Shared Decision Making and Risk in Adult Mental Health Services

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Dedication

For my dear friend, Dr Ben Campbell

(1984-2021)

Acknowledgements

To my amazing friend, Dr Ben Campbell. I never envisioned myself facing this final hurdle without you. I miss you more than words could ever say. Without you I would never have been able to do this, and I am so grateful to have had you in my life. Thank you for your love, support, kindness, hugs, wine, chocolate banana bread, drinks at the union, parties, trips, compassion, wit, sarcasm, and sass. I hope this project can, in some small way, represent you and your values and continue to shine the light of your influence in the world of Clinical Psychology. Let’s hope you were right and it’ll all “be fine”.

To my husband, Chris, and my babies, Everly and Miles. You’re my whole world. Thank you for being my motivation and reason for doing anything. Thank you for supporting me and being by my side every step of the way. I thank you for your understanding and patience. I love you all very much.

To my mum & dad who have always encouraged and believed in me. Thank you for all that you have done and continue to do to make it all possible! My brother, Dan, sister-in-law, Lucy and my niece, Lucia- thank you for your kindness and support during this whole process.

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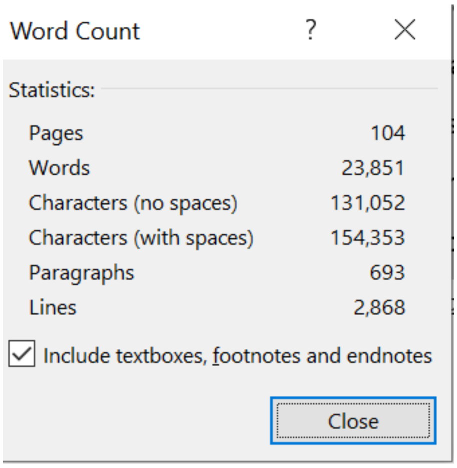
Finally, to all the participants who have kindly shared their experiences which have made this project possible- thank you.

WORD COUNT



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THESIS OVERVIEW

Risk assessment and risk management are considered a fundamental part of safe and effective mental health care for adults (Ahmed et al., 2021). Research and policy both advocate for a shared decision-making approach to risk assessment in mental health settings (Draft Mental Health Bill, 2022). For a decision to be 'shared' it must involve at least two participants, the sharing of information, and a decision that is made and agreed upon by all parties (Stacey et al., 2015). However, studies suggest that service users are often not involved in decisions about risk (or any aspect of their care) and often remain unaware that a risk assessment has taken place for them (Slade, 2017). This thesis aims, firstly, to explore within the existing literature, the attitudes towards and experiences of 'shared decision making' in mental health care from the perspective of staff and service users. Secondly, to look specifically at the discourses service users use to talk about their experiences of 'risk' and 'safety' whilst they have been detained under the Mental Health Act (1983).

The systematic review (chapter 1) aims to provide an up-to-date literature review of the experiences of and attitudes towards shared decision making in mental health services from the perspectives of staff and service users. The review uses a meta-ethnographic approach to synthesise qualitative themes from primary studies to produce higher order concepts. These are the role of service user ownership, the influence of fluctuating capacity, the importance of therapeutic alliance and changing clinician's behaviours and attitudes.

The empirical paper (chapter 2) recruited people with experience of detention under the Mental Health Act (1983) and uses a Foucauldian discourse analysis approach to explore how service users use language to construct their accounts of risk and safety whilst detained. The findings suggest that participants tended to understand risk and safety in terms of power and control (held by themselves and the mental health system), the role of the 'good' or 'bad' patient, coercion with an additional discourse around their perceptions of service user involvement. One of the key implications emerging from this study was that service users emphasised the risk they experienced from others on the wards and the risks experienced from the system itself.

The two papers are aimed for publication in British Medical Council (BMC) Health Services Research journal. Author guidelines for the papers are contained in appendix d. The chapters conform to author guidelines however, tables, figures and further contextual information are provided in accordance with thesis guidelines.

References

Ahmed, N., Barlow, S., Reynolds, L. *et al.* Mental health professionals’ perceived barriers and enablers to shared decision-making in risk assessment and risk management: a qualitative systematic review. *BMC Psychiatry* **21**, 594 (2021). https://doi.org/10.1186/s12888-021-03304-0

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CHAPTER 1: SYSTEMATIC REVIEW

A meta-ethnography of shared decision-making in mental health care from the perspective of staff and service users: a systematic review

Background: Human rights, recovery, and value- based approaches are integral to strategic changes and development in mental health care (World Health Organisation, 2021). Successfully integrating such person-centred values in mental health services will require a paradigm shift from traditional biomedical models of care to a more human rights-based approach. An important aspect of this is shared decision making (SDM) between mental health staff and service users. Whilst it is widely acknowledged SDM leads to improved outcomes (Slade, 2017), there are barriers and challenges to implementing this approach effectively in clinical practice.

Objectives: This systematic review aimed to assess existing empirical research exploring mental health service users and/or staff's attitudes towards and experiences of SDM in adult mental health care settings.

Methods: Systematic searches were run on four databases for papers between January 2010 and September 2022. Search terms pertained to studies reporting on mental health staff or service users' experiences of SDM in adult mental health care. Initial searches yielded 721 results. Included studies were analysed using a meta-ethnographic approach.

Results: The electronic database search resulted in thirteen full text articles. Data were synthesised using meta ethnographic synthesis, which produced four higher order themes with related subthemes. The four higher order themes were: the role of service user ownership, the influence of fluctuating capacity, the importance of therapeutic alliance and changing clinicians' behaviours and attitudes.

Implications: Both staff and service users found SDM to be an important factor in delivering high quality, effective mental health care. Despite this, participants had very little experience of implementing SDM in practice due to several personal, professional, and organisational challenges. This suggests that differences exist between what services strive towards achieving, and the experience of those implementing this in practice. These findings suggest

that further research needs to be conducted to fully understand the barriers of implementing SDM in mental health services with training delivered to staff and service users about SDM.

Introduction

Health and social care professionals tend to hold most responsibility for people in their care when there are concerns around risk, safety, and the person's capacity to keep themselves or others safe and well (Chamber, 2014). As a result, people who are patients or service users in mental health services particularly report having very little to no choice or control in their day-to-day care (Slade, 2017). Service users understandably report having difficult emotional responses to their limited involvement in their care, including a lack of understanding for the rationale of certain decisions (Duxbury, 2002). Conversely, caring for individuals in mental health settings presents challenges to healthcare professionals, including difficulties building a therapeutic rapport with a person whilst enforcing boundaries or restrictions. This is particularly prominent within inpatient settings (Akther et al., 2019). These issues together mean that difficulties can arise in the relationship between service users and healthcare professionals.

The main purpose of inpatient care is to ensure the safety and well-being of people experiencing mental health difficulties which place either themselves or the public at an increased risk of harm (Higgins et al., 2016; Akther et al., 2019). Most people admitted to inpatient mental health settings are there involuntarily, i.e. against their will or decision (British Psychological Society, 2012). In this situation, the ability to actively contribute to decisions related to their care is often denied to service users (Reynolds et al., 2014). Therefore, their right to confidentiality, right to give informed consent and to express autonomy are all removed. Within the United Kingdom, decisions to detain people under the Mental Health Act (1983) involve a series of complex ethical issues and balances to protect the individual's human rights whilst also keeping the person safe and protecting the public. The responsible clinician's right to enforce medical treatment to ensure the individuals safety is often referred to as a 'of care' to the service user. However, under certain circumstances, particularly where coercive interventions have been used for example, implicit or explicit pressure to accept certain treatments including forced practices such as involuntary admission, control or restraint may compromise the service user's dignity be (Duxbury, 2002; Whittington et al., 2009).

When service users are detained under the MHA their levels of distress can be demonstrated through physical behaviour (Care Quality Commission, 2012). This can lead to nursing staff using interventions such as control and restraint, seclusion or rapid tranquilisation. The Care Quality Commission (CQC) has a statutory duty to safeguard detained service users and guidelines on techniques to be used in the management of violence and aggression which state that such coercive interventions should be a last resort. Although mental health legislation differs across the world in terms of legality surrounding involuntary admissions, there are commonalities in balancing duties of care, protection and human rights (Fistein, 2009).

Shared decision making (SDM) places an increased emphasis on a partnership between service users and staff providing service users with enhanced control and choice as part of a more personalised approach to care (Ramon et al., 2017). As such, SDM aims to represent a balancing of power within the mental health system, valuing the patient or service user's experiential and healthcare professional's medical expertise more equally (Morant et al., 2015). Traditionally, mental health services have employed paternalistic approaches to assessing and managing service users risk status with limited opportunity for service user involvement (Duxbury, 2002). However, research suggests that involving service users in such decisions increases ownership and autonomy which reduces risks to themselves, to others and from others around them.

SDM is widely considered to be an essential part of service delivery in mental health practice across a range of countries. For example, in Scandinavia, service user involvement is enshrined in their first patient law as a right which promotes service users' integrity, autonomy and participation (Coulter et al., 2008; Fredrikkson et al., 2018). SDM can be seen as representative of a broader movement towards person-centred care in mental health services. Psychiatric care has long been criticised for its focus on labels and categories of disorders which are seen as dehumanising and labelling people as deviant without acknowledging subjective experiences of political oppression trauma, ethnicity and culture (Boardman & Dave, 2020). Person-centred care embraces the central principle of 'personhood', this principle guides the lens through which the individual's distress and experiences are viewed (Tieu et al., 2022) A person-centred approach shifts the focus away from diagnoses onto a person's strengths, values, history, beliefs and considers their identity within the context of their social, cultural and community connections (Anthony, 2004).

The increased value placed upon service user's opinions, preferences and experiential knowledge in SDM is widely endorsed by staff and service users. The SDM agenda has been widely operationalised by the Value Based Practice framework (VBP) which offers a practical model to implement democratic interpersonal approaches to decision making (Stacey et al., 2016). This proposes true collaboration can only occur when all participants are informed, involved and influential in the decision-making process (Grim et al., 2016). However, despite appreciation of SDM, there is growing evidence to suggest that it is not being implemented in clinical practice. Staff report concerns surrounding the competing responsibilities of their role, most notable their professional responsibility for managing risk (Grim et al., 2016) and challenges around service users' attitude towards SDM and cognitive capacity, and staff members own willingness and motivation to implement SDM (Kaminisky et al., 2017). Clinicians can also face uncomfortable experiences of competing organisational agendas, for example feeling supported to embed SDM even if this means service users are less adherent to treatment recommendations (Slade, 2017). A qualitative research synthesis exploring attitudes towards SDM reported that service users valued their voice being heard, listened to, and supported to express themselves to professionals (Stacey et al.,2016). However, service users also reported several challenges to SDM including fear of being judged, lack of trust and feelings of perceived anxiety.

SDM is becoming more integral to healthcare delivery in the UK following a supreme court ruling which stated that health professionals must "take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment and of any reasonable alternative or variant treatments" (Health and Social Care Act, 2012; *Montgomery v Lanarkshire Health Board, 2015*). Notably, risk is no longer determined according to the views of a "responsible body of medical men" but by the views of a "reasonable person in the patient's position". As such the National Institute of Clinical Excellence (NICE, 2021) recommends that SDM interventions are offered at multiple stages including before, during or after discussions to ensure people are involved in their care. Although robust models of SDM are highly recommended to address some of the issues highlighted above (NICE, 2021; National Health Service (NHS) , 2022), first-hand accounts of staff and service users experience of SDM in clinical practice within the evidence base are scarce. In situations where SDM is not implemented, service users understandably express a sense of powerlessness and helplessness which can impinge on self-confidence and self-esteem thereby hindering recovery (Bowers, 2016). Strengthening service user involvement through SDM can increase confidence and satisfaction with care (Rose & Sidhu, 2006). Qualitative research conducted into staff and service user's experiences of SDM in mental health services suggests that SDM is viewed as an important aspect of service delivery, however there are challenges to embedding such approaches in practice (Huang et al., 2019, Kaminskiy et al., 2017, Jørgensen & Rendtorff, 2018). To date, this has not been synthesised, and such a synthesis would have both clinical and research utility in the continued development of SDM in ***all*** mental health settings.

Review Question

The systematic review aimed to understand the attitudes towards and experiences of shared decision-making in mental health services from the first-hand perspectives of:

a) service users with personal experience of SDM

b) staff working in mental health services

Method

Protocol and registration

The review and protocol were registered on PROSPERO (CRD42023369472). The review was undertaken in line with the Preferred Reported Items and Meta- Analysis (PRISMA) guidelines (Page et al., 2021). Papers were assessed using the Critical Appraisal Skills Programme (CASP) for quality appraisal of qualitative evidence synthesis (Long et al., 2020). CASP was selected as it is the most used quality appraisal tool in health-related qualitative synthesis with endorsement from Cochrane Qualitative and Implementation Methods Group (Long et al., 2020).

Search Strategy

Systematic searches were competed using four electronic databases: APA Psych Info, CINAHL Plus, Medline and Scopus. The following search terms were applied to each database: “Shared decision-making” OR “patient involvement” OR “Shared decision making” OR “SDM” AND “mental health” OR “mental illness” OR “mental disorder” OR “psychiatric illness” AND “mental health staff” OR “mental health nurse*” OR “psychiatric nurse*” OR “mental health social worker*” OR “mental health practitioner*” OR ‘mental health clinician“ OR “service user*” OR “mental health patient*” OR “client*” OR “expert by experience*”.

An NHS-based librarian provided consultation on search terms. Searches were conducted in November 2022 and an additional Google Scholar search was conducted in January 2023 to ensure any further recent articles were identified, this search yielded no results. Hand searching was also conducted but yielded no extra papers and reference lists of included papers were searched. No grey literature was searched in addition to the above

Inclusion and Exclusion Criteria

Articles were included if they met the following criteria: research published in peer review journals; published between 2010 and 2022; utilised qualitative methods; explicitly reported the experience of or attitudes towards SDM from the perspective of mental health staff from any professional background or discipline and/or service users who had accessed any form of adult mental health care. For the purposes of this review, adult mental health care was classified as aged 16 or above.

