(PT3. MNN, Day 28)

Lastly, Shaun received a letter from his mother from whom he had been estranged for three years and although its content is not known, an insight into its impacts on his mental health was noted:

‘Shaun [is] tearful and distressed as mother previously said [she] wanted no contact with him. Expressed desire to drink a bottle of whisky and take an overdose.’

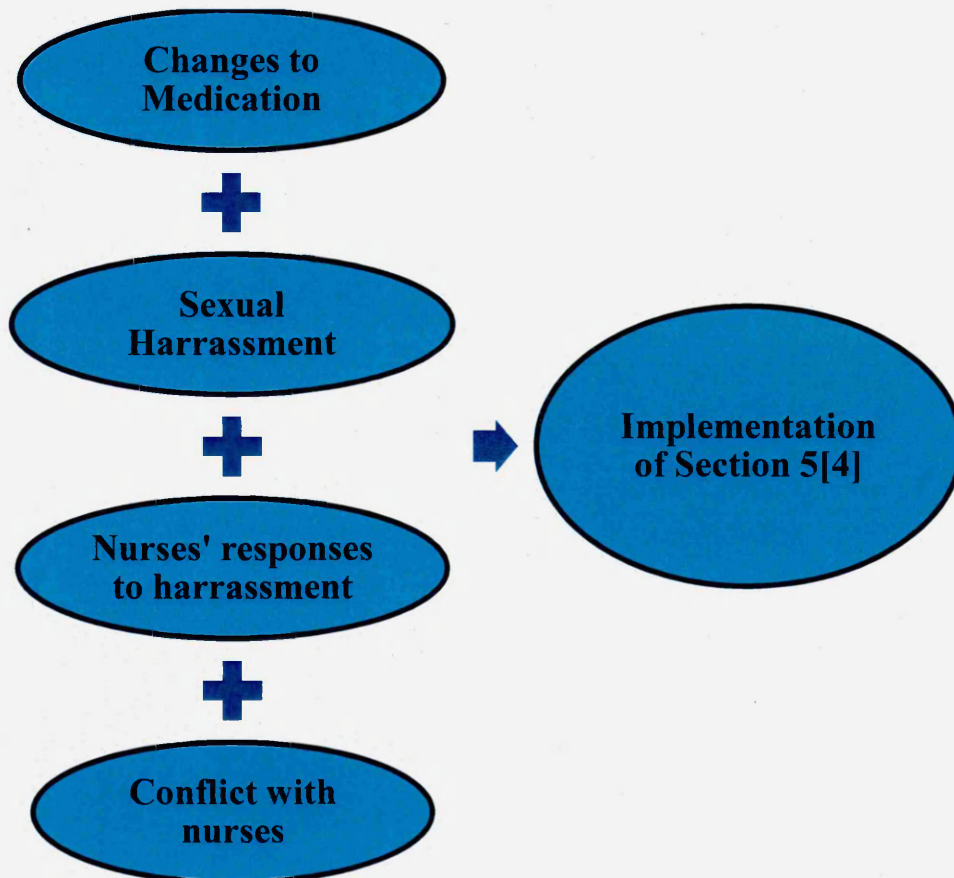
(PT3. MNN, Day 29)

‘Shaun continues to express his anger at his mother.’

(PT3. MNN, Day 30)

The proposed relationship of these events to the implementation of Section 5(4) is presented in Figure 17.

Figure 17 Summary of events leading to the implementation of Section 5(4) in Shaun’s story



One possible interpretation of the cumulative effect of these ongoing experiences is that they resulted in Shaun’s mental state on the morning of day 33 of his admission:

‘Feels unsettled’, ‘his thoughts “[are] all over the place”’, [and that he] ‘feels like “getting pissed”.’

(PT3. MNN, Day 33)

Based on his feelings, Shaun decided he would benefit from some time away from the ward and decided to go home; he returned shortly after stating that, ‘he felt unsafe’. In his haste to return to the ward he left his bag at home containing the two doses of medication given to him when he left. He asked both the nurses and doctors if he could be given more medication to replace the doses he left at home but this request was denied because it had already been dispensed. Although Shaun was given PRN medication he believed that he had been treated unfairly and this resulted in a number of arguments with the nurses. The outcome of this was that, despite the nurses’ attempts to persuade him to stay he left the ward again and went home.

Shortly after midnight (day 34) Shaun telephoned the nursing staff to inform them he intended to return to the ward. However, instead of returning Shaun telephoned the ward four hours later to say that he was in the hospital’s A&E department. The likelihood of Shaun being detained under the Act moved a step closer when he contacted the ward again to inform them that he intended to harm himself. The nurses intervened to prevent this and returned him to the ward informally, although it is unclear how this was achieved:

‘At 04.10 hours Shaun rang the ward stating he was on C floor and was about to hang himself. Nursing assistant [Name] went to look for him. Hospital security informed. Shaun was found with a ligature around his neck by nursing assistant [Name]. Shaun was escorted back to the ward accompanied by the police.’

(PT3. MNN, Day 34)

Shortly after returning to the ward Shaun was assessed and detained under Section 5(4):

‘On arriving on the ward Shaun was extremely abusive and hostile smelling strongly of alcohol, he refused to stay on the ward. Section 5(4) was implemented at 04.45 hours.’

(PT3. MNN, Day 34)

While Shaun's detention contained a number of memorable events he remembered little about his experiences:

'I can't remember much about that night at all. Well, I was near the door if I remember rightly. I mean I was quite obnoxious with them [but] I can't remember very much about it at all...so you'll have to [take] what they say. I can remember them saying, "Oh, I'm five-fouing you" [but] it's all very hazy as I say.'

(PT3. U5: 63-65. U12: 143-148. U17: 247)

Despite not being able to recall his detention clearly, Shaun believed that the nurses had made the right decision, although he makes the point that he did not agree at the time:

'I can't remember, but even though I can't remember, Mary or Maggie wouldn't say, "Do a Section 5(4)" if they didn't think it were necessary - because I know them and I've known them for some time... At the time I wasn't very happy...because I'm quite passionate about my freedom and my liberties and they've been taken away and taken away quite easily...'

(PT3. U13: 161-168. U16: 232-235)

8.4.3 Nurses have the holding power

In view of Shaun's previous comments about his detention it is perhaps not surprising that he also believed that nurses should be able to legally prevent patients leaving hospital during times of crisis. However, he also recognised that not all patients would agree with his opinion:

'I think they should be able to five-four people. I think they should be able to have some sort of holding power to stop people harming themselves and whatever. I think a five-four is a crisis thing and is only used in [a] crisis when there's no doctor or anything and so, yeah, I agree with it.'

(PT3. U3: 46-48, 53-55)

'I mean there are a lot of people [that] would disagree...but what do you do when there's not a doctor on the ward? ...I believe if the five-four were dropped..., then there'd be a lot more harm and self-harming and a lot more trouble. And if you decide, "Oh, perhaps I've made a mistake" then fair

enough. It's better to have saved somebody's life and made a mistake than not done anything at all and letting them go and self-harm or worse commit suicide.'

(PT3. U18: 263-265, 269-277)

Despite supporting the need for Section 5(4) Shaun expressed his concerns that patients were given insufficient information on the topic:

'I don't think they are because nurses can string you on and you ask several people on here what a Section 5(4) is and they wouldn't have a clue and they wouldn't believe that a nurse could hold them against their will. So no, I don't think any information or enough information is given out on sections [of the] Mental Health Act and nurses' holding power especially. You think it's only a doctor that can hold you, but it's not - it's a nurse.'

(PT3. U10: 109-116)

Shaun explained in more detail why he thought it was important to provide patients with information on the Act in general and Section 5(4) specifically:

'I think...it's about information and if we get an information leaflet and on that it could say about different sections and what they mean. Because people come in on a section and they don't know about a nurse's holding section at all. So they've already been sectioned in the community, so they come in and they think that their section is the only one - like a Section 2 usually - and they won't have a clue about five-four. Perhaps there could be a leaflet given about [the] nurse's holding power and how they go about it. So yeah, I think more information could be made available. Although if you go to a staff nurse and ask, then they'll tell you, but it's having that knowledge beforehand [knowing] what to ask and what you're asking about.'

(PT3. U11: 122-132)

Shaun recognised that being given this information may affect patients' attitudes to admission; however, he believed this would be a positive development:

Russell: 'Do you think having more information would affect service users' attitudes to admission?'

Shaun: 'It probably would, however it's better to be upfront and straight with everything than find out later on.'

(PT3. U11: 119-120)

Shaun illustrated his point by explaining what the consequence of not knowing about Section 5(4) would have had for him at the point of detention:

‘I mean if I hadn’t known about five-four, then I’d have been shocked that they could hold me and it’d have probably made a volatile situation even more flammable. Do you know what I mean? But I still think everybody has a right to know the fuller picture and not just what’s behind the scenes.’

(PT3. U11: 135-140)

Shaun was also of the opinion that nurses should be able to rescind the holding power. This opinion may have implied that he believed that if nurses were capable of deciding that a patient was experiencing a crisis that required them to remain on the ward then they were also capable of deciding when it had passed:

‘The only thing that pissed me off [was that] once they start the ball rolling, they can’t stop it... They have to get a doctor out and there’s a lot of paperwork involved. What it actually means [is] it gives you six hours to get a doctor to see you, but it could also give you time to readdress the issue [but] once you start a five-four the nurses can’t [say], “Oh, he’s okay now after an hour. Let’s stop it.” I think they should have more control over the actual section and what they do about it...than they’ve actually got...rather than let you go onto a Section 2 or 3 when perhaps it doesn’t need that. It perhaps just needs a bit of time out. For six hours or four hours or three hours you just need a bit of time out and a bit of stopping and a chance to talk.’

(PT3. U8: 92-94. U19: 279-295)

8.4.4 Aftermath one

Shaun’s initial unhappiness with his detention continued for a number of hours following the implementation of Section 5(4). This was reflected in the nurses’ comments on his behaviour:

‘Shaun was angry he had been sectioned, very confrontational and insisting he had been wronged...states that last night he had got lost in the hospital grounds and ended up “trapped” in some wire and he was sectioned for no reason whatsoever.’

(PT3. MNN, Day 34)

Shaun reported that while he was happy, on the whole, with how the nurses managed his detention he was less satisfied with his medical assessment. He offered the opinion that he was not consulted before being placed on Section 5(2) and also believed that further detention was inevitable. However, in Shaun's case this may have been due to his unwillingness to cooperate with the doctor during attempts to assess his mental state:

'Dr [Name] attended the ward and after consulting with [nursing] staff Shaun was placed on Section 5(2) of the Mental Health Act. Shaun has remained abusive, hostile and banging on doors. He has refused to speak with the medic and he ran down the corridor setting off the fire alarms.'

(PT3. MNN, Day 34)

However, Shaun did appear to recognise that perhaps he was unwilling to collaborate with the doctor:

'They got a doctor straight away. They tried their best to pacify me and sort me out, but I was having none of it. I weren't in the mood to talk. So that's not their stuff, it was mine.'

(PT3. U7: 83-85. U19: 295)

The reason given by the doctor for detaining Shaun was:

'Patient suffering from mental illness. At the moment he wants to leave the ward and his behaviour is erratic and poses high risk for himself. He tried to hang himself. He needs to stay in hospital (Safe and supervised place).'

(Form 12)

Although Shaun was placed on Section 5(2) and a first recommendation for Section 2 made, the process was not completed. This decision appears to be the result of three factors. Firstly, the senior house officer attempted to reason with Shaun by explaining to him that while there was sufficient concern about him to justify his detention there was a desire to avoid it:

‘[I told Shaun that] two doctors had examined him and from his behaviour believed him to be a danger to himself and others, but [we] are trying to work with him without [using] a section.’

(PT3. MNN, Day 34)

Secondly, Shaun appeared to respond positively to this plea. However, it is unclear whether he interpreted this as a genuine plea to work with him collaboratively or a veiled threat in which he is presented with a Hobson’s choice. That is, he could ‘decide’ to stay informally or he would be detained. Bean (1986: 5) uses the Latin phrase *coactus voluit*, that is ‘at his will although coerced’, to explain the patient’s decision in these circumstances. Shaun’s response to this is recorded verbatim and appears to reflect the dilemma he faced, namely the desire to be informal but wanting to leave the ward:

‘I won’t leave the ward if the section is revoked...I need help. I will work with you but I need to go out on my own.’

(PT3. MNN, Day 34)

Lastly, the doctor also appeared to take into account the opinion of David, the ward manager, who believed that placing Shaun on a Section 2 would be detrimental to his progress:

‘David feels that Shaun may be orchestrating the admission to seek help but at the same time wishes to control the situation. He does not feel placing Shaun under a section would facilitate working with him and may even be counterproductive.’

(PT3. MNN, Day 34)

The decision to rescind Shaun’s Section 5(2) and not convert it to a Section 2 was made conditional on the following:

‘1. Shaun to limit leave to [between] half and one hour daytime only with staff nurse. 2. Once a day MSE⁵⁶ by SHO to determine risk - If risk high >Section 2’

(PT3. MNN, Day 34)

⁵⁶ MSE is a medical abbreviation for mental state examination.

8.4.5 'Ripples on a pond'

Shaun's story also offered some insights into how detention under Section 5(4) may have an impact on the person and/or their care:

'I think the five-four didn't, but it's like ripples on a pond. It went to a Section 5(2), which I mean on reflection perhaps did have a bit of detriment for a couple of days like, or it had an effect on me whereby I lost my freedom and I had to ask when I could go out... And yeah, it did affect me, but the five-four itself didn't, but the ripples on the pond did.'

(PT3. U13: 153-157)

It is also suggested that 'the ripples on the pond' were evident in both his attitudes towards the doctors and nurses and the challenges he made to the restrictions placed upon him:

'[Shaun is] expressing disappointment regarding nursing staff in general [and] being detained under Section 5(2).'

(PT3. MNN, Day 35 and 36)

'Very hostile towards Dr [Name]... Shaun is angry at being detained. Shaun expressed being upset about being on a section.'

(PT3. MNN, Day 35 and 36)

It is also proposed that the 'ripples' from his first detention under Section 5(4) led to the second application of the holding power. Specifically, Shaun was involved in a difference of opinion with the night staff over his medication on day 37 which developed into a wider dispute with the nurses who had detained him on day 34. This dispute focused on Shaun's request to the nurses that they explained to him what had happened on day 34. When they refused his request it escalated to the point where it was considered necessary to apply Section 5(4) for a second time. The nurses' account of those events was documented as follows:

'Approached staff nurse Maggie in the office getting into argument about incident last weekend as he thinks Maggie sectioned him on five-four; told it was in his own interest as he wanted to self-harm self. Says he can't recall what happened and would like to recall events. Denied that he might have

been verbally offensive towards nursing staff. Became quite intimidating - manipulative. Expressed dislike about his treatment on the ward... Decided he wanted to leave the ward and go home. Explained that he can't do so as per Dr [Name]'s plan that he needs escorted leave limited to one hour daily. Adamant he was going on leave, packed his bag, phoned for a taxi. Doctor informed. Shaun continues to be intimidating. Stating that if he goes home he will self-harm; gassing himself. Section 5(4) implemented at 05.30 hours.'

(PT3. MNN, Day 37)

The official reason given for implementing Section 5(4) was:

'Shaun is intimidating, threatening to leave the ward and harm himself'.

(Form 13)

Shaun's story did not provide an account of how he came to be detained for a second time. However, he did offer an explanation for why he wanted to discuss his first detention with the nurses. Specifically, he was concerned that his behaviour had upset the nurses and this had subsequently affected their relationship with them. Therefore, he had been motivated to resolve these difficulties but he believed they were unwilling to talk about them:

'I've got a lot of regrets about my behaviour that got me onto the five-four and I can't take that behaviour away unfortunately, otherwise I would because it upset some of the nurses and it's the last thing I want to do. I'm in here and I want to get well and I can only do that with the nurses' help and I didn't take it... They said, "Oh, I'll never forgive you." ...I'd obviously said something and I can't remember what...and they won't tell me... [but] ...I obviously upset them that much that they wouldn't talk to me... I'm hoping [to put it right]. I'm working at it...'

(PT3. U6: 67-80. U13: 171-173. U14: 198-203)

8.4.6 Aftermath two

Following the Section 5(4) Shaun informed the doctor that he wished to leave the ward and harm himself; this resulted in him being placed on Section 5(2). The reason given for this decision was:

'Has history of psychiatric illness now wanting to leave - having repeatedly talked of ending his life since yesterday.'

(Form 12)

On this occasion Section 5(2) was not rescinded but regraded to Section 2. The reasons given by the two doctors for this decision were:

'Actively discusses suicide plans yet intent on leaving the ward. Negotiation and plans with Shaun (as an informal patient 'till Monday) have frequently broken down and elevated level of risk.'

(Form 4. Doctor 1)

'Shaun admits that on discharge or when allowed out he has impulses which he is unable to control. His intentions are to harm himself. He actively plans how this is to be carried out. He has previously put others in danger during these impulsive acts. Attempts to keep Shaun as an informal patient have not been successful.'

(Form 4. Doctor 2)

However, it appeared that the nurses did not agree with this decision or that Shaun would harm himself if he left the ward:

'It is strongly felt that Shaun is entirely responsible for his actions, and should he deliberately self-harm or commit suicide that this would be through misadventure rather than through planning.'

(PT3. MNN, Day 38)

Shaun described the consequences of his second Section 5(4):

'They did a five-four and then they did a five-two and kept me on the five-two and then they did the Section 2. So it was all due to this five-four.'

(PT3. U2: 32-35)

While Shaun complied with the restrictions of his Section 2 it was evident that he was unhappy with the situation. For example, a number of entries made by the nurses noted that he was, 'disappointment with certain responses from staff', 'wants his freedom

back', 'requesting to be allowed time off the ward', and 'threatening to "take matters into his own hands"' (PT3. MNN, Day 39). This dissatisfaction resulted in him lodging an appeal to have his Section 2 rescinded through a Mental Health Act Tribunal. He explained his actions and why he had lodged an appeal:

'[I] appealed and I'd got a solicitor on the case, I'd got a social worker on the case [because] I felt that I'd gained back all perspective of what was real and what wasn't real [when] I was out of control. [When] I asked to be regraded that [had] come back and I knew what was solid, real.'

(PT3. U15: 210-216)

However, before the Tribunal could meet it was decided at a multi-disciplinary team meeting to rescind his section. While welcoming the decision, Shaun was critical of the process leading to it. Specifically, he had concerns that he had not been informed or consulted about the decision. At the time of the interview he was still uncertain as to why he had been regraded. In addition, he believed that his experiences were not unique but common to all patients. Shaun commented that:

'Before my tribunal I got regraded but I don't know why I haven't seen the notes... The only reason I found out... [was] because the night staff told me. [You might be] seen by a doctor but after that it's not in your hands. The doctors talk about the sections, the nurses talk about the sections [but] you can't voice your opinion or concerns.'

(PT3. U14: 186-188. U16: 223-232)

8.4.7 Coda

Shaun's story ended here. He was now an informal patient again with the hopes and fears of someone who was eager to be discharged from the ward but anxious of what the future might hold.

8.5 Asif's Story: 'It's their law init? What can you do?'

8.5.1 Getting admitted

Asif was a 19-year-old man whose story began 14 months earlier when he was admitted to Longshaw ward under Section 2 of the Act. The admission was preceded by a 'two day history of strange behaviour including being withdrawn, not speaking to his family,

not sleeping, not eating or drinking' (MN). This behaviour resulted in him being given a diagnosis of a 'drug-induced psychotic illness after smoking cannabis and 'Skunk'.' This admission was relatively short as two weeks later his section was rescinded and he was discharged from hospital.

Seven months later Asif visited Pakistan where he became 'unwell and admitted to [a] psychiatric hospital there' (MN). His father visited Pakistan and returned with Asif to England. On their return Asif was taken to the A&E department where he was noted as exhibiting behaviours similar to the ones that preceded his first admission. Again, he was given a diagnosis of drug-induced psychotic illness. However, 'as the family were unwilling for admission to a psychiatric ward' (MN) he was referred to the community 'out-of-hours-team' and given a psychiatric out-patient appointment. However, he did not attend on three separate occasions.

The medical notes record that over the four months following his visit to the A&E department there was a deterioration in Asif's mental health 'characterised by over-activity, bizarre speech content, pressure of speech and [and] paranoid ideation'. At the end of this period Asif was admitted under Section 4 of the Act to Riverside Ward. On admission the Section 4 was regraded to Section 2. It is unclear what finally precipitated his admission or what, if any, emergency occurred that required an urgent admission under Section 4.⁵⁷

8.5.2 Making progress

During the first two days of admission Asif's behaviour was considered sufficiently challenging to require medication and for him to be secluded. For example, it was noted that:

'[Asif] was disinhibited and thought disordered. Increasingly threatening and kicked [Name]... Fearful of the consequences for the safety of others Asif was secluded...'

(PT4. NN, Day 2)

⁵⁷ The Code of Practice notes that, 'Application for admission for assessment under section 4 should be made only when: (a) the criteria for admission are met [for section 2]; and (b) the matter is of urgent necessity and there is not enough time to get a second medical recommendation. Section 4 should be used only in a genuine emergency, never for administrative convenience' (DH, 1999a, 6.1 & 6.2: 32).

Despite this difficult start Asif responded sufficiently well to his care by day 11 - possibly due to the reintroduction of his antipsychotic medication or the absence of non-prescription drugs - for him to be allowed to take periods of day leave from the ward. He maintained this improvement and by day 18 he began to take periods of overnight leave. On day 22 he was discharged from his Section 2 and granted a seven day period of leave. However, on day 26 Asif returned to the ward with his father who reported that he was agitated and aggressive again, and also not sleeping. A medical assessment was undertaken; however following this he was allowed to continue with his leave.

8.5.3 Returning to hospital

On day 28 the events precipitating Asif's detention under Section 5(4) were recorded as follows:

'20.01 hours. Phone call received from [father] who reported that Asif was talking to himself etc. [Father] said he would try to get Asif to return.'

'20.26 hours. Phone call received from [father] saying that Asif was refusing to return to the ward. Notified [father] that he would have to notify the police if he was still refusing to come back to the hospital.'

'20.47 hours. Asif returned to the ward quite angry. Asif was very hostile and threatening, attempting to 'square up' to staff. Immediately walked into dining room shouting "white bastards" at fellow patients. Was very hostile with his father calling him abusive names. Slapped father in the face at which point staff intervened. Asif then became extremely aggressive and swung 3-4 punches at [Name of nurse], none of which connected. Asif was then restrained and formally secluded. Accepted 5mgs Haloperidol [and] 2mgs of Lorazepam when he initially arrived on the ward.'

(PT4. NN, Day 28)

Asif's own story of his time in hospital was - at least at times - a partial and confused tale, however it did provide an account of a patient's experience of mental health problems and subsequent detention. He started by explaining the events leading to his admission:

‘I’m not really sure [what but] I think something happened to me. I just went really crazy...I drank a bit of alcohol and...I stayed awake for one full day. I think it was because of me staying awake all day on top of the whisky I drank... After that something happened to me and the world seemed a bit different for me...the world went a bit differently for me.’

(PT4. U1: 4-17)

Although Asif could not offer a detailed account of his actions he did seem to recognise that his behaviour was different in some way. He also recognised that his father was acting in his best interests although he did not want to return to the ward. Asif also provided an insight into his journey from home to hospital:

‘My dad brought me here because I was just going crazy at home. I didn’t sleep for a couple of days and I started messing about. Just going crazy, breaking things and all that... My dad brought me here because I’ve been here before...’

(PT4. U2: 20-25)

‘He brought me in the car and I just closed my eyes and the next thing I know my dad’s bringing me here. Obviously he did it because it’s good for me isn’t? Because I was going too crazy at home; shouting at my dad, so out of control.’

(PT4. U2: 46-50)

8.5.4 The road to detention

Asif was able to recall some of the events that ultimately led to his detention under Section 5(4). In doing so he offered an insight into his experiences of his mental health problems and behaviour at the time of his return to the ward. The consequences of these behaviours were that he was restrained and secluded⁵⁸ for almost five hours. Our conversation identified some of these experiences:

Russell: ‘Right, so can you remember what happened once you got onto the ward?’

⁵⁸ ‘Seclusion is the supervised confinement of a patient in a room, which may be locked to protect others from significant harm. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others’ (Code of Practice, 1999, 19.16: 96).

Asif: 'Er, yeah. I came in and I started fighting. This nurse...I started hitting him. I don't know why I was doing it and they did this to my hands.⁵⁹ And the next thing I know they're putting me into this room. Then I'm in that room for a couple of hours [and] I could see these kinda snake things or something. It's illusions init? I'm having illusions, see illusions. Yeah, the last time I came in it happened as well. Yeah, there was something really solid becoming a snake and little people coming out. It's all illusions I know because of the skunk. This time when I came I couldn't sleep. I didn't sleep all days because of that.'

(PT4. U3: 53-70. U5: 109-113)

Although the nurses may have believed that they had no other alternative but to implement seclusion, Asif's insights into his experiences of this procedure are worthy of note:

'This nurse put me into the room. Nasty! It was bad that...because you're in one room by yourself with no one to talk to. It's really bad; I don't think they should do that. Either they should lock me in my own room, that's okay so I can listen to some music, be by myself. But I was seeing things in there. Too many illusions...I couldn't get away from the snakes and pygmies.'

