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**SERVICE USERS' EXPERIENCES OF COERCION AND AUTONOMY IN
INPATIENT MENTAL HEALTH SERVICES**

Section A: Service users' experiences of coercion in inpatient
mental health settings and its impact on outcomes: A critical review

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Summary

Section A

Section A provides a critical review of the literature regarding service users' experiences of coercion in inpatient mental health settings. The findings from sixteen studies suggest the use of coercion in psychiatric inpatient services is complex and its impact on service users is not straightforward. Additional findings regarding service users' experiences and the impact on outcomes are discussed. Clinical implications include the importance of involving service users in decision-making processes and ensuring that support is offered after the use of intrusive coercive practices. Further research could employ a qualitative approach to explore how service users' autonomy could be increased.

Section B

This research applied an Interpretative Phenomenological Analysis to explore service users' experiences of autonomy whilst detained on a forensic low secure unit. Seven superordinate themes emerged; initial expectations of the ward, relationships with staff, perceived lack of autonomy, perceived sense of autonomy, compliance, motivators and changes over time. Clinical implications of the findings are discussed, including the role of therapeutic relationships, the importance of increasing opportunities for autonomy as the admission progresses and working collaboratively with service users to develop a shared understanding.

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Section A: Service users' experience of coercion in inpatient
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Abstract

Coercion within psychiatric services is widely seen as an unfortunate but necessary aspect of care. Coercion is complex and can be viewed on a continuum, from informal coercion; use of persuasion, through to more formal; use of restraint. This review focused on service users' experiences of perceived coercion whilst receiving inpatient psychiatric care.

A systematic search of PsychInfo, PsychArticles, Medline and Cinahl databases for studies relating to service users' experiences of coercion was completed.

Sixteen relevant papers were elicited, including two qualitative and 14 quantitative papers. Seven themes were identified; examples of coercive practice, measurement of coercion, factors contributing to perceived coercion, service users' experiences, impact on satisfaction with care, coercion and the therapeutic relationship, and the impact on outcomes. The review will explore these themes in further detail.

The findings suggest the use of coercion in psychiatric inpatient services is complex and its impact on service users is not a straightforward relationship. It is difficult to pull apart the impact of legal status from more day-to-day examples of coercion.

Further research could take a qualitative approach to deepen our understanding of the meaning that service users attach to coercion and explore how service user autonomy could be increased.

Keywords: Coercion, service user, inpatient, experience, perspectives

Introduction

Mental health difficulties are a growing public health concern for the United Kingdom with an estimated one in six individuals experiencing common mental health problems in any week (Mental Health Foundation, 2016).

Inpatient admission

For some, receiving treatment in a community setting may not be effective at times, therefore an admission to a psychiatric hospital could be required. Reasons for admission include a period of further assessment, to maintain personal safety (if the individual is at risk of harming themselves), risk of harm to others, or if more intensive support is required than can be provided in the community (Bowers, 2005). Between 2014 and 2015 there were 125,710 admissions to a mental health or learning disabilities hospital in England, a 3.5% increase on the previous year (Mental Health Foundation, 2016).

Inpatient services typically comprise a multidisciplinary team (MDT) including psychiatrists, mental health nurses, psychologists, occupational therapists and support workers. Psychiatric hospitals should provide access to a range of therapies, medication and 24-hour support (Mind, 2018). Each individual should be allocated a primary worker, to coordinate their care, be a point of contact and provide relevant information such as legal rights (Mitchell & Strain, 2015). Decisions regarding care should be discussed in regular ward rounds, which are an opportunity for professionals and the service user to review the treatment plan (Wagstaff & Solts, 2003).

Admission to psychiatric hospital can be on an informal (voluntary) or formal (involuntary) basis. If an individual agrees to go into hospital, this will be an informal

admission. However, if they do not agree, they can be detained under the Mental Health Act (1983, amended 2007).

The Mental Health Act

The Mental Health Act (2007) legislation in England and Wales provides health professionals with powers to detain, assess and treat people with mental disorders (The Kings Fund, 2008), in the interests of their own health or safety, or to protect the safety of others (Owen et al., 2009). Between 2005-06 and 2015-16 the reported number of uses increased by 40% (Department of Health and Social Care, 2018). In 2016-17 in England, an estimated 45,864 people were detained under the Act, (Baker, 2018).

The Mental Health Act (2007) is used when there is an urgent need for assessment or treatment and there are several sections under the Act which will determine how long the individual can be detained for (NHS Digital, 2017).

Two conditions must be met to detain an individual under the Act for assessment. A person must be:

- a. Suffering from a mental disorder of a degree which warrants the detention of the patient in hospital for assessment for at least a limited period.
- b. They ought to be detained in the interests of their own health or safety or with a view to protect others (Mental Health Act, 1983).

To be detained under the Act for treatment, an additional two conditions must be met:

- a. Treatment cannot be provided unless they are detained under this Section.
- b. Appropriate medical treatment is available for them (Mental Health Act, 1983).

The decision to detain an individual must be made by an Approved Mental Health Professional (AMHP), a registered medical practitioner and a Section 12 approved doctor (Mind, 2017).

The use of coercion in psychiatric inpatient settings

One definition of coercion is 'the act or process of persuading someone forcefully to do something that they do not want to do' ("Coercion", n.d.). Often being admitted to hospital under Section is viewed as coercive. However, in clinical practice, coercion is complex and frequently it is not explicitly defined (O'Brien & Golding, 2003). There are many more day-to-day examples of coercion on inpatient wards, and one broad definition of coercive practice in mental healthcare is "any use of authority to override the choices of another" (O'Brien & Golding, 2003).

Lidz et al. (1998) defined a hierarchy of nine graduations of coercive practice: (1) persuasion, (2) inducement, (3) threats, (4) show of force, (5) physical force, (6) legal force, (7) request for a dispositional preference, (8) giving orders, and (9) deception. Its use can be viewed on a continuum, from informal coercion; the use of persuasion and interpersonal pressure, through to the formal end; withholding of rewards as leverage or restraint and force (Miles, 2016).

Informal coercion may be used by clinicians with the intention to engage service users in treatment adherence or avoid formal coercion (Hotzy & Jaeger, 2016). Examples include 'negotiations', such as "you can have leave if you adhere to medication". The use of informal coercion is often "intertwined with the therapeutic relationship" (Hotzy & Jaeger, 2016) and is reliant on a level of trust between the service user and staff.

Formal coercion is more overt than the informal practices, and its use is regulated by mental health legislation (Valenti et al., 2015). Examples include involuntary admission to hospital under the Mental Health Act (2007), physical restraint, seclusion and enforced medication.

Coercive practice within psychiatric settings has been the subject of debate, however it is considered an unfortunate but necessary part of psychiatric care (Newton-Howes, 2010). It can be used when service users' have low motivation levels, to aid recovery and prevent lengthy admissions. When service users' do not accept their need for treatment, coercion can be used to alleviate symptoms or distress (Hiday, Swartz, Swanson, Borum & Wagner, 2002), either overtly through enforced medication, or more informally, for example using negotiations such as "if you engage with psychology or groups on the ward you can have Section 17 leave". Coercive practice may be necessary to ensure the safety of service users and others when they may not have capacity to do so themselves. Physical restraint or seclusion can be used to prevent physical aggression towards others or self-harm, however these should only be used in restricted conditions, after other less coercive strategies have been unsuccessful.

The situations discussed provide examples of "objective coercion". However further consideration should also be given to "perceived" coercion, where an individual may experience the perception of threat even where no threat has been intended (Szmukler, 2015). There are challenges in the measurement of perceived coercion, perhaps due to the difficulties in defining coercion. Several self-report measures have been developed including the MacArthur Admission Experience Survey ([MAES], Gardner et al., 1993), Perception or

Legal Pressure Questionnaire (Young & Belenko, 2002), and the Perceived Coercion Questionnaire (Klag, Creed & O'Callaghan, 2006). These measures focus on participation in treatment, particularly at admission. The Coercion Experience Scale ([CES], Bergk, Flammer & Steinert, 2010) was developed to measure the psychological impact during psychiatric coercive interventions.

Relevant policy

Although coercive practice may be unavoidable in certain situations, several recent policies and guidelines have sought to reduce these practices. Recommendations from the Department of Health (2014) suggested all services in which restrictive interventions may be used must have in place restrictive intervention reduction programmes. These should be based on a clear understanding of the legal context for applying restrictions and should provide effective training for staff (Department of Health, 2014).

National Institute for Health and Care Excellence (NICE) guidelines for the short-term management of violence and aggression in mental health settings suggest that restrictive practice should only be used if de-escalation and other preventative strategies have failed or if there is potential for harm to the service user or others if no action is taken (NICE, 2015). They state that restrictive intervention should not be used as punishment or for staff to establish dominance (NICE, 2015).

In 2015, the Mental Health Act Code of Practice set an expectation for mental health services to commit to reducing restrictive interventions (Department of Health, 2015). The Care Quality Commission (CQC) provided a best practice report, which identified having a positive and therapeutic culture throughout an organisation could reduce the need for

restrictive practice (CQC, 2017). Other crucial aspects of practice were; training for staff, quality improvement techniques and evidence-based approaches such as “Safewards”, involving the whole MDT and experts by experience in developing approaches (CQC, 2017).

There is a growing expectation that service users should be involved in all aspects of their care. Evidence suggests when service users are actively involved, this can improve outcomes and experience (NHS England, 2017). NHS England made a commitment to better involve service users by giving them the power to make informed decisions about their care (NHS England, 2017). This has been supported by the Five-year forward view (Mental Health Taskforce, 2016).

In a recent review of the Mental Health Act, a primary theme throughout was the importance of including service users' voices. Even when a service user has been deprived of their liberty, their opinions should still be heard and respected, as the greater the say an individual has in their care, the better the outcome (Department of Health and Social Care, 2018). The review suggests the following changes:

- Making shared decision making the basis, as far as possible, for care planning and treatment decisions made under the Act.
- Strengthening challenges to treatment.
- Providing in statute for people to express their choices in advance.
- Recording service user views alongside every decision made (Department of Health and Social Care, 2018).

The guidelines suggest a move towards less coercive care, through reducing restrictive practice and involving service users in their care, would be beneficial for service users and outcomes.

Relevant theory

The purpose of psychiatric hospital admission is to support service users to manage their mental health difficulties and perhaps 'recover', although understandably, the term 'recovery' is subjective.

Motivation to change is key in engaging service users in the recovery process (Skinner, Heasley, Stennett & Braham, 2014). One theory linked with motivation is 'Self Determination Theory' (Deci & Ryan, 1985). It identifies three needs all individuals require to enhance self-motivation; competence (the need to be effective), relatedness (the need to feel a psychological connection with others) and autonomy (the need to own one's actions). If these needs are undermined, it may result in diminished motivation and mental well-being (Ryan & Deci, 2000). According to this theory, autonomy is integral to service users being motivated to change and behaviour change is more effective when service users are autonomously motivated (Ng et al., 2012). However, coercive environments can undermine an individual's autonomy (Sheldon, 2012) and in turn their self-motivation, which may make the process of recovery more difficult when it was intended to aid recovery. It is possible that coercion could be counter-productive in these instances.

When considering how best to support service users in an inpatient setting, it is important to recognise the impact that coercion may have on their autonomy, self-determination and in turn, recovery.

Summary and literature review rationale

Coercive practice is at times necessary within inpatient psychiatric settings, to ensure the safety of service users and others is maintained. When individuals do not perceive the need for treatment, there is a view that coercion can be useful in preventing lengthy admissions. There are a range of coercive practices, from informal coercion, such as persuasion, to formal coercion, including involuntary admission. It is therefore likely that service users who require an admission to hospital will experience some level of coercion.

The current review will systematically review service users' experience of coercion whilst in inpatient psychiatric services. The following questions will be addressed:

- A. What experience do service users have of coercion in psychiatric inpatient services?
- B. How does coercion impact on outcomes, therapeutic relationships and satisfaction with care?

Method

Literature search

An electronic search of the literature was conducted using the databases Medline, Psychinfo, Psycharticles and Cinahl in August and September 2018. This was repeated in January 2019 to check for more recent publications. Additional searches of Google Scholar were included. The initial intention of the literature search was to review qualitative studies relating to service user experience, however as there were only a limited number of relevant qualitative papers available the search was extended to include quantitative studies as well.

The search terms [*Coer** OR *decision making* OR *control* OR *choice*] were searched for in the titles, and variations of the terms [*view** AND *mental health* AND

'inpatient' AND *'service user*'*] were searched for in the titles, abstracts and key words of the databases. For a full list of the search terms see Appendix 1. There was no temporal criteria placed on the search due to the literature originating from several different countries and therefore time frames regarding changes in policy or legal frameworks would not apply across the studies. The PRISMA flow diagram in Figure 1 illustrates the elimination process that lead to the final 16 papers.

Inclusion criteria

Studies were included if they had been published in peer reviewed journals, to obtain a high standard of research. Any study that investigated service users' experience of or self-reported ratings of coercion, whilst under Section on a general, adult psychiatric inpatient ward were considered. Most studies used involuntary legal status as evidence of coercion. Although research has found that voluntary service users may also experience elements of their care as coercive, their experiences may be different in comparison involuntarily admitted service users.

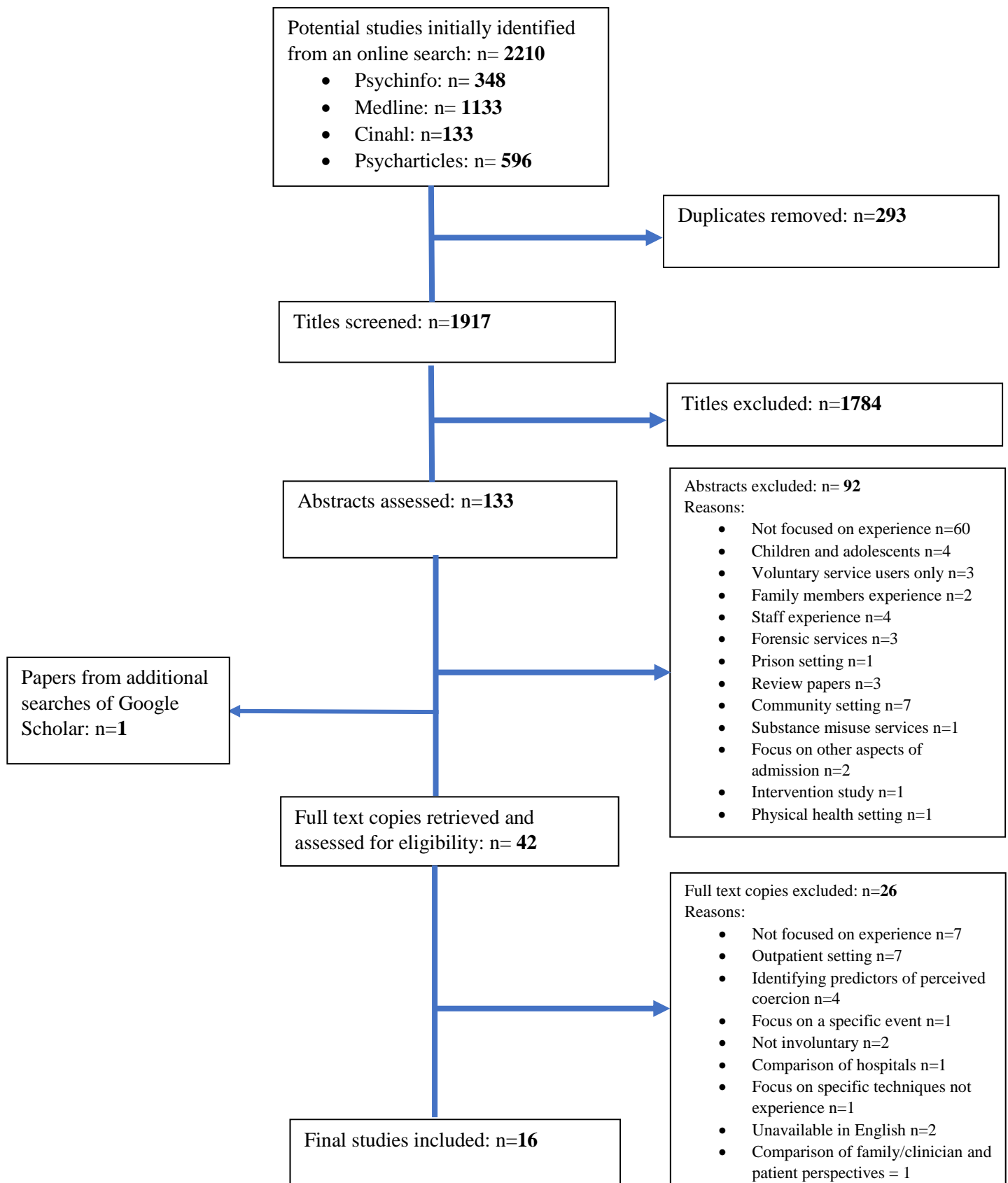
Studies including professionals, family members or carers' perspectives of coercion were only included if the experiences of service users could be distinguished from the other perspectives.

Similarly, studies that included the experiences of voluntarily admitted service users were included if these were reported separately from the perspectives of involuntarily admitted service users.

Exclusion criteria

Studies in forensic mental health settings were excluded, as typically admission length is a lot longer than in general psychiatric services and forensic sections often involve additional restrictions or procedural processes, such as involvement from the Ministry of Justice (MoJ). The involvement of many different agencies in forensic services impacts on the way some decisions can be made regarding service users' care. Although some experiences may be similar, the process of being detained on a forensic ward may subject service users to different experiences of coercion.