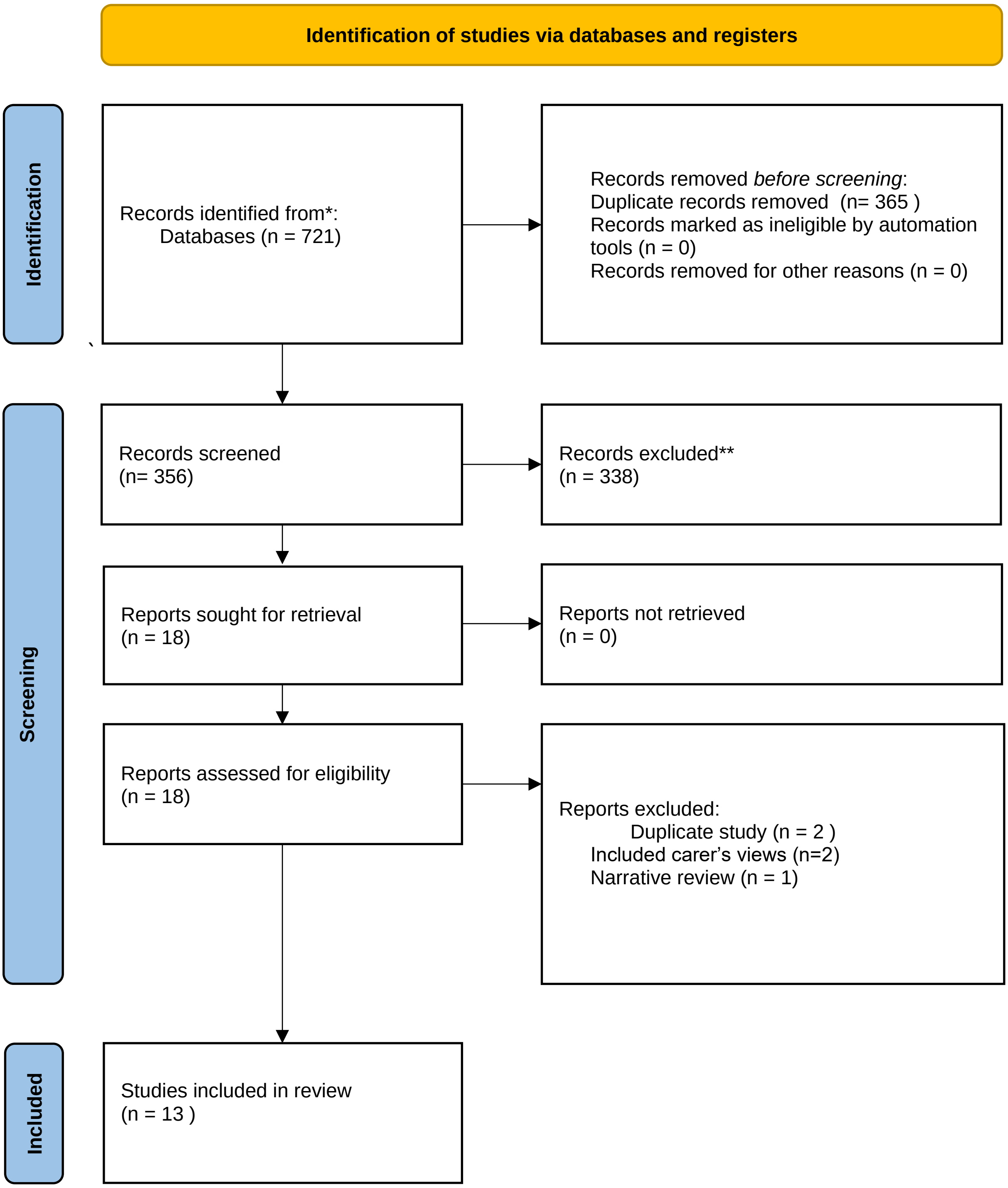
Articles were excluded if they included children or adolescents (i.e. aged below 16) as participants; were not explicitly reporting on shared decision making; included the perspectives of other individuals beyond the scope of the review question (i.e. family members); or did not report experiences of shared decision making in adult mental health settings; narrative reviews were excluded and papers that ***only*** utilised quantitative methodologies.

Due to language restrictions of the lead researcher only papers written originally in English or with an easily accessible reliable translation were included.

Study Selection

The search yielded 721 articles (APA Psych Info, 172; CINAHL Plus, 144; Medline, 177 and Scopus, 228). At stage 1 all duplicates were removed, 356 remained. Two researchers independently screened abstracts and titles. One researcher (CC) screened all abstracts and titles, and one researcher screened 10% of all selected papers at random (AWG). For stage 2, both researchers (CC & AWG) read all remaining papers (n= 18) against inclusion/exclusion criteria. Any discrepancies between stages were discussed between researchers. Uncertainties surrounding inclusion or exclusion were resolved by a third researcher.

Figure 1.1: PRISMA Diagram for searches of databases



From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. Doi: 10.1136/bmj.n71For more information, visit: http://www.prisma-statement.org

Data extraction and synthesis

A bespoke data extraction tool was designed by the author (appendix a). Using this tool, the following data was extracted: author, year of publication, title, setting, participants, geography, design and conclusions. The second tool was utilised to extract more detailed data specifically related to the review question, themes regarding participant's experiences of or attitudes towards shared decision making, outcomes from the research and clinical implications (appendix b). In line with a meta-ethnographic approach, the reviewer has reinterpreted the conceptual data (themes, concepts or metaphors) created by the primary study whilst considering the primary data (participant quotes) (table 3), (Satter et al., 2021).

Quality assessment

The quality of each study was assessed using the Critical Appraisal Skills Programme (CASP) checklist for qualitative synthesis (table 1). This is designed to appraise the strengths and limitations of qualitative research. The tool has ten questions which focus on different methodological aspects of the research, asking the researcher to consider whether the methods were appropriate, well-presented, and meaningful (Long et al., 2020). However, the tool has limitations, for example, it is considered to be less sensitive to accurately appraising research design and conduct (Hannes & Macaitis, 2012). Therefore, as recommended by Long (2017), the author administered this tool under supervision from an experienced qualitative researcher with broader and more robust knowledge of qualitative evidence synthesis and they reflected together on the quality assessment conducted.

Table 1.1: Critical Appraisal Skills Programme scores

Paper	Clear statement of research aims?	Was qualitative methodology appropriate?	Was the research design appropriate?	Was the recruitment strategy appropriate?	Was the data collected in a way to address research question?	Was the relationship between researcher and participant adequately considered?	Were ethical issues considered?	Was the data rigorously analysed?	Was there a clear statement of findings?	How valuable is the research?
Wesseldijk et al (2021)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Kaminskiy et al (2021)	Yes	Yes	Can't tell	Yes	Yes	No	Yes	Yes	Yes	Yes
Reed & Jackson (2019)	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Can't tell	Yes	Can't tell
Becher et al (2021)	Yes	Can't tell	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Yes
Gibson et al (2020)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Shepherd et al (2014)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Younas et al (2016)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell
Haugom et al (2022)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Huang et al (2021)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Dahlqvist et al (2015)	Yes	Yes	Yes	Yes	Yes	Can’t tell	Yes	Yes	Yes	Yes
Knight et al (2018)	Yes	Yes	Yes	Yes	Yes	Can’t tell	Yes	Yes	Yes	Yes
Woltmann & Whitley (2010)	Yes	Yes	Yes	Yes	Yes	Can’t tell	Can’t tell	Yes	Yes	Can’t tell
Klausen et al (2017)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

No papers were excluded from the review based on their quality. It is noted that the relationship between participant and researcher were not presented clearly in five of the papers, this will be discussed further in the ‘strengths and limitations’ section.

Results

Data synthesis

A total of thirteen papers were included in the synthesis, having met the criteria outlined above. A meta-ethnographic approach was used to collate and summarise the findings. This approach enables analysis of the strength and limitations of relationships between themes in the data, in addition to an assessment of the strength of the evidence contained within the studies (France et al., 2019).

Design and participant characteristics

The thirteen included studies were conducted in several different countries, including the UK (Gibson et al., 2020; Shepherd et al., 2014; Younas et al., 2016; Kaminskiy et al., 2021), Germany (Becher et al., 2021), Norway (Klausen et al., 2017; Haugom et al., 2022) , China (Huang et al., 2021) , Sweden (Dahlqvist- Jonsson et al., 2015), Australia (Knight et al., 2018), United States of America (Woltmann & Whitley, 2010) the Netherlands (Wesseldijk- Elferink et al., 2021) and New Zealand (Reed & Jaxson, 2019).

Most participants were recruited from community outpatient mental health settings (n=200), with some data from acute inpatient environments (n=73). Across all papers, a total of 153 service users views were sought, compared to 112 staff members. From the thirteen studies, 6 included the views of only service users, 4 included the views of only staff and the remaining 3 included the views of both staff and service users. A variety of mental health professional groups were recruited, including, psychiatrists, pharmacists, and mental health nurses. Papers that recruited service users were limited by only examining the views of those formally diagnosed with psychosis. Unfortunately, the professional discipline of some staff members was not provided in the papers and is therefore classified as ‘other’ (n= 38). Other demographics such as gender, age and ethnicity of the participants were inconsistently collected and reported, and therefore could not be synthesised.

Twelve papers collected data using a semi-structured interview format. Two papers used focus groups alongside semi-structured interviews (Dahlqvist-Jonsson et al., 2015; Huang et al., 2021), and another solely used narrative interviews (Knight et al., 2018). Notably, four of the included studies were part of larger mixed method studies, these papers were the qualitative aspects of their studies written separately to the quantitative data they had collected (Becher et al., 2021; Haugom et al., 2022; Huang et al., 2021; Woltmann & Whitley, 2010). The method of data analysis varied between papers. The authors used a wide range of different methods of qualitative analysis, including thematic analysis (Kaminskiy et al., 2021; Klausen et al., 2017; Reed & Jaxson, 2019; Younas et al., 2016), content analysis (Haugom et al., 2022; Becher et al., 2021), grounded theory (Dahlqvist-Jonsson et al., 2015; Gibson et al., 2020) descriptive approaches (Huang et al., 2021), narrative analysis (Knight et al., 2018; Woltmann & Whitley, 2010), a directed analysis (Shepherd et al., 2014) and a reflective lifeworld approach (Wesseldijk- Elferink et al., 2021).

Two studies looked specifically at experiences of and attitudes towards SDM in medication prescribing in mental health care from the perspective of staff (Shepherd et al., 2014; Younas et al., 2016). Two papers explored barriers and facilitators of SDM from the perspectives of staff and service users on an inpatient ward (Becher et al., 2021) and in a community team (Kaminskiy et al., 2021). With the remaining papers looking more broadly at general experiences of shared decision making in mental health services (n=9). Four of these papers explored service user's experiences of shared decision making whilst under the care of community mental health teams (Gibson et al., 2020; Haugom et al., 2022; Woltmann & Whitley, 2010; Klausen et al., 2017). One study looked at service users and staff experiences of SDM on an inpatient ward (Wesseldijk- Elferink et al., 2021) and a further two only explored service user's views without specifying the setting (Dahlqvist-Jonsson et al., 2015; Knight et al., 2018). Two papers explored only staff experiences of SDM, one on an inpatient ward (Huang et al., 2021) and one in a community team (Reed & Jaxson, 2019).

Table 1.2: Characteristics of included studies

Author (Year)	Research aim	Location	Setting	Population	Data collection method	Data analysis method
Kaminskiy et al. (2021)	Examine views about barriers and enables of SDM.	UK	Community mental health team	N=30 Mental Health Staff= 15 Consultant Psychiatrists= 7 Community Mental Health Nurses= 8 Service users= 15	Individual semi structured interviews	Thematic Analysis
Becher et al. (2021)	To examine barriers and facilitators of SDM with	Germany	Inpatient mental health wards	N= 32 Mental health staff= 14	Individual semi structured interviews	Qualitative content analysis

	acutely ill inpatients with schizophrenia.			Service users- 18	*Part of a wider RCT in to SDM.	
Gibson et al. (2020)	To examine how clients experience SDM within collaborative integrative psychotherapy	UK	University Research Clinic	N= 14 Service users= 14	Individual semi structured interviews	Grounded theory
Shepherd et al. (2014)	Sought to explore the attitudes and experiences of SDM in the prescribing of antipsychotic medication	UK	Community mental health teams	N= 26 Mental health staff= 26 Consultant Psychiatrists= 26	Individual semi structured interviews	Directed Analysis Method
Haugom et al. (2022)	To describe and explore experiences of SDM among patients with	Norway	Community mental health teams	N=10 Service users= 10	Individual semi structured interviews	Qualitative Content Analysis

	psychotic disorders in mental health care.				*Part of a larger study investigating the implementation of evidence-based practice for people experiencing psychosis	
Huang et al. (2021)	To identify mental health professionals' perceptions of shared decision-making regarding people diagnosed with schizophrenia.	China	Inpatient mental health ward	N= 33 Mental health staff= 33 Consultant Psychiatrists =10 Community Mental Health Nurses=23	Individual semi structured Interviews and focus groups Part of a larger study that examined perceptions of shared decision-making regarding from perspectives of people diagnosed with schizophrenia, families and mental health professionals.	Qualitative descriptive approach
Younas et al. (2016)	To explore the views and experiences of UK	UK	Not specified- identified as pharmacists	N= 13	Individual semi structured interviews	Inductive thematic analysis

	mental health pharmacists regarding the use of SDM in antipsychotic prescribing in people diagnosed with serious mental illness.		specialising within mental health practice	Mental health staff= 13 Pharmacists= 13		
Dahlqvist-Jonsson et al. (2015)	Aim of this study was to explore users' experiences of participation in decisions in mental health service	Sweden	Not specified- participants were recruited based on their experience of mental health difficulties and using mental health services	N=20 Service users= 20	Individual semi structured interviews and focus groups	Constructivist grounded theory
Knight et al. (2018)	To examine how participants reflect on their own experiences of SDM	Australia	Not specified- recruited participants based on lived experience of mental health difficulties	N= 29 Service users= 29	Individual narrative interviews	Narrative positioning analysis

Woltmann & Whitley (2010)	Service user decision making preferences and understanding of construction of decisions in community mental health.	America	Community mental health agency	N=16 Service users= 16	Individual semi structured interviews *Part of a larger mixed methods study	Narrative analysis
Klausen et al (2017)	To contribute to the understanding of shared decision making as an important aspect of user involvement in mental health care from the perspectives of service users	Norway	Community mental health centres	N=25 Service users= 25	Individual semi structured interviews	Thematic analysis
Reed & Jaxson (2019)	To investigate the experiences of qualified mental health practitioners in using a shared decision-making approach	New Zealand	Mental health and addictions agency	N= 4 Mental health staff= 4	Individual semi structured interviews	Thematic analysis