(PT4. U9: 180-188)

8.5.5 Getting detained

Asif remained secluded but he was informal for another three hours. However, the final stage of the process leading to the implementation of Section 5(4) began one hour after Asif's seclusion when Rory - one of the nurses - commenced his night shift. Having been apprised of Asif's situation, Rory was of the opinion that a patient could not be secluded unless they were formally detained. Although this opinion is incorrect the Code of Practice does states that:

'Seclusion of an informal patient should be taken as an indication of the need to consider formal detention.'

(Code of Practice 1999, 19.16: 96)

⁵⁹ Consistent with a restraint technique, Asif demonstrated his wrist joint being bent inwards.

Based on his belief Rory contacted the on-call doctor to discuss his concerns about Asif's situation and to obtain a Mental Health Act assessment. However, as the on-call doctor did not have the authority to detain Asif he suggested that Rory might want to implement Section 5(4). Based on his telephone conversation with the doctor Rory commented that:

'After I talked to the SHO I decided I'd five-four him in order to ensure that the SpR attended the ward to assess Asif. I'd not personally assessed him but based on the fact he was informal, secluded and from the information I'd received at handover I thought it was best for the patient.'

Field Notes⁶⁰

The official reason given by Rory for implementing Section 5(4) was:

'Arif had been secluded and it was apparent that continuous seclusion was indicated.'

LIF

Rory implemented Section 5(4) at 23.10 hours but he did not enter the seclusion room for another 30 minutes to inform Asif of his decision. Following this Rory recorded that he had:

'Explained to Asif that I had detained him under Section 5(4). He was unresponsive to this.'

(PT4. Seclusion Record, Sheet 2)

Asif's period of seclusion was terminated 35 minutes later and he was allowed back out onto the ward, although he was then nursed on Level 1 observation⁶¹ for another seven days. Asif's memories of his detention and its aftermath were incomplete but he was able to offer some insights into his experience. When asked if he recalled his detention he replied that:

⁶⁰ Rory refused to allow an audiotape recording to be made of the interview and therefore notes were made instead including verbatim quotes where possible.

⁶¹ In the Trust Level 1 observation requires a nurse to be within arm's reach of the patient at all times.

‘I think so. I’m not really sure... Umm, that was when I got out of that room, the room where they locked me in. I don’t know. I felt a bit calmed down and...I can’t really remember you know... Yeah; they gave me this paper saying under this Act you can’t leave...’

(PT4. U5: 93, 96-99, 103-105, 116-117)

Although he made no physical attempts to leave the ward he did recall making a request to do so:

‘I didn’t try getting out... I was telling them I wanted to go home because I [felt] better... I told them I’ll go home and I’d feel much better there. Yeah, I was telling my dad to tell the nurse I wanted to go home but they gave me this piece of paper [and] this nurse came and he told me, “You can’t go home because you’re under the mental act.”’

(PT4. U6: 122-126, 130, 133-135, 138-140)

Asif was also able to recall his thoughts and feelings about being detained:

‘It’s got to be wrong init. I felt like going home...I really wanted to go home. I just wanted to go home, but they wouldn’t let me go. Really sad init?’

(PT4. U7: 142-144, 148-149)

Prior to his detention, Asif had no knowledge of the fact that as an informal patient he could be prevented from leaving hospital. Had he been made aware of this he would not have agreed to his admission:

Russell: ‘Did you know about the law before you came in?’

Asif: ‘No I didn’t know about the law, no.... If I did I wouldn’t have come here. I’d have told my dad I didn’t want to come.’

(PT4. U12: 248-249, 252-253)

More specifically, he had no knowledge of Section 5(4):

Russell: 'Did you know that nurses could stop you going?'

Asif: 'No, I didn't know about that. No I thought I probably [could] go home you know.'

(PT4. U7: 150-151. U12: 252)

Although he had little opinion to offer on the topic, Asif did acknowledge the legislation and believed that he must comply with it, albeit reluctantly:

Russell: 'So, what did you think about [nurses] being able to stop you leaving?'

Asif: 'There's nothing to think about is there? I don't know nothing about this you know. I'm not a lawyer, you know what I mean? What can you say? ...It's the law init? You can't go breaking the laws can you? It's their law, what can you do? You know what I mean?'

(PT4. U7: 156. U12: 244, 247, 254-258)

8.5.6 Consequences

Although he did not believe so at the time, Asif acknowledged that the decision to detain him was the correct one. Asif also offered an insight into the inner turmoil he experienced during the events leading up to his detention:

'Maybe now I think it is better for myself init? I didn't think that I was [at] risk. At that moment I was thinking they should leave me, let me decide. Let me do what I wanted to do. Just let me get out at that moment. Let me chill out. You know, I'd have chilled myself out. [But] I couldn't control myself that's the thing. I couldn't control myself. Yer know what I mean? I couldn't do nothing. I couldn't control myself at that moment.'

(PT4. U10: 191-196, 218-221)

Following his detention Asif's behaviour was described as aggressive and confrontational (day 29). He was subsequently assessed by the SpR and regraded to Section 5(2) based on the belief that:

'He has a psychotic illness and lacks insight into his condition. His behaviour has been disturbed and he has voiced the intention of leaving the ward which would expose him to potential harm.'

Later on day 29 the doctor's holding power was converted to Section 2. The reasons given for this decision were:

'Mr [Name] presents with aggressive behaviour towards staff and family, and a reoccurrence of psychotic symptoms that appears to be secondary to substance misuse and poor compliance with medication. His insight is poor and does not appear willing to stay in hospital.'

Doctor 1 (Form 14)

'He appeared to be hallucinating and talking to himself, mumbling, his demeanour appears to be aggressive, agitated. He appears distracted and seemed to have no insight about his condition. He has shown aggressive behaviour towards staff and parents and seems unwilling to stay in hospital.'

Doctor 2 (Form 14)

Asif's deterioration was attributed to missing a 'few doses of Olanzapine' (MN, Day29) while on leave and having used cannabis and/or alcohol while out. However, Asif made good progress following his detention. Once again this was attributed to the reintroduction of his medication and the lack of opportunity to use cannabis and alcohol. Asif's rapid progress meant that by day 33 he was allowed to take 'day leave' and by day 35 he was granted overnight leave. Asif, while aware which section of the Act he was on and for how long, believed that he had recovered sufficiently to be allowed to go home:

Russell: 'So are you happy about being in hospital at the moment?'

Asif: 'Umm not really, no I want to go home. ...I feel safer at home... I'm on Section 2. It was Section 2 as well last time...I've calmed down now. I feel rested now. They said I'd be here like four weeks. I've been here four weeks before as well you know and it went alright. I think this time should be alright as well. Now I feel better, much better than before.'

(PT4. U8: 167-169. U11: 225-228. U13: 273-270)

8.5.7 Coda

Two weeks after his detention Asif was still detained and although his mental health was perceived by the multi-disciplinary team to have improved significantly, there were no plans to discharge him or to rescind his Section 2. However, on the day of the interview Asif had been granted Section 17⁶² leave and was packing to go home for the night. Asif concluded his story by offer a summary of his experiences:

‘I can’t really explain anymore. All I know is that when I came here I [hadn’t] slept for two days, I was really mashed...and [the] first thing I did was just hit that guy. After that it was in that room, after that I can’t really remember. I’ve been sleeping a lot these few days. I’ve been sleeping, sleeping and eating. That’s my life here...I just hang about on the ward.’

(PT4. U14: 291-298, 303)

8.6 Conclusion

This chapter has presented the stories of Mark, Carl, Shaun and Asif. The four stories do not produce full accounts of the implementation of Section 5(4); nevertheless they do provide insights into a previously undocumented phenomenon from the patient’s perspective. Participants’ inability to give a full account of their detention reflects the fact that they found it difficult to recall all aspects of what had happened to them. This was attributed to the mental health problems they were experiencing at the time of their detention; as Asif commented, ‘I don’t remember, I was mashed.’

A second issue common to all four stories was a lack of awareness surrounding mental health legislation. Asif and Mark seemed to have no knowledge - at the time of their admission and detention - of the Act in general and Section 5(4) in particular. In Asif’s case this would have had an impact on his decision to be admitted to hospital. For Mark, his confusion about his legal status led him to believe that he had no choice but to take the medication offered to him; something he did not want to do. Similarly, Carl believed that as an informal patient he could leave the ward and/or discharge himself whenever he wanted to. He was unaware that this was dependent on the outcome of ongoing risk assessments undertaken by nursing and medical staff. Shaun believed that

⁶² Section 17 allows patients detained under Part II of the Act, for example Section 2, to be granted permission to take leave from the hospital by their RMO.

there was a need for patients to be provided with more information on the Act so that they could make an informed decision about admission and their subsequent treatment.

The events surrounding the implementation of Section 5(4) generated powerful emotional experiences for the patients. In some cases these emotional experiences were short-lived and confined to the period before, during and immediately after the implementation of Section 5(4); however in other cases they were more long lasting. For example, Carl's emotional experience of being detained was still powerful at the time of the interview and he argued that his opinion of nurses had been permanently changed for the worse. This may suggest the need for greater attention being given to addressing the emotions generated by the use of Section 5(4). Any interventions should aim to ensure that patients maintain a positive relationship with healthcare professionals; therefore reducing any negative impact on their medical and life recovery.

Finally, there was a sense that the patients felt that any decisions made about their legal status was not a collaborative process. In addition, they felt that any decisions made about them were either communicated poorly or not at all. This was seen as making an already difficult time more difficult. The patients, for example Carl and Mark, wanted more involvement in the decisions that had the potential to significantly impact on their lives. Furthermore, they also sought greater clarity around a number of issues relating to their care, for example an agreement between nursing and medical staff as to what constituted risk. It is suggested that it is important to take these and other issues contained within the stories seriously as they have the potential to detract from the patient's recovery. If they are not addressed there is a danger that this may lead to further periods of detention and therefore disruption to their lives.

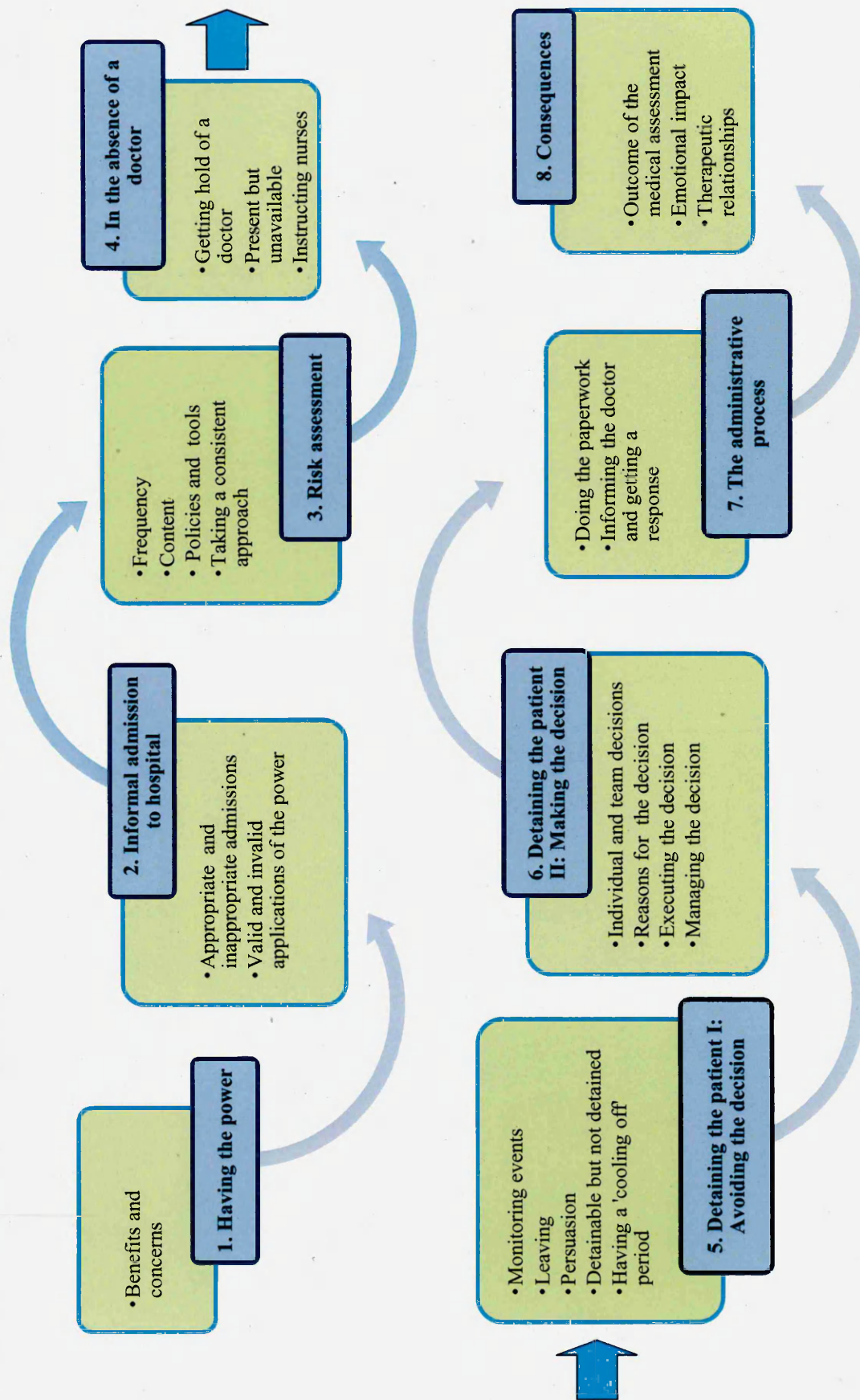
Chapter 9

A collective story of implementing Section 5(4)

9.1 Introduction

This chapter - developed from Stage 9 of the analysis (section 5.4.9) - presents the collective story of why and how Section 5(4) was implemented. The rationale for developing a collective story was in acknowledgement that the construction of the typology presented in Chapter 7 had not exhausted the data generated from the nurses' stories. Nor had it fully articulated the processes involved in the implementation of Section 5(4). Therefore, the collective story further illuminates the key elements associated with the application of Section 5(4). It is presented as a linear process, starting with the patient's admission to hospital and concluding with the consequences of the decision (Figure 18). However, the process of detention as told in the individual stories did not always follow the clearly defined sequence of events illustrated in Figure 18. In reality, some elements of the process occurred concurrently or in a slightly different sequence. However, the process of implementing Section 5(4) presented in this chapter is the one that best represents the majority of the stories.

Figure 18 Summary of the process of implementing Section 5(4) outlined in the collective story



9.2 Having the power

Nurses were generally in agreement that they should have a holding power. They believed it was an important tool in their repertoire for managing difficult clinical situations in the absence of a doctor:

'I do because there are times when doctors aren't around and...you don't want someone to leave hospital.'

Karen (S2T17. U22: 267-268)

'We have a lot of people come in voluntary but that can change very rapidly for lots of reasons and I think for their own protection, safety and sometimes other people's, then we need to be able act quickly to keep hold of people if we think there's a high risk.'

Ben (S2T14. U1: 36-38)

'I think it is an important part of working on an open ward.'

Stephen (S2T5. U30: 301-302)

Furthermore, Malc reinforced the need for what he described as the 'nurses' pulling power' by offering an insight into the problems faced by nurses before the introduction of Section 5(4):

'Prior to the '83 Act...I remember there were lots of instances where you were actually detaining a patient against their will, but with no legal backing and no respect for their rights and where they didn't have the benefit of a multi-disciplinary decision-making process. It was just left to the nurses to stop somebody leaving, so sometimes it'd happen at a weekend you'd end up sitting on some poor bugger, holding them under common law and sometimes [doctors came] and sometimes they didn't... It could be a couple of hours before somebody turned up [or] it could be a couple of days. I see the Act as trying to redress the iniquities of what was going on then. It's called nurses' holding power... It's actually a nurse's pulling power. A nurse can say to a doctor, "You will be here within this space of time and don't fanny around." ...A nurse can say, "We will have a multi-disciplinary review within this period of time and we'll resolve this issue and see whether it's a treatment issue or they can be discharged.'"

Malc (S1T1. U1: 10-17, 22-27)

However, not all nurses believed that there was a need for Section 5(4):

‘I can’t say I like the nurses’ holding power... But I think with litigation and a lot of things that are going off now that people aren’t prepared to take that risk [and feel they have to use it]. I can’t see a lot of benefit from it. I can’t really. All I can see is a load of paper work... I know that sounds a bit of an excuse...for not putting a section on, but it’s not really. It’s not. I can’t see the benefits. I think if we just use our nursing skills we can persuade people to stay.’

Maggie (S2T20. U1: 3, 9-10. U4: 63-66)

9.2.1 Benefits and concerns

Nurses believed that using Section 5(4) had benefits for both nurses and patients.

Typically, nurses commented that:

‘[It] gives us the power to keep people here legally... It’s a protection for them because they get assessed very quickly by a senior medic...within six hours.’

Ben (S2T14. U1: 24-31)

‘It keeps somebody on the ward legally without...leaving you open for any sort of litigation or criminal charges of wrongful imprisonment or anything like that.’

Joe (T15. U32: 490-502)

Furthermore, it was also proposed that its use: offered a ‘breathing space’; instilled a sense of security; and provided nurses with reassurance and justification for their actions:

‘Sometimes I think we implement a five-four [because]...it provides us with a sense of reassurance... I think sometimes we unconsciously extend its scope. We might implement a five-four not to prevent someone from leaving, but to justify our use of seclusion. We feel safer secluding a sectioned patient than we do an informal patient... I’d say we just feel safer under the umbrella of the Mental Health Act... Sometimes it’s a breathing space...’

Stuart (S1T2. U1: 18-19, 30-36)

'We had to eventually restrain this person and seclude them and we couldn't do that without five-fouring him basically... Well, it's the legal. We couldn't just incarcerate somebody against their will...'

Lee (S2T23. U1: 32-33)

Nurses also expressed concerns about having to prevent a patient from leaving:

'You're taking away somebody's freedom. If they're trying to leave the ward, then they probably don't want to be there, so to have members of staff stop you doing that on a ward which is a public place, I think at that moment at that time it's not a pleasant experience and it's not pleasant for the staff either. So although it's necessary, it's not a nice thing.'

Jackie (S2T16. U7: 126-131)

'The bad side of it would be the fact that you're taking someone's liberty away from them or you could be acting in an un-therapeutic manner. Someone, say who has a personality disorder, may need to take responsibility or manage their suicidal impulses in a different way, in a specific therapeutic way - then it's often negative for them to have their responsibility taken away.'

Alan (S2T2. U28: 463-469)

'It's a really stressful and unpleasant business because...[you're wondering] whether you're going to get hurt implementing it, whether you're having to restrain somebody, whether the person needs medication or seclusion. You know, that side of it's very difficult and unpleasant and I don't look forward to that...'

Alan (S2T2. U27: 443-445, 449-454)

Another nurse suggested that the use of Section 5(4) had the potential to stigmatise the patient:

'The Mental Health Act - including Section 5(4) - is stigmatising as everyone knows who has been sectioned. It is quite a taboo really, for society in general really. It's seen in newspapers, psychotic patient's been detained in hospital or sectioned or whatever.'

Stephen (S2T5. U27: 259-265)

However, Malc rejected the disadvantages associated with the use of Section 5(4):

'I view the Mental Health Act as a protective measure for the patients [but] you still get lots of mental health professionals - doctors - who see it as a sinister, oppressive thing. So you get lots of them who are unwilling to employ the Mental Health Act for that reason and I think it's completely erroneous. People talk about the stigma of being sectioned and I think it is nonsense. You know, what's stigmatising about making sure that someone's rights are respected? "Oh, it's an awful thing. Why did you section me?" "I've got to make sure that your rights are respected. I'm going to make sure that you're going to have regular reviews. I'm going to make sure that there'll be an independent party who will conduct these reviews." What's stigmatising about that?'

Malc (S1T1. U11: 376-378, 387-392)

9.3 Informal admission to hospital

Section 131 of the Act (DH, 1983) allows anyone to be admitted to hospital that 'requires treatment for mental disorder'. Furthermore, the Code of Practice (DH, 1999a, 2.7: 10) suggests that if 'the patient is willing to be admitted informally this should in general be arranged.' This suggests that the person is not only willing to come into hospital but also has the capacity to consent to their admission. However, an inability to consent to admission does not necessarily prevent an informal admission; the Code of Practice (DH, 1999a, 2.8: 10) states that:

'If at the time of admission, the patient is mentally incapable of consent, but does not object to entering hospital and receiving care or treatment, admission should be informal.'

In this study there were examples of patients who made the decision to be admitted to hospital and had the capacity to do so:

'I think two nurses came up to see me and...I just broke down and started crying and they suggested I came into hospital. I wasn't sleeping or eating properly... I didn't want to come into hospital. I wasn't sure what it would be like...but I needed to come in.'

Carl (PT2. U1: 39-48)

However, this was not the case for all patients admitted informally. For example, Andy's A&E medical notes suggested that he lacked the capacity to consent to his admission:

'Discussed with SpR re. MHA - If not actively resisting OK to come in informally. If tries to leave or refusing to go to [the] ward needs MHA assessment.'

Anna certainly believed that Andy's mental state compromised his capacity to consent to his admission:

'He was very chaotic in behaviour. He was extremely thought disordered. He couldn't stand up properly, he was falling over and he couldn't string a sentence together basically. Quite confused at times... He didn't know where he was [or] the reasons why he needed to be in hospital.'

Anna (S2T1. U1: 27-33. U2: 51-52)

Although Andy's informal admission appeared to comply with the guidelines offered by the Code of Practice (DH, 1999a), Anna and her colleagues did not believe it was appropriate:

'For some reason he was brought in informally...we didn't believe as a nursing team that he was capable of giving informed consent and being in hospital on a voluntary basis. We all felt that it was inappropriate for him to be here without him being able to give informed consent.'

Anna (S2T1. U4: 76-78)

Anna's tale was not unique as other nurses told similar stories and also believed this type of admission to be inappropriate. For example:

'[She] apparently had volunteered to come in. How I'm not entirely sure because she didn't seem to have the capacity, to be quite frank.'

Lee (S2T23. U3: 63-64)

Nurses believed that when a patient who appeared to lack the capacity to consent was admitted to hospital it increased the likelihood that they would have to deploy Section 5(4). This seems to be supported by the fact that 48.6% of patients were detained in the first four days of admission (section 6.3.4). Stuart commented on his own experience of this phenomenon:

'I've certainly come across instances where you feel that the admitting teams...have used whatever means they felt necessary to get [somebody] actually through the doors and then leave it in our laps - and five-fours are implemented.'

Stuart (S1T2. U5: 160-165)

Nurses attributed their need to implement Section 5(4) to the circumstances surrounding the patient's admission. They believed they were more likely to have to use Section 5(4) if the patient had been coerced, cajoled or misled into coming into hospital:

'It's a bit of a Hobson's choice I think for some people. I get that impression when they come in informally [they know] if they don't, then they won't be informal! *[laughs]*. It's a bit of a mockery really. It's terrible! It's terrible! It's awful! It's no choice really, is it?'

Lee (S2T23. U17: 719-723)

'Sometimes people come into hospital and...they don't want to be here...but they're brought in by the care co-ordinators or whatever and it looks like this person's been cajoled...into hospital and a couple of hours later you find nurses having to five-four them because they're wanting to leave or [because they] never wanted to be here in the first place...an assessment under the Mental Health Act before they [were admitted] would [have been] more appropriate than cajoling somebody into hospital. I think that's an inappropriate use of Section 5(4).'

Carol (S1T3. U1: 72-79)

While not necessarily agreeing with mental health professions, for example doctors, social workers and care co-ordinators, nurses did understand their motivation for admitting patients in this way:

'I think often it's [done] for the best of intentions, but I think it's a symptom of woolly-minded thinking. You know, they don't want to frighten people so they con them in and then once they're here the person who's tried to get them in isn't party to the uproar of what's gone next.'

Malc (S1T1. U5: 150-154)

'I mean, it's always the best to try and get somebody to come in voluntary. I understand it from their point of view.'

Sharon (S2T8. U26: 273-276)

'I think she should have been brought in on a section - but when people say they're willing to come informally then that's what happens.'

Rick (T10. U3: 23-24)

Nurses explained how such admissions led to them having to detain the patient:

'And when they get here they realise what it is and they start rebelling - quite reasonably so - [and saying]..."I'm leaving! I'm going home!" But then we've had all this information that, "...this person's deteriorated and they're frankly psychotic, they're at risk to themselves, they're a risk to others" and then we've no option then but to employ five-four - I mean especially out-of-hours.'

Malc (S1T1. U4: 140-141. U5: 156-157)

'So when they come to the ward and say, "How long am I going to be here?" we try to be honest with people [and say], "Well, you know, average stay is at least a few weeks and to be honest we think you're going to be in at least for this week." Then [they say], "Oh, that's not what I were told. I was told it would be a couple of days." So they want to go home and then we're faced with a situation and the risks involved of making a decision that it's in their best interests for us to detain them and we might [have to]... use the nurse's holding power straight away [because] the medic's not always immediately available. And it's frustrating you know. Please be honest with people, which is what you want to do with everyone, be honest and up front about things.'

Ben (S2T14. U3: 94-95, 108-115)

9.3.1 Valid and invalid applications of the power

Therefore nurses distinguished between valid and invalid applications of Section 5(4). A *valid* application of Section 5(4) occurred when a person had made an informed decision to be admitted to hospital and then their mental health had deteriorated afterwards requiring the nurse to prevent them leaving. An invalid application of Section 5(4) was seen as resulting from some individuals - doctors, social workers - not fulfilling their professional roles. In these cases the nurses believed that an informal patient should have been admitted formally:

‘Well, there’s a valid use of five-four when it’s a genuine need [when] there has been this deterioration which couldn’t reasonably be predicted. You know, something has happened post admission; something [like] a row with their family which has increased their stress. Then there’s the invalid use of five-four...where nurses are being taken advantage of because other professionals haven’t done their job... It’s actually abuse of the in-patient nursing staff as well as abuse of the patient.’