Studies which focused primarily on voluntarily admitted service users, clinicians or family member perspectives were excluded, as well as studies focused on substance misuse or not written in English.

Prisma diagram*Figure 1: A flow diagram of the search process of the review*

Quality assessment

Fourteen papers adopted a quantitative design, however there were a variety of methodologies used, including prospective cohort studies and quasi-experimental studies. To make comparisons of the quality of these papers, they were all assessed using the 'Quantitative Checklist' available in Kmet, Lee and Cook (2004; Appendix B). The two qualitative studies in this review were assessed using the Critical Appraisal Skills Programme Qualitative Checklist (CASP; 2018; Appendix C). CASP guidelines are recognised as an effective way of critiquing literature.

Review structure

The main findings of the review are presented according to overarching themes across the literature, regarding the factors that influence perceived coercion, service users' experiences and the impact coercion has on aspects of their care. This is followed by a critical appraisal of the research methodologies used and a discussion of the findings in relation to clinical and research implications.

Literature Review

Sixteen papers were included in the review. Two studies adopted qualitative methods; one conducted narrative interviews (Olofsson & Jacobsson, 2001) and another conducted ethnographic fieldwork (Larsen & Terkelsen, 2014). The remaining 12 papers used quantitative measures. Although many studies reported conducting semi-structured interviews, the findings were converted into quantitative data and analysed. A summary of each study is presented in Table 1.

Table 1: Information on the participants, setting, design and key findings of each study

Study and Country	Design	Participants	Setting	Measures used	Key findings
Gowda et al. (2018) – South India	Quantitative	200 inpatients were recruited through computer generated random number sampling	Psychiatric inpatient unit	<ul style="list-style-type: none"> • Interviews • Mini International Neuropsychiatric Interview (MINI 5.0) • Clinical Global Impression scale (CGI) • MacArthur Admission Experience Survey (MAES) scale 	<ul style="list-style-type: none"> • Perceived coercion score was the highest in service users experiencing physical restraint • Chemical restraint was also associated with higher levels of perceived coercion • ECT is associated with the lowest level of perceived coercion followed by isolation, seclusion and involuntary medication • Perceived coercion decreased between admission and discharge from hospital • Having a mood disorder, being from a rural area and a lower socioeconomic status was associated with being subjected to more than one form of coercion
Guzmán-Parra et al. (2018) - Spain	Quantitative	111 inpatients who had been subject to a coercive intervention	Two psychiatric units	<ul style="list-style-type: none"> • Coercion Experience Scale (CES) • Visual analogue scale of perceived coercion • Davidson Trauma Scale (DTS) • Visual analogue scale for global perceived stress • Client's Assessment of Treatment (CAT) 	<ul style="list-style-type: none"> • Higher levels of perceived coercion associated with the use of mechanical restraint and combined measures in comparison with involuntary medication. • 12.6% of participants had a score higher than the cut-off of the DTS, indicating event-related post-traumatic stress disorder • The use of combined measures and mechanical restraint were associated with higher score on the DTS in comparison to involuntary medication • The use of combined measures was associated with lower satisfaction with inpatient psychiatric treatment compared to the use of involuntary medication
Hoge et al. (1997) - United States of America	Quantitative	157 participants: 66 involuntary 91 voluntary	Two sites: One hospital emergency room that serves as the point of entry to inpatient psychiatric services	<ul style="list-style-type: none"> • MacArthur Admission Experience Interview (AEI) • MacArthur Perceived Coercion Scale (MPCS) scores were derived from the AEI 	<ul style="list-style-type: none"> • Involuntary service users reported significantly higher levels of perceived coercion in comparison to voluntary service users • Accompaniment by custodial staff (police or ambulance) was associated with an increased in perceived coercion in involuntary service users • Both voluntary and involuntary participants reported approximately the same number of influence attempts in the admission process

			One public-sector hospital		<ul style="list-style-type: none"> • The timing of influence attempts varied, with voluntary service users experiencing these attempts primarily prior to the admission and involuntary service users experiencing these attempts both prior to and after the admission • Regarding the understanding of the of the admission process there were mixed results; 44% of voluntary service users stated it was not their idea to be admitted and 22.2% of involuntary service users stated it was their idea to be admitted
Krieger, Moritz, Weil & Nagel (2018) - Germany	Quantitative	213 inpatients who had experienced coercion and 51 inpatient controls (inpatients staying voluntarily on a closed ward with no coercive treatment)	Three Psychiatric Intensive Care Wards	<ul style="list-style-type: none"> • Interview • Breif Psychiatric Rating Scale (BPRS) • Global Assessment of Functioning (GAF) • Beck Depression Inventory-II (BDI-II) • Patient health Questionnaire (PHQ-9) • Insight Scale (IS) • Self-developed questionnaire that investigates the attitudes of patients who have experienced coercion in the past 	<ul style="list-style-type: none"> • "noninvasive measures" (e.g., the use of a "soft room," observation in seclusion) were better accepted by patients than "invasive measures" (e.g., mechanical restraint, forced medication) • Forced medication and mechanical restraint were less well accepted than involuntary hospitalization, seclusion, or video surveillance • Participants expressed the highest level of understanding of the reasons for involuntary hospitalisation (49%) and the least understanding of forced medication (13%) • The retrospective understanding of coercive measures increased over the course of treatment • The majority of participants reported experiencing negative emotions, such as helplessness, at the time of the coercive measure
Lidz et al. (1995) - United States of America	Quantitative	157 inpatients	Two psychiatric hospitals	<ul style="list-style-type: none"> • MacArthur Admission Experience Interview • Four questions regarding "pressures" on the admission • Four questions regarding procedural justice 	<ul style="list-style-type: none"> • Procedural justice, negative pressures, hospital site and legal status were all strongly related to perceived coercion • Procedural justice and negative pressures both made a significant unique contribution to perceived coercion • Positive pressures did not significantly contribute • Procedural justice was the strongest predictor of perceived coercion • There were differences in predictors of perceived coercion found between the two sites • Legal status was only significantly related to perceived coercion at one site and therefore the use of legal status as a

Lidz et al. (1998) – United States of America	Quantitative	433 participants were interviewed. A subgroup of 171 participants were included in the study.	Two psychiatric hospitals	<ul style="list-style-type: none"> • MacArthur Admission Experience Interview with patients, admitting clinicians and other individuals involved in the patients' psychiatric admissions • Data from the medical records 	<p>measure of perceived coercion should be used with considerable care</p> <ul style="list-style-type: none"> • Negative types of coercion-related behaviour and force were more related to perceived coercion than positive types of coercion-related behaviour • The use of legal force, being given orders, threats, and "a show of force" were all strongly correlated with perceived coercion. • Force is typically only used in conjunction with less coercive pressures. • Positive symbolic pressures, such as persuasion, do not induce perceptions of coercion.
McKenna, Simpson & Laidlaw (1999) – New Zealand	Quantitative	69 voluntary and 69 involuntary patients	Two acute psychiatric inpatient services	<ul style="list-style-type: none"> • MacArthur Admission Experience Survey (AES) • Responses from the AES were converted into scores and related back to the following scales: • Perceived Coercion Scale (PCS) • Negative Pressure Scale (NPS) • Voice Scale (VS) 	<ul style="list-style-type: none"> • Involuntary service users had a significantly stronger sense of coercion than informal service users • Perceived coercion increased with an increase in perceived use of threats and force • The use of physical restraint after admission significantly increased perceived coercion • Service users brought to the hospital by the police had a significantly higher perception of coercion in comparison to those whose admission did not involve police • Service users with higher educational levels and females perceived a greater sense of coercion. • Service users with psychotic illness showed a trend toward a stronger perception of coercion in comparison to those who had no psychotic illness.
Larsen & Terkelsen (2014) - Norway	Qualitative	12 patients and 22 staff members	Locked psychiatric ward	Ethnographic fieldwork -patient observation and interviews with staff and patients	<ul style="list-style-type: none"> • The main themes identified were (1) corrections and house rules, (2) coercion is perceived as necessary, (3) the significance of material surroundings, and (4) being treated as a human being. • When rules were applied rigidly rather than flexibly, many service users perceived corrections as provocative • Service users often felt inferior • The majority of staff and some service users saw coercive treatments as necessary

Olofsson & Jacobsson (2001) - Sweden	Qualitative	18 involuntarily hospitalized psychiatric patients	Large university psychiatric clinic	Narrative interviews	<ul style="list-style-type: none"> • Many of the staff felt guilty for violating patients' dignity, although they ascribed responsibility for their actions to the "system." • Service users identified the use of restraints as the worst form of coercion
Strauss et al. (2012) - United States of America	Quantitative	240 inpatients Initially recruited for a randomised control trial of psychiatric advanced directives. The current study provided secondary analyses of the initial study sample	Psychiatric inpatient unit	<ul style="list-style-type: none"> • Medical record reviews • GAF • Structured assessment interviews including: • Current Alcohol and Drug Use (CAGE) • Self-rated health score • Items adapted from the utilisation section of the Duke Epidemiologic Catchment Area study • Perceived coercion subscale (PCS) • Global Evaluation of Care subscale of the Perceptions of Care survey 	<ul style="list-style-type: none"> • Lower satisfaction ratings were independently associated with three coercive treatment variables: current involuntary admission, perceived coercion during current admission, and self-reported history of being refused a requested medication
Katsakou et al. (2010) - England	Quantitative	778 involuntary inpatients: 546 were followed up at one month 473 at three months	67 acute wards in 22 hospitals	Assessment interviews, including: <ul style="list-style-type: none"> • Client's Assessment of Treatment Scale (CAT) • MacArthur Perceived Coercion Scale (MPCS) • Coercion Ladder (CL) • BPRS • GAF 	<ul style="list-style-type: none"> • There was a significant increase in satisfaction with care over time, with highest satisfaction reported at three months • Patients who perceived less coercion at admission and during hospital treatment were more satisfied overall • Coercive measures documented in the medical records were not linked to satisfaction ratings • Symptom improvement was associated with higher levels of satisfaction

396 at one year

Iversen, Høyer & Sexton (2007) - Norway	Quantitative	173 participants completed the admission interview Of these 94 completed the satisfaction questionnaire	Three closed acute wards in one psychiatric hospital	Admission interview: <ul style="list-style-type: none"> • Nordic Admission Interview (NORAI) • MPCS • GAF • BPRS • Satisfaction questionnaire 	<ul style="list-style-type: none"> • Service users detained under section 3 of the MHA were more dissatisfied than those under sections 2 and 4 • Satisfaction with treatment among involuntary service users was associated with perceptions of coercion during admission and treatment, rather than with the documented extent of coercive measures • No significant differences in perceived coercion between voluntary and involuntary service users indicating that legal status is a poor measure of coercion • Overall satisfaction with care was negatively impacted by accumulated coercive events and objective coercion alone • Objective coercion had a significant negative effect on overall satisfaction when the individual measures of coercion were analysed separately • Service user formal legal status was not significantly associated with satisfaction • Perceived coercion was not significantly associated with satisfaction • Overall service user satisfaction reported at discharge was low, while satisfaction with different aspects of treatment showed considerable variation. • Perceived coercion in the admission process did not affect satisfaction; this significantly underlines the need to further explore the interaction between subjective and objective measures for coercion
Theodoridou, Schlatter, Ajdacic, Rossler, & Jager (2012) - Switzerland	Quantitative	116 psychiatric inpatients	Psychiatric University Hospital in Zurich	<ul style="list-style-type: none"> • Semi-structured interviews with service users and admitting clinicians • Scale To Assess the Therapeutic Relationship (STAR) • MacArthur Admission Experience Survey (AES) • BPRS • GAF 	<ul style="list-style-type: none"> • Involuntary admitted service users reported more perceived coercion than voluntary service users • High overall ratings of the therapeutic relationship • Perceived coercion predicts the service users' appraisal of the therapeutic relationship; higher perceived coercion is related to a more negative service user-therapist relationship as rated by the service user • Higher perceived coercion ratings were related to a higher symptom level on the BPRS and a lower level of global functioning at admission

Sheehan & Burns (2011) - England	Quantitative Cross-sectional cohort study	164 inpatients	Five acute wards across two psychiatric hospitals	Structured interviews including: <ul style="list-style-type: none"> • MacArthur Admission Experience Survey (AES) • Helping Alliance Scale (HAS) • GAF 	<ul style="list-style-type: none"> • The quality of the therapeutic relationship was not found to influence the perception of coercion • A high perceived coercion score was significantly associated with involuntary admission and a poor rating of the therapeutic relationship • Service users experiencing low levels of perceived coercion had higher ratings of the therapeutic alliance • The therapeutic relationship confounded legal status as a predictor of perceived coercion • However, the causality of these relationships cannot be determined
Shannon et al. (2015) - Ireland	Quantitative	162 inpatients 102 were interviewed one year after discharge	One independent hospital and three community services	<p>Baseline only:</p> <ul style="list-style-type: none"> • MPCS • Structured clinical interview for DSM-IV • Scale for the Assessment of Positive Symptoms • Scale for the Assessment of Negative Symptoms • Young Mania Rating Scale • Birchwood Insight Scale • BDI • Beck Hopelessness Scale <p>Both time points:</p> <ul style="list-style-type: none"> • Objective Social Outcomes Index (SIX) • GAF <p>Follow-up only:</p> <ul style="list-style-type: none"> • Subjective QOL items from the Manchester Short Assessment of Quality of Life (MANSA) 	<ul style="list-style-type: none"> • Lower functioning predicted more coercive events • One year after discharge, objective Quality of Life (QOL) improved for 15% of participants and functioning improved for 70% • Accumulated coercive events did not predict these outcomes; the association between a higher number of coercive events and improved functioning lost significance when other factors were taken into account • Coercive events during psychiatric admission appeared unrelated to functioning and QOL at follow-up
Seo, Kim & Rhee (2013) - South Korea	Quantitative	266 inpatients: 146 completed follow up at 6 months	Psychiatric hospital	<ul style="list-style-type: none"> • BPRS • Self-report insight scale • Perceived Coercion Scale (PCS) 	<ul style="list-style-type: none"> • Decrease in both mental symptoms and insight over time • Neither coercive measures nor perceived coercion had a significant effect on the change of mental symptoms • Coercion had little contribution to the declining of symptoms

98 completed
follow up at 1
year

- Self-report number of coercive measures (threats, physical violence, restraint or forced medication)

- Coercive measures had no effect on the change of insight but perceived coercion was shown to have a positive effect on a change in insight
- Patient insight was shown to improve with increased perceived coercion

From the findings of the 16 papers there were seven themes identified, which will be discussed in greater detail throughout the review:

- Examples of coercive practice
- Measurement of coercion
- Factors contributing to perceived coercion
- Service users' experience of coercion
- Coercion and satisfaction with care
- Coercion and the therapeutic relationship
- Coercion and outcomes or recovery

Examples of coercive practice

A variety of examples of coercive practice were used, with the most common being involuntary admission to hospital. Olofsson and Jacobsson (2001) and Katsakou et al. (2010) focused solely on involuntary service users' experiences, whereas three studies compared these with voluntary controls (Shannon et al., 2015; McKenna et al., 1999; Kreiger, Moritz, Weil & Nagel, 2018).

Most other studies used legal status, alongside other specific coercive practices. These were divided between coercion during the admission process or practices over the duration of the hospital admission.

During the admission process, some examples of coercive practices included the use of persuasion, inducements (offers or promises), threats and force (Hoge et al., 1997; Lidz et al., 1995).

Regarding the course of the hospital admission, Gowda et al. (2018) followed the definition from the Mysore Declaration on Coercion in Psychiatry (Raveesh & Lepping, 2013). This provided six examples of coercive practice, many of which were adopted by other studies in the review. Examples included physical restraint (Gowda et al., 2018; Iversen et al., 2007; Seo, Seung & Rhee, 2013; Strauss et al., 2012), mechanical restraint (Kreiger et al., 2018; Guzmán-Parra et al., 2019; Larsen & Terkelsen, 2014), enforced medication (Iversen et al., 2007; Kreiger et al., 2018; Guzmán-Parra et al., 2019; Larsen & Terkelsen, 2014; Seo et al., 2013; Strauss et al., 2012), chemical restraint (Iversen et al., 2007), isolation (Kreiger et al., 2018), seclusion (Larsen & Terkelsen, 2014; Strauss et al., 2012), video monitoring (Kreiger et al., 2018), house rules or restrictions (Larsen & Terkelsen, 2014) or a combination of measures (Guzmán-Parra et al., 2019).

The majority of examples appeared to be based on the more 'formal end' of the continuum when considering coercion rather than the more day-to-day, informal uses.

Measurement of coercion

Two measures of perceived coercion were used most frequently by the studies. The MacArthur Admission Experience Interview (AEI; Gardner et al., 1993); a structured interview exploring service users' perceptions of coercion in the admission process, the nature of any pressures applied and their treatment by others. The second was the MacArthur Admission Experience Survey (MAES; Gardner et al., 1993), a 16-item questionnaire derived from the AEI. It contains four subscales; 1) perceived coercion (MPCS), 2) negative pressure scale (NPS) which focuses on the use of force or threat, 3) voice scale (VS) which focuses on feeling listened to, and 4) affective reaction. This is one of the most widely used tools for researching perceived coercion internationally (Golay et al., 2017) and it has established

reliability and validity. The MPCS can be used independently as a measure of perceived coercion. This subscale consists of five questions, rated 'yes' or 'no', with a maximum score of five (Gardner et al., 1993).