Wesseldijk-Elverink et al., 2021	To examine experiences of service users to enhance SDM	Netherlands	Inpatient mental health ward	N= 13 Mental health staff= 7 Service users= 6	Individual semi structured interviews	Reflective lifeworld approach

The raw data from the above studies was used to complete a meta-ethnographic synthesis. The data was extracted using a data extraction form (see appendix a and appendix b) to develop first and second order constructs. A list of key concepts from each paper were then developed and listed under each study name (see appendix c). As we included both mental health staff and service users, we also labelled whether the study had included service users, mental health staff or both groups. Each concept from each paper was compared to all other papers to check for presence or absence of commonality (Satter et al., 2021). This process was followed until a synthesis of first and second order interpretations were complete. The authors then synthesised these concepts into clusters to produce a reciprocal translation synthesis. Please see translations table and higher order concepts table below:

Table 1.3- Translations table for meta-ethnography

Descriptor (groups of similar concepts clustered together/ broad thematic headings	***First order data (participant quotes/ primary data from the studies)***	***Second order (themes developed by primary authors)***	***Third order (higher order concepts)***
Service user involvement	"We use different life domains on which the patient chooses his actions. We discuss it together, planning small steps to reach progress toward larger ends. Who am I to tell a patient that a goal is not achievable…I believe it is a (learning) process, for both of us." (Wesseldijk Elferink et al., 2021) "It is really client directed, it's really what they want to do rather than what I want them to do" (Reed & Jaxson, 2019) "You ought to think about openness and honesty when working in mental health service. They decided the treatment ... and the	Mutual understanding (Wesseldijk -Elferink et al., 2021) Knowing the client (Reed & Jaxson, 2019) Shared decision making in- admission, individualised treatment, different treatment contexts (Klausen et al, 2016) Consumer perspectives on decision making in case management (Woltmann & Whitley, 2010)	***The role of service user ownership***

	user; it was like you could say your opinion, and you sort of ... I felt, I felt it was a good treatment. I was a part of making the decisions. I LIKED THAT A LOT" (Klausen et al., 2017) "But I just think if I'd been given that information and going through it yourself and having time to discuss it, you're going to understand. I just think you'd feel like you had more control and, you know, that might reduce stigma, as well as you feeling you can take control of what's going on." (Kaminskiy et al. 2021)	Inward expert- self as expert in own presentation (Knight et al., 2018) Self – aware observer- greater confidence in own decisions despite expert advice (Knight et al., 2018) Being involved in shared decision making-being omitted, controlled or considered the underdog (Dahlqvisst -Jonsson et al., 2015) Willingness to engage patients in shared decision making (Huang et al, 2021) Participation as desirable and achievable (Haugom et al., 2022)	

		Experiencing decisions as shared (Gibson et al., 2020) Facilitators and barriers towards shared decision making-patient related factors (Becher et al. 2021) Enacting shared decision making in service user/ provider interactions (Kaminskiy et al., 2021)	
Diagnosis impacting mental capacity	"I didn't find it that onerous. I, I think that the community treatment order [worked] well for me, all it was, was just getting an injection every two weeks . . . I didn't fight it because I didn't want to go back to the voices. "(Knight et al., 2018) I think the biggest barrier with her is her complete and utter lack of suffering, there just isn't any. She also doesn't realize that she creates suffering in others, in her environment. She simply isn't accessible to any rational discussion' (Becher et al., 2021)	Conflicts with decision making authority (Wesseldijk -Elferink et al., 2021) Outward entrustor- looking to medical expertise for guidance (Knight et al., 2018) Barriers to implementation (Younas et al.,2016)	***The role of fluctuating capacity***

	“They might be acutely unwell...they might not be in a position to make a decision they might be forced to have treatment against their wishes so in that scenario you’re not going to be able to provide them with SDM. “ (Younas et al., 2016) “I don't know. I think sort of being asked was quite daunting ... But you go from sort of quite daunting like “I want support but I don't know what support.” And then like, being given that small amount of support like calms you down a bit because you're being shown what support you're getting. “ (Gibson et al., 2020) **“**Some patients are just too unwell to make that kind of decision, they can have no capacity at all to make that kind of decision at the time of admission, in which case we just have to go with what we feel is advisable at that time.” (Shepherd et al., 2014)	Perceiving shared decision making as unachievable (Huang et al., 2021) Varying degrees of involvement (Haugom et al., 2022) Deciding on treatment options (Shepherd et al., 2014) Daunting for clients to be asked to take part in difficult decisions (Gibson et al., 2020) Treatment decisions and stages of participation- no participation to beyond participation (Becher et al., 2021)	

Trust and collaboration between service user and staff	"I think the main thing is to be as honest as possible.....the honesty and the trust I think as well, and you know you kind of build up a relationship with somebody and you get to trust them. " (Kaminskiy et al., 2021) "I may be the expert, but I don't know how to apply that knowledge, [Psychotherapist] does. So, it makes sense to just kind of let [Psychotherapist] suggest stuff and me occasionally suggest stuff when I've got a better understanding of what we're talking about. " (Gibson et al., 2020) "It's about getting... Getting a person where there's good chemistry. Someone you can trust so you can tell them how you're feeling. You have to feel that you, like, you have a kind of, you know, trust, that you... I mean that you can trust someone and you feel you can talk to them. Because you don't get on in the same way with everybody. When you want to... so it's good" (Haugom et al., 2022) "It is important to build rapport with your clients to create a level of respect and	Therapeutic relationship as an enabler of shared decision making (Kaminskiy et al., 2021) Facilitators and barriers towards shared decision making- clinician related factors (Becher et al., 2021) Therapists supporting clients to become more active in decision making process (Gibson et al., 2020) Clients felt recognised as an individual and accommodated by psychotherapist (Gibson et al., 2020) Deliberation (Shepherd et al., 2014) Shared decision making requires a trusting relationship (Haugom et al., 2022)	***The importance of therapeutic alliance***

	engagement... this will create an environment that a client is ready and willing to set, and work towards goals." (Reed & Jaxson,2019)	Benefits of shared decision making (Younas et al., 2016) Participants views on case manager role in decision making (Woltmann & Whitley, 2010) User/professional relationships (Klausen et al., 2017) Therapeutic relationships (Reed & Jaxson, 2019) Bridging the therapeutic gap (Wesseldijk_Elferink et al., 2021)	
Clinicians impact on SDM	"It is often difficult to find time to plan and prepare a session with a client to ensure clear	Structural challenges to achieving shared decision making in practice (Kaminskiy et al., 2021)	***Changing clinician's behaviour and attitudes***

	and consistent treatment.” (Reed & Jaxson, 2019) “We used a directive approach and convinced him he is somewhat lazy. Before, we ruled out other things too, such as fear or suffering from negative symptoms… You have to be careful not to oversee these factors, it opens a broader perspective. It allows us to meet the person instead of taking things over because he is obviously not doing it by himself… and then we can make a strong case against the patient… How are you able to life on your own if you are even not able to come out of bed with help from us?” (Wesseldijk-Elferink et al., 2021) “Our culture has advocated obedience. . . for patients, experts and professors are authorities who should be respected...treatment decisions are up to	Barriers and facilitators to shared decision making-clinician and settings factors (Becher et al., 2021) Both parties presenting and recognising expert knowledge (Gibson et al., 2020) Information sharing (Shepherd et al., 2014) Shared decision making requires a trusting relationship (Haugom et al., 2022) Role of mental health pharmacists (Younas et al., 2016) Perceiving shared decision making as unachievable (Huang et al., 2021)	

	doctors, which is a tradition... " (Huang et al., 2021) "Some of the clinical teams I'm in are very collaborative and very collegiate... I've also worked in teams where there's very little conversation apart from between nurses and doctors, me as the pharmacist has to almost fight to say something" (Younas et al., 2016)	Conflicts with decision making authority (Wesseldijk- Elferink et al., 2021) Awareness of the practitioner (Reed & Jaxson, 2019)	

Overview of higher order concepts

All studies broadly supported the concept of shared decision making (SDM) in adult mental health services, while acknowledging and reflecting on challenges to embedding such interventions in clinical practice. This is reflected in the scarcity of the literature available evaluating the quality and effectiveness of SDM, despite being recommended and advocated as best practice (National Institute of Clinical Excellence, 2021; NHS England, 2015). The author identified four main concepts which were evident in each study (see Table 3). The relationship between the concepts as described in each study were considered, examined, and interpreted by the researchers. These are outlined below:

The role of service user ownership

All studies expressed positive views on service user ownership over decisions in their clinical care, particularly about medication. However, in most studies, service users reported they were not involved in such decisions. Service users reported that they were not given sufficient information from healthcare providers to fully engage in SDM despite expressing a preference to be included in decisions (Slade,2017). In 10 studies, strategies that promote ownership and self-determination were reported to engage service users in becoming active participants in their care. For example, asking service users what getting better means for them would elicit some of the person's values and overall perspectives which may help to formulate a shared care plan that considers what is valuable to the service user whilst balancing the clinician's perspective of the person's needs (Guidry-Grimes, 2020).

Clinicians felt that openness and active communication were important factors for service users (Younas et al., 2016; Shepherd et al., 2014: Huang et al., 2021). Personality traits, including empathy, assertiveness, a positive attitude, and willingness to compromise and cooperate, were noted by clinicians as possible influences on the willingness of service users to engage in such communication (Gibson et al., 2020; Haugom et al, 2022). Conversely, lack of motivation and reluctance to be open to clinician's suggestions were indicated as potential barriers. None of the papers offered any discourse on the perception of such factors as static aspects of the individuals being discussed or considered, or how this may dynamically shift based on mental state, mental health difficulties or other factors. It was suggested that clinicians should improve service user's knowledge by sharing information more readily, as lack of information was associated with feelings of helplessness and loss of control. Again, it is noted here that the target of the suggested intervention or behaviour change is the service user, rather than individual staff members, or the staff team. Some of the papers suggested clinicians should consider the importance and impact of power dynamics existing within the mental health system and seek to understand the feelings of powerlessness which may be present for the service user (Kaminskiy et al., 2021; Wesseldjik-Elferink et al., 2021).

Service users' aspirations regarding SDM varied. In some accounts, service users described being 'experts' in terms of their knowledge about their mental health and others described high feelings of dependence on clinicians (Knight et al., 2018; Huang et al., 2021; Kaminskiy et al., 2021) There was also fluidity between their positions. Service users and staff reflected that during times of crisis, service users may feel more comfortable with staff taking more ownership in decision making. It seems clear from the research that this should be an ongoing discussion between clinician and service user with reasonable adjustments made to facilitate engagement where possible and all decisions should be made in the service user's best interests, and the papers suggest the same. However, few of the papers offer discussion on the implications of the structures and cultures of mental health care, and how feelings of dependence in times of need may highlight a shift in power dynamics and change service user's preferences in SDM. For example, some of the papers highlighted that when a service user is experiencing a mental health crisis, they may prefer clinicians to have more influence over decisions they consider to be in their best interests (Younas et al., 2016; Knight et al., 2018).

In the study which examined service user experiences of SDM in psychotherapy settings (Gibson et al., 2020), service users experienced decisions as shared, felt comfortable in decision making and felt recognised as an expert in knowledge. This suggests there may be differences between settings in how service user ownership is considered (Slade, 2017). For example, decisions within a psychotherapeutic framework can be relatively complex and based upon client's difficulties with psychotherapist interpretation which requires joint exploration within a therapeutic alliance. By contrast, interactions with other mental health services may require fewer abstract decisions where a service user presents a series of symptoms to a practitioner to receive a diagnosis and subsequent treatment (Gibson et al., 2020). Some papers suggested that the key factor was service user 'readiness' to engage in treatment (Huang et al., 2021; Klausen et al., 2017; Haugom et al., 2022). As psychotherapy requires, and depends upon, client collaboration this may be the reason why people felt more able to engage in SDM.

One of the studies interviewed service users and staff following a training intervention for staff and service users in SDM. This research found that SDM had been embedded on the inpatient ward following this intervention. This could suggest that training in SDM may be a suitable intervention for both staff and service users in adult mental health care.

The influence of fluctuating capacity

Impaired decisional capacity due to symptoms of mental illness was identified as a barrier to embedding SDM within healthcare settings by both staff and service users (Klausen et al., 2017; Younas et al., 2016; Shepherd et al., 2014; Wesseldijk – Elferink et al., 2021). This included perceived inability of service users to participate, due to a lack of ability to be reflective or communicate effectively with staff members. Clinicians often highlighted limitations to service user engagement due to their symptoms (Knight et al., 2018; Huang et al., 2021; Kaminskiy et al., 2021). This was particularly highlighted in the studies conducted in inpatient settings. For example, mental health nurses in inpatient settings stated that service users were 'too unwell' to have active involvement in SDM. Some clinicians reported trying to incorporate collaboration by using basic actions such as going for a walk or having a conversation with a service user, rather than seeing this as a more formal process. (Klausen et al., 2017) Service users who had been diagnosed with serious mental illnesses expressed the most distrust and feelings of powerlessness in relation to the healthcare system. However, these participants still expressed they wanted to be involved in decisions about their care.

It was suggested by some staff members that they work with service users who are too 'high risk' or 'vulnerable' to be considered appropriate for SDM. In such cases, it was recommended that SDM approaches could be adapted (Shepherd et al., 2014; Dahlqvisst-Jonsson et al., 2015; Becher et al.,2021). It was argued that when people are most unwell, they are at the highest risk of feeling disempowered, therefore encouraging a service user to make even basic decisions is a way to provide a sense of control and increase motivation towards recovery. Participants reflected that this requires a high level of skill from the clinician in balancing safety and risk. The included papers make recommendations that mental capacity or 'insight' is not static and requires a dynamic dialogical approach, within which the goal should always be SDM. In some papers service users expressed that they had experienced attitudes which conveyed the message that ‘professionals know best’ and their views were not welcomed within a decision-making context (Woltmann & Whitley,2010; Knight et al., 2018; Huang et al., 2021).

The importance of therapeutic alliance

High quality and meaningful therapeutic relationships were highlighted in all included studies as a facilitator of SDM. Service users expressed a strong desire for clinicians to provide more than medical treatments and provide more therapeutic spaces to be empathic and insightful in supporting them to overcome their distress. The papers suggest the therapeutic process is based on trust, collaboration and sharing mutual aims and goals and this was reflected in the studies within the current review (Kaminskiy et al., 2021; Younas et al., 2016; Wesseldijk- Elferink et al., 2021; Becher et al., 2021; Gibson et al., 2020) Whilst good relationships facilitate SDM, it is suggested that the therapeutic alliance is strengthened by good quality SDM approaches. Continuity of staff and service user relationships was viewed as one of the most desired components of care, as this encouraged people to share their stories openly without fear of negative repercussions (Klausen et al., 2017; Dahlqvisst-Jonsson et al., 2015; Reed & Jaxson, 2019). When relationships appeared to be trustworthy and caring, service users were more open and understanding towards clinician’s decisions even when there were disagreements. Service users considered care that was compassionate and empathic to be instrumental in regaining a sense of independence. They reflected that this increased their ability to be more actively involved in SDM.