Malc (S1T1. U: 355-360)

9.4 Risk and risk assessment

Nurses discussed a number of issues relating to the risk assessment of patients and their relevance to Section 5(4).

9.4.1 Determining the frequency of risk assessment

The decision to implement Section 5(4) was, in part, determined by the risk assessments undertaken by both nurses and other professionals beginning before admission and continuing throughout the patient’s stay on the ward (Figure 18). The initial risk assessment undertaken by nurses during the admission process was used to identify any concerns they had about the patient’s health or safety or the protection of others. The outcome of this assessment determined the frequency with which any subsequent risk assessments were undertaken:

‘They have a risk assessment when they’re first admitted. Then the decision is made as to whether we continue with regular risk assessment. We either have shift or daily risk assessments or roughly weekly assessments because for every ward round we have to fill in a green sheet about how the person’s been over the past week.’

Richard (S2T3. U15: 449-455)

‘When a patient first comes in and risks are more apparent in terms of their harm to self or to others or vulnerability we tend to put them on a daily risk assessment for the first 72 hours which means that throughout that 24-hour period somebody really goes and sits down with them and does a formal risk assessment looking at the different areas that have been highlighted as risks and then assess them on that and then just write that up...and then we review it.’

Joy (S2T22. U15: 238-244)

The nurses made the point that although patients may not have been assigned to a formal level (shift, daily or weekly) they did receive regular risk assessments. They explained that ongoing assessments were undertaken during all of their interactions with patients which were then recorded on the daily record sheet:

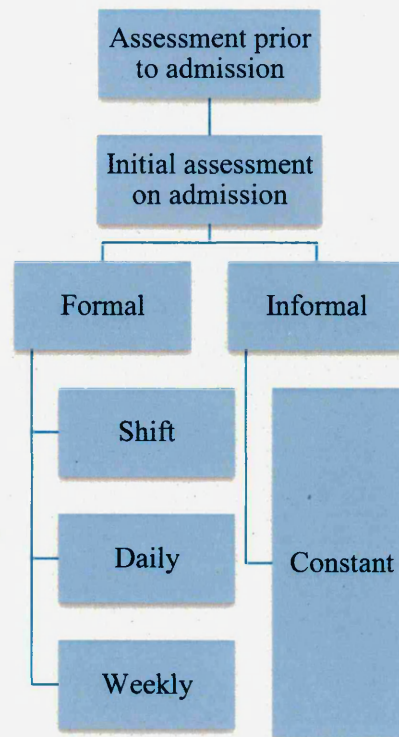
‘There are assessments going on every day...and 24 hours a day... It’s just what happens on a psychiatric ward really.’

Joe (S2T15. U31: 485-487)

‘Well, you’re risk assessing every time you speak to people on the corridors. It’s just part of the job and part of what you do as soon as you walk in through that door [and it’s documented] every shift. Yeah, every shift that person’s looked at; [their] care plan and the risk assessment [is looked at] to see whether there are any changes in that person’s presentation or not.’

Joy (S2T22. U15: 228-230, 232-234)

Figure 19 Summary of the risk assessment process



9.4.2 Doing the assessment

The documentation used in the Trust to structure and record the risk assessment consisted of a single sheet of A4 paper divided into four broad areas, comprising:

- Harm to self;
- Harm to others;
- Environmental; and
- Exploitation/Vulnerability.

Therefore when asked what factors they would consider in making their decision to implement Section 5(4) it was perhaps not surprising that nurses referred to these four areas:

‘Right, risk to self or others. Are they likely to harm themselves seriously? Are they likely to harm others? Environmental risk in that are they going to go out into Derbyshire, for example, in the middle of winter? And then there’s risk of exploitation and vulnerability...’

Richard (S2T3. U15: 420-424)

‘Well, we’ve got the admission standard risk assessment forms, and they cover four areas; risk to self, risk to others, environmental and vulnerability.’

Alan (S2T2. U18: 372-374)

Although there appeared to be some shared understanding about how these four areas should be interpreted, on the whole nurses were not consistent in what factors they explored during their risk assessment of the patient. Typical in this regard were Anna and Rick:

‘All different kinds of things really; risk of self harm, thoughts of suicide, harm to others, thought disorder, responding to command hallucinations..., deterioration of physical health..., [for example] people [who are] insulin dependent diabetic [but] don’t believe they need it, risk of absconding...’

Anna (S2T1. U14: 339-346, 357-361, 364-366)

‘The usual risk assessment really. Recent history, information from the family, information from the community team, [and] what the person’s saying. What are the triggers? What have they done in the past? What they’re saying now. Have they said it before? That’s the risk to themselves and others. A normal risk assessment. It’s not definitive, but it’d certainly make my decision for me.’

Rick (S2T10. U27: 267-274)

Nurses recognised these differences and offered some explanations for why they occurred. For example, Alan commented that:

‘It’ll be individualistic definitely... I think everyone’s got a style of their own and there’s no set assessment procedure... I’m sure everyone’s got their ideas from whatever they’ve read or learnt or whatever but I wouldn’t know if anyone’s particularly using a standard technique... I’ve discussed it with a colleague and we both [agreed] that we didn’t really have any prior knowledge [of] risk assessment...from our nurse training or from being qualified and that we were having to pursue our own methods of finding a technique.’

Alan (S2T2. U20: 382. U21:396-397. U22: 402-405. U23: 413-417)

9.4.3 Policies, procedures and risk assessment tools

Nurses believed that the Trust offered guidance on risk assessment but were unaware of its content or where it could be found:

Russell: 'Does the ward or Trust have policies on risk assessment?'

Richard: 'Yes, I think they do, but don't ask me what [or where] they are... Yeah. I would imagine - and you can quote me on this, but don't mention my name - the policy would be, "Don't put the Trust at any risk of being sued basically."'"

Richard (S2T3. U15: 507-516)

A number of standardised tools, for example Beck's depression,⁶³ suicide ideation⁶⁴ and hopelessness⁶⁵ scales and the Krawiecka, Goldberg and Vaughan (KGV)⁶⁶ scale, were identified and used occasionally when nurses considered them relevant. However, risk assessment tools were not part of any systematic risk assessment strategy deployed throughout the Trust. Most nurses cited the SOAPE⁶⁷ model as a general method for structuring their general assessment of the patient. However, there was less consistency when it came to undertaking the assessment of risk:

'We have got risk assessment guidelines that are kept in [the] nursing notes [but]...we don't follow them and we don't really follow any standard assessments. We don't actually have any formal training on risk assessment. I know I mentioned it in my appraisal the other day with my

⁶³ The Beck Depression Scale (BDS) is a 21-item self-report inventory measuring the presence and level of depression in a person (Beck et al., 1961).

⁶⁴ The Beck Suicide Ideation (BSI) scale is a 21-item self-report inventory assessing and quantifying suicidal ideation (Beck et al., 1979; Beck et al., 1988).

⁶⁵ The Beck Hopelessness Scale (BHS) is a 20-item self-report inventory designed to measure three aspects of hopelessness: feelings about the future, loss of motivation, and expectations (Beck et al., 1974).

⁶⁶ The KGV (Krawiecka et al., 1977) is a comprehensive psychiatric assessment tool that measures the presence, intensity, frequency and duration of a range of psychiatric symptoms and disorders, for example, anxiety, depression, hallucinations and delusions.

⁶⁷ The SOAPE model was first described in the UK by Desmond Cormack (1980). Based on the work of Weed (1971) in the USA, this model consists of five stages. Subjective (S) information is provided by the patient which is paired with objective information by the nurse undertaking the assessment (O). From this information (S and O) an assessment (A) is made of the patient's needs. From the assessment a plan is made to meet the identified needs (P). Finally, the plan is evaluated following the nurse's interventions (E).

manager and said that's something that I would really be interested in doing.'

Sharon (S2T18. U18: 199-201)

'No, not really. I think we've all got a fair idea of risk assessment, but no, there's never been a tool...that any one person uses.'

Ben (S2T15. U15: 588-590)

Nurses did recognise the need for a greater shared understanding of risk assessment in order to overcome some of the problems they associated with their current approach:

'There definitely should be a set of risk assessment tool used or at least ones that you're taught that you could say this is evidence based. But there doesn't seem to be. There seems to be a lot of bits of empirically based stuff and then just bits of old wives' tales. If so-and-so says the patient is suicidal then how do you know that? You know, what's your basis for saying that? "Well, so-and-so told me and they know what we're on about." Well, they might know what we're on about, but could this be the one occasion where we were talking bullshit?'

Simon (S2T18. U21: 304-312)

Some nurses attributed this problem to a lack of education on risk assessment during their pre-registration nursing courses, resulting in a need to develop their own working model, for example:

'This is a problem that we had when I first qualified you see because as a student we were never ever trained to use any tools or how to risk assess people as such. You sort of learnt and picked [it] up from what other people were saying and sort of [developed] your own style of risk assessing people.'

Joy (S2T22. U16: 246-250)

Still others questioned the relevance of formal tools. One reason for this was that the tools were perceived as impractical due to the frequency with which they were required to undertake the risk assessment process:

'We're asked to risk assess at the drop of a hat really and so they're not used...when we risk assess somebody. We're supposed to risk assess

somebody when they come back from leave, before they go for leave, you know, any changes in plan or treatment should be risk assessed really. So if you're going to do that, you're doing that possibly two or three times a day. So you're not going to want to put a depression scale in front of somebody three times a day. It's not useful in that way. Personally I think that a skilled nurse can do that without an assessment tool essentially. I mean if you're working on a ward...risk assessment should be continuous and ongoing and if you risk assess somebody on a daily risk assessment that morning and they give you all the right answers and then by the afternoon they're running around with a knife or a pair of scissors and they're crying their eyes out you don't need a tool to tell you they're at risk do you?"

David (S2T13. U16: 436-443, 447-454)

9.4.4 Taking a consistent approach

Nurses also acknowledged that there was a lack of a shared approach to undertaking risk assessment prior to implementing Section 5(4). However, this was not necessarily seen as a problem as they believed they could overcome these difficulties. They described some strategies for achieving this:

'Well, it's not going to be the same. That's why we work as a team. If somebody's worried about something you will say, "Hey, what do you think to this?"'

Joe (S2T15. U26 420-425)

'If I carry out a risk assessment, I'll probably ask a colleague of mine to do a similar thing and then we compare notes or if we 'handover' a shift and...I'll say, "I've spent so many hours with this person, I think X, Y and Z would somebody look with a fresh pair of eyes and tell me your ideas." I always ask around and say, "Does anybody want to look at Mr So-and-so and see what you think. Do you agree with me?"'

Anna (S2T1. U14: 372-380, 385-387)

'Well, we don't really. I mean we can read the risk assessments that have been carried out...from the previous days...and get some pinpoints on what's actually been asked. You're then looking at the initial risk assessment from when they came into hospital, the risk indicators, and it's just [a case of] keeping up-to-date with the notes on the patient to make sure that you're looking at the correct issues really.'

Stephen (S2T5. U25: 237-247)

9.5 In the absence of a doctor

Nurses identified a number of issues relating to the role of the doctor when making the decision to implement Section 5(4).

9.5.1 Getting hold of a doctor

When the patient is assessed to be a risk to themselves or others, a nurse may implement Section 5(4) when:

‘...it is not practical to secure the immediate attention of a practitioner for the purpose of furnishing a report under subsection 2.’

(DH, 1983)

Nurses recognised that they did not always have immediate access to a doctor and this increased the likelihood of the need to implement Section 5(4). Furthermore, the need to manage a psychiatric emergency meant that, at times, there was no opportunity to contact a doctor. For example one nurse observed:

‘Well, I wasn’t fully aware of exactly where they were, but as far as I remember they were in teaching. Plus...if there is an immediate risk then you might as well use it and there clearly was in my opinion a risk of that woman walking out the door. We couldn’t have done it with a clear rationale or had time to get hold of a doctor.’

Dan (S2T24. U18: 231-236)

The Act might be interpreted as implying that the absence of a doctor was an occasional event. However, nurses’ stories suggested that this was a more regular occurrence arising out of doctors’ working practices. Typically, Karen noted that:

‘Well, I mean we certainly don’t have senior medics on the ward after five [or] six o’clock. It would be rare because they’re on call [and] if we phone them and ask them [to come to the ward] sometimes they’re more prompt than others. You know, it depends what they’ve got on. If there had been a doctor on the ward at that moment in time I wouldn’t have had to use a five-four...but there wasn’t... I suppose you would need a doctor here all the time or within 10-15 minutes really. Some days are easier than others. Wednesday mornings for example, most of the doctors are in teaching sessions so it’s very difficult to get hold of [them]. There are other days

with out-patients and research sessions and various things meaning that the doctors aren't around.'

Karen (S2T17. U21: 248-261)

On other occasions the Trust's mechanisms for ensuring a doctor was available to undertake an assessment failed:

'There'd been some concerns expressed by a medic at the ward round on Wednesday... We had requested Dr [Name] or Dr [Name] see her, but I think there were a bit of a problem with consultants covering consultants that week with annual leave...over the Easter break that got in the way of it.'

Stephen (S2T5. U2-7: Lines 48-54, 61-65)

'We all felt then as a team that we needed to get in touch with the consultant [because] he needed to be detained... I'm not sure why that wasn't done; I know that we've recently had a changeover of doctors and consultants so there are still some people who are finding their feet. So whether that had something to do with it that could have been the case.'

Anna (S2T1. U6: 109-118)

9.5.2 Present but unavailable

To say that on all occasions when a Section 5(4) was implemented there was no doctor on the ward would be misleading. In some instances a doctor was on the ward but they did not have the authority to implement Section 5(2):

'I turned to the doctor and asked her if she was qualified to implement a five-two...and she said she wasn't. So I said to the doctor that I [was] going to implement a five-four...'

Alan (ST2. U1: 32-40)

'And the doctor was an SHO and was unable - in this Trust - to place him on a five-two. It fell to me then because we were actually keeping him illegally. I put him on the order up until the SpR came.'

Mark (S2T25. U32: 347-350)

On other occasions a doctor with the authority to use Section 5(2) was present on the ward but was reluctant to assess the patient. This was attributed to the doctor not being a member of the consultant's team responsible for the patient's care. Doctors argued that they should not undertake the assessment because they did not know the patient, although this was a common scenario during on-call, out-of-hours scenarios:

'This particular day there was a doctor in the office that wasn't working with the [patient's] consultant, he could have actually done the five-two straight off but we went through the five-four and the consultant passed it back to him because he was doing an MDT... I think it could have gone straight to a five-two, but he said...he was the registrar for Dr [Name], not for Dr [Name]. In all fairness to him he didn't particularly know the patient... People don't want to make decisions for other consultants which is fine, but neither do we want to use five-four if there is a doctor there. It does happen. It happens a fair amount.'

Beth (S2T7. U30: 276. U31: 285-287)

Lastly, nurses implemented Section 5(4) because a consultant was either: not responding to their attempts to contact them, unwilling to come to the ward, or had delegated a junior doctor who felt inadequately prepared for the task to detain the patient. For example:

'The SHO who came, tried several times to assess him and the SpR was not answering their call or responding to the phone. So she got in touch with the on-call consultant, who gave her power to put him on a five-two. The consultant - his voice was slurring so they thought he'd been in the pub - he wasn't willing to come out... The two junior doctors that were on weren't happy at having to section somebody. As soon as the doctor concerned came off the phone, she called in a colleague and said, "Oh, I've got to do a section and I've never done one before. What do you do?" And [the other] junior doctor...didn't know either. She felt that she didn't have the confidence to do that at that stage in her training. It was then that I decided. I said, "Right. Come on, let's five-four him...and [that was] easier for the doctor [and] the doctor was quite relieved really.'

Mary (S2T21. U2: 21-28. U10: 145-151)

9.5.3 Instructing nurses

The Code of Practice (DH, 1999a, 9.1: 39) states in relation to Section 5(4) that:

‘It is the personal decision of the nurse who cannot be instructed to exercise the power by anyone else.’

However, it was not uncommon for doctors to instruct nurses to implement Section 5(4). This was an issue that nurses had to address constantly:

‘There is an issue...the one where the doctor says, “Oh, such and such a client is distressed, but if they try and leave, then you put them on a five-four.” [It’s] cropped up before and I’m sure it’s been a long-term problem this...’

Alan (S2T2. U32: 503-506. U33: 512-513)

‘The burning issue with me about five-four would be...the doctors asking the nurses to do it...writing into plans, “Hold them on five-four”... They should [be doing a] five-two.’

Lee (S2T23. U3: 74. U15: 594, 600)

Nurses offered various examples of and explanations for this phenomenon:

‘I can remember one incident where a patient who the consultant wanted to remain on the ward, but was informal, was starting to leave the ward and the consultant was on the ward and everybody was saying, “Don’t let this patient leave the ward! Don’t let this patient leave the ward!” [And the consultant said], “We’ll have to put him on a five-four.” It didn’t seem like the consultant appreciated their role in this. That a consultant would stand next to a nurse and ask them to five-four their patient who they believed should remain on the ward seems to me to show a remarkable lack of insight and willingness to actually look after the people that they’ve decided they wanted to admit into hospital. I believe they felt that the situation was a potentially violent situation and they would have sooner I dealt with it than them.’

David (S2T13. U20: 541-554)

'Because they can't be bothered to do the work involved in assessing a client [either] through their own laziness or lack of confidence in their own judgement... Maybe I'm a bit cynical but I feel that doctors are reluctant to do what is a time consuming intervention really.'

Alan (S2T2. U33: 509-511. U38: 539-544)

'I had a consultant [who said] if I didn't use five-four he'd write a letter of complaint to my manager...it had been documented in his medical notes at the MDT that he should be assessed for five-four if he tried to leave. But I just went on how he was at that time and there were no grounds at all for keeping him here and I let him go... [I couldn't have] five-foured [him] at that time... I couldn't have picked up the phone and asked the consultant to come and assess a patient that was completely well....at that time there were no risks at all.'

Sharon (S2T8. U28: 290-311. U29: 313-321)

'You know, it's quite obvious that they're thinking, "Well, this person could do with being on a section, but I'm not doing it. I'll just document it so I've covered myself."... Why? Well, various reasons, I should think. One, they're very busy. Two, they haven't got the resources to be able to do it there-and-then. Three, they don't know how to do it... They're not sure, although they could ask us we know how to do it.'

Rick (S2T10. U32: 334-336. U33: 339-344)

There was also the occasional example of a doctor instructing a nurse not to implement Section 5(4) should the patient decide to leave the ward:

'He was a new patient; he was just coming to be reintroduced to his depot...and there was a message handed over from the consultant and the MDT, "If he tries to leave don't five-four him." And I just thought, "Well, you know, I'm not having that," I'm there in the situation and I feel it's appropriate... His behaviour escalated throughout the day until it got to the point where he said, "I'm going," and he was pushing the door and I just felt...he was disorientated to time and place. He had no idea he'd presented problems. I just thought, "I'm well within my rights here," you know, judging the situation to stop him and just get a doctor to come in and if they disagree, you know, that's up to them...'

Adam (S2T11. U26: 244-248, 252-259)

Some nurses felt that the action of doctors meant that they - if only to protect themselves - had no other choice but to comply with the doctor's instruction:

'It does say in the Mental Health Act manual that it is a nurse's decision and doctors aren't meant to write in notes to say that nurses should implement five-four...because it isn't their decision... Maybe doctors are unaware of this, I don't know. So yes doctors will often put, "Consider use of Section 5(4) of the Mental Health Act if patient wants to leave to leave the ward," and it puts us in a predicament because that's what it says. To cover ourselves then you have to do [it]...it's best that you do that.'

Rick (S2T10. U30: 305-312)

However, others explained how they disregarded doctors' instructions by justifying their clinical decisions:

'Yeah, I was told, "Oh, all you have to do is justify your actions by conducting a risk assessment. Then you can pretty much override a doctor's plan" and that would save you from your job being on the line should anything untoward happen to the client.'

Mark (S2T25. U30: 285-288)

Some nurses also emphasised that when they received instructions from doctors to use Section 5(4) they strongly challenged them. Other nurses were more pessimistic and believed that despite their protests about this practice doctors only responded to other medical colleagues. When a doctor objected it was not because they considered it a questionable practice but because it impacted on them as individuals:

'We don't let them off [but] it is water off a duck's back. They're not that bothered. What's anybody going to do? But it's more so when doctors were getting annoyed at doctors when it happens because often the doctor will have to come out eventually and they see the medical notes and the doctor's written this and they should be assessed. We've assessed them and got another doctor out and they're pigged off because the doctor's written it in the first place [and not assessed them for detention themselves]...[because they have] to come to the ward. You know, having to get out of bed from home, leaving their families, for example. It's not because they know that their colleagues shouldn't be writing [it]. It annoys them that they are.'

Rick (S2T10. U31: 318-331)

9.6 Detaining the patient I: avoiding the decision

The first part of the process that ended in the implementation of Section 5(4) focused on nurses' attempts to avoid making the decision to use it.

9.6.1 Monitoring events

While nurses did not provide an in-depth account of the patient's life on the ward between their admission and detention, their stories did describe the events leading up to the implementation of Section 5(4). In some stories these events took place over a relatively short period of time, for example, a nursing shift or in other cases over a number of days. In all cases the patient was identified as someone at risk and expressing a desire to leave the ward. However, if the patient remained on the ward the nurses preferred to monitor the situation rather than apply the section. When the person did state an intention to leave they would attempt to persuade them to stay, although this would ultimately fail, resulting in a need to implement Section 5(4). Typically one nurse commented that:

'Well, the patient was asking to leave for a day or two...and there were general concerns about him, but we were able to reassure him and ask him to stay... [We told him] why we wanted him to stay on the ward which was working okay. He saw a doctor in the morning and gave me assurances that he would stay around, but he just became increasingly more agitated and saying that he wanted to go... We...didn't think it was safe for him to leave the ward and we weren't able to persuade him to stay...to see a doctor and he was just trying to leave, trying to go out the door so...we detained him.'

Karen (S2T7. U1: 3-15)

9.6.2 Leaving the ward

Eventually, regardless of nurses' attempts to persuade them to stay, patients decided to leave:

'I think staff had been spending time with him and due to his illness I don't think he was able to take on board why people were asking him to stay and he was just going along with it because that's what people were asking him to do and he must have [had] a change of heart [and thought], "I'm not listening to you people anymore. I don't believe you. I'm just going to do what I want to do."'"

Karen (S2T17. U6: 62-67)

The patient's intention to leave was indicated to nurses by a range of behaviours (Figure 20). A patient demonstrating behaviour in any one of the four stages could lead to a nurse implementing Section 5(4). Examples given by nurses of the patient's intention to leave included:

'The ward was actually locked due to another incident and the patient was tugging at the doors and we'd asked her to come back once or twice and she'd come back at our request. But at this final outcome the client was like really yanking at the doors and demanding to be let out and therefore it wasn't legal to detain her with the doors...so we had to detain her.'

Alan (S2T2 U12: 279-285)

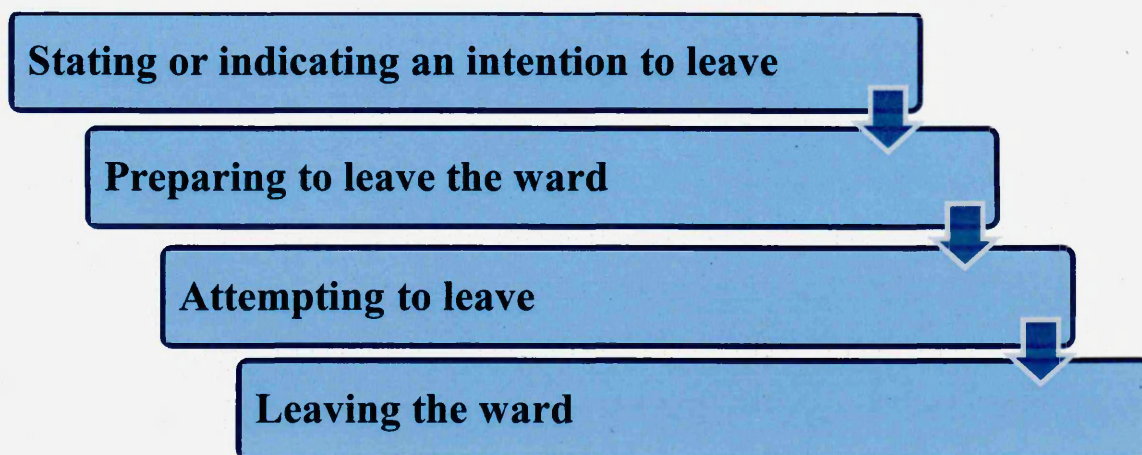
'He packed his bags and he walked off the ward...'

Ben (S2T14. U5: 222)

'He had his coat on and he was saying he was going to access his vehicle...'

Anna (S2T1. U3: 63-64)

Figure 20 The process of leaving the ward



9.6.3 Persuasion

When a patient attempted to leave the ward or stated an intention to do so, the nurses' first response - where circumstances permitted - was to invest time in attempting to

persuade them to stay or return to the ward. Although the process was not described in detail nurses did provide examples of their attempts to persuade the patient to remain on or return to the ward informally:

‘A discussion goes off, you know, normally, you [might say], “Oh, why don’t you stay? Come and talk to us or come and talk to a doctor if you’ve got any worries. Ring your relatives... Let’s get them here.” There’s a kind of discussion and there’s usually a, “No I’m not, I’m going,” and then the five-four.’