Katsakou et al. (2010) also used the Coercion Ladder (CL); a visual analogue scale, from 0-10, which measures the degree of coercion, threats or pressure that service users' experience. Iversen et al. (2007) also used one variable from The Nordic Admission Interview ([NORAI] Hoyer et al., 2002); service users' reports of physical force.

Two studies used measures independent of the MacArthur measures. Guzmán-Parra et al. (2019) used the CES (Bergk et al., 2010) which consists of 35 items and asks service users to rate how frequently they feel a specific emotion in response to a coercive intervention. Additionally, they used a visual analogue scale of perceived coercion, to establish the convergent validity of the CES. Kreiger et al. (2018) devised a questionnaire focused on service users' understanding of five coercive practices and their emotional responses to these.

Larsen and Terkelsen (2014) and Olofsson and Jacobsson (2001) did not use self-report measures of perceived coercion in their qualitative studies. They explored service users' experiences through the use of interviews and observations.

Factors contributing to perceived coercion

Seven papers primarily explored the factors that contribute towards service users' perceptions of coercion (Gowda et al., 2018; Guzmán-Parra et al., 2019; Hoge et al., 1997; Krieger et al., 2018; Lidz et al., 1995; Lidz et al., 1998; McKenna et al., 1999). Of these,

coercion during the admission process was the focus of four studies (Hoge et al., 1997; Lidz et al., 1995; Lidz et al., 1998; McKenna et al., 1999).

Links were found between legal status and service users' perception of coercion (Lidz et al., 1995; McKenna et al., 1999). Several studies found involuntarily admitted service users reported significantly higher perceived coercion compared to voluntary service users (Theodoridou et al., 2012; Sheehan & Burns, 2011; Hoge et al., 1997). However, legal status was not always predictive of perceived coercion. Iversen et al. (2007) found no significant differences in perceived coercion between involuntarily and voluntarily admitted service users. They indicated that 34% of voluntary service users reported high levels of perceived coercion at admission and 51% of involuntary service users reported low levels of coercion. This finding replicated Hoge et al. (1997) who implied that the link between legal status and perceived coercion is not straightforward. Some legally voluntary service users felt coerced into treatment and approximately 35% of involuntary service users did not feel coerced. However, it should be noted that Hoge et al. (1997) self-selected the cut off scores for the identification of 'coerced voluntaries' and 'uncoerced involuntaries'.

Within the admission process, the research indicated that it was not solely legal status which was predictive of perceived coercion and several specific practices were identified.

McKenna et al. (1999) suggested perceived coercion increased with perceived use of threats and force. Specifically, police involvement in the admission process and physical restraint after admission significantly increased perceived coercion. Accompaniment by custodial staff was also associated with increased perceived coercion in involuntary service

users (Hoge et al., 1997). However, they recruited participants from two admissions wards which employed separate processes, making it difficult to draw comparisons.

Some studies found negative pressures to be admitted to hospital, such as threats and force, were strongly associated with perceived coercion, whereas more positive pressures, such as persuasion, were not related (Lidz et al., 1995; Lidz et al., 1998). Lidz et al. (1998) identified that “a show of force” was strongly correlated with perceived coercion, indicating that the use of actual force was not necessarily required. However, these findings should be interpreted with caution, as a subgroup of only 177 out of 433 participants were included in this study due to the quality of information obtained, which may have biased the results.

Procedural justice (PJ), which highlights the importance of fairness in the process of legally detaining an individual and promotes service users having their voice heard (Canada & Hiday, 2014), was found to be a strong predictor of perceived coercion (Lidz et al., 1995). Increasing service users' ratings of PJ lowered ratings of perceived coercion (Sheehan & Burns, 2011) which was corroborated by McKenna et al. (1999) who showed PJ had a positive influence on perceptions of coercion.

Theodoridou et al. (2012) found that higher perceived coercion was associated with lifetime incidence of involuntary hospital admission.

Other studies focused on the experiences of service users across the duration of their admission. Gowda et al. (2018) investigated six variations of coercive practice; physical restraint, chemical restraint, involuntary medication, isolation, seclusion and Electro Convulsive Therapy (ECT). They found perceived coercion scores were highest in service

users' experiencing physical restraint, followed by chemical restraint. The use of ECT was linked with the lowest level of perceived coercion, followed by isolation, seclusion and involuntary medication. Service users were interviewed at two time points and it was found that ratings of perceived coercion decreased over the length of the admission (Gowda et al., 2018). The study had a good retention rates at the second time point, with 182 out of 200 participants completing the follow up.

Similarly, Guzmán-Parra et al. (2019) found combined measures; mechanical restraint (use of devices to restrict movement) and involuntary medication, and mechanical restraint alone were associated with higher levels of perceived coercion in comparison to involuntary medication alone (Guzmán-Parra et al., 2019). However, it was unclear how many experiences of the coercive event participants had had.

These findings were consistent in most studies. The use of "non-invasive measures", such seclusion, were found to be better accepted by service users than "invasive measures", including mechanical restraint and enforced medication (Kreiger et al., 2018). However, these findings should be interpreted with caution, as the measure of coercion used was a self-developed questionnaire which is awaiting validation. Additionally, the interviews were conducted in varying timeframes which may have produced some memory bias. They also found a low preference for enforced medication (Kreiger et al., 2018). This finding goes against those of other studies (Guzmán-Parra et al., 2019) but this may be due to other studies only comparing a limited number of coercive interventions.

In a qualitative study, service users identified several practices as being experienced as coercive; mechanical restraints, physical restraint, seclusion and close nursing supervision

(Olofsson & Jacobson, 2001). They also recognised more subtle forms of coercion such as not being listened to and not being allowed to decide (Olofsson & Jacobson, 2001).

Service users' experience of coercion

Five studies explored service users' experience of coercion (Guzmán-Parra et al., 2019; Kreiger et al., 2018; McKenna, Simpson & Laidlaw, 1999; Larsen & Terkelson, 2014; Olofsson & Jacobsson, 2001).

Kreiger et al. (2018) identified numerous negative emotional responses in service users after coercive measures were used, including helplessness, shame, rage, fear, loneliness, or disorientation. However, more positive emotional responses, such as relief and a sense of safety, were reported in relation to involuntary hospitalisation (Kreiger et al., 2018). Anger and feeling a loss of autonomy were also identified as prominent responses to being involuntarily admitted (McKenna et al., 1999).

In the two qualitative studies, feelings of inferiority and not being treated as human being were prominent themes that emerged in response to perceived coercive practice (Larsen & Terkelson, 2014; Olofsson & Jacobsson, 2001).

In Larsen and Terkelson's (2014) study service users reported that when rules were applied rigidly rather than flexibly, this was perceived as provocative and often left them feeling inferior. Although the rules and environment were supposed to be beneficial, these were often perceived as insulting and seclusion left some service users feeling as though they were not human beings with free will. However, some participants felt the use of seclusion was necessary at the time, although perhaps lasted too long. The use of restraints was

recognised as the worst form of coercion and described as being “hell” (Larsen & Terkelson, 2014). Although the methodology offered a more naturalistic approach to research, there was only one researcher who selected the interactions to observe and the participants to speak to, which may have introduced bias into the findings.

Using narrative interviews, Olofsson and Jacobsson (2001) identified a similar theme of “not being respected as a human being”. Service users reported specific experiences of not being listened to, or not feeling heard and indicated that the best way they had found to manage coercive experiences was to stay silent, agree and not protest. Often the coercive event, such as enforced medication was experienced as a punishment. Their responses to coercion included feeling frightened, feeling violated and depreciated by staff, and feelings of worthlessness (Olofsson & Jacobsson, 2001).

The negative impact of coercion was also indicated by Guzmán-Parra et al. (2019). 12.6% of participants scored highly on the Davidson Trauma Scale (DTS) indicating event related posttraumatic stress disorder in relation to a coercive experience. These scores were high in participants subjected to mechanical restraint or combined measures (Guzmán-Parra et al., 2019).

Coercion and satisfaction with care

Four studies focused on the relationships between perceived coercion and satisfaction with care (Guzmán-Parra et al., 2019; Strauss et al., 2012; Katsakou et al., 2010; Iversen et al., 2007)

Strauss et al. (2012) found that participants who were currently involuntarily detained reported lower satisfaction with care scores than those who were voluntarily admitted. Perceived coercion during the current admission, as well as a reported history of being denied a requested medication, was significantly associated with lower satisfaction with care. However, these findings were from an inpatient setting for veterans, which means they may not be generalisable outside of this context.

Similarly, perceptions of coercion were found to be associated with treatment satisfaction, when measured on the CL. Findings from the MPCS were not a significant predictor satisfaction when other factors were accounted for (Katsakou et al., 2010). This finding questions the use of the MPCS within this population. Over time, satisfaction ratings decreased with higher levels of perceived coercion throughout treatment. The study recruited a large sample size from several hospital sites across England, and therefore should provide generalisable findings. However, it should be noted that they also had a low retention rate at follow up which may have introduced bias to the findings over time.

Guzmán-Parra et al. (2019) found that combined measures were associated with lower satisfaction with inpatient care. This is supported by the findings of Iversen et al. (2007); overall patient satisfaction was negatively impacted by accumulated objective coercive events. Specifically, when physical force was applied, satisfaction with care was reduced. Accumulated objective coercion negatively impacted on four aspects of care; staff-patient relationships, ward environment, treatment programme and subjective treatment outcome (Iversen et al., 2007). However, it is important to note that the number of service users who were subjected to objective coercion during their admission was limited; 17 out of 94, and there was a high attrition rate.

Coercion and the therapeutic relationship

Two studies investigated the impact of coercion on the therapeutic relationship (Theodoridou et al., 2012; Sheehan & Burns, 2011). Findings from both studies were limited to the relationship with the admitting clinician and may not be generalisable to wider therapeutic relationships.

Both studies produced similar findings, namely that service user ratings of the therapeutic relationships were significantly associated with their ratings of perceived coercion; the lower the perceived coercion score, the higher the rating of the therapeutic relationship and vice versa (Sheehan & Burns, 2011; Theodoridou et al., 2012). Additionally, Theodoridou et al. (2012) found clinicians rated the therapeutic relationship less favourably with involuntarily admitted service users.

Coercion and outcomes or recovery

Two studies explored the impact of coercion on outcomes or recovery post-admission (Shannon et al., 2015; Seo et al., 2013).

Shannon et al. (2015) used Global Assessment of Functioning (GAF) and Quality of Life (QoL) scores as their outcome variables. Although higher numbers of coercive events during the hospital admission were found to be associated with improved functioning at follow up, this finding was not statistically significant when other factors were taken into account (Shannon et al., 2015). This indicates that coercive events during admission are not related to functioning or QoL one-year post-discharge. A significant limitation of this study was the amount of missing data and low retention rate at follow up.

Seo et al. (2013) found that although higher perceived coercion was associated with lower mental health symptoms and higher objective coercive events were related to higher mental health symptoms, these effect sizes were not statistically significant. However, high perceived coercion was found to have a positive effect on the improvement of insight over time (Seo et al., 2013).

Quality Appraisal

It is important to consider the methodological critiques alongside the above findings. A summary of each study's critiques can be found in Table 2. Using the quality checklists, the majority were found to be of a generally good standard, and they obtained similar scores, with some exceptions. All studies stated a clear aim of the research and adopted a suitable design, however the standard of reporting of this varied between studies. Conclusions primarily followed from results and most studies recognised their limitations.

Table 2: The main methodological critiques of each study

Study	Sample	Design/methods	Data collection	Results	Quality appraisal score (total 28) ¹
Gowda et al. (2018)	Good sample size achieved. Sample were randomly selected and screened	Used a validated scale (MAES)	Good retention rates at the second time point.	Thorough results section.	16
Guzmán-Parra et al. (2018)	Relatively small sample size. Not all eligible participants were recruited due to researcher availability. Reasons for non-participation were not included. Exclusion criteria not reported.	Detailed description of all measures used. The CES has high internal consistency and Cronbach's alpha was reported. The other measures used have been validated. The quasi-experimental design meant no causal relationships could be established.	The timeframe between the coercive event and participation in the study was unclear. Self-report measures.	Comprehensive descriptions of the data analysis process. Thorough results section.	16
Hoge et al. (1997)	Relatively small sample size. Inclusion and exclusion criteria were not detailed. Differences in voluntary status between sites. One legal category was oversampled at each site. Significant differences in ethnicity between the two sites.	Used a validated measure (AEI). Limited description of the measures used. Participants were recruited from two sites which had different admission processes.	Self-report measures	No description of the data analysis process provided. Self-selected cut off scores for perceived coercion.	10

Krieger et al. (2018)	Good sample size and inclusion of a control group. Details of exclusion from participation included. Detailed recruitment process.	Did not use a validated measure. Devised their own self-report measure but no psychometric properties available for reliability or validity.	Data collected at varying time points.	Comprehensive description of the data analysis process.	19
Lidz et al. (1995)	Relatively small sample size. Exact numbers and reasons for non-participation were not reported. Not all eligible participants were able to be interviewed within the timeframe.	Used a validated measure (AEI). Detailed description of the measures used.	Small timeframe in which interviews were conducted post admission. Interviewers were trained together and periodically reviewed each other's tapes.	Thorough results section.	16
Lidz et al. (1998)	Initially a large sample size. However, only a selected subgroup were included in the study based on amount and quality of the data.	Used a validated measure (AEI). Two coders produced factual account scores based on a detailed code book which may be prone to bias.	Small timeframe in which interviews were conducted post admission. They used a comparison of service user, clinical and collateral member's accounts to produce a factual account of the admission.	Limited results section. Some findings in the discussion were not mentioned in the results.	13
McKenna et al. (1999)	Relatively small sample size. Equal numbers between groups which were established by a power analysis.	Used a validated scale (MAES)	Timeframe of the assessment post-admission was unclear. Self-report measures.	Comprehensive results section.	19

	<p>Some participants were admitted more than once in the recruitment timeframe and participated multiple times.</p> <p>A large number of eligible participants did not participate (39%).</p>				
Larsen & Terkelsen (2014)	<p>Good sample size for qualitative research.</p> <p>Unclear how informed consent was obtained</p> <p>Limited demographic information presented.</p> <p>Men were overrepresented in the sample of both service users and staff.</p>	<p>Only minimal consideration of the ethical dilemmas was included.</p> <p>It was unclear how observations took place if some service users had consented and others had not.</p> <p>The observational aspect of the methodology removed the difficulties of bias in self-report measures.</p>	<p>Only a brief description of the ethnographic fieldwork was provided.</p> <p>Only one researcher conducted all the observations.</p> <p>No formal interviews were conducted with service users, only spontaneous conversations.</p> <p>The researcher selected situations to observe or individuals to interview, which introduced a level of bias.</p>	<p>Brief description of the analysis procedure.</p> <p>The findings have been translated from Norwegian to English, and the translation may have introduced bias into the quotes and meaning.</p>	N/A
Olofsson & Jacobsson (2001)	<p>Good sample size for qualitative data although women were overrepresented.</p> <p>Reasons for non-participation were provided.</p> <p>Limited demographic variables provided</p>	<p>Lack of credibility checks.</p> <p>Some consideration of the ethical dilemmas.</p>	<p>Only a limited description of the narrative interviews was provided.</p> <p>It was unclear whether these were semi-structured.</p>	<p>The data analysis process was unclear and included multiple analyses; domain and thematic.</p> <p>A second researcher also analysed the transcripts.</p> <p>Two core themes were identified.</p>	N/A

				One subtheme did not fit within either core theme. Appropriate use of quotes to support the themes.	
Strauss et al. (2012)	Reasons for non-participation reported. Good sample size achieved. Men were over-represented in the sample (87.92%). Participants were recruited from an inpatient hospital for veterans.	Part of a wider study, only brief description of the methodology was provided and referred to a separate study for further detail. Used a validated scale (MPCS). Clear descriptions of the measures used and Chronbach's alpha was reported for one.	Self-reported treatment history. Half were interviewed within two days prior to discharge and 82.5% were interviewed within four days of discharge. Mean length of stay was only 8 days.	Secondary analysis of the initial study sample. Clear description of the data analysis process.	18
Katsakou et al. (2010)	Recruited from 67 acute wards across 22 hospitals. Inclusion criteria and recruitment process were reported in a separate paper. Large sample size. Low retention rates, 70% at time two, 61% at time three and 51% at time four.	Used one validated scale (MPCS). The second scale (CL) did not have psychometric properties available for reliability or validity. Thorough description of the measures used provided.	Self-reported incidence of coercive interventions were corroborated by a review of medical records.	Comprehensive description of the data analysis process was provided. Thorough results section. Reported non-significant results as demonstrating a trend.	20
Iversen et al. (2007)	Relatively small sample size .	Used a validated scale (MPCS).	Interviewers were blind to service users' legal status. Follow up questionnaire had poor rates of	Comprehensive description of the data analysis process. Clarity of the results section could have been	20

	<p>Poor retention rate for the follow up questionnaire (54%). Comparisons were drawn between participants refused to participate, only completed measures at baseline and completed the follow up questionnaire.</p>	<p>Detailed description of the measured used was provided. The measure of satisfaction had two subscales excluded from the findings due to a lack of internal consistency.</p>	<p>completion (54%), reportedly due to staff forgetting to provide this to service users at discharge. They recorded the number of coercive events over the length of admission, based on participant reports and hospital records.</p>	<p>improved by the use of tables.</p>	
Theodoridou et al. (2012)	<p>Relatively small sample size. Inclusion and exclusion criteria were reported.</p>	<p>Used a validated scale for perceived coercion (MAES). Unclear whether the STAR has been validated. Chronbach's alpha reported. Interviewers were trained on interview technique and ratings of the BPRS and GAF.</p>	<p>Focused only on the therapeutic relationship with the admitting clinician.</p>	<p>Comprehensive description of the data analysis process. Thorough results section.</p>	21
Sheehan & Burns (2011)	<p>Relatively good sample size. A large number of potential participants were excluded due to ineligibility. Reasons for non-participation were reported. 75% of eligible participants consented.</p>	<p>Research design clearly identified. Thorough description of the measured used. Used a validated scale (MAES).</p>	<p>Focused on the therapeutic relationship with the admitting clinician.</p>	<p>Comprehensive description of the data analysis process. Thorough results section.</p>	21

Shannon et al. (2015)	<p>Relatively small sample size. 63% retention rate at follow up. Clear exclusion criteria. Comparable numbers of voluntary and involuntary participants although numbers were not reported. Limited demographic information obtained.</p>	<p>Used a validated scale (MPCS). Limited description of the measures used. Data was collected at two time points, however the timeframe of participation was unclear.</p>	<p>Low completion rate for some measures.</p>	17	
Seo et al. (2013)	<p>Clear recruitment strategy. Initially a good sample size, but poor retention rates at time two (54.9%) and time three (36.8%). Reasons for drop out were reported.</p>	<p>Data was collected at three time points. Used a validated scale (MPCS) however this was adapted for the Korean language and therefore validity may have been reduced. Clear descriptions of the measures used. Reliability and validity included and Cronbach's alpha was reported. Self-report measure of objective coercive events.</p>	<p>A large amount of missing data for at least one variable at time two (49.25%) and time three (65.41%).</p>	<p>Comprehensive description of the data analysis process. Used a full information maximum estimation for missing data. Very thorough results section.</p>	20

¹ A higher score indicates better quality.