Clinicians also emphasised the importance of mutual understanding to increase collaboration and goal setting. Staff reported that the more beneficial outcomes they observed from the choices made by service users, the more they were inclined to respect the autonomy of the service user. It was found that in complex inpatient settings, even basic principles of SDM can be used to enhance therapeutic collaboration. Furthermore, service users felt it was important for SDM to be incorporated in all mental health settings, at every point in their recovery journey.

Two of the studies focused solely upon SDM in prescribing of antipsychotic medication from the viewpoint of pharmacists and psychiatrists (Younas et al., 2016; Shepherd et al., 2014). Medication was the most dominant discourse regarding treatment in most of the included studies. Both studies discussed the importance of information sharing regarding medication side effects and health implications for service users to make an informed choice. Pharmacists felt more able to participate in SDM as they were external to wider healthcare teams, however they often felt their role in SDM was underutilised. Service users understandably have less adherence to medication when they feel they have not been adequately involved in making the decision to take them. Notably, pharmacists and psychiatrists tend to have limited interactions with service users as they are not usually directly involved in day-to-day care.

One study was conducted in China and described the importance of considering cultural features to make SDM culturally feasible and acceptable, particularly in regard to considering therapeutic alliances. Most studies into SDM have been conducted in western cultures and more studies are needed to fully understand cultural issues that may present barriers to SDM (Huang et al., 2021). It is suggested that SDM approaches are becoming increasingly common in countries other than those where it originated. This international recognition of the importance of SDM is considered to reflect the advancements in mental health care through service user involvement movements across the world.

Changing clinicians' behaviour and attitudes

Some clinicians expressed scepticism towards SDM approaches, particularly staff working in inpatient settings. It was found that some staff placed more value on safety, adherence and medication and felt this was conflicted with the values of SDM. Some staff also expressed a lack of trust in service user's abilities to be actively involved in their care and make wise decisions. Clinicians often reported being in dilemmas with competing demands between duty of care and promoting independence for service users. They felt challenged in trying to ensure that both were being always respected. In some cases, limited time and resources contributed to an inability to reflect on this, despite there being a wish to have this time to reflect. Staff participants reported that funding issues and organisational changes made it difficult to provide person centred care more broadly, which impacted their ability to engage in SDM with service users (Reed & Jaxson,2019; Becher et al., 2021; Kaminskiy et al., 2021). Due to restrictive practices, service users found they were omitted from decision making which they reported increased their feelings of anger and hopelessness with care providers. Conversely, service users within the least restrictive setting, the psychotherapy department, talked about consistency in experiences of positive attitudes towards SDM from clinicians.

It was suggested in several studies that clinicians should be sensitive to the needs and wants of the individual for true SDM to be achieved (Woltmann & Whitley, 2010; Klausen et al., 2017, Wesseldjik- Elferink et al., 2021). Service users emphasised the need to be relational in SDM with equal contributions from clinician and service user, wishing to be seen as an equal partner in the relationship. However, most service users acknowledged a desire to delegate decisions to professionals when they feel they need to, which may shift the balance of equality. It is key that clinicians reflect upon their own values and belief systems to consider the impact this has on their ability to share decision making responsibilities with service users. Positive encounters in these settings enhance service user's sense of agency, which in turn supports personal recovery. Recognition that service user's needs, ability to engage with, and desire to be involved in, shared decision making may fluctuate over time requires an empathic, sensitive clinician, who knows the service user well and is able to understand their viewpoints (Kaminskiy et al., 2021).

Discussion

Despite recommendations for SDM to be implemented in clinical practice, there are a lack of first-hand accounts of this from both staff and service user perspectives. This meta-ethnographic review provided an in-depth higher order interpretation of the existing literature (Atkins et al., 2008). Only thirteen qualitative studies reporting on experiences of and/or attitudes towards shared decision making in adult mental health care settings, from the perspectives of mental health staff and/or service users, have been conducted to date.

Broadly, the current review found that mental health staff and service users agree that SDM is good practice in adult mental health care. This is in line with policy guidance and recommendations within the UK for SDM by NICE, NHS England, the Mental Health Act (1983) and the Mental Capacity Act (2005). Similar policies and recommendations exist in other countries, although their presence is inconsistent in the papers and should be systematically explored. This review has identified several studies conducted in other countries which have different mental health services, policies, and laws (Becher et al., 2021, Klausen et al., 2017; Haugom et al., 2022; Huang et al., 2021; Dahlqvist- Jonsson et al., 2015; Knight et al., 2018; Woltmann & Whitley, 2010; Wesseldijk- Elferink et al., 2021; Reed & Jaxson, 2019). The included studies highlight several complexities and challenges to embedding SDM approaches in clinical practice. Notably, concerns about service user's capacity to engage, staff attitudes towards SDM and limited time and resources to invest in these approaches (Younas et al., 2016; Shepherd et al.,2017).

The first theme of the review centres around service user ownership of their involvement in SDM. All the included studies highlighted the importance of service user ownership in SDM, a view held by both staff and service users. The participants in the Woltmann & Whitley (2010) study emphasised the importance to service users of having a sense control over their lives, making the important link that mental health care is a significant aspect of their lives; within this frame, you could reasonably expect most people would expect decision making to be a mutual process. In the Kaminskiy et al (2021) paper, staff, psychiatrist and nurses all strived towards increased ownership, associating it with working towards self-management, and a process of involving service users in decisions. Feelings of control for service users in this study was increased through detailed information about the options service users had. Importantly, they also document the feelings of helplessness and lacking control resulting from not feeling involved in decisions such as changes in medication. While psychiatrists and nurses in this study valued service user ownership, the presentation of information seems to be the key mechanism by which ownership is reduced. This is often subtle, such as psychiatrists redirecting service users to leaflets about adverse medication effects rather than engaging in a wider discussion. This is an important point and is evidence of how well-meaning staff may unintentionally undermine shared ownership and SDM. There are likely underlying assumptions being acted upon here, the deconstruction of which could aid the development of interventions based at increasing SDM. Service user movements have significantly changed the role of the 'patient' in their own care (Chong et al., 2013). Policymakers have responded to this by introducing frameworks which emphasises person-centred care based on individual's circumstances and choices. Therefore, achieving SDM involves a full recognition of the person's expertise developed through their own experience of their mental health problems (Stacey et al., 2016). It is suggested that service users who are active participants in their care have overall better engagement which leads to more positive outcomes (Slade, 2017). Therefore, increasing service user ownership through SDM could lead to improved satisfaction with care, although this remains to be explored.

The second theme highlights the importance of fluctuating mental capacity of the service user and the impact this could have on SDM. This was particularly evident when staff considered the service user to have a serious mental health difficulty such as a diagnosis of Schizophrenia (Dahlqvisst- Jonsson et al., 2015; Klausen et al., 2017), or had been admitted to an inpatient service due to mental health crisis (Kaminskiy et al., 2021). It was suggested the characteristics of such mental health presentations would have a more significant impact on the service user's ability to engage in SDM. In fact, the construct of insight can simply become the frame through which professionals view, and therefore challenge, the service user's competence to participate based on the increased need for information and guidance when experiencing a crisis (Kaminskiy et al., 2021). Symptomology affecting decisional capacity and communication with people experiencing psychosis was the barrier to SDM most cited by staff in the Becher at al (2021) study.

Service users in the Kaminskiy et al (2021) study however don't refer directly to insight, but speak in more functional terms, such as poor concentration and memory problems – not excluding SDM but highlighting the increased need to support the person with information and guidance. Principle 2 of The Mental Capacity Act (2005) requires practitioners to help a person to make their own decisions before deciding they're unable to decide. This means that practitioners should take an active role in supporting the service user with their memory or communication to reduce their distress and help them to understand and weigh up information relevant to their decision (NICE, 2018). Although this is recommended, research suggests that SDM is not implemented routinely in clinical practice (Slade, 2017). NICE does offer clear guidance on how to implement SDM in mental health settings which also incorporates the importance of SDM at a cultural, organisation and strategic level (NICE, 2021).

Some studies have highlighted that service users would prefer staff to lead on clinical decisions when they feel their capacity is impaired by their mental health difficulty (Aoki et al., 2022). Service users emphasised the importance of building trusting relationships with staff to allow them to make decisions in their best interest (Dahlqvist-Jonsson et al., 2015). Mental capacity is part of the wider concept of decisional capacity which itself has several elements. Other contributing factors could include confidence in one's own decision-making ability, apprehension of the consequences of decisions, or lacking trust in the relationships. Haugom (2022) suggests that shared decision making increases this decisional capacity. Though the mechanism isn't clearly described, this review would suggest the influences are a combination of improvements made within the organisational systems while enhancing individual elements such as personal confidence. This suggests no clear distinction should be made between the organisation and the individual here, as each always exerts an influence on the other.

An important theme emerging from the review is that of the therapeutic alliance, and its contribution to shared decision making. Definitions vary, but most include a sense of warmth and openness, emotional bond, and shared expectations of the goals and tasks of therapy (Charles et al., 1999). A key element, and perhaps linked to that of shared expectations, is mutual collaboration (Jooston et al., 2008). There is overlap both in the language and practical application of therapeutic alliance and shared decision making. SDM is an act of mutual collaboration, which in turn is described as a key element of, or contributing factor to therapeutic alliance. While therapeutic alliance could be considered the quality of the relationship, and shared decision making an action taking place within that relationship, the literature seems to suggest the two are inextricably linked, with improvements in one contributing to improvements in the other (Wesseldijk- Elferink et al., 2021; Kaminskiy et al., 2021). Further work is required to provide clear definitions of how the two constructs may interact. Therapeutic alliance is considered an integral part of most if not all established psychotherapy models, which operationalise within the model collaboration and development of a trusting relationship. Much of the research on SDM focuses on medical settings, and further research could look at the possibility that psychotherapy models are operationalising not just alliance but the act of shared decision making albeit through different language.

However, there are several factors which may impact the ability for staff and service users to engage in SDM. Decisions in mental health settings are complex to navigate for both staff and service users therefore it takes considerable time to develop a trusting relationship and learn what is important to the service user (Deegan, 2007). Organisational and cultural constraints on mental health staff can mean they do not feel confident in involving service users in decisions about their care. Potential barriers cited in the research include limited time and resources to make reasonable adjustments, inadequate training in suicide prevention, fears about an adverse reaction from those considered to be a risk to others and fear of culpability and litigation (Ahmed et al., 2021).

Lastly, the review outlined the importance of considering organisational influences on the implementation of SDM. It is suggested that paternalistic practice and disciplinary forms of power are prevalent within the mental health system, and this presents significant challenges to achieving SDM in practice (Kaminskiy et al., 2017; Elwyn et al., 2012). De las Cuevas et al (2015) discuss this phenomenon in Latin America in particular, additionally highlighting that such views are more prevalent in older generations, perhaps hinting that changes are already taking place. Attitudes should be viewed within a culture, so it is unsurprising that overall sentiment towards SDM appears to be ambivalent, with only situational or topic dependent endorsement (Seale et al., 2006). Indeed, paternalism and mutual collaboration seem at first glance conflicting, perhaps this ambivalence is a hint at this conflict in the individual, as influenced by organisational structures. Service user reports also highlight these organisational issues (Klausen et al., 2017; Woltmann &Whitley, 2010). People often report themes of helplessness, being omitted from decisions, and being controlled, when describing their experiences of SDM in mental health care (Dahlqvist- Jonsson et al., 2015; Kaminskiy et al., 2021). People also reported the perception that their views were less valuable than those of the practitioner (Velligan et al., 2016; Dahlqvist- Jonsson et al., 2015). This perhaps mirrors some of the above noted staff perceptions (again as influenced by the cultures) that service users have a reduced capacity to make decisions, or indeed that there are risks in increasing their ability to do so, hence feeling the need for paternalistic control over decision making. There was also no reflection on the potential influences such views could have if pervasive through a certain setting. Clinicians placed emphasis on considering service users fluctuating capacity to engage in SDM, however were less reflective on their own individual biases towards SDM or organisational barriers (Guidry- Grimes, 2020)

Current literature suggests that on the whole service users, across cultures would prefer to engage in SDM rather than being engaged with services which paternalistically act on their behalf (Huang et al., 2021). However, there are several cultural factors that should be considered for SDM to be embedded effectively. For example, in China there are deep rooted cultural values which emphasise the importance of respecting authority and maintaining harmonious relationships (Tse et al.,2015). Therefore, people using mental health services in China may perceive some of the principles of SDM as a 'challenge' to the authority of the mental health system and be more apprehensive to engage.

Family involvement in SDM is also considered to be more important in more family-orientated cultures. For example, in countries such as China, Korea and Ethopia treatment decisions are very rarely made without input from the service user's family (Huang et al., 2019). Latin American service users also expressed a higher preference for family to be involved in their care (Hawley & Morris, 2017). This highlights the importance of involving families and significant others in decision making across cultures.

Overall, successful implementation of SDM approaches in mental health care will contribute to higher quality, more effective care. Particularly, when considering risk management in mental health care. Whittington et al (2013) suggest that when there are collaborative approaches to understanding risk in mental health services, there are more positive experiences for the service user, which increases engagement with services which leads to more effective risk management strategies and decreases the likelihood of high-risk behaviours. Conversely, defensive practices that do not subscribe to an SDM approach increase the likelihood of high-risk events occurring due to lack of engagement from service users.

Clinical implications

Staff and service users alike voice positive regard towards SDM, and its importance in developing a strong therapeutic alliance, as well as increasing the quality and effectiveness of mental health care delivery. However, very few experiences of its application in adult mental health care have been reported to date. A combination of practical barriers and cultural attitudes have been identified. Interventions to increase SDM will likely need to address both staff and service user experiences in parallel, as the services and systems that currently don't allow for opportunities for SDM both influence and are influenced by these embedded attitudes. Therefore, it is not as simple as creating time for SDM, but may include educational interventions such as staff training, or systemic changes such as processes that make use of those decisions. This will avoid staff perceiving initiatives as frustrating and unnecessary (Deegan,2007).