Adam (S2T11. U24: 223-227)

‘Sometimes you take the good copper and bad copper approach and the authority figure saying, “No, you’re not going anywhere. If you want to go any further I’m going to five-four you,” and then the other person who’ll probably step in and say, “Oh, come on. You don’t want that, do you? Remember what you were saying to me the other day?” Blah, blah, blah, and if they step in and then, “Yeah, okay then. I’ll come back” - that’s fine...because we are working in the patient’s best interest [and trying to] if we can avoid a five-four.’

Richard (S2T3. U12: 272-284)

‘It was mainly about reassurance. It was, “You’re safe here. We don’t want you to leave because we think you’re at risk.” Going through the procedure of what would happen and just lots of reassurance [but] there was no getting through to him...’

Joe (S2T15. U5: 131-136)

9.6.4 Detainable but not detained

However, from some stories it emerged that a patient who was considered detainable and was not prepared to stay on the ward was prevented from leaving but not placed on Section 5(4):

‘She had been making subtle attempts [to leave]. She would go down to the car park and then she would walk back to the ward and went to the garden, went behind Blackamoor ward, tried to go out that way, brought back, so it was just ongoing all morning. [She was] passively restrained. It wasn’t like a full restraint; just a person at each side of her... Passive [restraint] would probably be just a, “Come on Jane. Let’s go back.” Subtly just hold her arm softly and just bring her back to the ward as opposed to full restraint where you actually...have her arms locked... She didn’t resist... Well, it wasn’t difficult to bring her back.

However, while nurses were prepared to return people to the ward without detaining them, they believed that it was not reasonable to do this indefinitely:

‘On previous occasions...we had to restrain her and bring her back... This particular day...it took more force to turn her round and bring her back. Her level of distress was so acute. I think we’d already said that we couldn’t keep bringing her back like this...we can’t keep just putting our hands on people and stopping them going and locking the door. You know, it is in fact detaining somebody, isn’t it?’

Beth (S2T7. U1: 13-16. U2: 18-22. U3: 24-26. U7: 64-67)

‘I mean the first time she tried to walk out the interview room door we sat her down again, asked her to stay. We gave her some meds...and then tried to get a picture of what had happened while she was at home, but it was quite impossible to do really. She reiterated that she wanted to leave immediately and duly walked towards the interview room door after which I didn’t really feel I had any choice but to use the nurses’ holding power... So I think asking her to stop once and asking her to sit down was probably just about acceptable, although others may disagree with me.’

Dan (S2T24. U3: 55-62. U5: 85-87)

9.6.5 Having a ‘cooling-off’ period

Based on the above extracts, it is proposed that the nurses’ behaviour is not a conscious attempt to illegally prevent someone from leaving the ward - although it does constitute a de facto detention. Instead it is suggested that it is a genuine attempt to avoid implementing Section 5(4) in the hope that the patient can be persuaded to remain on the ward. Nurses attempted to explain their actions in such situations:

‘[I thought] the situation could have been dealt without five-four... Because, as I say, earlier in the day there were one or two occasions where she lost control briefly, but was able to regain it without the need for medications or sectioning or anything. She was able to go to the seclusion room and just use it as time out; briefly sit there for a few moments, do some breathing exercises and then come out again. Going on that basis, part of what we were doing was gauging, I suppose, whether that was going to happen again in this case before it escalated. But unfortunately, as I say, it did. She wasn’t getting any better at that stage.’

'I remember one occasion where we had a client who was attempting to leave and was at risk... This client was trying to exit the ward, but the ward was actually locked due to another incident... This patient was tugging at the doors and we'd asked her to come back once or twice and she'd come back at our request, but at this final outcome the client was really yanking at the doors and demanding to be let out and therefore it wasn't legal to detain her with the doors... Previously we had said, "Leave the doors. Come away from the doors," and she came away, but then kept going up repeatedly and it was at that point the discussion was about the ethics of keeping somebody here with the doors locked, who was informally demanding to leave... So we decided to detain her.'

Alan (S2T2. U12: 273-289. U13: 296-306)

Stuart took this one step further and argued that, at times, Section 5(4) may be implemented too hastily. He believed that it was reasonable in some circumstances to prevent a patient leaving without detaining them in order to provide them with the opportunity to 'cool-down' and therefore avoid the need to section them:

'There are instances [where] situations become inflamed. You've got someone who wants to leave and you don't really need to detain them for any length of time; they just need a 'cooling-off' period. It's that area where you're trying to dissuade them however forceful their arguments [or] attempts to leave are. As I say, I don't think it's unusual for people not to change their minds about leaving, but certainly they become less intent on leaving. So they finish up on a section when, as I say, half an hour 'cooling-off' time would probably be sufficient not to make it necessary.'

Stuart (S1T2. U3: 69-75)

9.7 Detaining the patient II: making the decision

This section describes issues concerning the point when the nurses made the decision to implement the section and the events following it.

9.7.1 Immediate decisions

When the nurses had finally exhausted their attempts to persuade the patient to stay they made the decision to implement Section 5(4). In some stories nurses - due to the speed at which the events occurred - did not have the opportunity to assess or attempt to

persuade the patient to stay. At such times nurses made an immediate decision to implement the section:

'So we came out of handover [and]...the first physical interaction I had with [Name] was when she came out of her room...in tears and seemed distressed, muttering something to herself which was quite hard to interpret because she was crying so much. She'd got her coat; she'd got a bag over her shoulder. She was walking down the corridor looking like she was going to leave the ward and...I tried to engage with her and she didn't want to talk. She seemed upset and started to make for the door. I asked her if she would talk to me and she still wasn't talking... So I didn't really feel I had an option but to lock the door, and then at that point as far as I was concerned that was the five-four done. So I had to go on all the things that I'd heard about her up until that point, which was a psychotic illness with violent tendencies, distressed and wanting to leave the ward essentially.'

David (S2T13. U4: 64-84)

'She just stormed out of the interview followed by the doctor, screaming and shouting on the corridor in a very distressed manner and stormed off the ward with the doctor and some of the other staff in tow... So I heard the commotion and left what I was doing to go out and join the doctor... The patient was declaring out loud, "I'm going to leave the ward! I'm going to go and kill myself!" and was really distressed. I didn't know the context of what the doctor's conversation with the client was [but] basically the doctor was...asking her to come back on the ward to continue the discussion. The patient was in the lift...[so] we stopped the lift and...[tried] to coax her back on the ward... And after about a minute or so it wasn't really working. The patient stormed out, walked directly past us all and made for the stairs with the view to [leaving] the premises. So I went in front and said, "Hang on! Stop! Wait a minute!" I implemented a five-four at this point [as] we were...obstructing the patient from leaving and it was going to potentially be a restrain procedure if this patient was not going to come back... I didn't know why she was storming off. All I knew was that I had an imminently suicidal client... I [simply] didn't know enough at that time.'

Alan (S2T2. U1: 32-73. U7: 195-204)

9.7.2 Team decisions

Nurses recognised that they were responsible for the decision to implement Section 5(4) and when the circumstances demanded it they felt confident to do so. However, where possible most nurses preferred to consult their colleagues about the patient and argued that the final decision to use Section 5(4) was made collectively rather than individually:

'I spoke to my colleagues. I always do if I've got the time to do so. I mean the first time I used it I'd just qualified and I didn't have the time...and I had to do it there-and-then but on Thursday morning we did have more time and I spoke to a deputy ward manager and the rest of my colleagues and they said, "Yeah I agree with you, we'll go ahead with it as a team and just take it forward." We just decided as a nursing team that we'd get the 'ball rolling' and get this man detained because that was what needed to be done.'

Anna (S2T1. U4: 80-80b, U7: 166-173)

'Well, sometimes you have to act very quickly and I'm sure there are situations when you do it without consultation, but my experience in the majority of cases when we've detained someone [is] we've discussed it.'

Beth (S2T7. U25: 235-237)

However, not all nurses recognised the benefits of consulting their colleagues:

'Some people take a team huddle approach to detaining people. They get together and talk about it first. I think this is a waste of time. If they need detaining, they need detaining. If I think somebody needs detaining I just get on and do it. What is there to talk about?'

Rory (Field notes)

Nurses saw a number of advantages in consulting their colleagues. Firstly, it was seen as a means to potentially avoid having to implement Section 5(4):

I think [it's] a good thing because it can avoid the detention of patients... Someone outside looking in...can give you...some good feedback. He might say, "What? What do you want to do that for? You must be joking! No, that's not a good idea," and they'd give their reasons why they wouldn't detain someone and it might make you think, "Well yeah, they're really valid points."

Andrea (S2T4. U8: 393-403)

'I mean a colleague may say, "Well, maybe I've got a better rapport with them, let me try" ...and that way we might avoid the five-four.'

Richard (S2T3. U11: 263-266)

Secondly, some nurses felt that they benefitted psychologically when the team supported their decision. As a result they found it easier to implement Section 5(4):

'I always feel a bit more comfortable if I've spoken to the team about it beforehand...because you need support from [your] colleagues because sometimes it's really difficult to know what to do.'

Sharon (S2T8. U13: 146-148. U14: 151-152)

'Maybe that's just a confidence thing on my part but...I think it is easier when everybody's saying, "Yeah, I think we should go ahead and do it."'

Joy (S2T22. U13: 140-171)

Finally, consulting colleagues was seen as important for purely practical reasons:

'You make sure that it's a decision that is agreed because...with five-four you invariably have to use some form of restraint...and when we go to restrain the last thing that you want is for you to grab hold of one arm and then the other arm to be free! So it's something that you make sure that everybody is aware that, "Right, we're going to five-four" and that they are in agreement.'

Richard (S2T3. U11: 236-237, 250-255)

Whilst on the whole a team decision was considered both desirable and good practice, nurses made it clear that where they disagreed with the collective position they would act individually:

'It's good when it's a team decision but there are times when you think, "Well no, this person isn't detainable" and people can be voicing other stuff. Or, vice versa, people can be saying, "This person's not detainable to me." And you think, "Well no, he is and we really should be doing this." So on that level it'd be nice if it was a team decision, if everybody was in entire agreement about why you were doing it. But at the end of the day, I mean it is the single nurse's duty to do this really if they feel it's necessary.'

Simon (S2T18. U24: 355-361)

However, the opposite was true for other nurses; some felt pressured to act on the agreed decision rather than their own position, even when they believed the patient not to be a risk:

‘And I’ll hark back to my first five-four in which I personally didn’t especially believe the patient was that out of control but the team decision was already to treat an illness that was diagnosed. So when they wanted to leave the ward, I needed to intervene in that respect - that somebody had decided this person was ill and needed treatment. Now I might not have agreed with that, but once that decision was made [by the] team, I’m not individually going to go against it, if you like.’

David (S2T13. U12: 242-247)

9.7.3 Reasons for making the decision

The decision to detain a patient was based on nurses’ concerns about the person’s health or safety or the need to protect others. These concerns were identified as part of the ongoing risk assessment process or from issues emerging during the events immediately prior to the detention as these two examples illustrate:

‘I was concerned that he was experiencing psychotic symptoms and hallucinations telling him to harm himself.’

Karen (S2T17. U8: 84-85)

‘I think it would have taken her quite a while to get out of the building. I think if she’d got to the car park, she wouldn’t know where she was... [She was] very disorientated, and I think she would have wandered the streets trying to find a way home and would have just been very vulnerable.’

Jackie (S2T16. U2: 60-64)

Nurses were also concerned that the risks were not just immediate but may have long-term consequences for the patient:

‘It was obvious that she wasn’t very well with these paranoid delusions. She was extremely vulnerable and open to exploitation from males...she admitted later that she’d arranged to meet this male patient at her house. I mean there was nothing wrong with that in most cases...but at that moment her mental state was incorrect and his own medical conditions that she was

unaware of, mainly HIV and Hepatitis B and C, could have serious implications for Sarah.'

Rick (S2T10. U2: 11-12. U5: 45-49)

Nurses provided less detail of their concerns about the patients they detained when completing official documentation. For example, the following examples were taken from local incident forms:

'Shaun is intimidating, threatening to leave the ward and harm himself.'

Maggie

'Increasingly becoming agitated and distressed, physically and verbally threatening. Wanting to leave the ward. Father concerned about current presentation - feels at risk from [Name]. Unwilling to speak to staff, adamant about leaving the ward.'

Joy

'Tina returned from leave yesterday following a disturbed incident involving a knife. Tina was very distressed today, wanted to leave the ward, unwilling to discuss with staff, unwilling to accept oral medication.'

David

Nurses' reasons for making the decision to implement Section 5(4) were explored in more depth in the typology presented in Chapter 7.

9.7.4 Implementing, communicating and explaining the decision

On implementing Section 5(4) the nurses communicated and explained their decision to the patient and what it meant for them:

'I said, "Well, I'm going to have to keep you here under the nurse's holding power." So we physically prevented him from leaving... He said, "What are you doing?" and we said, "We can keep you here." I explained to him we had the power to keep him here... He said, "You don't need to do that," but once I'd done it I said, you know, "It starts from the time I stopped you really," and just explained that we were calling a doctor straight away to come and see him and he could discuss it, [and] if the doctor were happy for him to go then fine.'

'I just said to him, you know, "Under the Mental Health Act I have the power to detain you for six hours and that's what I'm going to do. A doctor should be here within four hours. If the doctor's not here within six hours you're free to go.'

Adam (S2T11. U2: 32-35)

9.7.5 The laying on of hands

It has been argued that where possible nurses attempted to discuss the decision to detain the patient. However this was not always possible. When a more immediate decision had to be made nurses were required to interpret the actions of their colleagues for clues that the patient had been or was about to be detained. Examples of such clues given by nurses in their stories included: a request for the ward doors to be locked; a nurse blocking the path of a patient and not allowing them to pass; and a lift being stopped so that the patient could not exit the building. Joe gave an insight into how he recognised that the decision has been made to detain the patient:

Russell: 'Had a spoken decision been made to detain him?'

Joe: 'No because I knew that once Ben laid hands on him that he wanted him...to stay on the ward. Ben's my supervisor as well and he's always telling me, "Once you lay hands on somebody, that's it. You know, you're not going to let them go." So I knew once he'd laid his hands...put his hand on him, that was it, he would be five-fouled...[because] once you'd stopped his exit, you stopped his liberties of being able to leave the ward. There wasn't time to have a discussion about it, but there was no need to as I already knew...'

Joe. (S2T15. U1: 47-46. U3-U4: 97-100, 103-110)

In another story it was the patient's awareness of the situation that resulted in their detention becoming formal:

Russell: 'How did you know the patient was detained?'

Lee: 'It was the patient really...because at one point she said, "Can't you see I'm in a detained situation here? Can't you see I'm being restrained here?" So I thought, "She's right." So we just looked at one another and nodding in agreement and made it formal there-and-then...'

9.7.6 Dealing with the aftermath: nurses' and patients' responses

Nurses' stories also offered insights into how patients responded to being detained.

Some simply accepted the decision:

'Absolutely nothing. She just accepted that. There were a couple of times when she came and tried the door afterwards, but that was it.'

Beth (S2T7. U19: 178-180)

'He walked back up with us. We didn't have to drag him back up.'

Ben (S2T14. U7: 256-258)

'She calmed down very quickly once she realised that we weren't going to let her go out [of] the door. She kind of resigned herself to the fact that she was going to stay. She went back into the lounge and she was quiet and amenable.'

Jackie (S2T16. U1: 55-57)

In some stories nurses attributed the patient's acceptance of their situation to their mental state at the time of the detention:

'He was obviously...struggling with the reason why he needed to stay in hospital... He was still saying that he wanted to go, but at that point he said he'd come back onto the ward. He didn't really understand at that point why we were saying it [but] he did come back onto the ward and waited to see a doctor.'

Karen (S2T17. U11: 124-130)

It was also suggested that some patients 'accepted' the decision, not because they wanted to but because they felt that they had no alternative:

'I think she felt she didn't have a choice because there were quite a few of us about. There were at least five members of staff about, so she couldn't get away even if she tried to. She would be restrained if she tried to actively run off...'

Joy (S2T22. U10: 119-120, 123-124)

Others were less compliant when it was explained to them what the implications of Section 5(4) were. In these circumstances nurses had to physically restrain the patient:

‘So I said, “We’re going to have to place you on Section 5(4) and...bring you back to the ward for your own safety and for other people’s.” He was just acting aggressively...[so]...he had to be restrained to be brought back up to the ward.’

Sharon (S2T8. U5: 59-63. U4: 53. U3: 49-50)

‘And that’s when I said, “For that reason I detain you in hospital under Section 5(4) of the Mental Health Act. I don’t believe you’re safe to be leaving hospital...” [I] then explained to her verbally what I was doing, why I was doing it and Stephen and I put her in passive restraint to move her away from the door and said, “We want you to come back to the seclusion area and stay there for now with us” and we stayed with her while we talked to her.’

Andrea (S2T4. U2: 120-127)

For some patients their ability to understand their new circumstances or unwillingness to accept them led to nurses using further interventions in an attempt to safely manage the aftermath of the decision:

‘We had to take him to the...seclusion room...for his safety and he was given some IM medication...’

Sharon (S2T8. U6: 67-76)

‘She was placed on one-to-one observation...and she remains on one-to-one observation to this day...because of the potential for her absconding and these periods of high agitation.’

Josh (S2T6. U12: 182-188)

However, nurses attempted to manage the aftermath in the least restrictive manner as the situation allowed:

‘The distress just continued. When we tried to get any closer than a couple of yards, she was physically aggressive...she was warning us not to touch her and was raising her arms like she might hit out if you did touch her. So we just didn’t touch her really... I mean essentially I perceived it as better to

close the door and not fight with this girl rather than leaving the door open and waiting to see if she tried it and then putting hands on her. I mean she's a 17-year-old young Asian girl, so I don't think it would have been a particularly sensitive thing for me to have started wrestling with her. Although it might have been necessary, it wouldn't have been something that I'd have liked to have done.'

David (S2T13. U11: 196-212)

Nurses' stories also provided some observations on the patient's emotional response to their detention:

'I told this lady that I was going to put her on a five-four, explained what that was and...she said, "Don't put me on a section. I'm not a nutter."'

Jackie (S2T16. U1: 45-50)

'Yeah, he was actually quite upset about it. I don't think David fully recognised the implications of the five-four, but I do think he realised that it meant that his liberty could possibly be curtailed.'

Stuart (S2T12. U8: 119-123)

On the whole, the interventions used to manage the aftermath led to a quick resolution of the situation and for the benefit of the patient:

'She needed to be restrained...we had about six people involved...she had the IM... She became less distressed...and then calmed quite quickly and, you know, remained calm for the rest of the afternoon...'

Josh (S2T6. U2: 80. U4: 89-101)

'At this point I decided to lock the doors of the ward to prevent her from running off [while] she was distressed... I located one of the female staff nurses [and] allocated the role of trying to talk and reach out to the client and find out why [she] was so angry and try to de-escalate the situation...she saw the doctor and she was also offered Lorazepam as well to calm her down...she accepted it. [She]...was able to calm down with those interventions and then for the rest of the evening she remained perfectly calm [and] even apologised later...'

Alan (S2T2. U9: 224-236. U10: 238-250)

9.8 The administrative process

Once the Section 5(4) had been implemented, the patient returned to the ward, and the nurses had managed the aftermath of the detention the administrative procedure associated with the holding power was undertaken. This consisted of two main parts.

9.8.1 Doing the paperwork

The first part of the administrative process involved completing the paperwork to ensure that the patient's detention became legal and their rights were explained to them:

'So the patient was safe. She was on the ward, the doors were locked, the staff were allocated just to keep an eye on her, we'd informed [the] SpR, filled in the form giving times, get the leaflet explaining the rights and then go down and do that, then fill in the local incident report and get the other form that's needed for when the doctor arrives and then fill in the form to say I've given the rights and explained the rights and my opinion is she understands. Make an entry in the nursing notes as to the things preceding the decision and why you made that decision and what have you... So it's get the paper work together.'

Richard (S2T3. U14: 372-372, 400-408)

9.8.2 Informing the doctor and getting a response

The second part of this process involved contacting a doctor to inform them of the application of the section. The conversation provided the doctor with a brief account of the events leading up to the detention and the nurse's reasons for using the section. Anna offered an insight into this part of the process:

'I spoke to the consultant psychiatrist straight away... I think it was about twenty-to-ten in the morning that I implemented Section 5(4)... It was a fairly brief one because he was seeing somebody in his out-patient clinic at the time... Basically I said, "Joe Bloggs has just been detained under a five-four. I've implemented it [because] he's been putting his coat on, trying to leave the ward, he wants to try and get into his car. I'm quite concerned about his personal safety," and he said, "Yeah, I agree, I'll be up at one o'clock' to assess him." That was about it really.'

Anna (S2T1. U8: 216-220. U13: 315-323)

As the Code of Practice (DH, 1999a) requires doctors to assess the patient within four hours nurses would attempt to determine at what time the psychiatrist would arrive on the ward. Nurses commented on how quickly doctors responded to the situation:

‘The consultant was on the ward at the time [and] attended immediately.’

Sharon (S2T8. U6: 72-73)

‘I’ve always felt that they’re very responsive...when a five-four’s done. I’ve never known one to be late.’

Rick (S2T10. U29: 328-329)

‘The SpR came up within half an hour actually. He was very quick to attend...’

Mark (S2T25. U 125-126)

Other nurses were more critical of doctors’ responses to the implementation of Section 5(4):

‘There was no guarantee the doctor [would] actually come and see this woman within the six hours. It was a bit dicey really...but he did get to see her... I think he’d been in teaching or something and he wasn’t around until a particular time, but obviously I think a consultant needs to make that their top priority... He did see her but I think that [there] is a danger, at some point, somewhere or sometime...that might be a problem.’

Dan (S2T24. U19: 241-244)

9.9 Consequences

There were a number of potential consequences of the nurse’s decision to implement Section 5(4).

9.9.1 Medical assessment

The first consequence - as required by the Act - was that the patient was assessed by an appropriately qualified medical practitioner. There were two possible outcomes of this assessment.

9.9.1.1 Regaining informal status

In 17.3% of cases the outcome of the medical assessment was that the patient did not require a further period of detention under the Act. This was seen as the correct decision by nurses for two reasons. Firstly, they believed that at the time of the detention the patient was experiencing a transient crisis and that the implementation of Section 5(4) was only intended as a short-term intervention while they managed the crisis:

‘He was informal by the time I came back, but my understanding was that he’d been seen by [Doctor’s name] who’d regraded him informal... I wasn’t at all surprised and was quite pleased for Mark...and I’d given my opinion that he didn’t need another section...’

Ben (S2T14. U10: 355-360)

‘I was glad it lapsed because it’d served the purpose at the time to get him back to the ward and we thought his risks had lowered by the time the doctor assessed him.’

Joe (S2T15. U11: 217-221)

Secondly, they believed that the patient had engineered their detention. In such stories nurses felt compelled to detain the patient; not because they considered them to be a risk but because they had said the ‘correct things’ on record. Therefore Section 5(4) was implemented in order to ‘cover their backs’:

‘I mean we weren’t that sure whether or not he’d taken this overdose in the first place. Apparently there’d been this alleged assault on his ex-partner and he was asking whether if he was on a section he would be able to avoid questioning by the police, so we were quite suspicious of that, but still we wanted to be cautious and take extra care. I think the next day he was assessed. Certainly from our point of view in the day that he’d been here we didn’t feel that he was currently depressed. He was assessed by the consultant and discharged.’

Martha (S2T19. U5: 44-50)

Mary: ‘We didn’t want to five-four at all...[but] I think it’s what he wanted really.’

Russell: ‘Why do you think he wanted to be five-foured then?’

Mary: 'Why? Well, personally I think that he's got personal gains. I think that his DLA's⁶⁸ up...his daily living allowance is up for reassessment... Every three years it has to be looked at [to] see whether you can remain on it for another three years. I think that we get quite a few people admitted when the three years is coming to an end and they feel they need to come in hospital and have a breakdown for it to carry on for another three years.'

Mary (S2T21. U11: 176. U12: 177, 180-186)

In some cases the patients chose to discharge themselves from hospital once they became informal:

'[The SpR's] assessment was that he wasn't detainable. He went...down to A&E and was admitted to [Name]... He remained informal on [Name] and was discharged to home from there. I think he was referred back here, but refused to return to the ward and the consultant was of the opinion that if he doesn't return to the ward in two days, he can be discharged in his own absence.'

Simon (S2T18. U14: 169-171, 186-189)

9.9.1.2 Going through the numbers

In most cases the patient progressed to another section of the Act; in the first instance a Section 5(2) and subsequently to either a Section 2 or 3 (see section 6.2.2):

'He went onto a five-two [and] from there to a two.'

Karen (S2T17. U12: 141, 142)

'The senior reg came along and put her on a five-two with a recommendation for a three. And then within a matter of two days or so she was on a Section 3.'

Rick (S2T10. U19: 150-154)

⁶⁸ Disability Living Allowance (DLA) is a benefit for people under the age of 65 who have a long-term illness or disability, either physical or mental. The benefit is paid in respect of two types of need - one is care, the other is mobility. The care component is paid to help the patient with personal care. The mobility component is paid to help the patient get about. The patient may qualify for one or both components.

The decision to progress the patient onto another section also had consequences for the treatment they received and the nurses' involvement in its management:

'It very quickly went to a three and then she ended up having ECT⁶⁹ under Section 62...it was just horrendous... Staff had to restrain her all the way across...it took four staff she was fighting them constantly...'