Participants and recruitment

Although several studies achieved a good sample size, a substantial number had a relatively small sample, meaning their conclusions were limited in terms of their validity and reliability. This was often found in studies which collected data at multiple time points. These studies were prone to high attrition rates at follow-up, and retained between 36.8% (Seo et al., 2013) and 63% (Shannon et al., 2015) of participants at follow up, except for Gowda et al. (2018) who maintained 91% of participants. Only one study reported using a power analysis to establish recruitment numbers (McKenna et al., 1999). Two studies (Lidz et al., 1995; Guzmán-Parra et al., 2019) were limited by researcher availability, which meant not all eligible participants were able to take part.

Generally clear inclusion and exclusion criteria were reported. Due to ethical reasons, all studies excluded participants who were unable to provide informed consent, meaning service users who were severely unwell were unable to participate. Therefore, experiences of this population may be missing.

Only one study (Iversen et al., 2007) compared the demographic characteristics of study 'refusers' with participants and found there were no significant differences between groups. Certain demographic groups were overrepresented in a few studies, including white ethnicity (Hoge et al., 1997), males (Larsen & Terkelsen, 2014; Strauss et al., 2012) and legal status between sites (Hoge et al., 1997).

Data collection and analysis

The research took place in several countries, which all have different legislation and policies regarding restrictive practice. Some countries used mechanical restraint, which is not

used in the UK. Therefore, it may be difficult to draw comparisons between the experiences of service users across an international scope. Additionally, the studies were conducted between 1995 to 2018. Over the last 23 years there have been vast changes in mental health legislation across many countries, meaning the practice and policies regarding coercive interventions may have changed within this time frame.

Aside from the two qualitative studies (Larsen & Terkelsen, 2014; Olofsson & Jacobsson, 2001), most studies used subjective self-report measures of coercion, which may be prone various forms of bias, including memory and social desirability bias.

Due to the nature of the research topic, it was not possible to randomly allocate participants to specific groups. Numerous studies adopted an observational design which made it difficult to control for confounding variables and causality of the associations could not be established.

There were differences between studies regarding the timeframe in which recruitment took place. Several studies focused their assessment at admission (Hoge et al., 1997; Lidz et al., 1995; Lidz et al., 1998; McKenna et al., 1999), whereas others recruited at discharge (Strauss et al., 2012).

Generally, studies included comprehensive details of the data analysis, except for Hoge et al. (1997) who did not provide details. Both the qualitative studies provided either brief (Larsen & Terkelsen, 2014) or unclear methodology (Olofsson & Jacobsson, 2001) which made it difficult to evaluate the rigour of their analysis.

Examples and measurement of coercion

It is challenging to compare the findings across the studies due to the varying examples of coercion used. Although several studies included a full range of interventions, from persuasion to physical restraint (Gowda et al., 2018), other studies focused solely on legal status (Hoge et al., 1997; Lidz et al., 1995; Lidz et al., 1998), or specific coercive interventions, such as involuntary medication (Guzmán-Parra et al., 2019). These differences are reflective of complexity of coercion and the difficulties in defining coercive practice.

Discussion

This review aimed to explore service users' experiences of coercion whilst admitted involuntarily to general mental health inpatient services and to consider its impact on outcomes. Due to the limited number of two qualitative papers, quantitative papers were also included in the review. From the literature it was evident there was difficulty defining coercive practice. The findings will be discussed in terms of the specific review questions.

Service users' experiences of coercion

Experiences can be split between the admission process and more day-to-day coercion throughout the duration of the admission. Involuntary admission was assumed as evidence of coercion in several of the studies. However, there were conflicting findings regarding legal status and perceived coercion which indicate that it is not a straightforward relationship. Some findings suggested involuntarily admitted service users reported higher perceived coercion, whereas other findings did not establish a predictive link. Iversen et al. (2007) identified that a proportion of voluntarily admitted service users reported high levels of perceived coercion, which may be due to feeling pressured to agree to the admission, for fear of being sectioned if they did not. Additionally, some involuntarily admitted service users

reported low levels of perceived coercion. Whilst there is continued demand for beds, but inpatient mental health services have reduced, it is possible that legal detention may be required to access services. Therefore, some service users who agree that they require an admission may need to be admitted under Section to access the service.

During the admission process, findings suggested perceived coercion increased with the use of threats and force and decreased with increased PJ. This indicates it may be the process by which service users are detained that impacts upon their perceptions of coercion, not the outcome.

Factors that increase perceived coercion throughout the duration of the hospital admission were identified as invasive measures, such as physical restraint, and accumulated coercive practices. Service users preferred non-invasive practices, such as seclusion, and perceptions of coercion decreased over the length of admission. Although most studies focused on overt coercion, the qualitative findings indicate there are more subtle forms of coercion present, such as not being listened to and not being allowed to decide.

The qualitative perspectives provided some negative experiences of coercion, such as feeling helpless, and some experienced coercion as punishment. However, the coercive practices were also viewed by some as necessary at the time. Experiences were mixed in relation to being detained under Section, with some responding to this with anger and experiencing a loss of autonomy, whereas others viewed hospital as a relief and providing a sense of safety.

What is the impact of coercion on outcomes, therapeutic relationships and satisfaction with care?

Being detained involuntarily decreased satisfaction with care in some service users, although findings were mixed, demonstrating this is not a straightforward relationship. Over the duration of an admission, accumulated and physically invasive coercive practices were associated with lower satisfaction, but this was not supported by all studies, as one found perceived coercion was not predictive of satisfaction when other factors were taken into consideration. Perceived coercion was found to negatively impact on ratings of the therapeutic relationship with the admitting clinician, however this cannot be generalised to other therapeutic relationships.

Regarding functioning and quality of life post-admission, coercive events did not relate to these significantly. This can be viewed positively, as despite negative reports regarding the impact of coercion whilst admitted, these do not appear to negatively impact on future outcomes.

What does this review offer?

The studies included in this review were considered to be of good quality. All research designs and methodologies were appropriate, however the reporting of these could have been improved in some papers. The qualitative studies displayed good use of quotes in the results, although further description of the data analysis procedure was required in both. Generally, the quantitative papers had comprehensive results and the conclusions followed on from this. However, the frequent use of self-report measures may have introduced some level of bias to the findings. Additionally, rating experiences of coercion within categorical constructs did not allow for exploration of the meaning service users attached to these.

We must bear in mind that these are multi-national studies and the legal frameworks and legislation within mental healthcare vary in each country, therefore consideration should be used when comparing the findings. Additionally, as no time frame was imposed on the literature search, the studies were conducted across a broad timeframe, meaning the clinical practice and mental health legislation may have changed in this time and may not reflect the experience of current practice. Therefore, generalisability of the findings may be limited.

Taking this into account, the review identified several factors of coercive practice which impact on service users' perceptions of coercion and in turn their satisfaction with care and views of their therapeutic relationships. It is evident that the subject is complex, and many relationships are not straightforward. Legal status should not be presumed as evidence of coercion and the subjectivity of experiences should be taken into consideration. Additionally, despite service users' reporting some negative psychological impacts of coercion, its use in certain situations was recognised as being necessary (and did not appear to have long term impact in terms of outcome) and it is important to hold in mind the justification for its use; to maintain service user safety.

Relationship to theory and policy

According to Self Determination Theory (Ryan & Deci, 2000), autonomy is integral to service users being motivated to change. The findings within this review indicate that intrusive and accumulated coercive interventions can leave service users feeling helpless (Kreiger et al., 2018) and that they have lost autonomy (McKenna et al., 1999). According to Self Determination Theory this loss of autonomy may impact on their motivation to engage and be proactive in their recovery. However, contradictory to this, Seo et al. (2013) found that although there was some association, neither perceived or objective coercion were

significantly related to mental health symptoms. This suggested that the impact coercion may have had on service user autonomy did not affect treatment outcomes.

The findings from the review offer some support to the most recent updates to UK policy regarding reducing restrictive practice (Department of Health, 2015). The negative experiences service users reported (Kreiger et al., 2018), alongside some evidence that intrusive coercive practices can be traumatic (Guzmán-Parra et al., 2019), emphasise the need to limit its use to situations in which every other option had been unsuccessful. However, findings indicate that more day to day uses of threats or persuasion can also be perceived as coercive. This indicates that not only should we aim to reduce restrictive practice, but attention should also be focused on findings ways to decrease other aspects of less formal coercion and increase service user autonomy.

The recent review of the Mental Health Act (2007) recommended implementing shared decision making where possible (Department of Health and Social Care, 2018). One important aspect of care they highlighted was recording service users' views alongside every decision. Implementation of this into clinical practice may reduce feelings of not being listened to that service users reported (Olofsson & Jacobson, 2001) and in turn may reduce perceived coercion.

Clinical implications

The current review suggests coercion is a complex area with no easy solutions. Several valid tools were used to measure perceived coercion and it may be helpful to consider their use clinically, particularly during the admission process. The mixed findings regarding

legal status suggest this may not be a reliable predictor of coercion and some voluntarily admitted service users may also experience this process as coercive.

Evidence suggested that PJ reduced perceived coercion, which indicated it is the process by which service users are admitted which is important. Ensuring service users' views are heard by decision makers, as well as being transparent and providing explanations for decisions may help to reduce the perceptions of coercion in what is already a coercive practice.

There were several different factors which service users perceived as being coercive, including invasive measures. Typically, physical restraint, including its use during enforced medication, is performed by nursing staff and support workers. Therefore, it is possible that service users may perceive the nursing team as a more coercive profession. This brings into question the ethics of holding dual roles, as a care-giver and enforcer of the rules.

Although there was a mixed evidence base, it is likely that repeated, and more invasive coercive practices negatively impact recovery and could be experienced as traumatic for service users. It is important to ensure that support is offered to service users after an invasive coercive event. This may be best to be provided by professional staff who were not primarily involved in the event.

The qualitative findings identified that there are more subtle experiences which are perceived as being coercive by service users, such as not being able to decide. By involving service users in the treatment planning process, this may help to alleviate some level of coercion. Specifically, asking service users for their opinion on the treatment options may

enable service users to feel as though they have more of a choice. This is supported by the evidence that if service users are actively involved in care it can improve outcomes and experience (NHS England, 2017).

Interestingly, there was some evidence that staff perceive the therapeutic relationship more negatively when service users are involuntarily admitted. It may be useful for clinicians to acknowledge and reflect on their perceptions and the impact these may have on client care. This could be achieved through supervision or reflective practice. Clinical psychologists may be particularly suited to provide opportunities for staff to reflect on potentially difficult emotional responses to service users.

Research implications

It has been acknowledged that as legal frameworks and practices in mental health services vary between countries it may be difficult to generalise the findings. Therefore, regarding the topic of coercion, perhaps international collaborative studies are required (Szmukler, 2015).

The conflicting findings regarding legal status and perceived coercion indicate that future research should not focus solely on legal status as an indicator of coercive practice (Hoge et al., 1997). It was identified that there is a split between coercion in the admission process and throughout the duration of an admission. There are lots of more subtle coercive practices that may be overshadowed and could be considered in further research.

The studies focused broadly on the inpatient experience and did not identify the impact that coercion has on specific forms of treatment. In relation to psychological

interventions, it may be helpful to explore the impact on engagement and outcomes in therapy if attendance had been perceived as coercive.

The review highlighted that there is limited qualitative research concerning the narrative and personal experience of service users' in relation to coercion in inpatient mental health services. Most studies tended to focus on the objective presence of perceived coercion and not on the meaning attached to these experiences for service users. To deepen our understanding of service user perspectives, more qualitative research may be helpful.

The focus of this review was the experience of service users within general psychiatric inpatient services. However, these findings may not be generalisable to other populations within the mental health context. We know that there are differences in the legal frameworks and procedures used in forensic mental health settings. There are many additional factors to consider, such as the involvement of the MoJ and additional restrictions placed on service users, as well as a tendency for longer admissions. There appears to be limited research evidence of the impact of these additional factors in relation to the perceived coercion experienced by service users, therefore, more research is needed in this area.

It was highlighted at the beginning of this review that coercive practices are considered an unfortunate but necessary part of psychiatric care (Newton-Howes, 2010). As it is incredibly unlikely that the use of coercion could be removed completely from this environment, perhaps it would be helpful to explore how we can increase service user autonomy within inpatient settings? It may also be helpful to consider clinician's perspectives about the more informal coercive practices, when these are helpful and their decision making around this process.

Conclusions

The findings of this review suggest the use of coercion in psychiatric inpatient services is complex and its impact on service users is not a straightforward relationship. Although coercion is primarily perceived negatively by service users, at times it is recognised as a necessary process. However, in agreement with recent government guidance, the findings indicate that efforts should be made by services to reduce the use of invasive coercive practices, such as physical restraint.

The review highlights that it is difficult to pull apart the impact of legal status from more day-to-day examples of coercion in inpatient settings. Most research has focused on objective coercive practices, meaning relatively little is known about service users' experiences of more subtle uses of coercion, such as not feeling listened to, and the impact these have.

Future research employing a qualitative approach may be useful to deepen our understanding of the meaning that service users attach to coercion and to explore how service user autonomy could be increased in psychiatric inpatient settings.

Regarding clinical aims, it may be possible to reduce coercion in the admission process by using PJ. Throughout the duration of admission, service users should be involved as much as possible in the decision-making processes and if intrusive coercive events do take place, clinicians should ensure that support is offered to service users after the event. Additionally, psychiatric inpatient service could conduct restrictive practice audits to monitor its use and assess service users' experiences of coercion routinely.

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Section B: An Interpretative Phenomenological Analysis of male service users' experiences of perceived autonomy in low secure forensic services

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SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

Abstract

In forensic mental health services, the subject of autonomy is multi-faceted. Many service users in these settings have low motivation, therefore coercive practice may be used to aid recovery and prevent lengthy admissions. Restrictions can also be placed on service user autonomy to protect the welfare of the wider community. However, there is limited research regarding service users' experiences of autonomy in forensic settings.

This study employed an Interpretative Phenomenological Analysis to explore eleven service users' subjective experiences of autonomy whilst detained on low secure forensic mental health wards.

Seven superordinate themes emerged; initial expectations of the ward, relationships with staff, perceived lack of autonomy, perceived sense of autonomy, compliance, motivators and changes over time. The findings suggest service users have varied experiences of perceived autonomy which can be influenced by their relationships with staff and perceptions of being provided with choice.

In clinical practice, it could be helpful to consider how service user choice could be increased, such as providing options and ensuring service users feel listened to. It is particularly important to increase opportunities for autonomy as service users near discharge, to enable them to become more independent and break dependency on services.

Keywords: Autonomy, forensic, low secure, service user, experience

Introduction

Forensic mental health services

Forensic mental health services are specialist services provided for services users who present with a mental health condition and are considered to pose a significant risk of harm to themselves and/or others (NHS England, 2013). Service users may have complex and/or long-standing difficulties with their mental health and may require long-term treatment and rehabilitation which cannot be delivered effectively from general mental health inpatient services.

In the United Kingdom, the forensic mental healthcare pathway is comprised of several services, including three tiered inpatient services consisting of 'high', 'medium' and 'low' secure forensic hospitals (Joint Commissioning Panel for Mental Health, 2013). Services users are admitted to the appropriate level of service provision depending on the level of risk. Research within the forensic context has typically focused on high and medium settings, however we still know relatively little regarding service user' experiences of low secure services. Therefore, the focus for this study will be primarily on low secure services.