Co-developed, and co-delivered, staff training seems necessary if skills development and attitudinal changes are to be achieved in staff groups delivering care, especially in challenging and pressured environments such as acute inpatient units. This training should aim to share the first-hand experience of care in these environments, both of being engaged in and being denied the opportunity to engage in SDM. Co-developed and delivered training has been shown to increase empathy and attitudes amongst staff (Kaminskiy et al., 2017). This also gives an opportunity for staff to consider perceived individual behaviours and barriers against responses to environmental factors. Hearing first hand that an inpatient environment might be experienced as restrictive and frightening, and oneself vulnerable in that environment, especially whilst experiencing psychotic phenomena, may challenge the idea that people on the ward are simply withdrawn or not willing to engage. Staff may come to understand that in this context, the experienced behaviour, rather than symptomology, could be fear and mistrust that importantly could be overcome through strategies that emphasise empathy, warmth, and development of a trusting relationship. The higher idea to be embedded is that a person's ability to engage in SDM is not static but can be developed despite their current mental health difficulties, through changes to the environment and how we work - not just what we do, but how we do it, and the space we do it in.

Consideration should be given to the issue of the mental capacity to engage in SDM in the context of service user's current difficulties, given its frequent indication by staff in the literature as a reason for not engaging in SDM (Shepherd et al., 2014; Younas et al., 2016). Lacking or fluctuating capacity will certainly be an issue in environments like inpatient wards, however, training and processes should emphasise that it does not preclude joint decision making. For those who are considered to lack capacity interventions such as advanced statements, the involvement of family and carers (ideally pre-agreed), and least restrictive human-rights based approaches could be introduced and made common practice. Processes should necessitate careful consideration of mental capacity and the implementation of the MCA alongside human rights-based approaches, although this does not apply outside of England and Wales.

At the service level, consideration needs to be given to how SDM takes place, the spaces it takes place in, how much time is needed, and who takes the lead on that. It's possible that third parties could be helpful in promoting these practices, such as psychologists tasked with facilitating such approaches; it's likely more helpful that core staff take a lead supported by such external agents to ensure shift in general sentiment and value of SDM. One way to begin to implement this would be to audit current levels of SDM in the service.

Engagement in SDM should also be considered within a framework in the system in which it is used. There are key decision points in services, often involving concerns about risk, and these can be quite distinct in mental health inpatient units, for example around leave, discharge, or medication. Embedding SDM frameworks around these decision points could ensure SDM takes place, is documented appropriately, and most importantly is acted on. This could involve semi-standardised approaches that ensure wishes are documented alongside discussions of concerns and compromises that necessarily need to be made. *An example might be the careful consideration necessary for a person requesting leave though there is a considerable risk of the person harming themselves. It would be important here to document the wishes of the person, the importance of this to the person, and the importance of supporting the person from a human-rights perspective. The concerns of the person taking leave would need to be clearly articulated not in documentation but to the person, and it would help to document the discussion, any negotiations, compromises and final decisions.*

While these approaches are aimed at staff, many service users reported lacking confidence in their ability to engage in SDM. Interventions could be targeted at the individual level, with an approach for coaching the person through the processes involved. Emphasis should be given to the ability to *develop* the person's capacity for SDM, and staff supported to develop the skills to do so.

The mental health systems of many cultures have traditionally operated on authoritarian and paternalistic principles: namely that we care for people by taking control and making decisions because the person has reduced capacity to. For SDM to become common practice, these ideas need to be challenged. The above strategies and interventions could help to do this, to move towards a culture of sitting alongside the person to support them in their journey.

Finally, it is of paramount importance that any intervention implemented is researched for its outcomes, with process in place for adjusting ineffective elements. As Knight et al. (2018) highlighted, there is limited research on the effectiveness of interventions designed to improve SDM. It's important that we innovate to improve the quality of care, but where strategies have little supporting evidence, we must implement them systematically to ensure they are successfully achieving their aims.

Strengths, limitations, and future research

This is the first systematic review to look at *both* staff and service user's experiences of, and/or attitudes towards, SDM in adult mental health care. This allowed an exploration of similarities and differences between the narratives around staff and service users perspectives on SDM. We hope this will increase understanding and contribute towards developing robust SDM interventions which are more effective in clinical practice. Strengths of the review include alliance with PRISMA guidelines, and three reviewers screening papers. The CASP quality assessment tool was used to assess each included papers methodological rigour and quality. Furthermore, the review provides evidence that SDM improves service user's and staff experiences of mental health care. The papers included in this review are from a variety of countries which gives some insight in to how SDM is being incorporated within different mental health systems across the world. However, most of the included countries were westernised, so some biases will exist. Therefore, any attempts to generalise this work needs to be done so cautiously, and further reviews examining staff and service user's experiences of and/or attitudes towards SDM are warranted.

Despite the positive indications from this review findings should be treated cautiously due to the following limitations. First, comparison between studies was difficult due to different methods of data collection and analysis. It is also notable that four of the included studies were part of larger mixed methods studies, with the quantitative data published separately. This suggests a lack of focused research on the topic area. Secondly, the authors utilised different means of data analysis including thematic analysis, narrative analysis and reflective lifeworld approaches, often lacking consistency between studies. The studies were also conducted with different staff groups from different disciplines across different clinical settings which makes comparison difficult.

The studies varied in terms of their rationale, aims, reported demographics, participant groups, data collection, quality, and data analysis. This presented challenges when synthesising the findings from each study. Despite this, consistencies were found in the main themes identified by authors.

There are also limitations in utilising a meta-ethnographic approach. Although meta-ethnography is widely used in healthcare research, there is a lack of clarity surrounding the description of the data analysis (Satter et al., 2021). It was selected for the current review as it allows only for the inclusion of qualitative synthesis and can include multiple study designs. In terms of quality appraisal, there are some limitations to using the CASP framework, including a limited guidance on its application and being a less good measure of research design and conduct (Long et al., 2020). It is noted that in this study the CASP highlighted a flaw in some studies where it was not clear what the relationship was between researcher and participant.

It is suggested that more research needs to be conducted to further understand why SDM is not commonly taking place in practice despite being advocated for in the policy and literature. The review highlights the need to consider wider implementation of SDM approaches to ensure person-centred recovery practices are routinely embedded in adult mental health services. Further reviews may wish to look specifically at either service users or staff viewpoints or examine the perspectives of other stakeholders, for example, carers. In the future, concrete structured tools for implementing SDM which incorporates the quality of the relationship between service user and staff could be considered.

Conclusions

In conclusion, this review identified that service users and staff support the use of SDM in clinical practice. Despite the policy support for SDM, it has not been widely implemented in mental health care yet. However, a wide range of barriers to implementation were identified in the review, such as scarce time and resources, lack of understanding of SDM, lack of SDM models and training and service user capacity, which could be addressed through a range of clinical interventions and practices. This review presents unique perspectives of SDM from mental health staff and service users which can provide useful insights into the strengths and limitations of current SDM practices. These insights could be used to develop and implement SDM models in adult mental health care settings.

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Chapter 2: Empirical Paper

How do service users with previous experience of detention under the Mental Health Act use language to discuss risk and safety?

Introduction

The Mental Health Act (1983)

The Mental Health Act (1983) is the UK's central legislation covering the assessment, treatment and rights of people with mental health difficulties (House of Lords & House of Commons, 2022). In 2018 an independent review of the MHA concluded (Department of Health, 2018), and the UK government produced its response as a white paper: 'Reforming the Mental Health Act' (2021). The recently published Draft Mental Health Bill (2022) is the next step and aims to give people greater control over their treatment to ensure they receive the dignity and respect they deserve (House of Lords & House of Commons, 2022).

Tension exists between mental health laws and balancing the human rights of the individual with the protection of the public (Leung, 2002). Over recent years there have been evolving debates about whether the MHA protects the rights of individuals detained under it (Mental Health Foundation, 2021). People who are detained or 'sectioned' are considered to need urgent treatment for a mental health difficulty and are deemed at risk of harm to themselves or others (House of Lords & House of Commons, 2022). At present, detention rates in England are rising faster than elsewhere (Independent review of the Mental Health Act, 2021). This may be due to a lack of available community care, a significant reduction in acute care beds and broad concerns about increased 'risk aversion' amongst professionals due to recent high-profile judgements and inquiries (Independent review of the Mental Health Act, 2021). Issues around 'risk' are one of the core components of the current MHA reforms (House of Lords & House of Commons, 2022). It is suggested that one of the key four principles which underpin the future of the MHA should be that identified 'risks' should be those that the individual prioritises rather than a "slippery slope" towards a wider set of risks prioritised by 'the system' (Department of Health, 2018). An interim report produced during the consultation process outlined that a reformed MHA will have a greater focus on rights with the possibility of new guiding principles being introduced to the act which specifically focus on 'rights based and least restrictive approaches'. Furthermore, greater emphasis should be placed on people's abilities to make decisions about their care (Royal College of Psychiatrists, 2018). In UK law, it is required that the MHA is consistent with the Human Rights Act (1998). However, judgements from the European Courts have stated that compatibility with human rights is very doubtful (Leung, 2002). Being detained under the MHA can be a traumatic experience and has the potential to impinge upon an individual's freedom and dignity which is central to compliance with the Universal Declaration of Human Rights. Service users have specifically identified that lack of involvement in decision making regarding their care and information about their treatment contributes to a sense of powerlessness, lack of autonomy and low self-worth (Chambers et al., 2014).

When users of mental health services are detained under a section of the MHA, they are assumed to be a risk to either themselves or others (Chambers et al., 2014). These assumed risks are often not communicated to them, which can add to people feeling disempowered and unheard (MIND, 2010). It is anticipated that when service users are detained, they are reluctant to discuss risk through fear that revealing such information could lead to prolonged hospital admission (Reynolds et al., 2014). In addition, when service users are detained, it may also be difficult for them to develop their own views on their own risk (Sheldon, 2011).

Risk Management

The Community Mental Health Framework replaced the previously used 'care programme approach' (CPA) (NHS England, 2019). The framework proposes a shift away from ineffective predictive approaches to risk assessment and management towards safety planning and 'positive risk taking'. Though a welcome recognition of ineffective practices, it's worth noting there is currently no equivalent guiding document for mental health inpatient care (Mental Health Act: Code of Practice, 1983). Alongside this, a paradigm shift in mental health services is being driven by several approaches inspired by service user movements. These include recovery, rights, person-centered planning, positive behaviour support and service user involvement, and are thought to be changing services for the better (Laganis et al., 2015). However, the influence of these ideas is often missing from processes around risk assessment (Higgins et al., 2016). It is argued that the empowerment of service users is a great untapped resource within the NHS (Corrigan et al., 2014). Furthermore, it is suggested that an investment in true 'co-production' through participatory approaches should improve relationships, foster trust and improve collaboration in decision-making (Hall & Duperouzel, 2011).

Service User Involvement in Risk Management

Forced detention under the Mental Health Act (1983) is a highly contentious and challenging area for both mental health professionals and service users (British Psychological Society, 2012). As such, service users and staff often have conflicting views regarding what leads to episodes of compulsory detention. Service users understandably express negative views about being detained and a lack of understanding as to why detention is necessary. The meaning service users ascribe to their experiences of detention are varied and emotional (Duxbury, 2002). As service users are often unclear of the rationale for their detention, they can manage their risk status through 'playing the game', i.e demonstrating compliance by containing their own frustrations (Reynolds et al., 2014). In this sense, service users could be seen to demonstrate an awareness of their risks by acting as active agents in the management and concealment of those risks. It is suggested that whilst staying on inpatient wards service users are at greater risk of violence towards them and sexual harassment with service users reporting that they largely feel 'unsafe' (Rethink, 2004). Research into how service users manage risk in inpatient environments suggests that they either avoid potential risks, attempt to de-escalate potential risky situations, or seek safety from staff (Quirk, Lelliott & Seale, 2005). This acknowledges that service users who are detained are not merely passive recipients of risk management plans implemented by staff but are active participants in managing these unsafe environments themselves (Quirk, Lelliott & Seale, 2005). Furthermore, many service users are aware of the risks they pose to others and are willing to engage in ways to help reduce these risks (Campbell & Lindow, 1997). Despite this, it is clear in the current literature that the voices of the service user in risk assessment is clearly lacking. Whilst this is acknowledged in research, there is no mechanism for addressing these issues in practice. This leaves staff and service users unable to effectively collaborate in risk assessment and planning, therefore colluding with practices that encourage coercion.

Service user involvement (SUI) is a relatively new concept in adult mental health services (Walsh & Tickle, 2017; Sangill et al., 2019; Trevillion et al., 2022). Though mental health services have attempted to shift from a medical construction of mental health to a more holistic conceptualisation, the rhetoric around SUI is still inconsistent within public policy (Sangill et al., 2019; Trevillion et al., 2022). SUI in mental health services can feel like a complex construct, guided by diverse policy and practices with mental health service users occupying an ever- growing number of identities and roles. Theoretically, service users have become stakeholders in their own care in addition to developing services and informing national policy (Storm & Edwards, 2013; Walsh & Tickle, 2017). However, in practice staff and service users struggle to incorporate these philosophies in to care in a way which respects the service users 'experiential power' whilst acknowledging the boundaries that exist within 'traditional' mental health care (Noorani, 2013; Berzins et al., 2020). Debates continue about what constitutes good 'service user involvement' with some suggesting SUI should be seen as a continnum (Hickey & Kipping, 1998; Giacco et al., 2018). It is suggested that SUI can be enacted in three ways; as recipients of communication, subjects of consultation and agents of control (Peck et al., 2002). However, there appears to be a disparity between service users experience of being involved in their own care and their involvement in services more generally (Walsh & Tickle, 2017; Trevillion et al., 2022). In a broader sense SUI was viewed by service users as a collective activity which was empowering and respected. However, at an individualised position of 'patient' service users identified they lacked any sense of control or even a reasonable degree of consultation in their own care (Bjønness et al., 2020).

Positive risk management initiatives advocate for risk alliances between service users and staff (Department of Health (DoH), 2007; Whittington & Logan, 2011) and the Care Quality Commission's (2014) evaluation of mental health services was informed by human rights principles. Despite this, evidence suggests service users feel their perspectives are excluded from risk assessment and management (Sheldon, 2011; Langan & Lindow, 2007; Kroner, 2012) and that the processes adopted by services can present obstacles to recovery (Sykes, et al., 2015). Guidance suggests that risk assessment should be a person-centred process focused on values with explicit acknowledgement and management of risk between the professional and the service user (Whittington et al., 2007; Greenhill & Whitehead, 2011). However, for the clinician who wants to adopt an inclusive and empowering approach, there is little to guide a collaborative risk assessment and management process (Cusack et al., 2017).