Beth (S2T7. U11: 109-114)

9.9.1.3 Rubber stamping

In many stories the nurses believed that the progression of the holding power to another section of the Act was inevitable:

'When people are on the Mental Health Act it usually prolongs their admission... If someone's never been detained before, you really don't want to...go down the Mental Health Act [route because] it is sometimes unstoppable. With five-fours...usually the SpR that comes to see them to consider the five-two doesn't know the person so invariably they make the same judgement about risk as you've made so invariably they are five-two'd and there is a first recommendation done. [That's] because the decision - without wanting to sound conceited - to five-four is a good decision. The risk factors are usually there. So, for example, in this case I didn't know the person, certainly the SpR didn't and I outlined my concerns to the SpR, [and] they usually take my concerns into consideration as well. I mean I feel as though my practice is sound enough for my decision about risk concerns to be supported by the Specialist Reg. But it does feel at times they are simply 'rubber stamping' the nurse's decision.'

Richard (S2T3. U13: 311-343)

'If you put somebody on a five-four...you're almost handing somebody a psychiatric history [because]...you've set the ball rolling... There is a bit more pressure on a doctor to then go ahead with the five-two, which puts pressure on them to recommend another section, which then puts pressure on the next person to follow that through.'

David (S2T13. U12: 256-258)

⁶⁹ Electroconvulsive therapy (ECT) is a psychiatric treatment in which seizures are electrically induced in anaesthetised patients for therapeutic effect.

Evidence to support the suggestion that there was a tendency to 'play it safe' by some doctors came from the apparent discrepancy between one doctor's entry in a patient's medical notes and their rationale for implementing Section 5(2):

'Since...placed under section 5(4) by nursing team has settled down well and has not made any active attempts to leave the ward. When I saw him he expressed strong wish to leave the ward...but willing to stay until Monday to see treating team... No evidence of risk.'

(MN)

'Mr G. is an inpatient undergoing treatment for schizoaffective disorder. He has been expressing [a] wish to leave the ward and lacks insight into his psychopathology. Recently he has left the ward and was found to be perplexed, expressing delusional ideas. Hence in interests of his health and safety he needs to be detained until further management is worked out and reviewed by treating team.'

(Section papers)

David explained why he thought this occurred:

'I think it's because an awful lot of doctoring and nursing these days is about covering your back. It's about defensive nursing. It's about taking research and using it for all the wrong reasons. It's about saying that we need to keep everybody safe rather than saying we need to get people better. It's about saying we can't have somebody leave the ward because there is a one in a 100 chance that they'll kill themselves and I can't live with that, rather than if we keep everybody on the ward, then nobody will get better. There are risks involved in getting people better, especially psychiatric nursing, because there's risks with being alive and if you risk assess people in an overly defensive way, then that's what you end up with I think. I think through litigation, through the law, through people's expectations being altered about what's acceptable and what's not acceptable in terms of risk. In everyday life, you know, the risks that we used to take in terms of, say, wearing seat belts or crash helmets, all that's changed and, you know, within nursing that's changed as well. So you have to become more defensive.'

David (S2T13. U12: 260-273)

Some nurses felt frustrated at doctors' apparent willingness to simply 'rubber stamp' the nurse's decision:

‘To be honest I felt the doctor would have done whatever I’d have said. I made it clear to the doctor. I said, “Please make your own mind up,” and he was one of those doctors that said, “Well, what do you want me to do?” and I said, “Well, assess this man and read the notes and I’ll tell you what’s happened and see what you think and if you don’t agree with me, fine.” But the doctor did the five-two and made a first recommendation for a two but he was also taking leave from us, “Well, what do I do?” Does it need to be a three because he’s started on treatment?” So I was telling him what section he should be recommending...’

Ben (S2T15. U8: 261-268. U9: 327-335)

Finally, at least some doctors attempted to avoid ‘rubber-stamping’ the nurse’s decision but found themselves with no other alternative:

‘He...sat down...with the patient and attempted to negotiate and get a bit of background history and the patient listed some suicidal ideas and feelings, but then also said he was only just wanting to go to the local shops, but again stood up and started yelling, “I want the fucking doors open! Open them! Let me out! Let me out!” So the SpR did not or was not able to enter a decent negotiation with the client because he was refusing to do that by his behaviour in the interview. So the SpR, having not known the client and based on what had happened and the fact that he was not negotiating, placed him on a five-two.’

Mark (S2T25. U2: 98-108)

9.9.2 Emotional impact

Nurses’ stories also contained details of the emotional impact of implementing the section on them and other staff:

‘[I felt] a bit gutted really that we had to do it, although I felt we had to do it, but I just didn’t want to have to go down that road. You know, I wanted [to]...just keep it positive and just work with him.’

Adam (S2T11. U22: 203-206)

One nurse commented on having to enforce treatment on a patient in the aftermath of the decision to detain them:

‘The staff were very, very upset. The first time, as I say, I wasn’t actually on duty when they took her [to ECT], but people were really upset, you

know, going through a general hospital with somebody fighting them and the staff were trying their best to restrain her and keep her on a trolley...and it sounded like an absolutely horrendous situation for everybody concerned - patient and staff.'

Beth (S2T7. U12: 120-125)

Despite the emotional impact of nurses' experiences there was little opportunity to discuss them. For example:

'Not just five-four but other things like being part of the restraint team...some [are] quite horrid...and it's awful really for everyone. Obviously not just me; it takes the toll on everybody. But this leads onto debriefing because you don't really have time. We had a brief one. I mean Josh was co-ordinating said, "Right, quick debrief. Shut the door. Basically, is everybody alright?" I mean there wasn't time to sit around and discuss it. There seldom is. There just isn't.'

Lee (S2T23. U12: 462-467)

9.9.3 Therapeutic relationships

Nurses' stories also contained a number of other concerns they had about the potential consequences of implementing Section 5(4). For example:

'It can have a far-reaching effect if they're then put on a three... Well, I don't know whether it's still the case, but I think if they want to emigrate and travel abroad I think it can have a detrimental effect on people... It's a stigma I think sometimes... Some people feel quite stigmatised. Some it doesn't bother, but some people do feel quite stigmatised by it, and perhaps a bit fearful if they're coming into hospital a second time - if it's going to happen again.'

Maggie (S2T20. U16: 255-260, 263-265)

However, the most significant consequence described by nurses in their stories was the impact of the detention on their therapeutic relationship with the patient. This had two main elements: the Mental Health Act (DH, 1983) in general and Section 5(4) specifically.

9.9.3.1 The Mental Health Act

The use of the Act in any form was seen by some of the nurses as a potential barrier to developing therapeutic relationships:

'I mean it's always difficult to have a relationship when they're detained and we've had to impose treatment but it's one of those things really [we have to work with].'

Sharon (S2T8. U23: 229-234)

'Taking away a patient's rights, which is what you do when you bring somebody into hospital like that and denying their right to leave, can certainly have a negative impact... I mean how can you then go on to have a therapeutic relationship with somebody [who] doesn't like to be kept in hospital, so [the relationship's]...going to deteriorate as well.'

David (S2T13. U19: 516-517, 519-521)

9.9.3.2 Section 5(4) and the impact on therapeutic relationships

Some nurses believed that implementing Section 5(4) had - in at least most cases - no affect on their relationship with the patient. This was attributed to the effects of the patient's mental health problems on their ability to recall the events surrounding their detention:

'You know, when the five-four went on I don't think she was particularly taking anything on board and then not long after that the five-two went on and [then the] Section 3...[so]...it doesn't appear to have affected the relationship that I've got with her.'

Beth (S2T7. U13: 129-131, 135-137)

'No because I don't think he's got any recollection of the events. I dare say if I asked him about it he might remember the seclusion room, he might remember the fact that we took his belt off him and his boots, but no he wouldn't remember the five-four... So I don't think he'd bear any malice or anything.'

Ray (S2T9. U17: 294-299)

Other patients seemed to accept their fate:

'With Jane we've known her for a long time and this is not the first time she's been detained so I think she accepts it and she doesn't bear grudges...'

Joy (S2T22. U14: 175-177)

Some stories told of how patients expressed strong emotions at the time of their detention that had a detrimental effect on the therapeutic relationship. However, such effects were seen as short-lived:

‘How she felt? I know she felt really angry. She felt really pissed off with me, but I suppose by saying what she said later, about an hour later, “You’ve saved my life” She reached out and put her hand on my hand as she said it and I know she obviously felt okay with what I’d done.’

Andrea (S2T4. U10: 634-643)

‘I mean the first time that I used it I was the patient’s named nurse and she wouldn’t speak to me for about three to four days after that and growled at me on the corridor and [would say], “I can’t believe that you’re keeping me here.” She was quite upset with me...but it was short-lived.’

Anna (S2T1. U15: 448-451, 469)

‘Yes alright, it will be spoilt [in] the immediate aftermath [and] I’ll probably be the biggest bastard out for a little bit, but on a long-term basis I’ve not found that it has... And it’s certainly not been a factor that’s influenced my decision at all to five-four.’

Richard (S2T3. U16: 506-508, 512-514.)

However, some nurses believed that the use of Section 5(4) *did* have a long-term impact on their relationship with the patient:

‘I think some patients that we’ve had on the ward who have been detained...don’t want anything to do with the nurse that actually detained them and it really affect the relationship that you have with them. We’ve had a chap that’s been discharged recently and he came back and he was so very, very angry even on discharge about being detained and he still didn’t take it on board why he was detained. I suppose the difference with this chap and [Name] was [for] this chap it was his first contact with mental health services and he came onto the ward [thinking]...that he was coming for a scan and then he was going to go home. Whether it hadn’t been explained properly to him prior coming in, I don’t know, but when he was detained he ended up being restrained, given IM injections, so all that really affected his opinions of the services.’

Joy (S2T22. U14: 177-190)

One patient commented on the impact of their detention for their relationship with the nurse implementing the section:

Russell: 'Did it spoil your relationship with the nurse?'

Jane: 'I don't think so; no I still get on with [Name]. You may be a bit mad with them saying you can't go home or whatever but you should still think about your nurse and think that it's them that's in the right... I weren't really mad at the nurses but I were mad because I were in hospital and I knew it was the best place for me but I would just have liked to have gone home but I know the nurses were doing their job.'

Jane (PT5. U5: 158-165, 193-196)

9.9.3.3 Resolving difficulties

Meeting with patients to discuss the events of the detention was seen as important for resolving any difficulties that had arisen:

'I mean obviously you're taking some form of liberty away so it's going to be considered as nasty and wrongful from the client and they could probably hate you or dislike you or think you're a nasty nurse or nasty person for keeping them in... But on the other hand on the two occasions that spring to mind that a client has come back afterwards [and] apologised, "I'm sorry for trying to run away," and I was able then to say to the client, "You know, I didn't like having to place this restriction on you, but I was worried about you," and they saw my point of view and we've had a good [talk]. In that sense the therapeutic relationship probably was enhanced and not diminished...'

Alan (S2T2. U31: 482-486)

'I think if you're honest with people, you can maintain the therapeutic relationship. I think if you avoid talking about it again... it just gets missed and they could harbour thoughts, feelings about things, but... I gave her the opportunity to talk about how she felt and asked her if she wanted to speak to anyone else about it and not just me.'

Andrea (S2T4. U10: 650-656)

'It's a horrible thing to have to do, but on occasion when somebody's shown some degree of recovery you can go through it with them why you've done it and I think that's probably a good thing to do really [and] say, "Well, the reason we've done this is because I thought you were going to go and kill yourself quite frankly." "Well, yeah, I was." "Well, I wasn't wrong then,

was I?" In the short-term it will affect it quite negatively, but I think in the long term it's something that can be re-built.'

Simon (S2T18. U25: 371-378)

9.9.3.4 Therapeutic relationships and safety

However, despite nurses' concerns about the impact of Section 5(4) on their relationships with the patient they believed that safety came first:

'I think if somebody was to leave hospital when they weren't well enough and then harm themselves or somebody else they'd be more at risk of doing detriment to the therapeutic relationship if they were dead or they'd harmed somebody else [than]...if I was stopping somebody from leaving hospital because I was concerned about them being at risk.'

Karen (S2T17. U19: 215-216, 225-228)

'If it does damage the relationship permanently then although it's not ideal I think [if] you...had to choose one, which is the most important? Immediate safety would be slightly more important than the nurse-patient relationship. If that relationship fails at least you can say that you put safety first.'

Dan (S2T24. U2: 31-36)

9.9.3.5 Impact on nurses

Finally, the patient's behaviour towards the nurse also had the potential to negatively impact on the therapeutic relationship:

'He just says really insensitive things like, "You're past your sell by date," and "You should have gone years ago," and "You're thick" and he told the doctor that she didn't understand this word, that she should go back and do some training again...he was very abusive towards all of us. Really, really abusive. And so I was quite angry with him, with the things that he'd said - not only to myself, to other staff members - and I said on this night...I would have to build up a relationship from scratch because as far as I'm concerned...I've lost that relationship that we had. I said I didn't want to speak to him...and I didn't want my colleagues speaking to him... He was writing me letters to say he was sorry and then going behind my back and saying, "I hate her!" and quite manipulative, you know.'

Mary (S2T21. U3: 52-54. U4: 70-80)

Certainly the patient detained by Mary was concerned about how his behaviour might affect his relation with her and other nurses on the ward:

‘But the only regret I’ve got about Section 5(4) is Mary and the relationship I have with her. It isn’t what it should be or was or anything like that and that’s unfortunate... I upset some of the nurses and it’s the last thing I want to do. I’m in here and I want to get well and I can only do that with the nurses’ help...’

Shaun (PT3. U13: 171-173. U14: 200-202)

9.10 Conclusion

This chapter has presented the collective story - as represented in Figure 18 - generated from an exhaustive analysis of the interviews undertaken with the nurses in the study. More importantly, it has made visible for the first time a process concerning the events before, during and after the nurse makes the decision to implement Section 5(4). The collective story demonstrates that the decision to implement Section 5(4) is a complex process involving a number of factors other than the patient being considered a risk and a doctor being unavailable to undertake a medical assessment.

The collective story has also raised a number of issues that were significant for understanding how and why the section was implemented - some of which will be discussed further in the next chapter. For example, nurses raised concerns about the circumstances surrounding how some patients were admitted informally to hospital. In this example, the collective story highlighted the belief that patients can be misled into agreeing to hospital admission. The resulting conflict arising from this situation was attributed to the need to detain the patient.

Nurses’ relationships with doctors were another source of concern. Specifically, it was evident in nurses’ accounts that they believed that doctors either did not understand Section 5(4) or exploited it in order to avoid taking action themselves under the Act. This is worth further exploration as it has implications for the way nurses work productively with doctors.

Finally, nurses also provided valuable insights into how risk assessments were undertaken within acute settings. The collective story illustrated that despite attempts in recent years to encourage nurses to undertake risk assessments using systematic procedures this was not the case on a day-to-day basis. This is not to suggest that nurses do not undertake competent risk assessments, but highlights the process of how solutions have to be found to everyday problems of managing care in a demanding clinical environment.

Chapter 10

Discussion

10.1 Introduction

Section 5(4) (nurses' holding power) of the Mental Health Act 1983 empowers a nurse of the prescribed class to detain an informal in-patient receiving treatment for mental disorder for up to six hours or until a doctor arrives. Section 5(4) is applied when it appears that the patient - should they leave hospital - will be a danger to themselves or others, and it is not practical to secure the immediate attendance of a medical practitioner. The research presented in this thesis sought to gain an understanding of how and why Section 5(4) was implemented. In seeking answers to the research question the study has identified some significant and illuminating issues regarding the implementation of the section. This final chapter summarises and critiques the main findings and considers the implications for education, policy, practice, and research.

10.2 Key findings

When the evidence generated in this thesis was considered as a whole eight key findings emerged:

1. Although all patients detained under Section 5(4) entered hospital informally this did not mean that their admission was voluntary. Participants gave examples of patients being coerced, pressured or misled into accepting hospital admission.
2. Fifty-seven per cent of patients were detained under Section 5(4) within the first week of admission. Nurses attributed this to health care professions, for example psychiatrists, inappropriately admitting patients to hospital informally.
3. Patients were not provided with sufficient information to enable them to make informed decisions about their choices regarding admission and subsequent treatment.

4. Contrary to the Code of Practice (DH, 1999a, 9.1: 39) doctors attempted to instruct nurses verbally and/or in writing to implement Section 5(4); this was a major source of professional conflict.
5. In a seeming contradiction to the Act, examples were frequent given of Section 5(4) being implemented when there *was* a doctor - who might have assessed the patient for detention under Section 5(2) - present on the ward. Doctors were reported as being reluctant to undertake the assessments because: they did not know the patient, they did not know how to implement their holding power, or because the patient was under the care of another consultant. Nurses also reported that doctors were more likely to 'rubber stamp' their decisions and/or accept their recommendations than to act on their own independent assessments.
6. The health or safety of the patient and the protection of others were important considerations when making the decision to implement Section 5(4); however they were not the only considerations. Other considerations included: self-protection, a perceived lack of action by psychiatrists, and insufficient human resources.
7. Risk assessment, management, and prevention were a significant part of the nurse's role in acute in-patient care and also major considerations when making the decision to implement Section 5(4). However, nurses did not take a consistent approach when assessing risk. They attributed this to inadequate preparation before and after qualifying. Furthermore, standardised assessment tools were used infrequently as they were seen as impractical for assessing risk on a day-to-day basis, particularly when making clinical decisions in emergency situations, for example when implementing Section 5(4).
8. The events before, during and after the implementation of Section 5(4) resulted in strong emotional responses from both patients and nurses. These responses impacted negatively on the nurse-patient relationship and had implications for the patient's care.

Some of the issues raised by the findings presented in this study will now be discussed.

10.3 Informal admission

As noted above, there was a belief among nurses that psychiatrists - and to a lesser extent other healthcare professionals, for example social workers - inappropriately admitted some patients to hospital informally and this inevitably led to them having to implementing Section 5(4). In line with previous evidence (Bowler and Cooper, 1993; Ajetunmobi, 2001a; Shivram, 2006) this belief may be supported by the fact that in this study the majority (57%) of Section 5(4)s occurred during the first week of admission.

One explanation for this phenomenon might be that psychiatrists were simply following the Code of Practice (DH, 1999a, 2.7: 10) which states that, 'compulsory admission powers should only be exercised in the last resort'. Subsequently, the patient's mental health deteriorated rapidly after admission requiring nurses to implement Section 5(4). This explanation is based on the principle of the 'least restrictive alternative' that has its origins in the United Nations (UN) Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care. Specifically, Principle 9 which states that:

'Every patient shall have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others.'

(UN, 1991)

While the admission of a patient to hospital informally is a worthwhile goal, it is argued that this should not be pursued at all cost. The Code of Practice (DH, 1999a, para. 2.7: 10) notes that, 'informal admission is usually appropriate when a mentally capable person consents to admission, but not if detention is necessary because of the danger the patient presents to him or herself or others.' In addition, if the patient is 'mentally incapable of consent, but does not object to entering hospital and receiving care or treatment, admission should be informal' (ibid). While purely speculative it could be argued that some psychiatrists are placing too much emphasis on the principle of least restrictive alternative and admitting patients informally at the expense of the risks posed by their mental health. Similarly, it is also proposed that greater emphasis might be placed on assessing the 'likelihood that he or she will have a change of mind about informal admission' (ibid). While this statement is written specifically in relation to

determining 'informal admission prior to actually being admitted to hospital' (ibid), it is suggested that this idea is extended to the likelihood of the patient changing their mind soon *after* being admitted. Such an assessment would serve to clarify for the multi-disciplinary team and more importantly for the patient any concerns about their health. In addition, it would also serve to clarify the true meaning of the patient's legal status. This seems important because as Houlihan (2000: 865) notes, 'in practice the notion of informal status may be no more than a legal fiction.' Such a clarification would not only make transparent the rationale behind the patient's admission and proposed care but also forms the basis of developing a trusting collaborative working relationship. It is suggested that this is more likely to achieve positive treatment outcomes and aid both medical and life recovery than is a relationship based on deception.

The recovery model, with its emphasis on hope, strengths and weakness and a move away from pathology and illness (Roberts et al., 2008) has been seen as a way forward for mental health care in recent years (for example see Shepherd et al., 2008). However, some (for example, Frese et al., 2001) have suggested that patients cannot recover when they are subject to detention under the Act. This could mean that some psychiatrists are admitting a patient informally when formal admission would have been more appropriate in an attempt to endorse the philosophy of recovery-orientated practice. Others (for example, Roberts et al., 2008) argue that detention and the recovery model are not necessarily in conflict. Although, it is acknowledged that initially the number and types of choices that patients may be able to make may be limited by their formal legal status. Roberts et al. (2008: 173-174) take this further and suggest that:

'The therapeutic purpose of detaining someone and treating them against their will is to achieve the gradual handing back of choice and control in ways that are safe and to enable them to resume responsibilities for themselves.'

It could also be argued that in some cases admitting a patient informally is not the least restrictive alternative. Clisby and Starr (2008) have proposed that clinicians use only two variables to interpret the least restrictive alternative: voluntariness and environment. Using this approach voluntary treatment in the community would be seen as the least restrictive alternative and involuntary treatment in hospital the most restrictive.

Therefore, informal admission to hospital may be perceived to be less restrictive when compared to formal admission regardless of how this is achieved or the consequences of this for the patient or others, for example nurses.

Clisby and Starr (2008) argue that admitting at-risk patients informally is potentially likely to be more restrictive than it initially seems. For example, the patient's legal status on the ward can be seen to be ambiguous. A person considered at risk to self and others may have been admitted informally but both the multi-disciplinary team and the patient are aware that should they attempt to leave they will be detained. Therefore, they are informal but their status constitutes a *de facto* detention. In such circumstances it may be preferable for the patient to have been admitted to hospital under a section of the Act because they could ask for their legal status to be reviewed by a Mental Health Review Tribunal (Clisby and Starr, 2008).

Gilbert et al. (2008) have reported that the most common threat experienced by patients was the removal of their informal status unless they remained in hospital or received unwanted treatment. This approach has led some patients to 'fake it to make it' (Roberts et al., 2008: 175), that is the patient behaved as if they had medically recovered to avoid or have a section rescinded. Therefore, it is suggested that the least restrictive alternative 'encompasses far more than the two variables that are generally considered to apply' (Clisby and Starr, 2008: 6). Therefore, where possible, it is important to elicit the patient's view of what is the least restrictive alternative before deciding whether to admit them formally or informally (Clisby and Starr, 2008). Although recognising the difficulties this may pose, it is also suggested that psychiatrists consult more closely with the nursing team who will be required to manage the patient's behaviour following their admission.

Another possible explanation for the psychiatrists' actions is that they did not want to undertake the 'dirty work' (Cavadino, 1989, 1999) of sectioning the patient. Cavadino (1989) has reported that some psychiatrists thought that sectioning patients in order to admit them to hospital constituted a 'breach of trust.' Cavadino (1999) has discussed the 'gaoler role' of the psychiatrist and takes this to refer to situations where patients are detained in order to prevent them acting violently towards others. He distinguishes this

from acts of parentalism;⁷⁰ that is where the patient is detained in the 'interests of that particular individual' (Cavadino, 1999: 527). While, Cavadino's distinction would suggest that one form of detention is seen as less negative than another, for the purpose of this discussion it is suggested that admitting a patient under the Act is something that psychiatrists - and others, for example, social workers - try to avoid because it, 'represents an uncomfortable, disturbing departure from the normal consensual doctor/patient relationship' (Cavadino, 1999: 527). Such a situation may cause a conflict between a doctor's belief that they are a member of a caring profession whose function is to do good for the patient and not do harm which detaining the patient may be perceived to be. Therefore, if a patient can be 'persuaded' to enter hospital 'voluntarily' then this is the preferred option regardless of how this is achieved. However, it can be argued that this is no more than an illusion that the patient has both 'positive freedom', that is they have 'the ability to make effective choices about [their] own life' and that there is a lack of 'negative freedom', that is, 'the absence of coercion or constraint imposed by others' (Cavadino, 1999: 529).

A related issue was the suggestion by nurses that some patients were coerced, pressured or misled into accepting hospital admission. This finding is not a new phenomenon (see for example, Gilboy and Schmidt, 1971; Lurigio and Lewis, 1989; Lidz et al., 1993; Eriksson and Westrin, 1995; Monahan et al., 1995; Hoge et al., 1997; Poulsen, 1999; Lidz et al., 2000; Taborda et al., 2004; Bindman et al., 2005; Gilbert et al., 2008) and has led Hoge et al. (1997: 167) to refer to this group of patients as 'coerced voluntaries'. In preferring to admit a patient to hospital informally using these strategies it may be that practitioners are referring to a hierarchy of what Szmukler and Appelbaum (2008: 234) have referred to as 'treatment pressure' (also see Molodynski et al., 2010). In this hierarchy threatening a patient to come into hospital informally is seen as preferable to compelling them to do so under the Act, although Szasz (1972: 278) believes this to be no more than 'strategies of entrapment'. Such an approach may be an attempt - albeit misguided - to avoid the perceived negative experiences associated with compulsory admission. For example, Kaltiala-Heino et al. (1997: 318) reported that involuntary admission to hospital and coercive treatment 'arouses negative feelings in the patient, creates negative expectations about the outcome of the treatment, and fails to result in a

⁷⁰ Cavadino (1999) uses this term where others would use paternalism. However, the meaning remains the same.

trusting treatment relationship between the patient and the professionals.’ Kaltiala-Heino et al. (1997) also report poorer positive changes in the patient’s mental health and an increased likelihood that the patient will disengage with psychiatric services. However, others (for example, Birdman et al., 2005) - while acknowledging that patients detained under the Act associate their subsequent treatment with coercion - found no negative outcomes on discharge, for example in relation to engagement with psychiatric services or compliance with medication. Poulsen (1999) has also reported higher levels of perceived coercion among patients compulsorily admitted to hospital compared to those detained post-admission. Poulson (1999) suggests this may be attributed to the fact that admission under the Act is more stressful particularly when it has involved other agencies, for example the police.