There has been an increase in the number of forensic inpatient beds in recent years (Sashidharan & Saraceno, 2017), generally and in low secure services. In 2013 there were approximately 2500 individuals being treated across 150 low secure inpatient services within the United Kingdom (Joint Commissioning Panel for Mental Health, 2013). Admission to low secure services can come from numerous pathways; criminal justice services, forensic community mental health services, step-down from a medium secure unit or from general mental health services (Joint Commissioning Panel for Mental Health, 2013).

The core objectives of low secure forensic inpatient services are to assess and treat mental health conditions, support recovery and reduce the risk of harm (NHS England, 2013). All service users in these settings are detained under the Mental Health Act (2007) and many will have been in contact with the criminal justice system (NHS England, 2013). Often, there will be several agencies involved in an individual's care, including the inpatient multi-disciplinary team (MDT), a community forensic team, probation and the Ministry of Justice (MoJ).

Admission lengths can vary greatly, and a significant number of service users can remain detained for extended periods of time (Duke, Furtado, Guo & Völlm, 2018). Under a forensic Section of the Mental Health Act (2007), the length of admission is not pre-determined and is dependent on the progress that service users make, meaning it can be shorter or longer than the equivalent prison sentence (Adshead, 2000). In some circumstances, discharge is jointly decided upon by the responsible clinician in agreement with the MoJ.

Recovery model

The concept of recovery is subjective and can mean different things to each individual but is essentially person-centred and acknowledges that recovery does not necessarily translate to 'cure' but should instead focus on enabling individuals to live satisfying lives. Indeed, there is some evidence that suggests taking a recovery-focused approach to treatment is linked with better mental health and social outcomes for service users (Warner, 2010).

Slade and Wallace (2017) identified a difference between clinical and personal recovery. It has also been associated with social inclusion and the ability to engage in

meaningful social roles in society (Mann, Matias & Allen, 2014). In a Delphi study, service users with psychosis agreed on the definition “recovery is the achievement of a personally acceptable quality of life” (Law & Morrison, 2014).

In recent years recovery-focused approaches have been adopted by forensic services, and secure hospitals should provide care in line with its principles (Joint Commissioning Panel for Mental Health, 2013). One example of a strengths-based approach to offender rehabilitation is the Good Lives Model (Ward & Stewart, 2003). It works on the premise of building on individual’s strengths and their capabilities to reduce their risk of reoffending and has been applied successfully in sexual offending treatment programmes.

However, it is important to acknowledge that applying a recovery approach in forensic settings comes with its own specific challenges. Forensic service users’ have unique rehabilitative needs (Simpson & Penney, 2011) and an element of risk management must be considered alongside mental health and social recovery.

Self Determination Theory

Self-determination theory (Deci & Ryan, 1985) has been identified as a useful framework when considering recovery in mental health, particularly when higher levels of input or services are required in relation to risk (Abbott, 2008). Motivation to change is key in engaging service users in the recovery process (Skinner, Heasley, Stennett & Braham, 2014). The process of developing motivation can come from either intrinsic or extrinsic factors.

Self-determination theory recognises the importance of self-motivation and identifies three requirements necessary to achieve self-motivation: competence, relatedness and autonomy. Competence refers to the ability to do something successfully, relatedness is a sense of belonging and having a connection with others, and autonomy refers to having some sense of control over our own behaviours (Neimiec & Ryan, 2009). If any one of these factors are undermined, the individual's self-motivation can reduce, and in turn their engagement in the intended activity (Ryan & Deci, 2000). Regarding mental health, a reduction in self-motivation could lead to an interruption in the recovery process and perhaps a decline in mental well-being (Ryan & Deci, 2000), as well as longer hospital admissions.

According to this theory, autonomy is integral to service users being motivated to change and behaviour change is more effective when service users are autonomously motivated (Ng *et al.*, 2012).

Autonomy

Clarke, Lumbard, Sambrook and Kerr (2016) highlighted service user's sense of agency as a contributing factor to their recovery. To have agency is to feel as though decisions are our own (Young, 2018) and in the context of mental health services, service user autonomy can be defined as "the right of competent adults to make informed decisions about their own medical care" (BMA, 2013). In recent years, there has been an increased focus on service user autonomy and their rights to make informed decisions about their care (Zolkefli, 2017).

Having an autonomous position suggests service users should have a degree of control over healthcare decisions, however within mental health care this situation is complex

(Laugharne & Priebe, 2006). Specific practices in psychiatric inpatient services, including involuntary admission and enforced medication, can be viewed as coercive (Sashidharan & Saraceno, 2017), which impacts upon service user autonomy. Coercive practice is complex and can be viewed on a continuum, from informal coercion; use of friendly persuasion, through to the formal end; use of restraint and force (Miles, 2016). These practices are particularly prevalent in forensic psychiatry (Vollm & Nedopil, 2016).

Autonomy in forensic settings

In forensic services, the subject of autonomy and coercion is multi-faceted. Professionals working in these settings not only hold responsibility for service users, but also towards the wider public (Sen, Gordon, Adshead & Irons, 2007). Restrictions can be placed on service user autonomy to protect the welfare of the service users and staff on the ward (Adshead, 2000). This can result in staff prioritising risk management over their therapeutic relationships with service users (Sweeney, Clement, Filson & Kennedy, 2016).

Research suggests that many individuals within forensic mental health services will have low motivation levels (Cross & Kirby, 2002). To aid recovery and prevent service users from being detained for extended periods of time, coercive practices may be used. Additionally, often multiple agencies are involved in the decision-making process and the extent to which service users can consent to or refuse interventions is a matter of debate (Ashead, 2000).

This suggests that there may currently be a vicious cycle occurring in forensic inpatient services in which a lack of choice about admission to hospital and a lack of input into decisions about their care exacerbates low motivation and a subsequent lack of progress

or change. This then encourages coercive practice from the staff team, which further impacts on motivation.

Previous research

Despite a large discourse in the literature regarding the use of coercive practice and the potential benefits of service user autonomy, there is limited research regarding service user views and experience of autonomy in forensic services. Lamberti *et al.* (2014) explored the views of 31 service users enrolled in a Forensic Assertive Community Treatment (FACT) programme. They found that the experience of the service users was varied; some felt consistently coerced whereas others reported feeling less coerced and more autonomous over the length of the programme. Two factors particularly associated with the experiences of autonomy were the relationships with clinicians and criminal justice staff and the role of programme structure. Participants engaged more with treatment when clinicians were perceived as caring and empathetic and they were able to develop trusting relationships (Lamberti *et al.*, 2014).

However, as this research was conducted on participants receiving enforced care in the community, we cannot be sure whether the experience of autonomy would be the same for service users in forensic inpatient services and what factors within this setting may impact on their experiences. Additionally, the study only looked at the FACT treatment programme, which was an alternative to incarceration or a condition of release, whereas in inpatient forensic services there are varying forms of treatment, and so the way in which decisions are made may vary.

Aims and research questions

The current study aimed to explore service users' experiences of perceived autonomy in a male low secure forensic inpatient setting and the factors that influence this. The study intended to answer the following research questions:

- a. What are service users' experience of autonomy in a low secure forensic inpatient setting?
- b. What do service users' perceive as the factors that support/undermine autonomy?
- c. What do service users' perceive are the links (if any) between autonomy and recovery?
- d. How do service users' perceive changes to their autonomy over the length of their admission?

Method

Design

The study employed a qualitative design, using semi-structured interviews. Qualitative was considered appropriate as there was limited research regarding service users' experiences of low secure forensic inpatient settings and a lack of current understanding of service users' experiences of autonomy in this setting. This methodology allows for an in-depth and explorative approach to the subject.

The study utilised an Interpretative Phenomenological Analysis (IPA; Smith, Flowers & Larkin, 2009) approach. This approach is concerned with each individual's perceptions of an event. It aims to explore in detail how participants make sense of their experiences and the meaning that they attach to these (Smith & Obborn, 2008). As such, IPA was used to gain such understanding of the participants' subjective experiences of autonomy whilst detained on a low secure forensic mental health ward.

Although other qualitative methodology was considered, including grounded theory (Charmaz, 2008), IPA was considered the most appropriate to allow for exploration of the individual meaning that service users' attached to their experiences in this environment. Additionally, the role of the researcher and their interpretation of the data is acknowledged within IPA. The 'double hermeneutic' (Smith et al., 2009) process of interpretation consists of two stages; the participant's interpretation of their own experiences, followed by the researcher's interpretation of the participant's account. This dual stance allows for the research to attempt to make sense of participants' own attempts to make sense of their experiences.

An expert by experience who works for the private hospitals in which the study took place was consulted regarding the project and agreed to have an active involvement in the recruitment and dissemination processes. He was consulted on the overall aim and design of the research project, and he reviewed all the participant relevant materials. Using his recommendations, a summary information sheet was produced and clear explanations for key terminology were included. He also piloted the initial interview schedule and made some suggestions regarding the wording of questions and increasing the number of prompts and examples included. Regarding the demographic information that was obtained from participants, the expert by experience recommended that medication type and offence history should not be collected and reported that he felt informing participants that this information would be collected would put them off from taking part in the research. This advice was carefully considered, and it was decided that medication type would be important to include as the way in which oral medication can be consented to and enforced differs from depot medication and may impact on experience of autonomy. It was decided not to include offence

history as many service users will have had to disclose this to professionals numerous times and may be put off disclosing this to an independent researcher for fear of being judged.

Additionally, with the focus of the research being on service user autonomy, it was felt that asking about offence history could appear coercive and it should be participants discretion whether they felt it had impacted on their experience of hospital and autonomy. Additionally, the expert by experience informed us that participants may be more willing to engage in the research if he were to conduct the interviews himself. However, due to the methodological rigor required for IPA and the requirements for the researcher to be immersed in the data it was decided that it would be important for the researcher to conduct the interviews.

Therefore, it was agreed that the expert by experience would participate in the initial recruitment presentation at the first site and he agreed to review and participate in the dissemination of the findings.

During these negotiations with the expert by experience it was important to ensure that his role in the research was meaningful and contributions carefully considered. However, we also had to ensure that the methodology used was robust and would enable valid findings to be drawn. Therefore, his recommendations were discussed and reviewed with the research team and negotiated with him respectfully if it was felt that his suggestions were not able to fit into the necessary methodology and rationales for this were provided.

Participants

Due to the in-depth analysis that is required in IPA, smaller sample sizes are recommended (Smith & Osborn, 2008). As the methodology takes an idiographic approach which focuses on the individual, the sample is required to be as homogenous as possible (Smith et al., 2009). Therefore, to maintain homogeneity in the current study only male

service users were recruited from all male low secure forensic wards. Other studies using IPA to research service user perspectives in forensic mental health have obtained between 7 (Ferrito, Vetere, Adshead & Moore, 2012), 10 (McQueen & Turner, 2012) and 11 participants (Clarkson, Murphy, Coldwell & Dawson, 2009). In line with previous research, the recruitment target was 10 to 12 participants.

Eleven service users participated in the study. They all met the following inclusion criteria:

- Currently detained under the Mental Health Act (2007) on a low secure forensic inpatient unit
- On the unit for a minimum of three months
- Had capacity to give informed consent
- Considered safe to meet with the researcher individually by the clinical team
- Able to speak English to a standard that enabled them to take part in an interview

The time period of three months was established as all service users would have had their first care planning meeting (CPA) and the HCR-20 risk of violence assessment tool (Douglas, Hart, Webster, Belfrage, Guy & Wilson, 2014) would have been completed. This detailed risk assessment enabled staff to make a thorough assessment of their risk. Three months provided a reasonable time period for participants to have gained enough experience on the ward to draw upon in the interview. An assessment of capacity to consent to the research was conducted by the responsible clinician on the ward and reviewed by clinical staff on the day of the interview.

Demographic information, including age, ethnicity, mental health diagnosis, Section under the Mental Health Act (2007), medication type and the length of admission; both on the low secure ward and the total admission including other wards, was obtained. This was used to set the context of the participants' experiences. The Section that service users are under dictates how decisions about their care can be made and the agencies that may need to be involved in this process. Detailed demographic information can be found in Table 1.

The participants ages ranged between 23 and 61 years old and the majority (6 out of 11) were White British. There was a large variation in the total length of hospital admission, from four months to 35 years and further variation in length of admission to the low secure ward; four months to four years. Most participants were under a forensic Section of the Mental Health Act (2007) with the exception of one who was detained under Section three. Six participants took oral medication only, four were prescribed a depot (injection) and one participant was not prescribed any psychiatric medication.

Reasons for non-participation were noted and included; not wanting to be audio-recorded, not interested in the research topic and not wanting to sign informed consent.

Table 1: Participant demographic data

Participant	Age	Ethnicity	Diagnosis	Section	Length of current admission	Total length of admission	Medication type
1	32	White British	Paranoid Schizophrenia	3	15 months	2 years 5 months	Oral
2	45	Somalian	Paranoid Schizophrenia and Dissocial Personality Disorder	37/41	11 months	16 years	Oral
3	23	White/African	Paranoid Schizophrenia	N37	8 months	8 months	Depot and oral
4	43	White British	Schizophrenia	47/49	4 years	5 years	Oral
5	58	White British	Emotionally Unstable Personality Disorder (EUPD)	37/41	2 years	35 years	Only for physical health
6	40	Black British	Schizoaffective Disorder	37/41	2 years 6 months	13 years	Oral
7	44	White British	Schizoaffective Disorder, EUPD and Anti-social Personality Disorder	37/41	3 months	12 years	Depot and oral
8	36	Black African	Paranoid Schizophrenia	37/41	3 months	8 years	Oral
9	61	White other	Mixed personality disorder (Paranoid and anti-social)	37/41	9 months	25 years	Depot
10	45	White British	Paranoid Schizophrenia	37/41	2 years	13 years 6 months	Depot
11	48	White British	Paranoid Schizophrenia	37/41	4 months	4 months	Oral

Recruitment

Purposive sampling was used to recruit participants from two low secure wards within two private forensic hospitals under the same provider. All the service users were NHS patients.

All service users on the ward were invited to attend a recruitment presentation (Appendix D) held after the ward community meeting. Attendance was voluntary, and the presentation was delivered by the lead researcher and the expert by experience consultant. All service users were informed that a £10 Argos voucher would be provided after participation as a 'thank you' for their time.

Service users who were interested in taking part were provided with a summary of the study (Appendix E), the full participant information sheet (Appendix F) and were offered the opportunity to speak individually with the researcher and expert by experience.

All potential participants were given a minimum of 48 hours to consider the information before consenting to take part.

Interview schedule

A semi-structured interview schedule was developed (Appendix G) in collaboration with an expert by experience. The schedule aimed to explore participants' experiences of perceived autonomy, with a view to evoking the meaning the service users attached to these experiences.

The interview schedule began by asking some general questions regarding the participants' admission to the low secure ward and the type of care and treatment they were receiving. The schedule aimed to consider all aspects of care, including the interactions that service users had with staff members. The main focus of the questioning was on how decisions about treatment were made and how autonomous service users' felt regarding their care, as well as the factors that influenced their level of autonomy. The impact of these experiences on their wellbeing and recovery were explored, as well as any changes in their experiences of autonomy over the duration of their admission.

Ethical considerations

A university research review panel approved the initial study proposal (Appendix H). Following this, ethical approval was obtained from an NHS research ethics committee review (Appendix I) and the Research and Development department of the private hospital provider (Appendix J).

Informed consent was obtained from all participants prior to the interview and all participants were made aware of their right to withdraw from the study at any time.

Participants' capacity to consent needed to be considered and was discussed with the clinical team prior to inviting participants to take part. The researcher asked all participants to demonstrate their understanding of the project prior to signing informed consent.

Within forensic services, there is a large range of educational level amongst service users and some service users may have learning disabilities, meaning reading ability may be limited. A shortened summary of the information sheet was made available, as well as the

opportunity to meet one to one with the researcher, to go through the full information thoroughly.

Due to the nature of the research topic, it was possible that the interview could bring up distressing experiences for the participants, therefore throughout the procedure efforts were made to minimise any potential distress. The researcher paid attention to the participants' emotional responses to questions and participants were made aware they did not have to answer any questions they were not comfortable with and could end the interview at any point. Clear boundaries were set regarding risk and confidentiality prior to the interview and participants were informed that any reports of risk of harm would be passed onto the clinical team.

There was the potential that reports of staff malpractice could be disclosed during the interview process. Although this did not happen, the researcher had planned to discuss any potential disclosures with their research supervisor immediately, and to report the claim to the hospital's clinical manager if necessary. To be aware of what would constitute malpractice the researcher familiarised themselves with the appropriate professional codes of conduct.

Also, there was potential for participants to inform the researcher of undisclosed offences that the ward staff were unaware of. Details regarding the procedure that would need to be followed if this were to happen were included in the participant information sheet.

Procedure

Once service users expressed an interest in taking part, the researcher met them on the low secure ward at an agreed time. After checking the participants' understanding of what

participation would involve, they signed informed consent (Appendix K) and completed the semi-structured interview which was audio-recorded. Definitions of 'Autonomy' and 'Recovery' (Appendix L) were provided in written form prior to the interview and left within sight. The interviews took place in a private room on the ward and clinical staff were made aware. After completion, participants were given a £10 Argos voucher and they signed a form to acknowledge receipt of this. The interviews lasted between 25-63 minutes depending on their individual responses to questions. No participants reported any distress at the end of the process and many said they had found the interview helpful or relaxing. All participants were informed that the researcher would return to the ward to give a feedback presentation (Appendix M) once the study was completed.