Several government reports and subsequent policies outline that service users should be empowered to have shared responsibility or 'joint ownership' of their risk and safety plans

(Royal College of Psychiatry, 2018; House of Lords & House of Commons, 2022; Department of Health, 2007), however, despite this, the views of the service user remain largely ignored (Langan & Lindow, 2007; Chambers et al., 2014). Policies and practice which are seen to prioritise recovery and minimise risk are often viewed as mutually incompatible (Department of Health, 2011). As such, it is implied that promoting recovery agendas will result in increased risks (Perkins & Repper, 2016; Royal College of Psychiatry, 2018). Research suggests that not involving service users in discussions about safety and risk can promote inaccurate reporting and over inflation of perceived risk, in addition to unnecessarily depriving people of their civil liberties and right to know what information is being written about them (Langan, 2009). For these, and many other reasons, service users can develop a mistrust of the intentions of services and therefore become reluctant to discuss risk as part of their recovery process through fear of being 'kept in hospital' (Chambers et al.,2014). In the current social, political and cultural climate there is a danger that people perceived as a 'risk' to society will be further excluded and marginalised (Langan & Lindow, 2007).

Available literature largely focuses upon the experience of managing risks from the perspective of mental health professionals (Higgins et al., 2016; Downes et al., 2016; Cusack et al., 2017). Research exploring the service users' perceptions of risk is, by comparison, limited. This is especially true regarding perceptions of risks that service users may present with whilst detained under the Mental Health Act (Higgins et al., 2016). Studies suggest that mental health nurses believe promoting positive risk taking is essential for the service user's recovery (Downes et al., 2016). However, it has also been noted that service user's views on what they need or require often differ from those of the professionals who care for them (Forrest, 2000). Langan (2009) has suggested that service users are rarely involved in discussions about risk and safety, despite this being part of the national agenda (The Five Year Forward View in Mental Health, 2016; Best Practice in Managing Risk, 2007; Draft Mental Health Bill, 2022). Policy does not provide clear guidelines about the extent or limits of involvement and provides rather vague standards such as 'promoting safety and positive risk taking (House of Lords & House of Commons, 2022). It is extremely rare for a risk assessment to even be signed by a service user (Langan, 2004). Perhaps this is the case at present because the research regarding service user perceptions of risk is lacking.

It is suggested that service users are reluctant to discuss their risks and safety whilst detained due to fears that it could result in prolonged hospital admission, forced treatment and increased stigma (Bowers, 2016). Upon reflection on their experiences of being detained, it is suggested that service users speak more freely and openly on their perspectives on risk and safety without fear of the potential repercussions (Rose & Sidhu, 2006).

There is an obvious conflict that exists between encouraging service user involvement in practice and containing risks that service users may pose to themselves or other people (Rose et al., 2002). Although involvement is advised and encouraged in NICE guidelines (NICE, 2021) there is little guidance for clinicians or service users about how this should be implemented. There are very few examples of risk assessments or management plans that attempt to integrate service user's views on their own risks and safety (Coffey, 2006; Bowers et al., 2009). Even fewer facilitate a collaborative discourse between clinician's and service users about risk (Laganis et al., 2015). Rose and Sidhu (2006) retrospectively investigated the views of those previously detained, with participants suggesting a tendency to conceal risk from the care team for fear of prolonged detention. As such, service user involvement in risk assessment remains an area in need of further research, particularly with regards to the views of those deemed a 'risk to others' (Langan, 2009). Most of the literature in this area is quite dated (Langan, 2009; Forrest, 2000; Ryan & Morgan, 2004) indicating that since their publication there have been little developments of note in this area. Therefore, we do not currently understand what service user's perspectives are on issues related to risk and safety whilst they are detained under the MHA.

This project aimed to understand how service users use language to construct an account of risk and safety based on their previous experience of detention under the MHA.

Method

Design and qualitative methodology

A qualitative interview study was conducted, which used a Foucauldian discourse analysis approach (Kendall & Wickham, 1999). Foucauldian discourse analysis is considered a critical discourse approach which is interested in how power and social structures shapes our understanding of knowledge.

Semi-structured interviews were carried out with eight participants who had previously been detained under the Mental Health Act.

Sample: Strategy and Recruitment

Participants were recruited using purposive sampling from service user groups in an NHS Trust and University of Liverpool Experts by Experience group. Eligibility for the study included the following inclusion criteria: must be over the age of 16, have had ***at least*** 12 months since an inpatient hospital admission in a mental health ward. The supervisory team agreed on this period following admission to allow participants time to process their experiences based on previous research suggesting detention is a traumatic experience (Akther, 2019). Participants had to speak English as a first language. Due to the chosen methodology, the way in which participants use language to construct their accounts was integral to the study. The additional use of an interpreter to aid translation may have impacted upon the specific way participants selected their language. Participants were required to have had experience of detention under the Mental Health Act (1983), to be as inclusive as possible there were no specific sections outlined. Anybody who was subject to a ‘community treatment order’ (CTO) was also excluded from the study as this is still considered to be an additional restriction under the Mental Health Act. Exclusion criteria included only having experience of ‘involuntary’ or ‘informal’ inpatient admission, being under the age of 16, and not speaking English as a first language.

Ethics

This study was approved by an NHS ethics committee (see appendix e) with sponsorship from the University of Liverpool. All participants gave informed consent, both written and verbal, prior to any interviews. Participants were informed they could withdraw from the interview at any time without having to provide a reason (see participant information sheet, in APPENDIX F).

Expert by Experience Involvement

Integral to the development of this study was the involvement of an expert by experience. The expert by experience was recruited via the University of Liverpool Expert by Experience group hosted by the Doctorate in Clinical Psychology programme. The expert by experience had lived experience of detention under the MHA and had acted as an advisor, consultant, and writer on the role of experts by experience within mental health services. They were involved in developing the aims of this research, a recruitment strategy and contributed to questions for the semi-structured interviews

Procedure

Participants attended an interview with a researcher at the University of Liverpool or via online platform, Zoom. Each interview lasted approximately one hour. The study was advertised using a poster (see appendix g) and participants were asked to contact the researcher directly if they were interested. If participants fulfilled the inclusion criteria, they were invited to participate in an interview where they were provided with a participant information sheet and consent form. Participants were required to provide the researcher with contact details for any professionals who remain a part of their mental health care (General Practitioner (GP) or specialist community services). Participants were asked for permission for the researcher to contact these professionals should any risk issues arise during the interview which would require immediate attention. A topic guide was used to conduct the interviews (see appendix h). Questions explored participant's awareness of risk, whether they had any active involvement in discussing issues of risk or in formal risk assessments and challenges or barriers to discussing risk. This ensured that there was some consistency between the interviews whilst being open ended to allow participants to construct a discourse of their individual experiences.

At the end, participants were debriefed, advised of contact details for the lead researcher should they have any queries regarding their involvement and asked if they would like to receive any disseminations of the research at the end of the study. Participants were received a £20 shopping voucher as reimbursement for completing the interview.

Interviews were recorded and transcribed verbatim, including additional details specific to critical discourse analysis including, interruptions, word emphasis and hesitations

(Oliver et al., 2005). Six of the interviews were transcribed by an external transcriber with the remaining two transcribed by the researcher. The researcher immersed themselves in the data by listening to the interviews and adding any further relevant detail.

Table 2.1: Interview methods and lengths

Participant number	***Interview method***	***Length of interview*** ***(mins: seconds)***
1	***Face to Face***	***20:25***
2	***Face to Face***	***28:56***
3	***Face to Face***	***34:28***
4	***Face to Face***	***49:30***
5	***Video conferencing****	***45:33***
6	***Video conferencing****	***43:33***
7	***Video conferencing****	***60:35***
8	***Video conferencing****	***49:30***

Interview method was changed due to restrictions throughout COVID 19 pandemic.

Table 2.2: Participants characteristics and demographics

Participant number	**Age**	**Gender**	**Ethnicity**
1	**57**	**F**	**White British**
2	**45**	**M**	**White British**
3	**49**	**M**	**White British**
4	**24**	**M**	**White British**
5	**22**	**F**	**White British**
6	**30**	**F**	**White British**
7	**No age given**	**M**	**White British**
8	**No age given**	**M**	**White British**

Data Analysis

Foucauldian discourse analysis was used, which focuses on how language practices form and maintain power structures within society (Buckland, 2016). This involves a critical examination of how language is utilised to construct and maintain power, as well as how power operates within specific discourses or 'discursive practices' (Buckland, 2016). Foucauldian discourse analysis is a particularly useful approach for exploring power imbalances inherent within systems such as the adult mental health system (Kendall & Wickham, 1999). Discourse analysis considers how the texts (in this case the interview transcripts) are constructed in terms of their social, cultural, political, and historical situatedness (Johnson et al., 2012). The texts were viewed as conveying aspects of reality in particular ways; they are a reflection and a construct within their context (Johnson et al., 2012). Thus, the study participants were considered speakers whose interviews offered specific discourses in relation to risk, safety and detention under the Mental Health Act (1983).

Analysis followed a five-stage process (Kendall & Wickham, 1999): (1) recognition of a discourse as a body of statements that are regular and systematic. For the current study, this was identified as the 'medical' discourse of Psychiatry which is dominant in inpatient mental health environments; (2) identification of the rules of the production of statements; (3) identification of rules which delimit the sayable and the identification of rules which create spaces in which new statements can be made. The service users in this study, therefore, would be understood to make statements about 'risk' and 'safety' within a particular frame of reference; (4) identification of rules by which a new statement can be made; (5) ensuring practice is material as well as discursive. The language service users use to discuss 'risk' and 'safety' have an impact on how risk is assessed and managed on inpatient wards. Therefore, discursive practices aren't limited to thoughts on a topic but have a physical consequence.

Each transcript was read repeatedly by the lead researcher, and initial notes were made on meanings and interpretations as per guidance provided by Goodman (2017). Transcripts were then transferred to the software package NVivo to aid collection of similar discourses. Appropriate text was provided with 'codes' to ascertain whether discourses were consistent across texts (see appendix I) These were then discussed with one supervisor, before wider discussion with the supervisory team.

Quality

Several frameworks are available to assess the quality of qualitative research (Seale & Silverman, 1997; Engel & Kuzel, 1992; Guba & Lincoln, 1982). Such frameworks allow focus on transferability, credibility, dependability, confirmability, audit trails and reflexivity (Elliot et al., 1999; Nowell et al., 2017, Yardley, 2000; Yin, 1989). The current study draws upon a range of methodologically specific and non-specific frameworks to provide a breadth of quality assurance methods which are summarised in the table below:

Table 2.3: Quality assessment framework

Quality assurance principle	**Evidence presented in the current research**
Researcher owning their perspective	A reflexive statement is available in appendix j.
Situating the sample	Participant characteristics and additional demographic information is available in table 2
Using direct quotations to support theme development	The 4 discourses and discursive constructions are accompanied by supportive quotes to illustrate points
Triangulating theme development	Development process discussed, refined, and redefined through supervisor feedback and input
Credibility checks	Overall discourses discussed with three supervisors from different disciplines (clinical psychology and mental health nursing).
Audit trail	Examples of discourse development can be found in appendix k and reflective journal entries made throughout the process

1. Elliot, Fisher, & Rennie (1999); 2. Nowell et al (2017); 3. Yardley (2000); 4. Yin (1989)

Credibility checks were held with one supervisor to discuss themes developed from the researcher, to reflect upon their own position and consider interpretations, which may not be within their awareness (Yardley, 2000).

Reflexivity

Reflexivity is an important aspect of all qualitative methodologies, including Foucauldian discourse analysis. This refers to how a researcher's assumptions, positions and interests influence the research process (Goodman, 2017). A reflective journal was kept throughout the research process for the researcher to consider their own experiences, values, and the impact this could have on the research to ensure any analysis made based on participants' accounts were ecologically valid. A research statement summarising the researcher's position, experiences, background and values is included in appendix j.

The researcher also had regular supervision to broaden reflections, check credibility of discourses, and interpretations of participants accounts.

Results

Four major discourses were identified (please see appendix k for all discursive constructions present within the analysis). These occurred most frequently, were relevant within the context of the research, and best answered the research question. The major discourses guide the presentation of the analysis:

- **'They're a little bit power crazy some of them'**- The restriction and resistance discourse
- **'Some crazy people on that ward'**- The 'good' and 'bad patient' discourse
- **'Your care plans and your risk assessments, all of their silly stuff'**- The illusion of service user involvement discourse
- **'If you won't take your tablets, I'm going to have to section you'**- The coercion discourse

Vocabulary and Positioning

The participants' accounts about risk and safety were saturated with medical discourse. This vocabulary was dominated by terms such as: "medication", "psychiatrists", "doctors", "nurses", "patients", "injections", "illness", "sectioned". Participants were less likely to use vocabulary less aligned with the dominant discourse, for example, 'service user', 'recovery' and 'involvement'.

Participants may be using their language to position themselves as a 'patient' with language and knowledge of 'mental health inpatient wards'. This may be an example of archaeology in the Foucauldian approach discussed by him in his book 'The Birth of the Clinic' (1963), Foucault discusses the transformation of medicine becoming the dominant discourse in the clinical environment, one that speaks 'of itself, to itself'. This is important to consider within the context of the current study as participants are giving a historical account of a time in a clinical environment which could potentially be dominated by the medical discourse. When considering some of the later themes in detail, it is suggested that these are not always relics of language but could be part of an internalised 'service user' identity. This aligns with the 'medical gaze' (Foucault, 1965) which exists within and beyond mental health inpatient environments. Participants use their speech to convey a similar idea- that psychiatric knowledge and practices are used by the mental health system to exert power and control over how service users can speak of their experiences of these environments (Kendall & Wickham, 1999).

The Medical Gaze

The concept of the 'medical gaze' (Foucault, 1963) refers to the exertion of power by mental health professionals and how it shapes the experiences of service users. The concept is visible as a central thread through each theme in this discourse, whereby power was the core process underlying decision making. Participants described key elements of the concept through their interviews, highlighting issues of the power of being observed and analysed, experiences of being objectified by the system as subjects of medical knowledge and authority, and ways they felt controlled. Gender differences were identified in how participants responded to this and made sense of the situation.