Therefore, it is suggested that while attempts should be made to treat people using the least restrictive alternative other factors should be given equal consideration, for example, whether the patient is likely to have a change of mind about informal admission shortly after arriving in hospital. In addition, professionals need to give consideration to the impact any clinical decisions may have for their colleagues following the informal admission of a patient to hospital. Future research could explore the appropriateness of why patients detained under Section 5(4) in the first week of admission were admitted informally.

10.4 Information

The Act (DH, 1983) clearly established the rights of patients formally admitted to hospital to receive information on their legal status and to appeal against detention. In addition, the current Code of Practice (DH, 2008, 2.45: 18) states that:

‘...patients should be made aware of their legal position and rights. Local policies and arrangements about movement around the hospital and its grounds must be clearly explained to the patients concerned. Failure to do so could lead to a patient mistakenly believing that they are not allowed freedom of movement, which could result in an unlawful deprivation of their liberty.’

However, less attention has been given to the information provided to informally admitted patients, when and by whom. One finding of this study was that patients felt that they possessed insufficient information about the Act (including Section 5(4)) to

make an informed decision regarding informal admission and subsequent treatment. This finding is not uncommon, for example Rogers et al. (1993) reported that of a sample of 516 people admitted informally to hospital, 80 per cent felt that they had not received enough information about their treatment. In other studies informal patients were unaware that they had the right by law to leave hospital and refuse treatment (Sugarman and Moss, 1994; Birdman et al., 2005). Patients also believed that the information they had received had been insufficient to the point that their admission was not genuinely voluntary (Rogers, 1993). Furthermore, Goodwin et al. (1999: 49) report that 'lack of information remains a source of anger and frustration among service users... and prevents them from exercising informed choices regarding their own treatment.'

The choice agenda in health has been the focus of a number of policy documents in recent years (for example, DH, 2003b; DH, 2004; CSIP, 2006a; CSIP, 2006b). The Care Services Improvement Partnership [CSIP] (2006b: 2) states that 'choice is about the power to make decisions - it gives people more control over their own lives.' The Department of Health's (2003) 'Building on the Best' sets out their vision for supporting greater choice in the NHS. While consumers welcomed this proposal, the Government's public consultation 'Choosing Health?' revealed that people 'wanted improvements in the quality and accessibility of information as an essential prerequisite to making informed choices about their health and health care' (DH, 2004b: 1). 'Better information, better choices, better health' (DH, 2004b) recognised that high quality information was central in enabling patients to make informed choices about their treatment options and where to receive it. In order to make choices patients need 'the right information at the right time with the support they need to use it' (DH, 2004b: 3). The document (DH, 2004b: 3) goes on to state that:

'High quality information empowers people. With poor information they cannot make effective choices; and without information they have no choices at all. A lack of information can be damaging for patients, their relatives and for health professionals.'

The issue of choice and informed decision-making has also been addressed in relation to mental health care (CSIP, 2006a; CSIP, 2006b). Although recognising at times that people with mental health problems may be in a state of crisis which may limit their

ability to make choices, it is suggested that 'a choice of care options' (CSIP, 2006b: 6) be given. They also need to be given the 'information they need about each option and then be supported to make their own decisions' (ibid). This might also include information on the implications of choosing to accept to come into hospital voluntarily as an informal patient.

However, SANE (2008) have reported that NHS mental health services are not delivering on the choice agenda. Their research suggests that 'in reality many service users still experience a 'paternalistic' service, whereby choices are made by the clinician or organisation providing the care' (also see Barnes et al., 2000a; Barnes et al., 2000b). Therefore, it would seem that if the aims of the choice agenda are to be met then patients need to be provided with the right type of information at the right time, and by the right person. This is important as the findings of this study suggest this impacts on the patient's willingness to remain in hospital and receive treatment, and also impacts on the need for nurses to implement Section 5(4).

Fennell (1998: 332) has stated that 'for informal patients truly to understand their "right" to leave hospitals would have to tell them that it may be removed by decisions of doctors or nurses to restrain them from leaving hospital.' Therefore, it is suggested that all patients be informed - before and on admission - that if they have been admitted informally to hospital they are legally entitled to leave when they want, and also have the right to refuse treatment. This information should also inform patients that their informal status may change should nurses or doctors decide to exercise their holding powers. In relation to Section 5(4) patients should not only be alerted to its existence but given the opportunity to discuss the circumstances in which it could be applied. Currently any information making individuals aware of the legal implications of accepting an informal admission to hospital is only available through voluntary organisations such as Mind and SANE. For example, Mind provides some basic information on the process of admission (Mind, 2004) and informal and formal mental health care (Mind, 2011). However, the potential disadvantage of this method is that it relies on patients being aware of such information, having the means and skills to locate it, and then understanding its implications in advance of any discussions with healthcare professions about the possibility of in-patient care.

Sugarman and Moss (1992, 1994) have argued that mental health services should develop information sheets to be given to informal patients on admission explaining their rights and that the content should also be explained verbally. Sugarman and Collins (1992) piloted the introduction of one such leaflet at a regional secure unit. Its introduction led to concerns among staff 'that informing voluntary psychiatric patients of their rights may lead to premature discharge' (Sugarman et al., 1995: 246). Following the introduction of the leaflet there was a significant reduction in average hospital stay but no increase in the number of informal patients being detained, suggesting that they were no more insistent on leaving or refusing treatment (Sugarman and Collins, 1992). In addition, informal patients who had received the information leaflet were rated as being no more insistent on discharging themselves than those who had not been informed of their rights.

Although, doctors and nurses may wish to avoid the subject of detention before it is absolutely necessary, it is suggested that informing the patient of the possibility and the circumstances in which it may occur will empower them to make an informed decision about whether to accept an offer of hospital admission. It may also serve to alleviate fears associated with admission; particularly when the person has been admitted previously (Bindman et al., 2005). Sutherby et al. (1999: 56) have demonstrated in relation to the development of crisis plans that discussing the possibility of enforced treatment led to 'positive effects on the patient's attitude to self, their illness and treatment, and their relationship with the clinical team.'

Finally, in relation to providing any information prior to admission a problem may arise in terms of who is best placed to deliver it. The admitting clinician is in the right place at the right time but may not be the best person to deliver it due to a potential conflict of interest. The clinician may wish to admit the patient informally using the least restrictive alternative but at the same time be required to give the patient sufficient information to make an informed choice. SANE (2008) have commented that:

'Clinicians are a source of information and expertise and therefore have to negotiate subtle differences between being selective and biased in the information they provide. When a service user's ideas about their best interest conflicts with the clinician's opinion, the latter has to decide whether it is appropriate to attempt persuasion.'

Therefore, it is recommended that there is a need to undertake further research with relevant stakeholders to ascertain what information patients want in these situations and who should give it to them.

10.5 Implementing Section 5(4)

The last decade has seen an increasing focus in official documents and reports (for example, DH, 1999b; DH, 1999c; DH, 1999d; DH, 2001b, DH, 2002; University of Manchester [UN], 2006; UM, 2010; UM, 2011) on risk assessment, risk containment and risk minimization to the point that it has been argued by some that it 'has become the *raison d'être* of much mental health policy and practice' (Buchanan-Barker and Barker, 2005: 543). The decision to implement Section 5(4) is one way in which nurses contribute to the national safety and protection agenda, for example it functions to reduce the rates of self-harm and suicide.

The Act (DH, 1983) permits a nurse to prevent an informal patient from leaving hospital for their health or safety or for the protection of others; that is they have been assessed as being at risk. Morgan (2000: 1) has defined risk as:

'The likelihood of an event happening with potentially harmful or beneficial outcomes for self and/or others... possible behaviours include suicide, self-harm, aggression and violence, and neglect; with an additional range of other positive or negative service user experiences.'

However, at the start of this study little was known about the reasons why nurses implemented Section 5(4); that is how they interpreted the meaning of health, safety and protection (Allen and Johnson, 1992; Bowler and Cooper, 1993; Salib, 1998; Pym et al., 1999). Furthermore, the Act (DH, 1983) does not define risk explicitly or state what factors nurses should consider in determining the decision to implement Section 5(4). In addition, while so called 'soft law' (Glover-Thomas, 2011: 582) such as the Code of Practice (DH, 1999a) and risk assessment tools developed by some NHS Trusts offer guidance on the subject, in relation to Section 5(4) it is left to individual nurses to decide for themselves what is meant by risk to self or others.

While risk was a major determinant when making the decision to implement Section 5(4) there was no standardised approach used by nurses to assessing this within the Trust. Instead nurses in implementing Section 5(4) used what Glover-Thomas (2011: 588) has termed 'self-authored 'working definitions'' in interpreting health, safety and protection. These definitions were derived from personal experiences, information gained from their colleagues, and any written material they had encountered. As Alan noted, 'I think everyone's got a style of their own and there's no set assessment procedure' (S2T2. U20: 382). In these 'self-authored' approaches nurses used what Glover-Thomas (2011: 595) refers to as a 'risk recipe' approach to determining the need to implementing Section 5(4). That is, determining risk was 'analogous to 'completing' a recipe - the culmination of factors or 'ingredients' generates a result' (ibid: 595). That is a nurse will implement Section 5(4) when they conclude that 'a patient poses a risk to self or others where the requisite combination of factors or 'ingredients' (both clinical and non-clinical) exist in his or her case' (ibid: 596).

This personalised 'risk recipe' approach used by individual nurses in the study resembled what Doyle and Dolan (2002: 650) refer to as the 'clinical' or 'first generation' approach to risk assessment. In this approach the nurse's assessment is unstructured and it is based on their professional judgement as to what information is considered important in making their decision. While this has the advantage of being flexible and allows the nurse to focus on case-specific factors it has been criticised for being unstructured, informal, having the potential for missing important information, lacking consistency and not conducive to best practice principles (Doyle and Dolan, 2002; DH, 2007b). In addition, it may mean that assessors are unable to articulate why or how they reached a decision. Nor is there any evidence to suggest that decisions using this method are accurate. Therefore one implication of this is that a potentially 'at risk' patient detained by one nurse may have been allowed to leave by another (see Carl's story).

The 'second generation' (Doyle and Dolan, 2002: 651) or actuarial approach to determining risk has focused on 'static risk factors that have been shown to be statistically associated with increased risk in large samples of people' (DH, 2007b: 18). This approach uses standardised tools to make predictions of risk. While the actuarial approach is considered to be more accurate than the unstructured clinical approach (see

for example, Grove and Meehl, 1996) it is not without limitations. For example, tools may exclude important risk factors because there is insufficient proof to justify their inclusion. The actuarial approach may also result in the exclusion of important case specific factors (Doyle and Dolan, 2002). In addition, a tool's ability to make a prediction may be reduced if the patient being assessed does not come from the population for which it was developed (DH, 2007b). Finally, some have questioned the precision of some instruments for predicting future behaviours (Hart et al., 2007). Nurses in this study - like others elsewhere (for example, Godin, 2004) - were aware of risk assessment tools and recognised their benefits for a long-term risk management plan. However, they believed that they were less useful for determining the fluid nature of risk when a patient may have to be assessed several times a day, or when assessing a patient during a crisis such as when making the decision to implement Section 5(4).

A 'third generation' or structured clinical judgement approach to risk assessment has been advocated as a way of overcoming the limitations associated with the two approaches outlined above (see for example, Doyle and Dolan, 2002; DH, 2007b). This approach emphasises the importance of undertaking risk assessment based on evidence based predictors using suitable tools (for example the Historical Clinical Risk - 20 [HCR-20]).⁷¹ In addition, this approach also suggests that the risk assessment should take account of the practitioner's 'clinical experience and knowledge of the service user; and the service user's own view of their experience' (DH, 2007b: 18). However, this third option is still not without problems in relation to the implementation of Section 5(4), for example it still requires nurses to incorporate standardised tools into their assessment. However, the 'fluidity of risk' (DH, 2007b: 23) encountered at the time of crisis may mean that it is not possible for nurses to use tools sure as the HCR-20. This is not to reject the structured clinical judgement approach but to suggest that consideration needs to be given to how this approach can be adapted to meet the needs of managing risk in the fluid environment that is acute in-patient care.

Therefore, what is being advocated, in line with current best practice recommendations (DH, 2007b), is that all NHS Trusts ensure practitioners conduct risk assessments using the structured clinical judgement approach. The aim of this recommendation would be

⁷¹ The HCR-20 is a 20 item violence risk assessment tool that allows the practitioner to collect qualitative information about the patient (Dolan and Blattner, 2010).

to overcome some of the potential difficulties arising from the more personalised approaches to risk assessment utilised by nurses in this study. Furthermore, consideration needs to be given to the type and number of risk assessment instruments adopted if their introduction is to be successive. Higgins et al. (2005) have reported that considerable variation exists in; the number of instruments used in NHS Trusts, their content and the point at which they are completed. For example some NHS Trusts (for example Mersey Care, 2011) recommend up to 12 different tools that can be used at specified points during the patient's admission to assess different types and levels of risk. Again this has the potential to complicate the assessment process and is likely to lead to a lack of consistency in relation to which tool to use in what circumstances; clear guidance is required in such situations.

Hawley et al. (2006) have also reported considerable variation in the length of risk assessment documentation with the number of items ranging from five to 148. The majority (84.2%) of pro forma used a forced-choice format (for example, Yes/No or tick-boxes) consistent with the actuarial approach to risk assessment. Therefore, although nurses have positive attitudes to risk assessment and the completion of relevant documentation, it may be possible that the amount of time taken to complete tools 'may affect the quality of information recorded' (Hawley et al., 2010: 444) (also see Royal College of Psychiatrists, 2008: 29-35). The standardisation of risk assessment procedures and the accompanying documentation needs to be considered by stakeholders as this is likely to have positive benefits, for example in the completeness of data obtained at the time of undertaking the risk assessment (Stein, 2005; Dinniss et al., 2006).

While best practice guidelines (DH, 2007b) seem wholly appropriate to the assessment and management of risk over the course of an admission, they seem impractical for helping nurses to interpret the health, safety, and protection criteria during times of crisis. Therefore, developing a brief risk assessment method that nurses can refer to at such times would be beneficial. This could follow the approach taken by Bowers and colleagues (Bowers et al., 2003; Bowers et al., 2005b) who, in developing a number of anti-absconding strategies, produced pocket size laminated cards containing the indicators of absconding on one side and strategies for managing them on the other. Therefore, it is recommended that future research may wish to explore whether

individual and situational factors can be identified that are associated with the implementation of Section 5(4). The trends reported in Chapter 6 could provide a starting point for this research.

Nurses in this study reported a lack of formal pre- or post-qualifying education on risk assessment and management. The Department of Health (DH, 1999b; DH, 1999c; DH, 2007b) has recommended on a number of occasions that practitioners receive education in this area, stating that 'all staff involved in risk management should receive relevant training which should be updated at least every three years' (DH, 2007b: 6). Therefore, some consideration needs to be given to meeting nurses' training needs. For example, Davies et al. (2001) reported that 76 per cent of 159 trusts provided training to junior psychiatrists compared to 54 per cent of ward-based nurses. Reasons given for poor attendance were that the training was not compulsory and that staff were unable to take time off from their clinical commitments. It is suggested that in order for nurses to meet the requirements of the best practice guidelines that all NHS Trusts offer regular mandatory training on risk (for example see Tees, Esk and Wear Valleys NHS Foundation Trust, 2009). The delivery of any training would need to be flexible and available in a number of formats in recognition of the practical problems faced by practitioners, particularly ward-based staff (Kettles et al., 2008). Therefore, although attending workshops is a popular and effective means of providing training (Doyle et al., 2003) other options include the development of workbooks or electronic formats that could be completed online should be considered. Undertaking audits and offering practitioners feedback on their practice, perhaps during clinical supervision, may also have positive benefits for improving practice (Jamtvedt et al., 2007; Masson et al., 2008).

Consideration also needs to be given to the content of any risk training. This needs to be based on best evidence and any content developed nationally to avoid local interpretation of risk and intervention being taught as a model of practice. This may serve to avoid 'entrenchment of misunderstanding to take place' (Glover-Thomas, 2007: 595), although Haque et al. (2008: 404) suggest that any 'workshops are likely to be most effective when delivered 'in-house''. Following the Department of Health's (2007b) recommendations the content of such training should explore areas such as; indicators of risk, risk management, communication and therapeutic relationships, and

the relevant aspects of the Mental Health Act (also see Doyle et al., 2003). In addition, more positive aspects should be addressed, for example collaborating with patients and their carers to explore therapeutic risk which Stickley and Felton (2006) suggest supports life-recovery models of care and the choice agenda. There is also a need to ensure that mental health nurses receive adequate pre-qualifying education on risk; this will serve to ensure that individuals are competent in these nursing skills at the point of registration.

It has also been reported that Section 5(4) was implemented for a number of non-clinical reasons (see Chapter 7). For example, as self-protection when a doctor had instructed a nurse in writing to detain a patient or to initiate a multi-professional review of the patient's care. In this 'outcome-based' model nurses used risk strategically to justify their decisions to implement Section 5(4) and at the same time achieve the desired outcomes underlying their motivations (Glover-Thomas, 2011). In this approach nurses engaged in what Peay (2003: 74) has referred to as 'post-hoc rationalisations', that is individuals would decide on their desired outcome 'before retrospectively cherry-picking a key factor or combination of factors to justify it' (Glover-Thomas, 2011: 601). These rationalisations would be recorded in writing on Form 13 and/or local incident forms.

Where an outcome model to decision making had been deployed practitioners generally believed that they had no other alternative but to implement Section 5(4) to achieve their desired aim. At the centre of many of these stories was the nurse's relationship with the medical practitioner. In the case of psychiatrists instructing nurses to implement Section 5(4) it is unclear why they believed it was legitimate to do this as it clearly contradicts the Code of Practice (DH, 1999a). Research suggests that some doctors have poor knowledge of mental health legislation including their own emergency holding powers under Section 5(2) of the Act (Lynch et al., 2000; Jackson and Warner, 2002; Baig et al., 2008; Wadoo et al., 2011). Although knowledge of Section 5(4) has not been addressed in existing research it is reasonable to suggest that doctors also have a poor understanding of nurses' holding powers which could explain their clinical actions. In addition, in a number of recent texts (for example, Zigmond, 2011) that provide psychiatrists with guidance on using the Act little attention is given to Section 5(4). It is therefore recommended that any training received by doctors

working in psychiatry should include sufficient information on Section 5(4) to address the problems raised in this study. Research may also wish to explore, if a lack of knowledge is not the issue, why doctors persist with a practice that is contrary to the guidance given in the Code of Practice dating back to 1990 (DH, 1990), for example factors surrounding power imbalances in the doctor-nurse relationship (see for example Stein, 1967; Fagin and Garelick, 2004).

10.6 The impact of implementing Section 5(4)

A number of studies have reported the impact of formal versus informal admission to psychiatric hospitals on treatment outcomes using quantitative measures (Katsakou and Priebe, 2006), but few have offered insights into the patient's actual experiences (Katsakou and Priebe, 2007). In a review of the quantitative evidence exploring the relationship between involuntary admission and treatment, Katsakou and Priebe (2006) reported that patients do demonstrate clinical improvement in their mental health and view their admission and treatment positively. However, a substantial number of patients do not feel that their admission was justified or beneficial. Although patients' views do become more positive over time, that is 'the length of time that has elapsed since admission' (Katsakou and Priebe, 2006: 234).

Katsakou and Priebe (2007) have also undertaken a review of the qualitative literature of patients' experiences of involuntary hospital admission and treatment. Katsakou and Priebe (2007: 172) suggest that the main themes emerging from the literature were patients' 'perceived autonomy and participation in decisions for themselves, their feelings of whether or not they are being cared for and their sense of identity.' However, the findings of these studies were limited by their sample sizes, the fact that some focused on coercive interventions generally rather than the detention process specifically. Nor have any of the existing studies provided in-depth accounts of the events before, during and after the patient's detention. The in-depth accounts of patients' experiences of their detention under Section 5(4) presented in this study have made a contribution to addressing some of these limitations. The findings have provided insights into the events leading up to the patient's admission, life on the ward and also events leading up to their detention, and its aftermath. These insights raise some issues worthy of further discussion.

Supporting the review of the literature undertaken by Katsakou and Priebe (2006) patients in this study believed, on the whole and with the passage of time, that the decision to detain them was the correct one as it had prevented them and others coming to harm. However, the emotional responses of patients were characteristically negative with typical responses including fear, anger, and shock. In addition, this led to a sense of injustice, disempowerment, depersonalisation, poor self-esteem, and infantilisation. Patients also reported being threatened with seclusion, enforced medication, and further detention if they did not comply with their new legal status. The outcomes of this included: increased conflict with both doctors and nurses; a lack of cooperation; disillusionment with the ability of staff to help them; and attempts to abscond. Nurses also experienced strong emotions during the detention process including: sadness; a sense of failure at having to implement the section; and fear of potential or actual aggression and violence.

The findings of this study support those reported elsewhere in relation to the experiences of patients who have been subjected to compulsory admission to hospital and subsequent treatment (Barnes et al., 2000b; Olofsson and Jacobsson, 2001; Johansson and Lundman, 2002), and also those subjected to coercive interventions including physical restraint (Bonner et al., 2002; Hawkins et al., 2005), and seclusion (Meehan et al., 2000). For example, Olofsson and Norberg (2001: 92) reported that patients felt that coercion 'made them feel insecure as if they were in chaos, failing (as human beings) and having their integrity violated.'

When the patient disengages with the service through refusing medication, leaving the ward or refusing to cooperate with key healthcare professions, such as their key-nurse or psychiatrist, it is likely to negatively impact on their care. For example, it may lead to longer admissions, extended periods of detention, and the need for coercive interventions such as enforced medication. Olofsson and Norberg (2001) have suggested that the way to avoid the need for coercion - in this case the implementation of Section 5(4) - or to minimise its impact is to develop 'a good relationship with the patient' (ibid: 93) by spending time with them and to undertake therapeutic work (for example counselling) as soon as possible following admission. The nurse-patient therapeutic relationship has long been recognised as the foundation on which all care and recovery is based in mental health nursing (for example Peplau, 1988).

Some authors have suggested the implementation of Section 5(4) or simply the fact that it exists is likely to impact negatively on the nurse-patient relationship (Bean, 1986; Hoggett, 1984; Unsworth, 1987; Hoggett, 1996; Cutcliffe et al., 2000; Rogers and Topping Morris, 2000; Hale, 2010). Research supporting these assertions is limited. For example Carver and Ashmore (2000) reported that 29 per cent of nurses believed that using Section 5(4) did negatively affect nurses' relationships with the patient. In contrast, Dimond (1989: 545) reported that nurses who had implemented Section 5(4) had not noticed 'any harmful effects on their relationship with the patient' and that 'there was no resentment from the patient'. However, up to this point no attempts have been made to ask patients (or nurses) what they think about the issue of Section 5(4) and therapeutic relationships. Although in relation to compulsory admission in general Barnes et al. (2000b: 13) have reported that, 'for the majority, the impact was adverse, leading to a lack of trust of workers, a guardedness and unwillingness to reveal true feelings, and a reluctance to seek help.' Others, such as Hughes et al. (2009), have reported a more variable response from patients with some reporting very positive relations with nurses following their detention. Other patients did respond negatively to their experiences while a third group reported a more positive relationship as they were allowed 'more freedom of movement' (ibid: 156).

This study has gone some way towards filling this knowledge gap and for the first time providing a patient's perspective on this debate. Certainly all patients reported short-term negative effects, particularly towards the nurse implementing the section, and also some nurses towards the patient. Some nurses recognised the potential for more long-term effects and at least one patient (Carl) reported that it had permanently affected his opinion of healthcare workers (doctors and nurses). However, it was also suggested that any problems could be overcome but, at times, participants were less clear as to how this could be achieved. As this was not a longitudinal study it is impossible to say if and how these concerns were addressed in practice.

Olofsson and Norberg (2001: 98) have reported that when nurses had an 'established relationship' with the patient coercive interventions had less negative impact afterwards. Patients also reported that during times of conflict associated with coercive interventions it was important to meet with staff who would 'have time to listen and

talk to them' (ibid: 94) about their experiences, and that nurse could demonstrate that they cared about them in a non-judgemental manner. When such conditions were in place patients felt more positive about their experiences. However, in line with previously reported research on acute in-patient settings (for example, Quirk and Lelliott, 2001; Cleary, 2004), patients felt they had insufficient contact with nurses and when they did there was little opportunity to discuss their concerns. Certainly in this study any attempts to talk to the patient about the incident, where they existed, were ad hoc rather than part of any systematic process. Therefore, in relation to coercive interventions - in this case Section 5(4) - it seems important to offer patients the opportunity to discuss their experiences. The aim of this would be to minimise any negative impact on the therapeutic relationship. This seems particularly important as Hoge et al. (1993) have reported that during times of conflict patients focus their negativity on the relationship with the person performing the coercive act (for example, the implementation of Section 5(4), rather than the act itself.

It is also possible that regular contact time could prevent conflict developing between nurses and patients and therefore decrease the likelihood of having to implement Section 5(4) should they decide to leave the ward (Secker et al., 2004). While it cannot be stated conclusively that a lack of nurse-patient contact resulted in the use of Section 5(4), it is not unreasonable to propose that such experiences may lead to boredom, frustration, or aggression which may lead to a desire to leave as noted in other areas of acute care. For example, Bowers et al. (1999: 200) reported that one reason given by patients for absconding was a 'negative relationship with professional staff.'