A written summary of the findings was produced for the clinical team at both wards, the R&D department and NHS ethics.

Data analysis

The recommendations provided by Smith et al., (2009) were used as a guide to structure the data analysis. Once interviews were completed, they were transcribed verbatim by the lead researcher using NVivo 12 computer software (QSR International, 2018). The researcher read through the transcripts whilst listening to the audio recording and following this, transcripts were then re-read, and areas of initial interests were noted. The line-by-line coding was then performed, and for each participant the development of emergent themes and connections across themes were identified. The researcher then grouped themes and developed superordinate and subthemes for each participant. Once this was completed for each transcript, patterns were identified across all participants and overarching superordinate themes were developed.

Quality Assurance

To ensure the quality and validity of the IPA approach to data analysis the researcher engaged in a bracketing interview with a colleague. Bracketing is a process which consists of identifying one's own beliefs and knowledge regarding the subject under investigation to put these aside prior to data analysis (Carpenter, 2007). The researcher's assumptions about the decision-making processes and impact of these on service user autonomy in the context of low secure services were identified, and the potential impact these had in relation to the research process was reflected upon in supervision. Additionally, the researcher also kept a reflective diary throughout the duration of the project.

During data analysis, theme development was discussed with two research supervisors, both of whom had experience of working in forensic services. These discussions were used to inform and amend the developing themes.

Results

From the analysis of the data, seven superordinate themes emerged. These are presented, along with the corresponding subthemes in Table 2. The themes are described in further detail below, with the inclusion of direct quotations from participants.

Table 2: Overview of superordinate and subthemes

Superordinate Themes	Sub Themes
Initial expectations of the ward	Level of security A step towards achieving goals
Relationships with staff	Trust Respect Two-way relationship Being treated as a human being Consistency A source of support
Perceived lack of autonomy	Restrictions of the system Professionals hold the power A lack of choice Two options; comply or don't Psychological impact of a perceived lack of autonomy
Perceived sense of autonomy	It's your choice Autonomy is "allowed" Psychological impact of feeling autonomous
Compliance	Negative consequences Positive consequences
Motivators	Discharge from hospital Recovery
Changes over time	No changes Gaining confidence

Initial expectations of the ward

This superordinate theme encompasses the participants' expectations of the low secure ward and their emotional responses prior to arrival.

Level of security

Most participants expressed positive expectations of the transition to the low secure ward.

'It was quite a nice surprise actually, they (...) said, "You're going to low secure", so I was quite pleased' (P4).

These were often based on their assumptions of how restrictive the low secure ward would be in relation to past experiences of higher security. If their expectations were met, this increased their perceived autonomy and vice versa.

'When I first saw the ward, I wasn't happy with it. Although it may be low secure in terms of a label it is more restrictive and much more restrictive than my last hospital' (P9).

A step towards achieving goals

Many participants viewed the move as a step in the right direction, towards their ultimate aim of being discharged from hospital. This opportunity evoked a positive emotional response in many, perhaps as they perceived that they were making progress.

'I felt very, very happy because I felt I deserved a chance to gain a reward. (...) it's one step to getting your freedom back (...) so I felt really happy' (P8).

Relationships with staff

One of the most important aspects of care that participants identified was their relationships with various staff members on the ward. There was some variation in participants' experiences of these interactions, as well as variation in individuals' perceptions of their relationships with the different professional groups. This superordinate theme encapsulates the experiences in relation to staff.

Trust

Trust was considered by many participants to be an important factor in their relationships with staff, which enabled them to engage in therapeutic work. There was acknowledgement that the development of trust is a process and can be impacted by the dual role that clinicians hold; caregivers and enforcers of boundaries.

'I mean trust is not something that comes straight away in the people you know, you have earn that trust' (P5).

It was recognised that trust also works both ways and many participants valued being trusted themselves. As staff developed more trust in the service users, they were able to take more positive risks regarding their care and allow more freedom, in turn enabling service users to feel more autonomous.

However, this trust was viewed by some as fragile, and a lack of trust led to restrictions being enforced and service users feeling powerless.

'They give you a little bit of trust, if you throw it back in their face then they take it away' (P4).

Respect

Respect was also viewed by many to be important in the development of relationships. However, a lack of respect could in turn hinder relationships.

'I've experienced an undercurrent of resistance, an unfavourable way I'm spoken to. I suspect it's to do with my offending history and staff are incapable of leaving their feelings behind when they come into the gates' (P9).

Participant's interpretation of a lack of respect towards him appeared to be guided by his own views and feelings towards his offence history. The disgust that he felt in relation to his offence was projected onto staff members, resulting in him feeling as though he was not viewed as a person in the current context, but as a product of his offence. Therefore, a lack of respect that was perceived may have been influenced by the participant's judgement of himself rather than objectively based on staff member's actions.

Two-way relationship

There were some mixed responses regarding relationships with staff. It was recognised that the relationship between service users and staff is a two-way relationship, which requires both parties to act in the way they wish to be treated themselves.

'Be nice to them, be nice to me, it goes both ways' (P2).

It appeared that service users could be quite sensitive to the actions of staff and their attitudes towards the relationship were variable. One factor which did influence the relationship was power. The physical environment on the low secure ward already highlighted the differences in power between service users and staff. These power dynamics, and in turn the amount of autonomy service users perceived themselves to have, could be

enhanced or minimised in the interactions with staff. There was a sense that staff members interpersonal style influenced service users' perceptions of autonomy.

'They show me the power or show me authority, which I don't like' (P2).

Being treated as a human being

Being treated as a human being enabled the power dynamics between staff and service users to be reduced. It appeared that service users' perceptions of how staff viewed them impacted on their relationships as well as autonomy. Being viewed as an offender or a diagnosis limited their autonomy and provided less room for growth. Whereas being seen as a whole person enabled staff to provide more autonomy.

'They see us more as the kind of person not the illness. And so that's been really encouraging because (...), nobody wants to see themselves as just a problem or, or a workload' (P10).

However, being seen as a diagnosis left some participants feelings defective and less of a human, diminishing their sense of autonomy.

'It's just medication, that's all they're interested in, (...) it's a bit like an animal really, like in a zoo (...) There's no humanity involved' (P11).

Consistency

Consistency with staff was identified as having an important impact on the therapeutic relationship. It was recognised that the development of positive therapeutic relationships is a process which takes time. As staff get to know the service users better, service users begin to feel understood and respected, which increased their perceptions of autonomy. However, the use of agency staff or difficulty in retaining permanent staff could disrupt this process, decreasing their autonomy.

'You don't know them, and you haven't built up a rapport with them. And come Christmas day, boxing day and New Year's Eve and New Year's Day you're surrounded by strangers, it's nasty' (P7).

This appeared to be particularly problematic during key events, perhaps as these significant times may bring up more memories of past events or serve as a reminder of the life outside of hospital that service users are missing out on. In turn, these key events may be distressing for service users, and perhaps destabilise their mental health. Therefore, relationships with staff may be more important at these times.

Often the participants had lived very chaotic lifestyles outside of hospital, and many had difficulties in developing and maintaining healthy attachments with others. The ward environment and consistency of staff enabled trusting relationships to form, providing an opportunity for service users to practice maintaining healthy relationships for when they return to the community. Without this consistency, service users were not provided with the opportunity and repeated patterns of difficulties in relationships may have continued. Further to this, the high turnover of staff may also replicate the abandonment that many service users experienced in their lives.

'I've had about 5 or 6 different consultants (...)they get to know you, (...) and then you get a new consultant and you really have to start from scratch to build up their trust and to build up their faith in you' (P4).

A source of support

Positively, several participants referred to their relationships with staff as providing a source of support. At times when service users' motivation levels were low, staff holding

onto the hope for them appeared to be important. A feeling of competence can help to foster autonomy. Therefore, staff holding the hope may enable service users to increase their self-belief and in turn their autonomy.

'They're very supportive, very encouraging and they want the best you. So, it's kind of good to know that there are people behind you who see a future for you outside the hospital' (P10).

Perceived lack of autonomy

Participants reported a broad range of experiences in relation to perceived autonomy. This range of experiences highlighted the subjective nature of the topic and the differences in perception that individuals can have to similar situations. This superordinate theme reflects the experiences of several participants in relation to perceived autonomy.

Restrictions of the system

One factor which influenced the experience of autonomy was the restrictions of forensic services. All participants who commented on this were under forensic sections of the Mental Health Act (2007), which impacted on the way decisions regarding their section 17 leave and discharge from hospital could be made. The involvement of additional agencies in the decision-making procedure meant that often the process would take a long time leaving participants feeling frustrated and decreasing perceptions of autonomy.

'They only just sent off the the Ministry of Justice about 2 weeks ago, that could take months, so it's quite disappointing really' (P11).

Professionals hold the power

Many participants referred to decisions about their care being made by the professionals, which led to many participants feeling as though staff held all the power. If this

power was perceived as being one-sided it left participants feeling powerless and experiencing a lack of autonomy.

'Well, the team made the decision in relation to hospital, they (...) both basically agreed that I should go into hospital' (P11).

A lack of choice

For several participants there was initially a strong sense of having a lack of choice. Disagreements with the decisions that had been made or feeling unable to decide on their treatment options themselves implied they experienced little to no autonomy in regard to their care.

'We don't have much choice you know. We get told when we can go out. We get told the medication that we're given' (P6).

However, it was clear from the participants' responses that the experience of autonomy was not straightforward and perhaps some aspects of care contradicted this overall feeling. Most participants experienced having the least choice about their section 17 leave but experienced more involvement in decisions regarding psychological therapy or OT groups. This is perhaps influenced by ability of staff to enforce certain decisions. Medication could be enforced under the Mental Health Act (2007), whereas in therapy service users may have to be present, but they may have more choice in whether or not to engage in the process, enhancing their perception of autonomy in this situation.

Two options; comply or don't

Despite experiencing a lack of choice about their treatment options, participants expressed an ability to decide whether or not to comply with the decisions made by

professionals. This can perhaps be seen as a defence against the restrictive environment in which they are situated and a way to establish autonomy over their own behaviour.

'The way I see it, if you want to do something you do it and if you don't want to you don't do it. I think you have some level of choice, you have free will' (P8).

Psychological impact of a lack of autonomy

Participants reported several negative emotional responses to their perceived lack of autonomy, including depression and frustration.

'Well I'm really miserable with the medication, it really depresses me a lot' (P11)

'There is nothing you can do, it's depressing and frustrating' (P1).

The lack of autonomy was likened to being treated as a child and was perceived as hindering recovery by restricting the level of 'normality' in hospital. However, it could also be perceived as containing. Due to lengthy admissions many participants may have become institutionalised and in turn their independence diminished. In these circumstances, having staff make the 'right' decision for them relieved the sense of fear of making the 'wrong' choice. It is possible that this lack of perceived autonomy may foster dependence on services.

Perceived sense of autonomy

There was variety in the experiences of autonomy among participants and several spoke about feeling autonomous regarding their treatment in hospital, in contrast to the previous theme. These opposed experiences are encompassed in this superordinate theme.

It's your choice

Several participants expressed having a lot of choice about their care, particularly regarding how much to engage. This experience was prevalent when participants felt listened to and feeling autonomous in the decision-making process enabled participants to engage fully in the treatment itself.

'I feel as though I've always been (...) invited to contribute any opinions about how I think my care pathway should look' (P4).

It is possible that some of the variance in the perceptions of choice may be in relation to service users' personality and ability to be assertive. It also appeared relative to their previous experiences; those who had experience of high secure settings reported having more choice on the low secure ward. Whereas participants who had come straight from the community, perceived having less autonomy. Therefore, their perceptions may be influenced by their more recent experiences of 'freedom'.

Autonomy is 'allowed'

There was an understanding in some participants that due to the restricted environment they were in, their autonomy had to be 'allowed' approved by someone in a position of authority. Therefore, their perception of autonomy increased when their perspectives were aligned with the clinical team.

'I think I've had good choice. I ask for what I want to do, and they've granted it' (P5).

In turn perceptions of autonomy could diminish if requests were denied, which highlights the importance of developing shared understandings between staff and service users regarding their level of risk and treatment needs.

'If they said no to several places then I'd feel like they were setting boundaries (...) and that would kind of hinder my sense of whether I was in charge or not' (P10).

Psychological impact of feeling autonomous

The sense of being autonomous had a positive impact on participants, enabling them to develop self-confidence, become more independent and to feel empowered. Gaining more autonomy appeared to be important in the recovery process, for service users to feel prepared for life outside of hospital.

'The things I've had most choice about (...) have helped me gain confidence and more self-awareness about what I actually want' (P10).

However, it was acknowledged that despite most participants wanting more autonomy, this could also be daunting and anxiety provoking, particularly when they had become institutionalised.

'If you have the freedom to make all your own choices then you can become kind of anxious about making wrong choices' (P10).

Compliance

Many participants referred to the rules and the regime of the low secure ward as impacting on their level of autonomy. This superordinate theme reflects on participants' experience of compliance with the rules and treatment on the ward.

Negative consequences

There was a sense from several participants that compliance with the rules was often born out of a fear of the negative consequences associated with non-compliance. These

consequences varied, but were often associated with the loss of a privilege, such as leave or involved staff enforcing treatment under the legal framework, including enforced medication. There was an overwhelming sense of fear from some participants that they would continue to be detained in hospital if they did not comply with the rules of the ward.

'You're living in fear like you do the slightest thing wrong and it's blown all out of proportion and you're going to be kept in longer and longer and longer' (P7).

Positive consequences

However, it was not only negative consequences that appeared to motivate service users to engage with treatment. There was also a sense of hope of making progress and being allowed more freedom if they were able to demonstrate their compliance and prove that they could be trusted. Through this process, it appeared that the positive consequence of compliance was to gain more autonomy and a sense of hope for the future.

'When I cooperate with the staff my choices are much more bigger because I can choose to do the right thing' (P3).

Motivators

The purpose of the low secure unit was to provide treatment for mental health conditions and support recovery and wellbeing. However, for this process to be successful, it was important that service users engaged with the process. Motivation can be derived from two sources; extrinsic motivation involves an outside demand or reward, whereas intrinsic motivation is internal, and an individual strives for personal satisfaction. This superordinate theme encapsulates the factors which motivated service users to engage with their treatment on the low secure ward.

Discharge from hospital

Most participants identified being discharged from the ward as the primary extrinsic motivating factor. For most, this was their ultimate goal and therefore their decision to comply with treatment, which perhaps was not always deemed as necessary by service users, was influenced by their focus of doing everything required to be discharged.

'I just want to get out of here' (P1).

'So, this is what I have to do, to get out of here' (P2).

Recovery

However, the desire to leave hospital was not the only motivating factor. Recovery and progress regarding their mental health and developing a good understanding of themselves and their behaviour was identified as an important intrinsic motivating factor. Some participants recognised the unhelpful patterns of behaviour throughout their lives that had led to their current admission and the want to make positive changes for the future

'I'd rather be here for a bit longer than I'm supposed to be to make sure we get it right (...) I don't want to go out through a revolving door (...) that's the last thing I want' (P4).

Changes over time

The length of admission to the low secure ward varied greatly between participants, from a few months to a few years. This superordinate theme captures the possible changes in the service users' experiences of autonomy over the length of the admission.

No change

When reflecting on the potential changes from their admission to the ward to their current experiences, several participants simply stated there had been "no change". They

experienced their level autonomy as static. Many of the participants who held this view had only been on the ward for shorter periods of time. This meant that many only had access to limited Section 17 leave and one participant had not had any leave since he had arrived. Therefore, the perception of change may be dependent on the length of admission, progression made and closeness to discharge.

Gaining confidence

Other participants acknowledged changes in their autonomy, specifically that it had increased with time. One important factor that facilitated this was the participants own mental wellbeing and confidence to be able to make a decision.

'It's just become easier for myself, my choices have become easier, I feel more intact, sense of stability' (P3).

Increases in perceived autonomy were recognised as a sign of progress and linked with mental health recovery. They were perceived as an acknowledgement of the effort that is required to progress.

'It has changed a little bit. I think they value my opinion a little more knowing that I've worked so hard to get where I am' (P4).

Discussion

The aim of the research was to explore service users' experiences of autonomy whilst detained on a low secure forensic ward. The results found that there was a lot of variation between participants' experiences, which indicates that perceived autonomy is subjective and similar objective experiences can be perceived in different ways by individuals. The findings are discussed in relation to the research questions.

Experiences of autonomy

Regarding perceived autonomy, participants reported mixed experiences, with some feeling as though they had a lot of autonomy, whereas others reported a distinct lack. For these participants, a lack of perceived autonomy either lead to feelings of powerlessness and frustration, or it could be perceived as containing if service users had been institutionalised.

Feeling autonomous was experienced as empowering and it enabled service users to develop self-confidence in their decisions. However, too much autonomy could also be experienced as overwhelming and developed fears regarding making the 'wrong' decision.

There were differences in the experiences of participants between the two recruitment sites. Participants from one site reported that there were difficulties with consistency with staff on the ward, with high turnover, which impacted on their ability and willingness to form trusting relationships with staff. As relationships with staff appeared to be relevant to participants experience of autonomy, it is likely that these differences between the sites will have affected the participants' perception of autonomy and may account for some of the differences in the findings. The high turnover of staff also impacted on participants perception of their ability to 'move on', as some reported that when they felt they were making progress, their psychiatrist would leave and the progress would be put 'on hold', impacting on their autonomy.