Major discourses

'They're a little bit power crazy some of them'- The restriction and resistance discourse

Several discursive practices within the participant's accounts referred to unequal power, and the "authority of the system" and therefore individuals within. Inequality of power is here understood as a lack of mutuality in terms of the control people have over their care and is specifically identified in the discourse as decision making that is restricted through practical means, or the expectation of the system or individuals. Within the context of the current study, this suggests that participants may feel some risk from the system itself which could lead to them feeling unsafe within inpatient environments. Some physical mechanisms are identifiable within the discourse, restrictive control that results from environmental factors such as locked doors, or the coercive effects of staff power to make decisions around leave on compliant behaviour. Within this there is a sub-discourse of regaining power and control, and the strategies people use to do so.

The speech used in service user's accounts indicated that they felt staff had significantly more power and control within the therapeutic relationship.

> “Because in those type of places I learnt pretty quickly that if I don’t behave in here, I’m not going home again”- P2

> “I think some staff (0.5) don't understand the concept (0.5) that you are unwell (1) they're a little bit power crazy some of them (0.5) I mean I come across it when I was working, but more so when I'm unwell you know it's (0.5) you don't know what you're saying, you don't know this, you don't know that, do as I say not as I do”- P3

Participants likened this to prison, a place you were unable to leave.

> “Some will treat you like a prisoner (1) Um (3) basically they treat you like you have no capacity whatsoever.”- P3

Participants described responses to their position that focused on regaining the power and control they lacked; i.e. attempts through which they could move from powerless to powerful, or controlled to in control. Through the lens of the system, the person’s actions may be labelled as independent aspects of the individual, such as resistance to treatment, symptomology, or indicators of risk. Understood in the context of the systems power and control, however, the person’s actions should be considered responses to the system itself, and the position it imposes upon them. Varied degrees of sophistication of responses were seen when considering the immediate and longer-term consequences to such responses.

> “Some staff members are scared of patients, and it was as simple as that (3) that's how it was. (1) The more violent and the more unpredictable a patient was, the less likely the staff was to intervene (1) and that's a fact. Unless they were numbered up to fuck.”- P2

Here the participant describes how some patients are trying to achieve short term control over the staff team through violence and unpredictability, specifically, they could stop staff intervening through fear. However, there are longer term implications to behaving in this way:

> “I didn’t want to end up smacking somebody and getting restrained (1) but (1) it was just that thing if I tell them this, they are going to keep their eyes on me and it will be documented I am going to end up getting this label of being a trouble causer, and I’m not I just want to get through my time”- P3

More sophisticated responses moved from reducing restrictions, to aiming to getting those with power to make the decisions the person would themselves make given the option. These attempts often seemed to employ some degree of concealment, such as choosing not to share risk to ensure an earlier discharge:

> “I think (0.5) like I said I think that if I talked about [risk] I'd probably remain in hospital a bit longer (3) but I think what I felt was that they'd use it against me”- P6

This discourse demonstrates that service users feel concerned about being considered a risk by staff and indicated that staff hold the control within inpatient settings. Participants talked about feeling uncomfortable with this power imbalance and attempted to mediate this in different ways, such as being violent, actively concealing risks and behaving in a certain way to avoid being perceived as a risk. Furthermore, participants linked the concept of being a risk with some punitive consequences, for example prolonged hospital admissions.

However, such responses to the inequity of power do not seem aimed at getting the service users’ mental health needs met. Policy would suggest systemic structures and processes are in place to care for people’s mental health needs, but participant experiences seem to reflect needs of having some control over one’s own life. Participants did not consider humanising liberation through the restoration of dignity via engagement (Friere, 1968), and perhaps this is important when considering necessary change: the onus shouldn’t be on patients to comply and engage in shared decision making, the systems need to place more emphasis on the value of true collaboration between staff and service user in order to make that possible.

‘Some crazy people on that ward’- The ‘good’ and ‘bad patient’ discourse

Participants positioned themselves relative to others on the wards to achieve particular discursive ends. In some accounts, participants talked about being compliant with treatment plans, and not being violent, interpreted as ‘the good patient’ discourse. Participants often positioned themselves as being ‘good’ patients by describing the behaviours of others as ‘risky’ or ‘bad’. The participants therefore linked ‘risk’ with being ‘violent’ which is ‘bad’. Notably, participants also linked ‘bad’ or ‘risky’ behaviours with being considered more unwell. Within their accounts all of the participants seemed to be concerned about risks from others.

Participants used their language to position themselves as different from people who were ‘risky’ or ‘violent’:

> *“I know yeah (1) they were really bad. You know, you’d have to be to be (1) hauled away really (1) but I wasn’t. I wasn’t that bad. During me illness I have never been violent, you see some violent people, you know”- P1*

> *“It's not always about risks to me (1) or that I would pose a lot of the time on that ward in particular because of the nature of what it was it was risks to you from others. Rather than you risking all the people because they were some fucking crazy people on that ward”- P2*

For some participants, this was thought to relate to illness, rather than individual choice.

> *“The first I ever thought about thought about risks and I thought oh he's risky (1) was when you're on a ward with other people that are ill, you’ve got to understand then you understand because of their illness the different elements and they’re poorly that sometimes they will kick off they start screaming and shouting or kicking things”- P4*

Participants talked about how they fulfilled the expectations the mental health team placed upon them to comply with treatment. It appeared that once participants were aware of these expectations, they adjusted their parameters and performed within the context of what they knew was being observed. Some talked about ***actual*** compliance whilst other talked about pretending to perform within the parameters, possibly to be considered a 'good' patient. Participants linked being 'good' with being compliant, which led to being considered 'recovered' or 'better' within the dominant medical discourse.

> *"Ahhh that I was getting better (1) after having the medication and stuff so I think (1.5) through my behaviour and the changes in my behaviour I think they could see that my risk level had changed as well yeah think through observation so the nurses could observe that"- P6*

> *"I didn't feel alright I didn't feel that (3) all that comfortable (3) because you've got it you've gotta (3) you've gotta remember anything that is said (2) in those types of meetings (1) obviously it's all recorded and that (0.5) could mean (4) that could mean the difference of going out for a walk or not."- P5*

> *"I developed the happy knack in the med's room (1) of slipping the tablet under my tongue (1) and then spitting it out once I got back into my room into a matchbox. (4) Arguably not the smartest trick in the book (1) but it felt right to me as an individual in the patient"- P4*

The above quotation illustrates how participants were keen to be seen to be compliant with what the system expected from them and even acts of 'rebellion' were performed within the parameters of the systems expectations.

Another wider discursive construction that was present in the data was how participants perceived themselves as a 'risk' due to being violent or aggressive towards others. Some participants spoke about this as a behaviour that emerged because of mental health related experiences for example, being aggressive due to psychotic beliefs they were being harmed whilst an inpatient. However, some participants spoke about using violence and aggression to reduce the risk to themselves from other service users and the system. Notably, there appeared to be a gender difference between males and females about how they protected themselves from threat in these settings. Men appeared to talk more about physical dominance and acts of aggression and women talked more about being considered a risk within the context of their diagnosis. Male participants discussed their dominance:

> *"I had two bars of soap and two pair of socks (2) I had to get stopped at the door (1) and then (coughs). That was quite hard to talk about because I'd just been caught with it (1) and they're saying what's this and what are you going to do with it? (coughs) And I'm like well (2) You know what it is (1) you know what I'm going to do (0.5) but to be fair though it was better to have to sit down and explain it (1) rather than just be like oh forget about it."- P2*

> *"If somebody got in my face, I would punch them (laughs) (1) basically (1) this did cause me to get restrained quite a few times like (0.5) because I have picked a couple of chairs up and threw them at people before today and (0.5) I tried to stab one fella with my knife and fork (1) because he was winding me up during dinner time. "- P3*

> *"I knew I know I knew I could keep myself safe because (2) I'm 6 foot and nobody is going to attack me are they?"- P4*

Female participants framed the concept of behaving in a 'risky' way differently. Female participants tended to attribute aggressive behaviour with being unwell and therefore less in control of their actions:

> *"Like it wasn't that I was going to hurt meself it was that I wanted to hurt other people this time and that's not very like me you know"- P8*

> *"I couldn't tell them the truth of what I was thinking (0.5) based on my psychosis but I think that (2) based on my behaviour I think the fact that I*

> *was so impulsive and aggressive and shouting at them and stuff I think they could see that I was a risk to both myself and other people."- P6*

Participants appeared to consider people who were risky as the 'other' and talked about feeling afraid of them. Participants talked about how they themselves could have been considered a risk but framed this to say that violence would be justifiable in their situation, as they were protecting themselves.

'Your care plans and your risk assessments, all of their silly stuff'- The illusion of service user involvement discourse

As explored in the above discourse, service users could be viewed as actors within, and responding to, paternalistic models of care provided through a system which establishes an imbalance of decision-making power in favour of staff figures. Participants were asked explicitly about who they felt risk assessments belong too, most participants were unclear about who they belonged to and felt staff were significant contributors to risk assessment:

> "it's about you isn't it so about me and what's about me (2) but the staff read the you know (unclear) that service users read it you know I read it and the staff read it belongs to both of us or maybe me"- P4

Naturally, this lack of mutuality challenges true shared decision making, which would equally value the opinions of all agents involved, if not favour the service user, about whom decisions are being made. The discourse around service user involvement articulated this dissonance.

Participants were explicitly asked about their involvement in any decisions related to risk and safety. Some participants struggled to articulate whether they had any involvement in their care and if so, how they were involved. One participant who had been on a forensic inpatient ward discussed involvement in more formal risk assessments.

> *"Because I don't think I've seen a risk assessment you know I've just seen*

> *like the risk planning I don't know I don't think I have like I don't even know what risk assessments have been done for me."- P8*

> *"Say for instance (1) on a Monday, my key nurse has come to me and said you've got a CPA coming. (2) I'm doing your updated risk assessment today (1) I'll run it through with you this week your CPA is next Wednesday, for instance, you know what I mean. (1) So, even if I wasn't there while it was getting done (1) they'd still (0.5) run it (0.5) by me"- P2*

Most participants agreed that service user involvement was important and identified several factors that could facilitate more effective service user involvement. Good relationships with staff were a facilitator of meaningful involvement in their care:

> *"Just ones who you could sit down with and have a decent conversation and they're not just gonna try and fill your head with shit about how you need to change your life and all that bollocks" - P2*

> *"They can't really know your risk until they know you"- P8*

Participants also talked about the importance of service user involvement in their care, particularly with regards to risk:

> *"Because if the service users not involved then (3) you could quite easily (2) form an opinion (1) as a healthcare nurse or consultant that isn't entirely (1) true to the facts (2) so it is essential that the service user is involved in any form of risk assessment."- P5*

Although participants considered service user involvement to be beneficial, a counter-discourse did emerge in some discussions where service users spoke about not wanting to be involved in their care and trusting the judgement of mental health professionals with important decisions. They felt the responsibility to make decisions about risks was with clinicians, particularly when they felt their experiences of mental health difficulties impacted on their capacity to make decisions in their best interest, at the time.

> *"I mean I, I didn't always (5) I didn't always agree with them but (1) I have to (4) submit in many ways because (2) erm (2) my own my own judgement was impaired (3)."- P5*

> *"The staff. (2) Because at the end of the day we're in there because we are not capable of being out here on our own (2) they've got a duty of care for us which means they should be looking after us and everybody around us."- P2*

Although participants felt positively about service user involvement in risk assessments, few had actual involvement with a formal risk assessment, and some expressed some negative views of their involvement, feeling this lacked meaning.

> *"But every time we had one of them they would go through your risk assessment and your care plans and all their silly stuff"- P2*

Participants gave conflicting accounts of involvement in decisions around risk. All participants advocated for service user involvement, but some used their accounts to highlight potential challenges towards this, such as organisational challenges, staff attitudes and mental capacity. Few participants had an example of being involved in formal risk assessments but had input in risk discussions. However, there are varying accounts of how beneficial this has been. Mental health services are embedded in governmental structures (Kendall & Wickham,1999). Within the wider Foucauldian discourse there are 'rules' of the delineation of the sayable and what can operate within this. This is evident within the service users discourse about involvement taking place within the framework of the institution.

"If you won't take your tablets, I'm going to have to section you'- The coercion discourse

Some participants highlighted issues related to coercion – they perceived their actions or decisions were influenced by those in the system, or system itself, without their full consent or agreement. Coercion can take many forms in mental health settings, from overt uses of force to more subtle processes, such as the negative labelling with consequent restrictions and fears.

Naturally, coercive practices can impede on the person's ability to exercise their own choices, potentially undermining autonomy, and any restrictive practices should be weighed up against ethical and human rights considerations. However, such restrictions often reflect an attempt to manage risk. Mental health systems may believe risk justifies coercion, the idea that such intrusions on the person's autonomy or rights is necessary to prevent harm to themselves or others. However, assessment of risk is inexact, and often takes place within systems conditioned to perceive that people with mental health problems are risky (Foucault 1980; Arrigo & Williams, 1999).

> *"Now I've been honest at this point (1) doctor (name) said to me (3) will you now take your tablets (2) and I said well I don't believe in them (name of doctor) and they're not having any effect what's the point (1) they're making me worse (2) he said well look(1) if you won't take your tablets (1) I'm going to have to section you"- P7*

Participants perceived that they were presented with choices, but that the choice had already been made.

> *"Yeah but like they said to me, me doctor, who came out to see me and assess me, who sent me back to (name of hospital) said like if I don't go voluntary she would put me on a six month section so I would have had to stay for 6 months so I was a bit like oh god just go back voluntary"- P8*

> *"And they said you know if you don't agree they'd give it to me forcibly [the injection]"- P8*

> *“So, I had to behave (0.5) because (0.5) I wanted to get better anyway (1) because I was asking for help before I went there so I thought there is no point in misbehaving while I am here because I won't get the help and I will just be here longer. So, I learned quickly that (1) you need to behave yourself or you are going to other places”- P2*

Some participants reflected that they felt coerced into making decisions, such as taking medications to receive leave.

> *“I wouldn't take risperidone I lost my leave (1) I had to stay in hospital for 24 hours a day seven days a week you know because I wouldn't take risperidone so then I started taking risperidone and they gave me more leave more leave more leave you know”- P4.*

The above discourse may reflect participants experiences of having no choice but to comply with what the system was asking of them through fear of punitive consequences.