Regular contact with their key-nurse would also give patients the opportunity to become involved in the decision-making process regarding their post-detention care; something the participants in this study felt excluded from. Although it may not be reasonable to expect patients to be consulted on all aspects of their care and detention at all stages of the process (at least initially), it is suggested that giving patients the autonomy to make decisions about some aspects of their care may reduce their sense of powerlessness. For example, when patients defined by nurses as 'difficult' were given choices about some aspects of their care the patients' feelings of anger were reduced (Breeze and Repper, 1998).

Therefore, like other emergency interventions, the events before, during and after the implementation of Section 5(4) have the potential to evoke strong emotional responses in both patients and nurses that can last for significant periods of time (Wadeson and Carpenter, 1976; Bonner et al., 2002; Lee et al., 2003). These emotional responses may negatively impact on the therapeutic relationship and hence treatment outcomes. Therefore it is recommended that NHS Trusts develop policies and procedures to ensure that adequate support and debriefing is built into the post-detention period for both nurses and patients. The purpose of this would be to limit the impact of the potentially traumatic events associated with detention (for example restraint, forced medication and seclusion) under Section 5(4) and other sections of the Act implemented following admission to hospital.

In relation to the patient, the purpose of this debriefing process would be to provide them with the opportunity to talk about and gain an understanding of the events surrounding their detention and why it had occurred. It would also serve as a forum for them to ventilate their feelings regarding their experiences and in doing so help to minimise their short- and long-term impact on the patient's medical and life recovery. This process could also help the patients to come to terms with their new legal status and form the basis to engage them to participate in a collaborative treatment plan. It may also serve to lessen the likelihood of nurses having to enforce the detention through coercive means, for example locking ward doors (Ashmore, 2008). This debriefing process may also help to overcome the fact that patients feel 'ignored and unheard... in the aftermath of untoward incidents' (Bonner et al., 2002: 471). There should also be the opportunity for patients to have access to a person who is independent of the ward or service where the detention has taken place, for example ex-patients who had been through similar experiences.

Similarly, nurses' stories highlighted the fact that they had no formal mechanisms for discussing their experiences. It would therefore also seem important to offer nurses the opportunity to discuss their experiences and minimise the potential of developing any long-term problems. For example, it has previously been reported that untoward incidents experienced by nurses have the potential to reactivate distressing memories associated with earlier traumatic events (Bonner et al., 2002)

It is also suggested that the debriefing process should be undertaken systematically by following established, evidence-based procedures (for example, Mitchel, 1983; Dyregov, 1989) by practitioners who have undertaken appropriate training. In addition, debriefing should not be seen as an isolated event as a recent review of the literature suggests that single sessions may not successfully prevent the development of conditions such as post-traumatic stress disorder (Rose et al., 2009). There may be a need to follow up the initial debriefing a month after the event to prevent the development of more long-term problems. Future research may also want to explore any long-term consequences of short-term detentions such as Section 5(2) or Section 5(4).

Nurses may also benefit from 'being taught emotion-focused coping strategies, such as stress or anger management' (Hawkins et al., 2005). Such strategies may help nurses deal with their feelings before, during and after the events. Such strategies, along with an in-depth post-detention analysis of the events surrounding the use of Section 5(4), may help nurses to develop different ways of managing these types of crisis situations in the future and, in at least some cases, avoid the perceived necessity to use the holding power. In addition, informing nurses of the effects of implementing Section 5(4) on the patient may serve to increase their level of understanding of the patient's perspective. In doing so, this may remind nurses of the need to manage such situations in an empathic way.

10.7 Recommendations

A number of issues arising from the findings of this study have been discussed. Based on the discussion the main recommendations can be summarised as follows:

1. The meaning of least restrictive alternative and its implications for all major stakeholders (patients, professionals and carers) needs to be addressed. This will serve to clarify the patient's legal position and ensure that their rights are not abused.
2. Ensuring that patients receive adequate information is essential. Organisations involved in the care and treatment of mental health problems should have protocols in place to ensure that patients receive sufficient information on

relevant topics. This will enable patients to make informed choices about their hospital admission and subsequent treatment.

3. NHS Trusts need to develop a standard multi-professional approach to risk assessment that is practical to use during emergency situations, for example when considering the decision to implement Section 5(4). Therefore, it is recommended that a brief risk assessment tool is developed that nurses can refer to during such emergencies. The tool could take the form of a pocket size laminated card containing, in this case, the indicators of risk associated with the implementation of Section 5(4). Any indicators included should be derived from the best available evidence and developed nationally and collaboratively with patients and carers.
4. There is a need to ensure that all mental health nurses receive training and regular updates in risk assessment and risk management specific to the implementation of Section 5(4).
5. Both doctors and nurses require further training in interpreting and implemented the Act. This training would focus on ensuring that doctors and nurses have adequate knowledge of their holding powers (Section 5(2) and Section 5(4)) and their individual responsibilities.
6. Post-incident debriefing should be offered to all those involved in the process. Events before, during and after the implementation of Section 5(4) result in the expression of strong emotions by both nurses and patients. Such emotions need to be actively managed to ensure that any negative impact on the patient's care is minimised.
7. Patients should be given the opportunity to discuss their experiences of detention with their key-nurse in order to minimise any negative impact on the therapeutic relationship. Regular contact with their key-nurse following the implementation of Section 5(4) would also give the patient the opportunity to become 'involved in shared decision-making' (NICE, 2011: 7) regarding their post-detention care. In addition, nurses should be offered education exploring the impact of

implementing Section 5(4) on the patient. The purpose of this would be to encourage a deeper and therefore more empathic understanding of the patient's perspective. It would also serve to enable them to reflect on how they manage the events before, during and after the implementation of the holding power.

10.8 Quality issues

The final issue to be addressed in this study is that of rigour, that is the extent to which the findings presented in this thesis can be trusted. Streubert and Carpenter (1999: 28) state that:

‘The goal of rigor in qualitative research is to accurately represent study participants’ experiences.’

Guba (1981) and Guba and Lincoln (1994) have proposed four criteria for establishing the trustworthiness of qualitative research: credibility, dependability, confirmability, and transferability. Credibility is concerned with the probability that credible findings have been generated. Streubert and Carpenter (1999: 29) suggest that one way to establish credibility is ‘through prolonged engagement with the subject matter.’ It is proposed that the credibility of this study was enhanced by the fact that data were generated from real-life situations over a one-year period from four different acute wards. In addition, data reflected Section 5(4)s implemented on different days of the week and over the 24-hour period. Therefore, prolonged engagement in the field and the use of multiple sources of data (triangulation) produced an in-depth account of the phenomenon under study (Seale, 2002).

Another strategy for establishing credibility of a study is to see ‘whether participants recognize the findings to be true to their experiences’ (Streubert and Carpenter, 1999: 29). Some have suggested that this can be achieved through member checks, that is transcripts and reports are given to participants to assess the ‘accuracy’ of the researcher’s interpretations (Bailey, 1996). However, it was decided not to undertake member checks in this study as it was not considered practical (McConnell-Henry et al., 2011). For example, some nurses did not wish to receive copies of transcripts following interviews. In addition, due to reasons of confidentiality it was not possible to forward copies of transcripts to patients who had been discharged.

Member checking has been criticised because it is said that it relies on the assumption that there is a fixed reality that can be represented in accounts of research (Bailey, 1996; Carlson, 2010), a position rejected by the philosophy adopted in this study. In this study it was proposed that the accounts of the implementation of Section 5(4) generated during interviews were co-constructions of the events arising from the conversation between researcher and participant. Therefore, it is suggested that member checking would have limited utility in this instance. However, the findings of the study have been presented to nurses (including some participants) working on the four wards within the research site on a number of occasions. Feedback confirmed the credibility of the findings.

Dependability is concerned with the extent to which the findings generated in a study could be replicated if the research was to be repeated with the same or similar participants in the same or similar settings (Searle, 2002). It is worth noting that the ontological and epistemological position taken in this research would suggest that any attempts to repeat the research in other acute settings might expect to find a great deal of variability in any findings generated (Guba, 1981). However, it is proposed that the dependability of this research has been established through the rigorous application of the methods used to generate and analyse the data in the study. The methods and analytical techniques have been described in detail along with the decisions made during the research. This information could be used by future researchers as a template for undertaking similar research on Section 5(4) in other contexts.

Confirmability (also referred to as neutrality) refers to the extent to which the findings of the study are the 'result of the participants in and conditions of the research' (McGloin, 2008: 52) and not the result of other influences such as the 'biases, motivations, interests, or perspective of the inquirer' (Searle, 2002: 104). While every attempt was made to ensure that the research was undertaken in a 'neutral' manner - in order to hear the stories that participants wanted to tell - it is accepted that at times I may well have influenced the direction of an interview. However, it is suggested that the interview is a social event and any meaning derived from it is constructed from the interaction between researcher and participant. In addition, the findings presented in this study are a further construction based on my interpretation of the data. Therefore, it

is argued that the researcher's influence on the findings can only be minimised not eliminated. For example, at times during interviews I pursued issues that were of interest to me. However, I attempted to minimise the impact of this by asking open questions that allowed participants to answer in ways they thought fit with minimum interruption from me. Therefore, the confirmability or neutrality of my findings can be judged by 'auditors' examining an 'audit trail' of how this research was conducted.

Carcary (2009: 15) suggests that by implementing an audit trail:

'an auditor or second party who becomes familiar with the qualitative study, its methodology, findings and conclusions can audit the research decisions and the methodological and analytical processes of the researcher on completion of the study, and thus confirm its findings.'

The research audit trail may be intellectual or physical in nature. Evidence of the intellectual audit trail in this study includes the rationale given for: undertaking the study; the philosophical stance adopted in the research; the choice of methods; and the analytical strategy deployed. The physical research audit trail includes: the review of the literature and the development of the research protocol; ethics committee documentation; the evidence generated (interviews and documentation); and the coding of quotes in the text to enable them to be located in the original transcripts (Shenton, 2004; Carcary, 2009; Mason, 2010).

Transferability 'refers to the probability that the study findings have meaning to others in similar situations' (Streubert and Carpenter, 1999: 29). Streubert and Carpenter (also see Lincoln and Guba, 1985; Sandelowski, 1986) argue that the responsibility for determining transferability of the findings 'rests with potential users of the findings and not with the researchers' (ibid). Therefore, it is difficult to say whether the accounts of how and why Section 5(4) was implemented presented in this study are representative of the views held by nurses and patients in other NHS Trusts, only those reading or hearing the findings can decide that. However, feedback received on the presentation of the findings at research conferences (for example Ashmore, 2010; Ashmore, 2011) suggests that nurses did recognise similarities to practices on other acute wards in the United Kingdom. Some have argued that the fact case study research often focuses on

small numbers in single settings limits the transferability of any findings generated (Holloway and Wheeler, 1997; Meyer et al., 2000; McGloin, 2008). Such criticisms seem to be more relevant to the positivistic concept of generalisation rather than that of transferability. Future researchers may wish to explore the constructions presented here by taking a more systematic approach, perhaps using a Delphi method or focus groups with practitioners from different trusts to test the wider applications and utility of the findings (for example the typology) generated in this study.

10.9 Conclusion

As this thesis draws to its conclusion it is argued that the question posed at the beginning of the study is as significant now as it was then. The number of Section 5(4)s implemented in the period 2010-2011 has been one of the highest ever recorded (NHS ICHSC, 2011). Yet, during the duration of this study only one new empirical study (Shivram, 2006) on Section 5(4) has been published and this has only confirmed rather than added anything new to the existing body of literature. Since the start of the study the Mental Health Act 1983 has been amended (DH, 2007a) and Section 5(4) has passed into the new Act unchallenged. In addition, with the introduction of the approved mental health professional (AMHP) some nurses will be given additional powers.⁷²

The review of the literature undertaken in this study demonstrates that nearly 28-years after the introduction of Section 5(4) we are no further forward in understanding how and why this legislation is operated in practice. This study has made a significant contribution to addressing this deficit by presenting findings that have implications for policy, practice, research, and education. There are no examples in the literature of the process by which nurses implement Section 5(4). The relatively straightforward official process for implementing Section 5(4) as suggested by the Act (DH, 1983) and the Code of Practice (DH, 1999) was presented in Figure 1. This study makes a distinct contribution to the literature by demonstrating in the collective story (Chapter 9) that the use of Section 5(4) is a much more complex process. The findings showed that while risk was an important determinant in nurses' decisions to implement Section 5(4) it was not the only determinant. Other determinants, for example self-protection, illustrated a

⁷² A nurse with additional training can take on the role of the AMHP. This role will mean that some nurses will assess patients for longer periods of detention under the Act, for example Section 5(2).

complex relationship between nurses, patients, and doctors when implementing Section 5(4) (Chapter 7).

Previous research has offered some insights into the impact of compulsory admission and treatment on the patient (see for example Barnes et al., 2000b; Gillard et al., 2011), however there has been few attempts to produce in-depth accounts of the events before, during and after the implementation of the Act specifically in relation to short-term sections such as Section 5(4). The findings in this study offer valuable insights into the patient's perspectives on the impact of their detention and the consequences for their subsequent care. Their stories suggest that there is a need for professionals to give greater attention to patients' narrative accounts as they may help to avoid the need for them to deploy Section 5(4).

All research is not without limitations and this study is no exception. One potential limitation of this study is the fact that only four patient interviews were completed. This fact arose from the problems associated with recruiting patients to this research (see section 4.5.3.3). For example some patients declined an invitation to participate in the study, some were judged to lack the capacity to consent, and still others had been discharged before they could be contacted. While this was unavoidable it was also unfortunate as more patients' accounts of the implementation of Section 5(4) had the potential to enrich the study further. However, it is suggested that this limitation did not detract from the trustworthiness (Guba, 1981; Guba and Lincoln, 1994) of the findings presented in this thesis as each story provided an in-depth account of the detention from the patient's perspective.

Furthermore, since September 1983 over 34,000 people have been detained under Section 5(4) yet their stories have passed into history untold. Therefore, despite the problems identified above, it was important to include the stories told by Mark, Carl, Shaun, and Asif in this thesis in order to give patients' experiences of this phenomenon a 'voice' for the first time. To have excluded the patient's 'voice' would have served to collude with what McIntosh Johnson and Dodds (1957: 8) - in their seminal work 'The Plea for the Silent' - have called the 'conspiracy of silence' surrounding the detained patient. A decision was made to exclude the patients' stories from the collective story presented in Chapter 9. This decision was made for two reasons. Firstly, the

development of the collective story was an attempt to account for important nursing data that had been excluded from the findings presented in Chapter 7. In contrast all patient data was analysed and presented in full in Chapter 8. Secondly, - while acknowledging that the patients' narratives may have brought a further dimension to the collective story - I believed (due to their small number) that the impact of their 'voice' would be 'diluted' or even 'silenced'.

Numerous references were made by nurses to the influence of the psychiatrist on their decision to implement Section 5(4). Therefore, the absence of a medical perspective on this can be considered another limitation of the study. A medical perspective on some of the issues raised may have enhanced the study further. The absence of a medical 'voice' can be attributed to the failure to recruit psychiatrists to this research. Those psychiatrists who were approached declined an invitation to participate in the study on the grounds that they were too busy or simply that they did not want to. Others did not respond to my attempts to make contact with them.

It is suggested that limitations may also lead to opportunities and so it is with this study. Therefore, future research may wish to obtain a medical perspective on detention in order to explain some of the issues identified in this study. For example, the informal admission of patients who are then detained by nurses soon after. In view of the difficulties encountered in recruiting psychiatrists to this study, consideration should be given to undertaking a collaborative project with medical practitioners to increase the likely success of any such research. The collective story and typology developed in this thesis also identified important findings. However, they were developed from data generated in one NHS Trust and therefore future multi-sited research may wish to explore the dependability of these findings.

Finally, Clark and Bowers (2000: 390) have suggested that, 'psychiatric nurses have been largely absent from debates over mental health legislation. A nursing contribution to the literature is virtually absent.' It is proposed that the finding of this thesis make a significant contribution to the literature on mental health legislation from a nursing perspective.

‘They asked for my story. I have told it. Enough.’

Hill (1998: 160)

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Record for the purposes of
Mental Health Act 1983 section 5(4)

Regulation 4 (1)(h)
Mental Health Act 1983

To the Managers of (name and address of hospital or mental nursing home)

.....
.....
.....

(Full name of patient).....

It appears to me —

- (a) that this patient, who is receiving treatment for mental disorder as an in-patient of this hospital, is suffering from mental disorder to such a degree that it is necessary for the patient's health or safety or for the protection of others for that patient to be immediately restrained from leaving the hospital;

AND

- (b) that it is not practicable to secure the immediate attendance of a registered medical practitioner for the purpose of furnishing a report under section 5(2) of the Mental Health Act 1983.

I am (full name of nurse), a nurse registered —

Delete the phrases
which do not
apply.

- (a) in Part 3 (first level nurse trained in nursing persons suffering from mental illness);
OR
(aa) in Part 4 (second level nurse trained in the nursing of persons suffering from mental illness (England and Wales));
OR
(b) in Part 5 (first level nurse trained in the nursing of persons suffering from learning disabilities);
OR
(bb) in Part 6 (second level nurse trained in the nursing of persons suffering from learning disabilities (England and Wales));
OR
(c) in Part 13 (nurses qualified following a course of preparation in mental health nursing);
OR
(d) in Part 14 (nurses qualified following a course of preparation in learning disabilities nursing);

of the professional register.

Signed

Date

Time

Appendix 2 Local Incident Form

COMMUNITY HEALTH TRUST

LOCAL INCIDENT REPORT - SECTION 5(4) MHA 1983

Name of Hospital Ward

..... Date

Name of patient RMO

Doctor Informed Time Date
(name)

Reasons for Section 5(4) being implemented:

.....
.....
.....
.....
.....
.....
.....

Signature of Nurse

.....

(Name in blocks)

RECORD OF LEAFLET

Leaflet No 1 handed to patient? Yes/ No

Has the leaflet been explained verbally? Yes/ No

Can relatives be informed of Section? Yes/ No

Does the patient appear to understand? Yes/ No

Signature of staff explaining leaflet

(Name in blocks)

SECOND COPY TO REMAIN ON WARD

Record of time at which power to detain
under Mental Health Act 1983
Section 5(4) elapsed

Mental Health Act 1983
Section 5(4)

(Full name of patient)

Complete (a) or (b) whichever occurred first

(a) Registered medical practitioner arrived

(time) at

(date) on

(b) The patient ceased to be detained

(time) at

(date) on

Signed _____

Status _____

Appendix 4 Databases, search terms and the number of abstracts located

Search Terms	Databases				
	ASSIA	CINAHL and BNI	Medline	PsychINFO	Lawtel
Section 5(4)	0	16,980	17	0	0
Section 5(4) NOT Midwifery NOT Caesarean	-	392	-	-	-
Nurse's holding power	6	4	9	5	0
Holding powers	83	5	10	401	1
Mental Health Act 1983	233	134	756	404	533
Mental Health Act 1983 NOT Treatment	-	127	490	-	-
MHA	15	100	866	135	7
MHA NOT Treatment	-	-	494	-	-
Compulsory detention	29	17	49	104	6
Formal detention	8	2	6	42	1
Emergency psychiatric interventions	46	3	3	937	0
Containment interventions	26	10	10	303	0
Involuntary Commitment	53	1247	1220	1096	0
Involuntary Commitment NOT Treatment	-	173	589	14	-

Appendix 5 Short version of the research protocol

Using the nurses' holding power (Section 5(4)) to prevent patients from leaving hospital

Summary

Background

Section 5(4) (Nurses' Holding Power) of the Mental Health Act 1983 empowers mental health nurses to prevent psychiatric in-patients who are admitted on an informal basis from leaving hospital if they are assessed to be a risk to themselves or others. The use of this section has risen from 770 incidences in 1997-1998 to 1953 in 2001-2002 (DH, 2002). This accounts for 9.87% of all informal patients who are detained after being admitted to hospital.

Despite the increased use of this legislation and the important role it plays in determining the care of the potentially at 'risk' patient, very little research exists concerning its use in practice. Despite the fact that this section is now 20-years old, what is clear is that our understanding about how it is used is incomplete. Specifically, there is still no understanding of the process by which patients are prevented from leaving hospital by nurses from both a nursing and patient's perspective. This would seem to be an important process to understand as it may have ethical, legal, policy and practice implications for both mental health nurses and patients.

Aims

The aim of this study is to explore, describe and explain the process by which mental health nurses detain a patient under Section 5(4) of the Mental Health Act (DH, 1983). This will be achieved by exploring nurses' and patients' understandings of the events that they believe were involved in the decision to use Section 5(4). In addition, it will provide an in-depth account of what happens once the section has been used and the impact of these events on those involved in the process.

Methods

The study, using a case study approach, will involve:

1. The collection of population characteristics e.g. age, gender and other background data e.g. date and time of detention for all Section 5(4)s used on the four adult (16-65 years) in-patient wards in the Trust during the course of the study. This information will be collected with the help of the Medical Records and Patient Information Departments;
2. The collection of documentation (policies, procedures etc) used within the Trust relating to the use Section 5(4) as well as other nursing interventions e.g. risk assessment tools and locked ward policies. This information will give the researcher an insight into the role that such documentation play in the decision to use Section 5(4);

3. Individual interviews will be undertaken with patients detained under Section 5(4) and nurses using the holding power. In addition, interviews may be undertaken with significant others e.g. the doctor(s) who have been involved in the detention process. These interviews will provide an understanding of the reasons for implementing this section and any consequences of its use from a number of perspectives.

Interviews will be audio-taped with the participant's permission and last between 45 and 60 minutes. Participation in the interviews is voluntary and based on verbal and written informed consent. Anything discussed will be anonymised and treated in confidence.

4. Nursing and medical notes will be reviewed to gain an understanding of the patient's history leading up to their admission, their care since admission and the events leading up to their detention.

Potential Benefits

In addition to gaining an in-depth understanding of the processes involved in the implementation of Section 5(4), the study has a number of other potential benefits for nurses and patients. These include the production of advanced directives for patients in relation to future care and the identification of support mechanisms for the aftermath of what is potentially a traumatic process for both mental health nurses and patients.

Russell Ashmore

Appendix 6 A4 summary of the study

A multiple case study of the process of detaining patients under Section 5(4) of the Mental Health Act 1983

A Quick Guide

Researcher: Russell Ashmore, Lecturer, University of Sheffield.

Aim

To explore, describe and explain the process by which nurses prevent patients from leaving hospital by implementing Section 5(4) of the Mental Health Act (DH, 1983).

Design

A multiple case study design

Data collection

The study will generate data from a number of sources including:

- Routinely collected statistics on a sample of Section 5(4)s implemented during the study period;
- Local policies and protocols from all adult in-patient wards within the Trust;
- Interviews with nurses implementing the section and patients who have been detained under the holding power and any significant others, for example doctors who have been involved in the detention process. The interviews will last between 45 and 60 minutes and audio-taped with the participant's permission;
- Documentation, for example nursing and medical notes, Forms 13 and 16.

Ethics

All relevant ethical procedures have been followed and permission given to undertake the research by the North Sheffield local research ethics committee and the Sheffield Health and Social Research Consortium.

Data Analysis

Analysis will use both qualitative and quantitative approaches in order to answer the research questions.

Plan

The study will take approximately 12 months to complete the data generation period.

Appendix 7 Final Local Research Ethics Committee approval letter

Sheffield Teaching Hospitals NHS Trust

North Sheffield Ethics Office
1st Floor Vickers Corridor

Direct Line: 0114 271 4894 or 271 4011
Fax: 0114 256 2469

Email: Sue.Rose@sth.nhs.uk

Northern General Hospital
Herries Road
Sheffield
S5 7AU

CMHN/AD/02/06/03

Ashmore/NS2003 6 1671

Please quote this number on all correspondence

26th August 2003

Russell Ashmore
Lecturer in Mental Health Nursing
Department of Mental Health and Learning Disabilities Nursing
Humphry Davy House
Golden Smithies Lane
ROTHERHAM
S63 7ER

Dear Mr Ashmore

**A multiple case study of the process of detaining service users under section 5(4) (Nurses holding power) of the 1983 Mental Health Act.
NS2003 6 1671**

The Chair/Honorary Secretary of the North Sheffield Research Ethics Committee has considered the modifications submitted in response to the Committee's earlier review of your application on 2nd June 2003 as set out in our letter dated 4th June 2003. The documents considered were as follows:

- Revised application form.
- Protocol version 2 dated July 2003.
- Signatures of consultants giving permission for service users to be approached.
- Certificate of insurances from the University of Sheffield dated 3rd June 2003.
- Patient information sheet and consent form version 2 dated 8th July 2003.
- Mental Health Nurses' information sheet and consent form version 3 dated 4th August 2003.
- Significant Others' information sheet and consent form version 3 dated 4th August 2003.

The Chair/Honorary Secretary, acting under delegated authority, is satisfied that these accord with the decision of the Committee and has agreed that there is no objection on ethical grounds to the proposed study. I am, therefore, happy to give you the favourable opinion of the committee on the understanding that you will follow the conditions set out below.

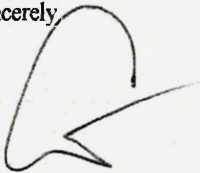
Conditions

- You do not recruit any research subjects within a research site unless favourable opinion has been obtained from the relevant REC.