Factors that support or undermine autonomy

Relationships with staff played an important role in the development of autonomy. Trusting relationships were perceived as supportive and enabled participants to feel autonomous. This is similar to the findings of Lamberti et al., (2014) who suggested participants engaged more in treatment when staff were perceived as empathetic. However, if staff were perceived as being judgemental this could undermine service users' perception of autonomy.

Perceived autonomy increased when the clinicians and services users had a shared understanding and in turn it could be diminished when views and opinions were not aligned. This highlights the importance of working collaboratively.

The power dynamics between service users and staff could be enhanced or minimised in interpersonal interactions. Feeling listened to and respected as a human being reduced the perception of differences in power and in turn improved autonomy.

Perceived autonomy was often relative to previous experiences, particularly of being in higher secure services or having recently been in the community. The perception of previous experiences of autonomy impacted on the current experience.

There were significant differences between participants demographic details, particularly in terms of their length of admission to hospital. Reports of their experiences indicate that as length of admission increased, so did experience of autonomy, which may be

due to greater time to develop relationships with staff or more time to 'prove' their commitment to recovery and therefore more trust and freedom. In terms of ethnic diversity, the majority of participants were white British. Within forensic services, typically there is a high proportion of ethnic minority service users relative to the general population, and therefore the participants within this study may not be fully representative of this population. Although there did not appear to be significant differences in reports of experience of autonomy between white British and ethnic minority participants, it is possible that their perceptions of relationships with staff and other experiences of hospital may have been impacted on by their cultural differences.

Autonomy and Self Determination Theory

The experience of the participants aligns with Self Determination theory. Self-motivation to engage in treatment and feel involved in decision making could be increased by trusting and supportive relationships with staff, which implies that the participants experienced a connection to members of staff, and therefore the requirement of relatedness described by the theory would have been met.

In terms of competence, by providing service users with opportunities to demonstrate their ability to engage in treatment successfully, such as going on section 17 leave and returning on time, or completing therapy, this also increased their autonomy and sense of control, and in turn their motivation to repeat to continue.

Links to recovery

Feeling autonomous and being involved in decisions regarding their own care improve motivation and engagement in treatment and appeared to be linked to recovery and a sense of hope or progress. However, a lack of autonomy was often experienced as being treated like a child and in turn hindered recovery.

A lack of autonomy often meant service users were motivated to engage in treatment by extrinsic factors, such as being discharged, rather than intrinsic factors such as recovery. In regard to Self Determinations theory, motivation, and in turn outcomes, improve when service users are autonomously motivated. Therefore, their perceived lack of autonomy may impact on their motivation to engage in the recovery process.

Changes over admission

There were mixed findings in relation to changes in autonomy over time, with some participants identifying changes and others perceiving autonomy as static. The perception of change may be dependent on the length of admission, progression made and closeness to discharge.

Implications for clinical practice

The findings highlight the importance of therapeutic relationships in managing the power dynamics and in turn affecting perceived autonomy. Consistency in staff is key to allowing trusting relationships to develop. Staff can get to know service users both in terms of their histories and their more day-to-day presentations. Feeling seen as a human being and

not just an 'offender' can increase autonomy. Additionally, trusting relationships may also encourage clinicians to take more positive risks and in turn provide service users with higher levels of autonomy.

A lack of perceived autonomy may foster service user dependence on services. Coercive practice is often used to motivate service users to progress, but this can develop dependency on services and limit's service users' ability to make their own decisions and develop their autonomy. Therefore, it is important for clinicians to consider how dependency can be minimised and independence promoted as service users approach discharge and reintegration into the community.

In clinical practice, it could be helpful to consider how service user choice could be increased, such as providing options and ensuring service users feel listened to. It is also important to gain an understanding of how service users feel about decision making as they may experience this as overwhelming and anxiety provoking. If so, clinicians could initially provide choice from a couple of options where possible, to increase service users' confidence in their abilities.

Feeling understood and respected increased perceptions of autonomy. Working collaboratively is important and helpful in developing a shared understanding of service users' risk and treatment needs. Clinical psychologists can have a role in this through individual work with service users to collaboratively develop formulations of risk and offending behaviour or mental distress and also sharing service user formulations with teams.

Critical reflections and implications for future research

A strength of the study was the time taken to plan and develop the participant materials and interview schedule, in collaboration with an expert by experience. Its limitations were that it only considered male perspectives and only recruited service users who were perceived as 'well'. It is possible that relationships with staff and perceptions of autonomy may differ in service users who are considered 'unwell'. Recruitment was not evenly distributed between the two sites and there appeared to be differences between them; one site had more difficulties with staff retention and participants from the other site reported less autonomy. One limitation was that some participants only answered questions directly and found it difficult to expand or provide examples, which made it challenging for meaning to be interpreted. Although, this is perhaps reflective of the client group. Additionally, the 'thank you' voucher could be seen as coercive, however all participants reported that they were not participating for the money, but to make a difference for future services.

Further research could seek to establish clinicians' perspectives of autonomy in this environment and triangulate the findings with service user views.

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Section C: Appendices of supporting materials

Appendix A: Full list of search terms for Section A

[*'coer*'* OR *'decision making'* OR *'control'* OR *'choice'*]

and

[*'view*'* OR *'experience*'* OR *'perception*'* OR *'perspective*'* OR *'narrative'* OR *'stories'*]

and

[*'mental*'* OR *'psych'* OR *'mental health'*]

and

[*'inpatient'* OR *'admission'* OR *'admitted'* OR *'hospital'* OR *'section'* OR *'rehab'*]

And

[*'service user*'* OR *'patient'*]

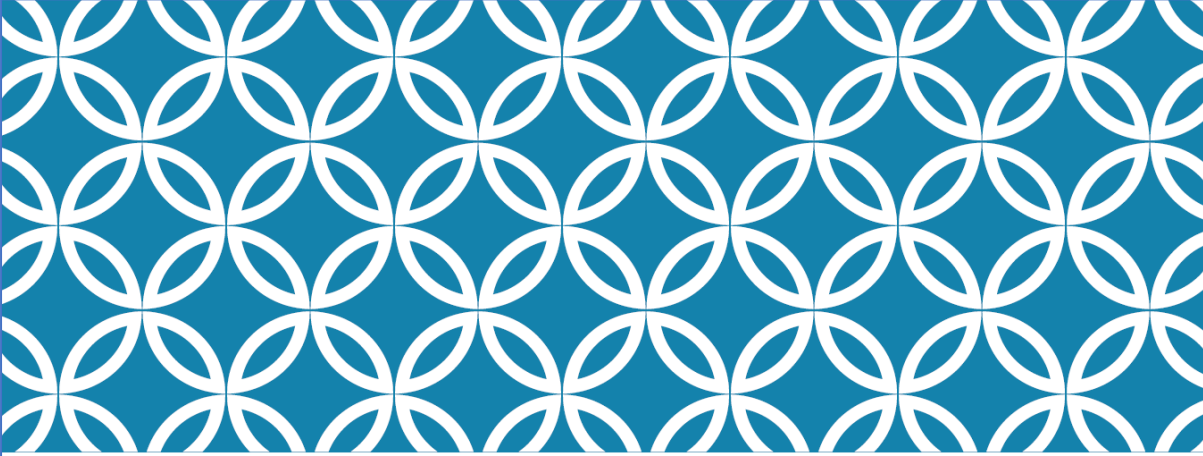
Appendix B: Quantitative quality assessment checklist (Kmet, Lee and Cook, 2004) for

Section A

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Appendix C: Qualitative quality assessment checklist (CASP, 2018) for Section A

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Appendix D: Participants recruitment presentation

**PERCEIVED AUTONOMY ON A LOW
SECURE WARD: SERVICE USER
EXPERIENCES**

Remy Gray & [REDACTED]

OVERVIEW OF THE PROJECT

- ❖ The main aim of the project is to help us understand service users' experiences of making decisions about their own care while on low secure forensic wards
- ❖ We would like to hear about your views and experiences of making your own decisions whilst you have been in hospital
- ❖ If you are interested in taking part we would invite you to have a one to one interview with the lead researcher Remy, who is an independent researcher and does not work for [REDACTED]

WHY IS RESEARCH IMPORTANT?

- ❖ To further our understanding
- ❖ To give service users a voice and an opportunity to talk about their experiences
- ❖ To inform the way services work
- ❖ The findings from research can enable change to happen in the future

WHO AM I?

- ❖ I am currently a third year trainee Clinical Psychologist at Canterbury Christ Church University
- ❖ I am independent from [REDACTED]

WHAT IS THE PROJECT ABOUT?

❖ **What do we mean by autonomy?**

❖ For this research, we are going to think of autonomy as your right to make decisions about your own care without anyone else influencing your decision. Autonomy means that other people can give their opinions and advice, but they don't make the decision for you.

❖ **What kinds of decisions are we talking about?**

❖ They could be small decisions such as whether you have a shower in the morning or the evening, or they could be big decisions such as if you go to a therapy group or not.

❖ We are interested in hearing about your views and experiences of autonomy and making your own decisions whilst you have been in hospital.

WHO CAN TAKE PART?

❖ You must have been on the ward for at least 3 months

❖ The staff team on the ward must agree that it is ok for you to take part in a one to one interview

❖ You must be able to understand what would be required of you and can make the decision to agree to take part

❖ You must understand verbal English language

WHAT WILL TAKING PART INVOLVE?

- ❖ If you agree to take part I will invite you take part in a one to one interview. This will take place on the ward
- ❖ During the interview I will ask you questions about your experiences of being on the ward, the type of care you have received, how decisions about your care have been made and how your experiences have made you feel
- ❖ I will also ask a member of the staff team to provide some basic information about you, such as your age, diagnosis and how long you have been on the ward
- ❖ Once you have finished the interview you will receive a £10 Argos voucher as a thank you for taking part

IMPORTANT THINGS TO REMEMBER

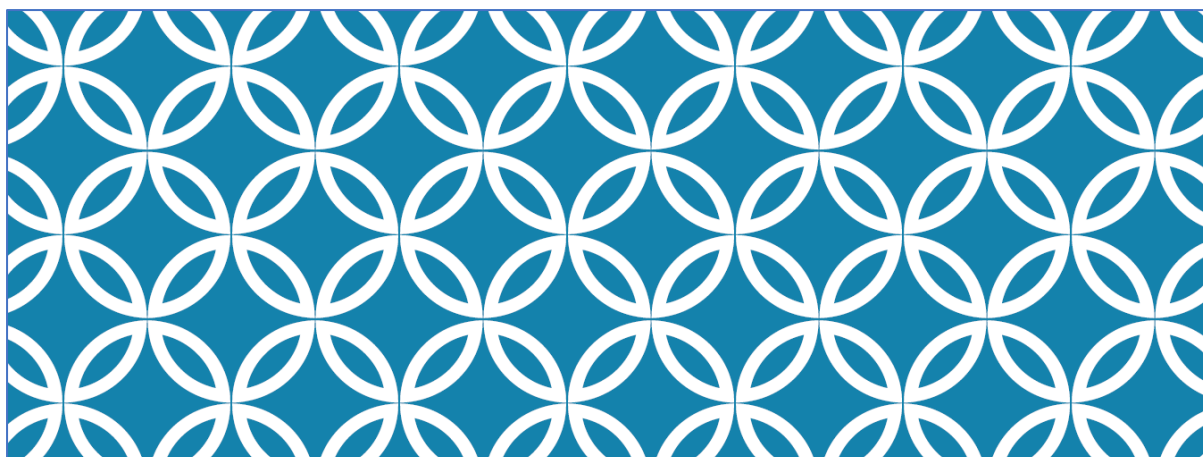
- ❖ I am an independent researcher and I am not part of [REDACTED] Hospital
- ❖ The things that we talk about will be confidential. No members of [REDACTED] staff will be present during the interview or will see or read the information you provide
- ❖ The research project has been approval by Canterbury Christ Church University, NHS ethics and [REDACTED]
- ❖ Taking part in the research project will not affect your care
- ❖ You have the right to withdraw from the research at any time

THE BENEFITS AND POSSIBLE DISADVANTAGES OF TAKING PART

- ❖ We are hoping that what you and other service users say, might help us think about these issues for all service users in forensic units
- ❖ We cannot promise the study will help you but we hope the information we get from this study will help improve the future treatment of others who access low secure forensic inpatient services
- ❖ I will be asking you some questions about your experiences of being on a low secure unit. Whilst I hope this will not be distressing for you, I cannot guarantee that it will not bring up certain feelings in you

HOW CAN YOU GET INVOLVED?

- ❖ If you are interested in taking part please let [REDACTED] or Remy know
- ❖ We can provide you with an information sheet that gives further information about the project and what taking part would involve
- ❖ After reading the further information, if you would like to take part you can let [REDACTED] ([REDACTED]) know and she will arrange an appropriate time for me to meet with you to complete the interview
- ❖ If you have any questions or would like to discuss taking part further, [REDACTED] and Remy will be available after the presentation



ANY QUESTIONS? |

Appendix E: Participant summary sheet**Research Project Summary**

Name of Researcher: Remy Gray

What is the project about?

The main aim of this study is to help us understand service users' experience making decisions about their own care whilst on a low secure forensic ward. I am interested in hearing about your views and experiences of making your own decisions whilst you have been in hospital. I am hoping that what you and other services users say, might help us think about these issues for all service users in forensic units, and might go on to think about changes we need to make to systems.

Do I have to take part?

It's entirely up to you if you take part. If you do decide you want to take part, you can change your mind at any point and this will not affect your care or rights in any way.

What will happen to me if I take part?

If you agree to take part, you will be invited to attend a one to one interview with me. I am an independent researcher and do not work for [REDACTED]. No members of [REDACTED] staff will be present during the interview or will see or read the information you provide. The interview will take place within the low secure unit, you will not be asked to travel anywhere. The interview will take between half an hour to one hour, but we can take as many breaks as you need. During the interview I will ask you some questions about your experiences during your time on the ward. The interview will be audio recorded using a Dictaphone so that I have a complete record of our interview and don't forget anything important that you said. I will also ask your permission to speak to your clinical team to get some extra information around your current admission; I will ask them your age, what diagnosis you have, the section of the mental health act that you are on and how long you have been in hospital for. After your interview with me, you will receive a £10 Argos gift card to say thank you for your time.

Will information from or about me be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence, except in specific situations. All identifiable information, such as your name, will be disguised so no one other than the lead researcher can identify you. For more information about this, please read the full study information sheet or ask me for further details.

What will happen to the results of the research study?

Once all the data has been collected it will be studied and used to develop a better understanding about service users' experience of making decisions about their care on the unit. This will be included in a written report. You will not be identified in this report but it may contain quotes from your interview. After the results have been finalised I will attend the low secure unit to feed the findings back in a presentation that you will be invited to attend.

Service user summary page

Version: 2.0 Date: 11/01/2018

IRAS Project ID: 238758

Appendix F: Participant information sheet**Information about the research****Research project: Perceived autonomy in low secure forensic services: Exploring service users' experiences.**

Hello. My name is Remy Gray and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in some research that I am carrying out from my university. Before you decide if you want to take part, it is important that you understand why the research is being done and what it would involve for you. This leaflet has some information about the research. Part 1 tells you the reason for this study and what happens next. Part 2 gives you more detailed information about how the study will be carried out.

Talk to others about the study if you wish.

Part 1 of the information sheet:**What is the reason that I am doing this research?**

The main aim of this study is to help us understand service users' experience of autonomy on a low secure forensic ward. What do we mean by autonomy? For this research, I am going to think of autonomy as your right to make decisions about your own care without anyone else influencing your decision. Autonomy means that other people can give their opinions and advice, but they don't make the decision for you.

What kinds of decisions am I talking about? Well they could be small decisions such as whether you have a shower in the morning or the evening, or they could be big decisions such as if you go to a therapy group or not.

I am interested in hearing about your views and experiences of autonomy and making your own decisions whilst you have been in hospital. I am hoping that what you and other service users say, might help us think about these issues for all service users in forensic units, and might go on to think about changes we need to make to systems.

Why have I been invited to take part in this research?

We are interested in the views of service users who have experience of a low secure hospital setting. You have been invited to take part in this study as you are currently on a low secure unit.

Do I have to take part?

No, it's entirely up to you if you take part. This is an example of where you have autonomy about your decision. I can give you information that you need to make this decision, but ultimately the decision is up to you.

If you do decide you want to take part, you change your mind at any point and this will not affect your care or rights in any way. This is because this research is independent of the unit. If you do agree to take part, I will ask you to sign a consent form. Your clinical team and I will think about what information and help you might

need in making the decision to consent, but if we think that you are not able to consent at this time, unfortunately you will not be able to take part in the study.

What will happen to me if I take part?

If you agree to take part, you will be invited to attend a one to one interview with me. I am an independent researcher and do not work for [REDACTED]. No members of [REDACTED] staff will be present during the interview or will see or read the information you provide. The interview will take place within the low secure unit, you will not be asked to travel anywhere. The interview will take between half an hour to one hour, but we can take as many breaks as you need. During the interview I will ask you some questions about your experiences during your time on the ward. The interview will be audio recorded using a Dictaphone so that I have a complete record of our interview and don't forget anything important that you said. I will also ask your permission to speak to your clinical team to get some extra information around your current admission; I will ask them your age, what diagnosis you have, the section of the mental health act that you are on and how long you have been in hospital for.

Expenses and payments

After your interview with me, you will receive a £10 Argos gift card to say thank you for your time.

What are the possible disadvantages and risks of taking part?

I will be asking you some questions about your experiences of being on a low secure unit. Whilst I hope this will not be distressing for you, I cannot guarantee that it will not bring up certain feelings in you. If you do become worried, upset or angry, it will be possible to stop the interview at any point. You may wish to take a break and continue when you feel comfortable to. However you may choose to end the interview if you don't feel you can carry on and I will not include your information in the study unless you want me to.

What are the possible benefits of taking part?

We cannot promise the study will help you but we hope the information we get from this study will help improve the future treatment of others who access low secure forensic inpatient services.

What if there is a problem?

If you have any problems about the study, please tell us about it. Information about making a complaint will be in part 2 of this sheet. And remember, if you have any problems during the interview we can take a break or you can choose not to carry on. Just let me know.

Will information from or about me be kept confidential?

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

This completes part 1.

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

Part 2 of the information sheet

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

You will have the right to leave the study at any time if you wish to, without giving a reason and without this affecting the standard of your care or your legal rights. If you choose to leave the research after you have finished your interview, it will be possible to remove your data from the study up until December 2018. After this we will not be able to remove your interview from the study as we will no longer be able to know which interview belongs to which person.

What if there is a problem?

If you have any worries about any part of this study, you should ask to speak to me and I will do my best to deal with your concerns. You can leave a message for me on a 24-hour voicemail phone line at 01227 927070. Please say that the message is for me, Remy Gray, and leave a contact number so that I can get back to you. If you remain unhappy and wish to complain formally, you can do this by contacting Professor Paul Camic, Research Director, Salomons Centre for Applied Psychology – paul.camic@canterbury.ac.uk, telephone: 01227 92 7166.

How will the data be collected?

If you agree to take part in the research, I will ask your permission to speak to your clinical team to get some information around your current admission; I will ask them your age, what diagnosis you have, the section of the mental health act that you are on and how long you have been in hospital for. You will be asked to take part in a one to one interview with me, and no members of [REDACTED] staff will be present for this unless you choose to have someone there with you. The interview will be audio-recorded using a Dictaphone to ensure the information you provide is recorded accurately. Only I, as the lead researcher who is interviewing you, will listen to the recording. The interview will then be typed up and all personal identifiable information removed. It will be possible for you to ask for a copy of the written transcript to check the information is accurate if you wish to do so. The audio recording of the interview will be deleted when the project is completed and the typed up transcript will be stored on a secure disk for 10 years at Canterbury Christ Church University.

Will information from or about me from taking part in the study be kept confidential?

Yes. Except for the situations described in the next two sections, all information that is collected from or about you will be kept strictly confidential. All identifiable information, such as your name, will be disguised so no one other than the lead researcher can identify you. Any quotations used in the research report will have identifiable information removed so they cannot be linked back to you and your consent to use these will be asked before you agree to take part.

Who will have access to my personal data during the study?

Your personally identifiable data will only be accessed by me, the lead researcher during the study. I will be the person who interviews you. Other members of the research team will only have access to data that cannot identify you.

Are there any circumstances where you would pass on information about me?

During the interview, if you disclosed any information that indicated either you or someone else may be at risk of serious harm, I would have to pass this information on to an appropriate person. However, I would let you know about this before doing so. Additionally, if you told me any information about staff malpractice (acting inappropriately) that went against the code of conduct, I would need to discuss this with my research supervisor and may have to inform the hospital's clinical manager in these instances. Additionally if you were to tell me about any offences that the staff were not aware of, I would have to pass this information onto the ward manager, who would deal with it appropriately.

How long will my data be kept for?

The audio recordings will be deleted once the research study has been completed. Written transcripts with identifiable information removed will be kept on a secure disk in the clinical psychology programme office at Canterbury Christ Church University in Tunbridge Wells for 10 years. Your personal details will be deleted, unless you ask to be contacted and informed of the results of the study.

Involvement of the clinical team

Your clinical team on the low secure unit will be told about your decision to take part in the research, but they will not have access to any of the information you provide during the one to one interview, except in the situation described above.

What will happen to the results of the research study?

Once all the data has been collected it will be studied and used to develop a better understanding about service users' experience of making decisions about their care on the unit. This will be included in a written report. You will not be identified in this report but it may contain quotes from your interview. After the results have been finalised I will attend the low secure unit to feed the findings back in a presentation that you will be invited to attend. The study will be examined by Canterbury Christ Church University. It may also be published in a professional psychological journal at a later stage.

Who is organising and funding the research?

The study is funded by Canterbury Christ Church University as part of my Clinical Psychology doctorate training.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by London Camden and Kings Cross Research Ethics Committee. It has also been looked at by Canterbury Christ Church University and the Research and Development department at [REDACTED].

Further information and contact details

If you would like to speak to me and find out more about the study or have questions about it answered, you can leave a message for me on a 24-hour voicemail phone line at 01227 927070. Please say that the message is for me, Remy Gray, and leave a contact number so that I can get back to you.

If you are unhappy with the research study please contact Professor Paul Camic, Research Director, Salomons Centre for Applied Psychology – paul.camic@canterbury.ac.uk, telephone: 01227 92716

Appendix G: Interview schedule

Interview Schedule

Hello... Thank you for agreeing to meet with me today. The interview should last between half an hour to an hour. During the interview I am going to ask you some questions about the experiences you have had whilst you have been on the low secure unit.

Before we start I am going to introduce a couple of words which I might use quite a lot and which mean different things to different people, so I'm going to explain what they mean to me in this research. The first is Autonomy and the second is recovery.

Autonomy can be defined as "making your own choices about your care in hospital". A couple of examples of decisions regarding your care may be; whether to attend groups on the ward, whether to have a shower in the morning and whether to build relationships with members of staff on the ward.

From the definition given, do you feel you understand what is meant by autonomy?

Could you give me an example from your everyday life now or from before you were here about a choice you have made for yourself?

Recovery can be defined as "the progress and the potential changes you have made whilst you have been in hospital". It may also mean the steps you are making towards being discharged from hospital.

From the definition given, do you feel you understand what is meant by recovery?

I have written down the definitions of both autonomy and recovery that we have just discussed, so I will leave that where you can see it throughout the interview in case you would like to check it at times. Or you can ask me if you would like me to repeat the definition.

(I will bring a written card with the definition of autonomy used above written on it and place this in front of the participant and myself so they can check it throughout the interview if needed).

Please answer the questions as honestly as you feel able to. If there are any questions you do not want to answer just let me know and we will move onto the next question. If at any time you would like to take a break or end the interview please let me know.

1. Admission to the low secure unit

- First of all can you tell me how long you have been on the low secure unit?
- When you were admitted, did you come straight to this ward or were you moved from somewhere else?
- Is this the first time you have been involved with forensic services?
- How were you told that you would be coming to hospital?
- How did you feel about coming to this hospital?

2. Care on the low secure unit

- What type of care/treatment have you received since you have been on the ward?
 - Seen a psychologist?

- If yes, roughly how many times have you seen them?
- Attended any groups?
- How were the decisions made regarding your care?
- How much choice have you had about your treatment?

3. Interactions with staff

- How would you describe the interactions you have with members of staff on the ward?
 - **Prompts if needed:**
 - What are your interactions like with your primary nurse (key nurse/named nurse)?
 - How would you describe the interactions with staff in your ward rounds?
 - How are your interactions with staff in your CPA meetings?
 - Do you meet with other members of the staff team e.g. the OT? Psychologist? Psychiatrist?
 - If you see a psychologist/OT/Psychiatrist, what are your interactions like with them?
- How did you feel about these interactions?
- What was it about the interactions that affected how you felt?
- How much choice about your care did you feel you had during your interactions with staff?

4. Autonomy

- Since you have been on the ward, how much choice have you had about your care in hospital?
- Have you had more choice about some decisions than others?
- Which decisions did you have most choice about?
 - How did you feel about that?
 - What was it about the decision that affected how you felt?
- Which decisions did you have least choice about?
 - How did you feel about that?
- Can you tell me about a time when you felt able to make a decision about your care in hospital?
 - (If yes, prompt for further examples)
- Are there any other decisions that you have had a choice about?
- What helps you to make your own decisions?
- Is there anything you think makes you feel less like you have a choice?

5. Change over the admission

- Has your experience of autonomy and making decisions changed in the time that you have been here?
- In what ways has it changed?
- What do you think has led to this change?

6. Impact of autonomy

- Do you think that some of the experiences we have been talking about (refer back to reported experiences) have had an impact on you?

- In what way have they affected you?

7. Recovery

- How has your experience (or lack) of having a choice about your care impacted on your recovery?
 - (If needed, I will repeat the definition of recovery)
- Can you give any examples?

8. Final thoughts

- Do you have any final thoughts or anything you would like to add to what we have discussed today?

9. How did you find the interview?

Thank you for taking part in this study.

Appendix H: Research proposal approval from Canterbury Christ Church University

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Appendix I: Letter of favourable opinion from NRES ethics board

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Appendix J: Private hospital Research and Development approval

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Appendix K: Participant consent form**Consent form**

Title of the project: **Perceived autonomy in low secure forensic services: Exploring service users' experiences**

Name of researcher: **Remy Gray**

Please initial in the box

I confirm that I have read and understand the information sheet for the above study, or the lead researcher has read it to me. I have had the opportunity to think about the information and ask questions.

I understand that taking part is voluntary and that I am free to leave the study at any time without giving any reason and without my medical care or legal rights being affected.

I agree to my clinical team being told that I am taking part in the study.

I agree that the lead researcher can ask my clinical team about the conditions of me being in hospital (eg. My diagnosis and how long I have been at this hospital) and understand that my name will not be on this data so I will not be identifiable to anyone other than the lead researcher.

I agree to my interview being audio-recorded to ensure the information I provide is recorded accurately. I understand that the audio-recording will be deleted once the research is completed and the written transcript without my name on it will be saved on a secure disk for 10 years.

I agree that quotes, without my name included, from my interview may be used in published reports of the study findings.

I understand that I will receive a £10 Argos gift card once I complete the one to one interview.

I agree to take part in the above study.

Name of Participant _____

Date _____

Signature _____

Name of Person taking consent _____

Date _____

Signature _____

Appendix L: Interview materials – Autonomy and Recovery definitions**Autonomy:**

Making your own choices about your care in hospital.

Examples:

- Whether to attend groups on the ward
- Whether to have a shower in the morning
- Whether to build relationships with members of staff on the ward

Recovery:

The progress and potential changes you have made whilst you have been in hospital.

It may mean the steps you are making towards being discharged from hospital.

Appendix M: Feedback presentation for service users

OVERVIEW OF THE PROJECT

- ❖ The aim of the project was to explore service users' experiences of perceived autonomy whilst on a low secure forensic ward
- ❖ **What do we mean by autonomy?**
- ❖ We thought of autonomy as your right to make decisions about your own care without anyone else influencing your decision. Autonomy means that other people can give their opinions and advice, but they don't make the decision for you.

OVERVIEW OF THE PROJECT

❖ The study intended to answer the following research questions:

- a. What are service users' experience of autonomy in a low secure forensic inpatient setting?
- b. What do service users' think are the factors that support/undermine autonomy?
- c. What do service users' think are the links (if any) between autonomy and recovery?
- d. How do service users' view changes to their autonomy over the length of their admission?

WHAT DID WE DO?

- ❖ We recruited participants from two low secure forensic wards
- ❖ 11 participants agreed to take part
- ❖ Each participant took part in an individual interview with the researcher which lasted between 25 – 63minutes
- ❖ Participants were asked questions about their experiences of being on the ward, the care and treatment they had received, their relationships with staff, how decisions had been made about their care and how much choice they felt they had about their care

DATA ANALYSIS

- ❖ We used Interpretative Phenomenological Analysis (IPA) to analyse the data – this approach tries to identify the meaning that individuals attach to their experiences
- ❖ The interviews were typed up and anonymised so no participants could be identified
- ❖ The researcher listened to and read each transcript a few times to identify themes in the participants' responses
- ❖ Once this was completed for all 11 participants, the researcher compared the themes across all participants and developed 'superordinate' themes to cover all participants' experiences

WHAT DID WE FIND?

- ❖ Seven overarching themes emerged
- ❖ 1) Initial expectations of the ward
- ❖ 2) Relationships with staff
- ❖ 3) Perceived lack of autonomy
- ❖ 4) Perceived sense of autonomy
- ❖ 5) Compliance
- ❖ 6) Motivators
- ❖ 7) Changes over time

INITIAL EXPECTATIONS OF THE WARD

- ❖ Level of security
 - Positive expectations of the low secure ward
 - Expectations were based on the assumptions participants had about the level of security
- ❖ A step towards achieving goals
 - Opportunity to achieve the ultimate goal to be discharged from hospital

RELATIONSHIPS WITH STAFF

- ❖ Trust
- ❖ Respect
- ❖ Two-way relationship
- ❖ Being treated as a 'human being'
- ❖ Consistency
- ❖ A source of support

PERCEIVED LACK OF AUTONOMY

- ❖ Restrictions of the system
- ❖ Professionals hold the power
- ❖ A lack of choice
 - Many participants felt that they did not have a choice about their care on the ward
 - They felt they had more choice about OT groups and psychology and less choice about Section 17 leave and medication
- ❖ Two options; comply or don't
- ❖ Psychological impact of a lack of autonomy
 - Feeling depressed and frustrated
 - Some participants felt relieved that they did not have to make the 'right' decision

PERCEIVED SENSE OF AUTONOMY

- ❖ It's your choice
 - Some participants felt that they had a lot of choice about their care and that their views and opinions were listened to by staff
- ❖ Autonomy is 'allowed'
 - Although some participants felt they had autonomy about their care, they felt that this had been 'allowed' by the staff who held authority
- ❖ Psychological impact of feeling autonomous
 - Developed self-confidence, gained independence, felt empowered
 - Sometimes too much choice felt anxiety provoking

COMPLIANCE

- ❖ Negative consequences
 - Fear of loss of privileges (leave), enforced medication or being detained in hospital for a long time
- ❖ Positive consequences
 - Making progress and gaining freedom

MOTIVATORS

- ❖ Discharge from hospital
- ❖ Recovery

CHANGES OVER TIME

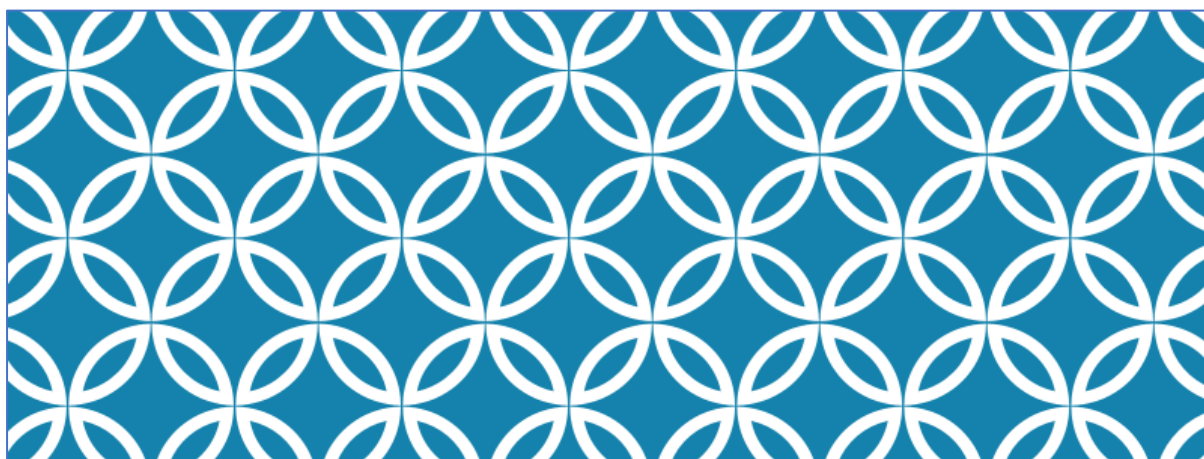
- ❖ No change
 - Autonomy is static and does not change over the admission
- ❖ Gaining confidence
 - Autonomy increases with mental well-being and confidence
 - Increased autonomy is a sign of progress

OVERALL CONCLUSIONS

- ❖ Varied experiences of autonomy between participants
- ❖ Relationships with staff are important in increasing perceptions of autonomy
- ❖ Increasing autonomy empowered participants
- ❖ A lack of autonomy may make service users feel that they lose confidence in themselves and their decisions, and make them feel dependent on services

HOW CAN WE USE THE FINDINGS?

- ❖ Consistency of staff is key
- ❖ Trusting relationships and a shared understanding help to improve perceptions of autonomy
- ❖ It may be helpful to consider how choice about care can be increased, such as providing options and making sure service user views are listened to



ANY QUESTIONS? |

Appendix N: Author guidelines for journal chosen for publication – International Journal of Forensic Mental Health

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articles, reviews

- Should be written with the following elements in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion;

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- Should contain an unstructured abstract of 100 words.
- Should contain between 3 and 5 **keywords**. Read making your article more discoverable, including information on choosing a title and search engine optimization.

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Please refer to these quick style guidelines when preparing your paper, rather than any published articles or a sample copy.

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Please use double quotation marks, except where “a quotation is ‘within’ a quotation”. Please note that long quotations should be indented without quotation marks.

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