- You do not undertake this research in an NHS organisation until the relevant NHS management approval has been gained as set out in the *Framework for Research Governance in Health and Social Care*.
- You do not deviate from, or make changes to, the protocol without prior written approval of the REC, except where this is necessary to eliminate immediate hazards to research participants or when the change involves only logistical or administrative aspects of the research. In such cases the REC should be informed within seven days of the implementation of the change.
- You complete and return the standard progress report form to the REC one-year from the date on this letter and thereafter on an annual basis. This form should also be used to notify the REC when your research is completed and in this case should be sent to this REC within three months of completion.
- If you decided to terminate this research prematurely you send a report to this REC within 15 days, indicating the reason for the early termination.
- You advise the REC of any unusual or unexpected results that raise questions about the safety of the research.

A full record of the review undertaken by the REC is contained in the attached REC Response Form. The project must be started within three years of the date on which REC approval is given.

Yours sincerely



Dr C M H Newman
HONORARY SECRETARY - RESEARCH ETHICS COMMITTEE
Senior Lecturer in Cardiology/Honorary Consultant Physician

Cc Dr P Ramcharan, R & D Consortium

Encs

Appendix 8 LREC and Research Governance timetable

Date	Details
11/04/03	Application submitted to LREC.
12/05/03	Invitation to attend LREC received.
02/06/03	Attendance at LREC meeting.
03/06/03	Non Clinical Trial Insurance certificate received from the University of Sheffield.
04/06/03	Letter received from LREC with eight points for attention.
16/06/03	RGD notified of NHS LREC of submission of request for approval to undertake study in NHS Trust.
18/06/03	RGD request the completion and submission of research application form together with all relevant documentation.
05/07/03	Completed application form and relevant documentation submitted together with a request that the RGD arrange an honorary contract with Trust.
10/07/03	Revised LREC application submitted.
17/07/03	E-mail received confirming receipt of documentation and acknowledging that they will arrange an honorary contract.
25/07/03	Letter from LREC received identifying five points for attention.
04/08/03	Revised LREC forms submitted.
08/08/03	<p>Feedback received from LRGD Peer Review Panel, including:</p> <ul style="list-style-type: none"> - 'The project had been reviewed to the satisfaction of the Panel'. - A number of advisory comments on the study that did 'not require the researcher to provide a formal response.' - Advised that I should 'allow at least two months' to complete the research governance process.

26/08/03	Final LREC approval received.
17/09/03	RGD request the completion and submission of research application form together with all relevant documentation.
22/09/03	Contacted RG Department to explain that all documentation had already been submitted and that I had received a positive peer review. Informed that the process will remain suspended until I submitted the requested documentation.
23/09/03	All documentation resubmitted.
10/10/03	E-mail received stating that the governance process has been started.
10/10/03	Received e-mail stating that 'previous messages sent in error', that is the need to resubmit documentation. My original application had been 'misfiled' and that the original application would now proceed.
13/10/03	E-mail received from [Name] the Trust's Area Manager and Research & Development Lead asking whether I had ward manager's support to undertake the project and stating that I would need to apply for 'funding to backfill staff time required by their participation in the study.'
17/10/03	Responses to queries submitted.
22/10/03	E-mail sent to LRGD requesting clarification of outstanding issues that needed resolving before approval could be granted
30/10/03	E-mail received summarising outstanding issues (management approval, hosting arrangements, and honorary contract/ letter of approval) on application and who was responsible for dealing with them. Also asked to explain way I was not undertaking the study in collaboration with either a patient or a member of the Trust staff.
30/10/03	Response sent in relation to outstanding issues.
14/11/03	Request submitted requesting progress on outstanding issues.
21/11/03	Confirmation received stating that 'NHS Management

	Approval' to undertake the project in the Trust had been given.
24/11/03	Contacted RGD to clarify the likely completion date of the governance process.
4/12/03	Confirmation received from RGD stating that all outstanding issues had been resolved and that 'you will be pleased to know you finally have Research Governance approval' and that the study could start.
13/1/04	Notified that approval had been withdrawn until a CRB check had been completed and the Trust issues a Letter of Authority/ Honorary Contract.
14/1/04	CRB check application form completed and submitted.
15/1/04	Human Resources Department contacted to arrange a Letter of Authority.
16/01/04	Request from hosting trust to obtain and complete an Occupational Health Questionnaire and possibly undertake a medical examination.
	Occupational Health Questionnaire completed and returned to hosting trust.
22/1/4	CRB check received.
29/1/04	Letter of Authority received from host Trust confirming that the governance process was now complete and the study could commence.



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222 9601

Dean : Professor Betty Kershaw DBE

e-mail: R.Ashmore@Sheffield.ac.uk

MENTAL HEALTH NURSES' INFORMATION SHEET

Title of Research Study:

Using the nurses' holding power (Section 5(4) to prevent patients from leaving hospital.

Introduction

You are being invited to take part in a research study. Before you decide whether to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If there is anything that is not clear or if you would like more information please do not hesitate to ask me (See contact numbers at the end of this sheet). Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

An increasing number of patients who choose to come into hospital to get help with their mental health problems are prevented from leaving at some point in their stay by nurses under Section 5(4) of the Mental Health Act 1983. This section, also known as the "nurses' holding power", allows mental health nurses to prevent a patient who they believe to be a risk to themselves or others from leaving hospital for up to six hours or until the doctor arrives to assess the patient. However, little is known about how and why this section is used.

The aim of this study is to gain a greater understand of the issues that are involved in the decision to detain a patient, what happens once the section has been used and what are the impact of these events for both patients and nurses. Such an understanding could assist nurses to become more effective in their decision to use or not to use this section and improve patients' care and rights during such situations.

Why have I been chosen?

You have been chosen as a potential participant in this study because of being a mental health nurse who has recently used Section 5(4) to prevent a patient from leaving hospital. Your experiences of this would be very useful to the study because you could offer an account of why you believe you prevented the patient from leaving that no one

else knows. You could also give information on how the detention was dealt with, what happened to the patient afterwards and what you thought, felt and understood by the entire process. Similarly, your opinions about how it affected the patient's care and your relationship with them after the event would also be useful.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect you in any way.

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

As part of this study, you will be asked to take part in an interview with Russell Ashmore for about one hour to talk about your experiences. During the interview, you will be asked a number of questions about what happened when you prevented the patient from leaving hospital. The interview will be audio-taped with your permission. You are free to stop the interview at any time or choose not to answer certain questions. The researcher may return at a later date to ask you some more questions about your experiences or to clarify your earlier comments, this will last for about 30 minutes.

Where and when will the interviews take place?

The interview will take place in a private room on the ward or a place of your convenience and at a time that suits you and your work commitments.

What are the possible benefits of taking part?

I will use the information to try and understand your point of view and that of those who have been cared for by you. The information you provide by participating in this study may improve the way mental health nurses use Section 5(4) and also the care of future patients who are detained under the Mental Health Act. It is hoped that participating in this study will be of some benefit to you. However, this cannot be guaranteed.

What if something goes wrong?

Whilst there are no anticipated risks associated with participating in this study, if you feel that you have been harmed by taking part in this research project, there are no special compensation arrangements. If you feel that you have been harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it. Regardless of this, if you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints mechanisms should be available to you.

Will my taking part in this study be kept confidential?

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about that section you were involved in which leaves the hospital will have your name and ward details removed so that you cannot be recognised from it. No names will be mentioned in any reports of the study. In addition, care will be taken to ensure that you cannot be identified from details in reports of the research. All notes and/or tape recording made during the study will be

stored so no one else can see them. Once the study has been completed, they will be destroyed in accordance with national and local policies.

What will happen to the results of the research study?

The findings of this study will form the basis of a PhD study that will be submitted to the University of Sheffield on completion. A report of this study will be published in a number of nursing journals as well as being presented to relevant people in Sheffield Care Trust and presented at a number of nursing conferences. A copy of the study's findings will be made available to you on request.

Who is organising the research?

Mr. Russell Ashmore who works as a Lecturer in Nursing for the University of Sheffield is undertaking the research. He is conducting the study as a student on a post graduate course at Sheffield University. Two experienced researchers will closely supervise him. Whilst Russell Ashmore's background is in mental health nursing, his role is strictly that of researcher. He is not receiving any payment for undertaking this research.

Who has reviewed the study?

This research has been reviewed by:

North Sheffield Local Research Ethics Committee
Nothorn General Hospital
Sheffield
Telephone: (0114) 2714011

What if I have any further questions ?

Please contact:

Russell Ashmore
Telephone: (0114) 2229959
E-mail: R.Ashmore@Sheffield.ac.uk

Thank you for agreeing to take part in this study

Version 3 August 2003



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☎ (0114) 222 9959

Dean : *Professor Betty Kershaw DBE* **Fax** (0114) 222 9601

e-mail: R.Ashmore@Sheffield.ac.uk

PATIENT INFORMATION SHEET

Title of Research Study:

A study of why mental health nurses prevent patients from leaving hospital under a section of the Mental Health Act 1983.

Introduction

You are being invited to take part in a research study undertaken by Russell Ashmore, a student and lecturer in the School of Nursing & Midwifery at the University of Sheffield. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If there is anything that is not clear or if you would like more information please do not hesitate to ask me (See contact details at the end of this information sheet). Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

An increasing number of patients who choose to come into hospital to get help with their mental health problems are prevented from leaving at some point in their stay by nurses under a Section 5(4) of the Mental Health Act 1983. This section is also known as the "nurses' holding power".

The aim of this study is to gain a greater understanding of the issues that are involved in the decision to detain a patient, their experiences and how it turned out in the end. We will be talking to a group of nurses who have used the "holding power" in the past as well as you. It may help nurses to use their holding power more appropriately and to understand the views of patients as part of their decision-making. This will be fed back into policy.

Why have I been chosen?

As someone who has recently been prevented from leaving hospital by a nurse, your experiences of this would be very useful to the study because you could offer valuable insights about the process by telling me your experiences and the outcome for you.

Do I have to take part?

It is up to you to decide whether or not to take part. If you decide to take part, you can still withdraw from this study at any time or choose not to answer certain questions without giving a reason. If you decide not to take part or wish to withdraw from the study this will not affect the standard of care you receive.

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

You will be asked to meet me, Russell Ashmore, to talk about your experiences of hospital and the period during and after the nurses' holding power was used. This interview should not take any longer than one hour and, with your permission, will be tape-recorded. I may return at a later date to ask you some more questions about your experiences and, this interview will last for about 30 minutes. Any tape recordings (audiotapes) made of the interviews will be destroyed once the study has been completed.

I would also like your permission to look at your medical and nursing notes to find out what was written down about why you were detained. I would also like to collect some information about your age, diagnosis, and ethnic origin, how long you have been in hospital and whether you have previously been detained under the Mental Health Act from your notes.

Where and when will the interview take place?

The interview will take place in a private room on the ward or a place of your convenience and at a time that suits you and your care. The interview will take place as soon after you are detained as possible.

What are the possible benefits of taking part?

I will use the information to try and understand your point of view. The information you provide by participating in this study may not directly benefit you but it is hoped that the findings may be of benefit to future patients who have been detained under the Mental Health Act.

Will my taking part in this study be kept confidential?

I am a researcher employed by Sheffield University and I am completely independent of the services where you have receiving care. All information you provide will be treated in the strictest confidence and will not be shared with anyone in your name. Your name will not be used on any written notes or reports of the study. All notes and/or tape recording made during the study will be stored so no one else can see them and where on computer will meet the requirements of the Data Protection Act. All data (notes, audiotapes and transcripts) will, on completion of the study or in the case of you choosing to withdraw from the study, be destroyed in line with national and local guidelines.

The doctor in charge of your care during your stay in hospital has already be asked and agreed for me to talk to you about participating in this study.

What will happen to the results of the research study?

This study will be written up and a copy sent to Sheffield University as part of my studies there. A report of this study will be published in a number of nursing journals and a copy sent to relevant people in Sheffield Care Trust and patients' groups. In addition, the findings will be presented at a number of nursing conferences. A copy of the study's findings will be made available to you on request.

Who is organising the research?

Mr. Russell Ashmore who works as a Lecturer in Nursing for the University of Sheffield is undertaking the research. He is conducting the study as a student on a post graduate course at Sheffield University and is supervised by Dr. Paul Ramcharan and Dr. Julie Repper who work in the Department of Mental Health & Learning Disabilities.

What if I want to complain about how I have been treated during the study

If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints' mechanisms should be available to you.

Who has reviewed the study?

This research has been reviewed by:

North Sheffield Local Research Ethics Committee
Northern General Hospital
Sheffield
Telephone: (0114) 2714011

What if I have any further questions?

Please contact:

Russell Ashmore
Telephone: (0114) 2229959
Pager: 07625 527665
E-mail: R.Ashmore@Sheffield.ac.uk

Thank you for agreeing to take part in this study

Version 2 8th July 2003

Appendix 11 The nurses' consent form

MENTAL HEALTH NURSES' CONSENT FORM

Title of Project: A study of why mental health nurses prevent patients from leaving hospital under a section of the Mental Health Act 1983.

Name of Researcher: Russell Ashmore

Please initial each box

1. I confirm that I have been given a copy of the information sheet dated 4th August 2003 (version 3). ☐

2. I confirm that I have read and understand the information sheet dated 4th August 2003 (version 3) for the above study and have had the opportunity to ask questions. ☐

3. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. ☐

5. I am aware that findings and recommendations from this research will be published. ☐

6. I agree to take part in the above study. ☐

Name of nurse

Date

Signature

Researcher

Date

Signature

One copy each for the nurse and for researcher.

Version 3. 4th August 2003

Appendix 12 The patients' consent form

PATIENT'S CONSENT FORM

Title of Project: A study of why do mental health nurses' prevent patients from leaving hospital under a section of the Mental Health Act.

Name of Researcher: Russell Ashmore

Please initial box

1. I confirm that I have been given a copy of the information sheet dated 8th July 2003 (version 2) ☐
2. I confirm that I have read and understand the information sheet dated 8th July 2003 (version 2) for the above study and have had the opportunity to ask questions. ☐
3. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. ☐
4. I understand that sections of any of my medical notes may be looked at by Russell Ashmore and responsible individuals from Sheffield University or from regulatory authorities where it is relevant to my taking part in the research. I give permission for these individuals to have access to my records. ☐
5. I am aware that findings and recommendations from this research will be published. ☐
6. I agree to take part in the above study. ☐

Name of Patient

Date

Signature

Name of Person taking consent
(if different from researcher)

Date

Signature

Researcher

Date

Signature

One copy each for patient and researcher. One copy to be kept with hospital notes

Version date: 8th July 2003

Appendix 13 Example of completed pro forma

Use of Section 5(4) (Nurses' Holding Power) Summary Sheet
About the Patient
Code number: A765489B
Name of patient's consultant: Dr Jones
Age: 45
Ethnic origin: Asian
Sex (Male/Female): Male
Date of Admission: 12 th March 2003

About Section 5(4)
Date on which Section 5(4) was used: 21 st April 2003
Time at which Section 5(4) was used (From Form 13). Please use 24 hour clock: 13:25 P.M.
Time at which medical practitioner arrived or patient ceased to be detained (From Form 16). Please use 24 hour clock: 16:30 P.M.
Name of ward where Section 5(4) used e.g. Maple Ward: Blackamoor
Name of nurse detaining the patient (From Form 13): Beth Smith
Outcome of holding power (i.e. Informal or name of Section transferred to e.g. Section 5(2), Section 2: Section 5(2)

•Please attach to this form:

A copy of the Section 5(4) Local Incident Report

A print out of the patient's Mental Health Act history. If no previous history exists, please write

'first detention' below: First Detention

RA/V2/Feb0204

Appendix 14 Timeline of events leading to Shaun's detention

Day	Medication	Sexual Harassment	Other Events	Mental Health Act
17	Diazepam (DZP) reduced Started new anti-depressants			
18	Further reduction of DZP		Day leave	
19			Leave PM	
20		Made compliant of 'sexual contact' from male patient.		
21	Complained of side-effects of new medication: 'dazed, disorientated and confused' Unable to remember some day-to-day events; 'head is spinning', 'low in mood'.	Reported physical inappropriate sexual contact 'triggering thoughts of incidents that have happened in his past regarding sexual abuse'.		
22	Reported feeling low in mood due to changes in medication	Reported verbal and physically inappropriate behaviour.		
23		'Touched' by patient.		
24		Not happy with how staff have dealt with his complaint.		
25	'Low in mood and poor sleep attributed to decreased DZP and changes to AD.	Expressed dissatisfaction with how nurses are managing patient who his pestering him. Felt pressure of making compliant to police. Decided to press charges.		
26		Expressed anger at nurses for not taking his compliant seriously.		
27	Complained that DZP has been reduced too quickly	Complained about staffs' responses to his harassment.		
28	Reported 'feeling psychotic' Dr increased DZP	Nurses described his behaviour in nursing notes as manipulative in relation to sexual		

		accusations.		
29				
30	Reported dizziness due to AD Changes made to medication			Received letter from mother
31	DZP decreased			Expressed anger at receiving mother's letter. Reports feeling anxious as a result of letter.
32				Wrote to mother asking her not to contact him again. Expresses 'thoughts of self- harm'
33			Argued with nursing staff over medication Decided to go on leave but decides to return to ward.	
34			Contacted by A&E staff to say that Shaun had presented himself there. Found on A&E corridor with noose around neck. Returned to ward but very hostile to staff and demands to leave	S5(4) applied @ 04.45hrs > 5(2) > 1 st recommendation for S2
35				Following reassurances that would not leave becomes informal again
36		Discussed reporting harassment to Police.		
37			Entered into heated argument with night staff and states intention to leave the ward	S5(4) applied > S5(2)
38				S2 completed.

Appendix 15 Examples of vignettes constructed during the analysis

Vignette 11: Adam's story

Peter's admission to hospital - his first - was precipitated by excessive cannabis use resulting in him hearing voices and provoking a number of fights in the community. He was admitted to hospital for his own safety and the safety of others.

On Friday and Saturday Peter left the ward with some other patients and had spent this time smoking cannabis. He returned to the ward on Saturday night and experienced difficulties in sleeping and was expressing paranoid ideas stating that 'people are breaking into my room'; there was no evidence to suggest that this was true.

On Sunday Peter entered the ward office and tried to ring the police telling the nurses that that he did not trust them and made a run for the door leading to the hospital exit stating that he wasn't safe on the ward. Because of the events prior to Peter's admission, including arming himself with a knife, his current presentation and also that he had been traumatised when he witnessed an ex-patient who had returned to the ward on the Friday burning himself to death. Adam believed that he had no other option but to detain him under Section 5(4).

Vignette 17: Karen's story

The patient had been in hospital for about a week and for the last day or two had been asking to leave. The nurses were concerned about his safety and had attempted to reassure him and persuade him to stay. On the day of the detention the patient saw a doctor in the morning and gave assurances that he would stay on the ward. During the day he had been asking to leave but the nurses kept saying, "we'd like you to stay." The patient would go away for half an hour and come back and ask the same thing again.

The doctor's assessment was that he was concerned about his safety and 'believed he needed to stay in hospital'. However, as the patient was willing to comply with treatment and stay on the ward the doctor did not believe there was a need to detain him. The nurses recognised that the doctor could have detained him but did not. However, the nurses believed that this was the correct thing to do and suggested that the doctor was recognising their ability to persuade the patient to stay and therefore avoid the 'detention route'.

But by the evening the patient was reported as becoming, 'increasingly more agitated' and saying, that 'he wanted to go'. The nurses were concerned that, 'he was experiencing hallucinations telling him to harm himself'. The nurses did not believe that it was safe for him to leave the ward and could not persuade him to stay. Karen and another 'E' grade spent 'quite a bit of time with him trying to persuade him to stay. However, he would not agree to see a doctor either and he was 'trying to go out of the door' so they detained him and also explained why they had done so. The patient continued to express a desire to leave and continued push at the locked ward doors but the nurses did not need to restrain him. Eventually, he allowed the nurses to guide him away from the doors. The nurse's reason for detaining him was that, 'he was experiencing hallucinations telling him to harm himself'. The doctor assessed him and converted the holding power to Section 5(2); this later became a section 2.

Appendix 16 Working titles given to the stories based on the evaluative comments made by the nurses

Transcript	Nurse	Story Title
1	Anna	'We didn't believe as a nursing team that he was capable of giving informed consent and being in hospital on a voluntary basis.'
2	Alan	'It all turned out to be [a] scam [but] it was probably the right thing to do at the time.'
3	Richard	'If I'd known Sarah I probably wouldn't have five-foured her.'
4	Andrea	'I felt let down by him as part of the team and felt that our considerations weren't listened to really.'
5	Stephen	'The consultant hadn't [seen] her. We had requested [an assessment] but there was a bit of a problem with consultants that week with annual leave...over the Easter break that got in the way of it.'
6	Josh	'I was unsure whether it was correct to five-four her... [as] the client wasn't actually trying to leave the premises.'
7	Beth	'Several times prior to the five-four we'd had to bring her back from outside, [under] restraint...and you can only do that for so long, can't you.'
8	Sharon	'It is, as they say, a team decision because you're never on your own on a shift.'
9	Ray	'And I weren't sure how much you can do under common law.'
10	Rick	'It was obvious that she wasn't very well; she was extremely vulnerable and open to exploitation.'
11	Adam	'I just wanted this admission to be as positive as possible and I didn't want it to end in a section.'
12	Stuart	'I think that to some extent I'd probably already made my mind up beforehand, that if the situation arose...I would five-four him.'
13	David	'So I didn't really feel I had an option, but to lock the door, and at that point as far as I was concerned, that was the five-four done.'
14	Ben	'I thought he'd get himself into bother. I didn't think...he was going to walk [out] and kill himself [but] he was going to be vulnerable.'
15	Joe	'So I knew once he'd lay his hands on him, that was it, he would be five-foured.'
16	Jackie	'I think that we've got no choice.'

17	Karen	'We didn't think it was safe for him to leave the ward and we weren't able to persuade him to stay.'
18	Simon	'A bit of a battle between myself and the on-call consultant.'
19	Martha	'We weren't sure whether or not he'd taken [an] overdose but we wanted to be cautious and take extra care.'
20	Maggie	'I did feel a little bit manipulated...in a corner really and I thought "There's nothing else I can do. I'm going to have to section you."'
21	Mary	'His behaviour's really manipulative...[and] I think it's what he wanted really...his DLA was up for [renewal].'
22	Joy	'It's a silly reason really but the morning staff were really reluctant to five-four her because it was her birthday.'
23	Lee	'We really tried not to do it, but we had to.'
24	Dan	'It was obvious from the moment she walked through the door that it hadn't gone well.'
25	Mark	'I thought it was a very difficult, unnecessary five-four...brought about by a lot of poor assessments and poor treatment plans.'

Appendix 17 Definitions of preliminary story types

Number	Story Type	Definition
1	S5(4) as health, safety or protection	This type is the closest to S5(4) as defined in the Act: the patient is assessed as a risk to either self or others, wants to leave the ward and no doctor is available to undertake an assessment.
2	S5(4) as a response to an inappropriate informal admission	The nurses believe that the patient should never have been admitted informally as they lack the capacity to consent and that they reason they have is a failing in the medical system although the intentions may have been honourable. Nevertheless, the use of S5(4) is a direct consequence of this.
3	S5(4) as a lack of clinical knowledge about the patient	S5(4) is implemented by the nurse because they have insufficient information to make an adequate assessment as to whether the patient would constitute a risk should they leave the ward.
4	S5(4) arising from situational factors	S5(4) arises out of the fact that the ward is clinically busy. This may mean high numbers of patients being observed by nurses, undertaking medication rounds, having patients in seclusion. In summary, S 5(4) is a proxy for a reduced number of staff which may mean the resources or time is not available to engage with the patient and attempt to persuade them to stay on the ward without formal detention.
5	S5(4) as catalyst	This type of S5(4) is used purely to facilitate a process that is perceived as beneficial for the patient. However, there is no evidence that the patient is a risk should they leave or attempt to leave the ward.
6	S5(4) as a response to medical inaction	The implementation of the S5(4) is seen to be a direct consequence of a doctor refusing to detain a patient who the nurses think should be and then an incident arises that results in them implementing S5(4).

Number	Story Type	Definition
7	S5(4) as self-protection	An incident occurs where the patient is not considered to be at risk but the S5(4) is implemented as a means of protecting the nurse when they feel threatened; 'to cover their back'
8	S5(4) as patient manipulation	Nurses believe that the patient wants to be detained and 'manipulates' them into implementing S5(4), for example saying they are going to kill themselves when the nurse does not believe they will. There are elements of self-protection built into this type of S5(4).
9	S5(4) as a negative experience for the patient	The emphasis of this type of S5(4) is that attempts have been made to avoid using the section; it is a last resort. The nurse's attitudes towards the power or the consequences for the patient are likely to be negative.
10	S5(4) as a negative experience for the nurse	This S5(4) is not dissimilar to nine. The difference being that it is perceived as have a negative outcome for the nurse rather than the patient.
11	S5(4) as a last resort	Similar to nine and 10 nurses attempt to avoid using the section but finally recognise that there is no other choice but implement the holding power.
12	S5(4) as a short-term intervention	Nurses believe that the patient needs to stay on the ward at this time but does not need a long-term detention and that S5(4) is preferable to a medical section. The nurses rely on the crisis being resolved and their ability to convince the SpR that the patient should become informal again.
13	S5(4) as a response to the limitations of common law	S5(4) is used when other means of keeping the patient on the ward have failed. Usually, they are examples in the story of the patient being prevented from leaving without formal detention (including de facto detention). However, there comes a point where the nurse feels their actions cannot be justified further.
14	S5(4) as a legal justification for implementing containment interventions.	Shares similarities to 13, is implemented to justify other intervention, for example enforced medication or seclusion.