Discussion

This study explored how service users with previous experience of detention under the Mental Health Act (1983) use language to discuss risk and safety. The Foucauldian Discourse Analysis framework developed by Kendall & Wickham (1999) was used for the analysis. The author identified four major discourses: restriction and resistance, the 'good and bad patient', the illusion of service user involvement, and coercion. Each of these will be discussed below with consideration of their links to existing research. Risk is central to each of these discourses. But of particular interest is the emergent and frequently featured discourse around risk from the system and the environment.

Firstly, participants talked about discourses related to restrictions they felt and their ways of resisting these whilst detained. This could be considered a response to the power and control held by the system. Restrictions are put in place as an attempt to manage perceived risk; regulating the perception of those risks was often the means of resistance. The compulsory treatment of people detained under the Mental Health Act (1983) allows for the use of, 'control and restraint', 'seclusion' and covert medication administration, demonstrating the overt power psychiatry has in these settings (Roberts, 2005). However, there are more subtle exertions of power in inpatient environments which were highlighted in addition to the above by the participants. For example, needing to 'behave' or take medications to be released.

Foucault considered the surveillance oriented architectural design of the panoptic, to contemplate its metaphorical application to systems and organisations. 'Panopticism' thus moves from describing prisons which ensure prisoners are "seen but do not see" (Foucault, 1991), to organisational and societal norms that influence or regulate behaviours, even in the absence of surveillance, through the "internalised gaze" – the watched becoming the watcher. Psychiatric inpatient settings employ several panoptic strategies through interventions such as observations, nursing records and risk assessments which create and maintain a sense of service users' 'constant and permanent visibility' (Foucault, 1991). Creating this sense can maintain a power relation which ensures that service users regulate themselves within the 'norms' allowed by psychiatry (Roberts, 2005). Some participants discussed the idea of being monitored and in some cases appeared to internalise this monitoring process themselves. For example, one participant talked about being uncomfortable with how conversations during review meetings with staff could lead to further restrictive measures being placed upon them i.e. losing their leave. Some language used is reminiscent of discourses around prison, with one participant describing doing their "time" on the inpatient unit, as if they were serving their punishment for not thinking, feeling, or acting, as was expected in society. This aligns with findings from a Akther et al (2019), which concluded that service users experience detention under mental health legislation as a punishment rather than a treatment with a view to recovery.

Secondly, participants' discourses featured the concept of the 'good' and 'bad' patient. They appear in several ways: construction of the self as good, positioned against other 'riskier' therefore 'bad' service users; complying or appearing to comply with expectations; or owning the 'bad' position for subjectively justified reasons such as experiencing the system as violent towards them. From a Foucauldian perspective, someone who is unable to engage in normative behaviours is viewed as 'abnormal' (Foucault, 1963), furthermore, when an individual is positioned as 'mentally ill' it invites them to see themselves as such. In this context, service users may have incorporated this identity and positioned themselves in this way, which increases reliance on mental health services to enable them to behave 'normally'. Conversely, service users may find a sense of belongingness within mental health services, as a system that accepts and, in some cases, reinforces the idea they have 'abnormalities'. The 'good' position measured against these norms could be the accepted 'normal' of 'abnormal'. Belonging is also a powerful driver of positioning against the 'other', here the 'bad' patient or 'abnormal'. This may explain why participants felt a reliance on mental health staff when they felt 'too unwell' to engage. Service users may internalise the panoptic power of psychiatry and 'the medical gaze' described by Foucault and therefore become observers of themselves and others within the parameters set by Psychiatry. The internalised medical gaze will have resultant behaviours and actions which are influenced by the medical and societal norms imposed upon the person. Note that the positioning of a person as mentally unwell will generally be achieved through the act of diagnosis. This is not a call to draw back entirely categorical labelling, indeed some find comfort in a name to their experiences, and currently commissioning and research require such categories to effectively study and organise services. Rather, services such be considerate not just of the needs of the person in labelling difficulties, but also of the results of such an act – the act of diagnosis itself should be considered in a person-centered formulation, and part of the person's experiences that may be influencing current thoughts, feelings, and behaviours.

Ryan (2000) proposed that service users employ their own risk management strategies. These are either proactive, taking an active part of what happens to them, through asserting their wishes or taking direct action, or passive risk management. Notably, this is linked to length of illness experience (Ryan, 2000). People with less experience of using services had fewer proactive risk management strategies, which may relate to 'insight', i.e. where service users understood and accepted their diagnosis. Certainly, 'recovery' from certain mental health difficulties could be characterised by a general reduction of symptomology, increase in insight, and the development of strategies to support self-managing problems as they arise (MIND, 2010). Through a Foucauldian lens however, we must question whether such experience related changes represent a mostly linear 'recovery' or action based on the dynamically internalised norms of the medical and societal systems. An interplay of both processes exists to varying degrees within individuals and services, and across sets of problems, considering the differing levels of acceptance, understanding and stigmatisation across diagnoses (Castillo et al., 2013). In the present study, many participants discussed how they operated within the system to achieve their goals, often around discharge or leave, rather than how they worked with the system (or vice versa) to achieve recovery. It is important to acknowledge that the desire of services is not to control people but help them recover. However, from a participant perspective, structures and processes appear to be built around the idea that a certain degree of control and authority is necessary. This seems to have the opposite effect: the primary responses of service users are aimed at regaining control and power, not over the system but themselves. Rather than instilling a focus on recovery, the system itself prompts what Reynolds (2014) called "playing the game".

Thirdly, participants offered some conflicting discourses about service user involvement. This may reflect the wider discourses which exist around service user involvement and survivor activism within mental health services. Some argue that service user involvement movements have moved away from being a political force driving radical reforms of the mental health system due to being victim of governmentalisation which seeks to limit its scopes and capabilities (Noorani, 2013). Collaborative risk assessment and management has been recommended in national mental health policy for over a decade

(Markham, 2021). However, is not routinely embedded in clinical practice. Some participants were unsure whether they had been involved in any formal risk assessments, and those that had did not express a clear sense of ownership of the insights, decisions, or documents. Participants reflected on informal conversations about risk with trusted staff. Participants demonstrated an awareness that the information they shared regarding risk in these conversations would be utilised by staff to inform their clinical decision making. This is in line with existing research which highlighted the importance of feeling enabled to talk about risk within the context of a supportive therapeutic relationship (Langan & Lindow, 2007; Reynolds, 2014). Although it could be stated that participants have been engaged in some discussion about risk, the language used is important here. Descriptions such as 'informal', or as being with 'trusted' staff hints at untrusted staff, and a fear of something from others that stifles collaboration. Absence of feelings of ownership of decisions, and discussion of more formal processes seem to express collaboration with processes of the system rather than engaging with support to make decisions about themselves. There may be differing views between professionals and service users about what is happening in these processes (Kaminskiy et al., 2021) but the language used should be considered as indicative of the internal processes. Here it seems to reflect participants views that they are subject to the authority and power of the system, and engaged in its processes, rather than as mutual agents making decisions solely focussed on their recovery. Markham (2021) suggests that the more experience people have of detention the more sophisticated their responses to managing their own risk status becomes. For example, over time, service users are less likely to use overt means of aggression as they learn that this can lead to prolonged admission (O'Dowd, 2022; Langan & Lindow, 2009; Rose et al., 2017).

Foucault (1961) argues that the power psychiatry holds over service users limits their ability to adopt a more person-centred, inclusive approach to include an individual's values and preferences into their care. This seems to hold true for the discourses of some participants of this study, who described decision making influenced by the feared consequences of labels such as 'trouble-maker' or being seen to be aggressive or acutely 'unwell'. Others talked of physical restraint, to prevent aggression or administer medication, or both. Such approaches can be legitimised through ideas such as the 'lack of insight' that can accompany acute 'illness' (Whittington & Logan, 2011; Salize & Dressing, 2004) – which some discourses reflected in the current study. This is further reinforced by the wider societal discourse which exists around mental illness which emphasises the risk of violence (Abherhalden et al, 2006). Therefore, some mental health professionals may prefer a more paternalistic model as it prevents challenging conversations and negotiations with service users regarding risk (Abherhalden et al, 2006). However necessary they may seem, through a Foucauldian perspective it should be recognised that first of all acts such as restraint and forced medication are violent acts, which are legitimised to such a degree that they are rarely talked about in such terms, especially within services. Whilst this may not seem a practical consideration, it would be interesting to weigh up the level of restraint used in in-patient environments, against actual (rather than perceived or feared) level of violence or aggressive acts from people on those wards. Conversely, these discourses impact social policies which are then more likely to advocate for restrictive practices (Markham, 2021). The shift to inclusivity and ownership requires more than a shift in processes. A systemic rethink of the oft positively correlated ‘safe and well’, as directed by such narratives as those included in this study, could lead to organisations which recognise that safety, as achieved by restriction through the assumed authority of another, does not equate to the well-being of the person subject to those restrictions. Even if the authoritative agent is successful in keeping the person ‘safe’, it is measured by their definition, often neglecting the fact that processes which restrict liberties are experienced as particularly unsafe. There is a need to protect the public, and to support people who may hurt themselves, but there are many numerous risks involved in all acts undertaken to achieve these, and society should be careful about which they focus on, those which are accepted, and especially those which may fall out of view.

Strengths and limitations

This study adds to the limited evidence to date examining service users' perspective on risk whilst previously detained. It also explores views of risk from others and from the system, where the larger body of existing research is concerned with risks posed by the person (Markham, 2021). The author has experience as staff on inpatient units in several differing roles, but also has experience as a service user within secondary services. Their lived experience of both sides of the dynamics contemplated in this paper could be considered a strength when discussing the views of the participants.

Inclusion of participants previously subject to detention drew participants with a broad range of experiences. Whilst a strength in terms of range, interviewing people with experience of a specific type of inpatient environment and a specific form of detention could have allowed closer examination of the dynamics at play in that setting. Whilst this research provides a good understanding of participants' subjective experiences, future research could consider limiting to either forensic or acute in-patient, particular section of the Mental Health Act, and duration or number of detentions. Some participants had been admitted informally at some time, and so may have drawn on experience of those admissions through the interviews, as this was not an exclusion criterion for participation. Again, future comparisons of informal and detained experiences could helpfully add to this research.

Some participants were part of service user involvement groups and while perhaps more prepared to challenge services, they may have also been influenced by a dominant narrative that could exist in such groups, framing their experiences within those narratives, rather than their own personal views. No questions were asked about this, meaning that the personal nature of the narratives was assumed.

Qualitative research can be criticised for being small-scale and lacking rigour. However, the author has taken additional measures through quality assessment processes to ensure the data is in-depth, reliable, and credible. For example, triangulating theme development, consultation with expert by experience and creating audit trials of the process followed. There are also criticisms to utilising interview data in discourse analysis. However, data cannot be easily spilt in to 'naturally occurring' or 'contrived', it is argued that all data comes from real people speaking in real life situations which naturally generates action directed talk (Speer, 2002). This was appropriate for the current study as the limited prior research in this area suggested that people may be apprehensive about talking about their experiences of risk (Langan &Lindow, 2009). Therefore it was felt it would be more beneficial to offer a topic guide to support participants and hopefully reduce anxiety about sharing their experiences.

Clinical implications

Potential Impacts

The four themes arising through the analysis were concerned with how participants shared their experience of risk and safety, with the response to power and cultural norms running through as a central thread.

Analysis suggests that aggressive incidents can be driven by responses to feelings of powerlessness and lack of mutual involvement in risk-based decisions, rather than as indicative of 'illness'. Incidents such as these can lead to further restrictive practices, physical and emotionally traumatic harm to staff and service users, cost implications for organisations (ultimately redirecting resources from the service user), and solidified sentiment around the need for management through power and authority (Kaminskiy et al., 2021) While a central tenet of medical practice is "do no harm" it appears that some harm incurred by these participants is iatrogenic – it is an unintended consequence of the way the system tried to care for the person (Luxford, 2016).

Potential Interventions

Foucault observed organisations and societies, and the resultant themes here reflect that both staff and service users are agents within, and responding to, systemic norms and systems (Kendall & Wickham, 1999). Organisational transformation is a complex and lengthy process, but it is also incremental (Mahone et al., 2011). The following are suggestions of interventions at the individual, team, and organisational levels that could contribute to cultural shifts which balance problematic power dynamics, benefiting the service user and others within the system.

Central to any intervention is a risk formulation that differs from the metric informed risk assessment traditionally used. Risk formulation allows for the complexities of the persons' life and the resultant risk profile that is not only unique but subjective (NICE, 2022). Importantly, it allows for development of a joint understanding that effectively enables joint decision making about those idiosyncratic risks (Lewis & Doyle, 2009). It's important to acknowledge that a level of risk remains but risk based decisions are aimed at reducing those risks while respecting the rights of the person (Greenhill & Whitehead, 2011). When we understand the negative effects of relying on metrics and a broad-brush stroke cut off which we feel is protective of a risk that the metrics potentially predict, we must make a decision that balances those two risks: the risk being realised vs the harm we'll do through overly restrictive practice (NICE, 2022) This tolerance of remaining risk also must include support through the organisation for the person themselves to choose what risks remain; some risks require immediate intervention, but many do not, and providing and supporting space for personal choice about how those risks are reduced can prevent unintended harms, such as the traumatic experiences of restrictive practices or the harm of concealed risk (NICE, 2022).

Interventions at the Individual Level

The analysis suggests that interventions at the individual level should aim to address the lack of involvement in risk assessment, enable genuine empowerment in decision making, address the fear that expressing risk will result in adverse consequences, and should introduce transparency about iatrogenic risks and risks from staff interventions such as restraint (NICE, 2022).

Joint risk formulation allows the person to describe risks in a personal and subjective context. When embedded in practice it has also been shown to changes staff member's relationship with those risks as the shared understanding on which decisions are to be made considers nuances of subjective experience and responses to environmental factors (Zisman-llani et al., 2021). Inpatients should be empowered through this process to explore their fears of being on the ward, and of the staff team if present, and how they might act in response, as the participants of this study described. These fears are a valid part of the person's experience, having them heard and accepted by the environment itself contributes to developing a trusting collaborative relationship.

Traditional risk assessments generally conclude in a 'plan' outlining what the assessor is putting in place to manage the evident risks. There is a conflict between personal choice and the fear of potential risks being realised, and many risk averse decisions are influenced by practitioners’ fear of litigation. Shared decision making should give meaningful choice to the person about how they reduce risks and the distress leading to them. Some choices will be too difficult, and there will be times when the risks are too great to allow what services may consider an unwise decision on the part of the person, but they should be made explicit on any documents developed. Where the person can make decisions, they should be free to do so in an informed and meaningful way, in line with the Mental Capacity Act, which recognises our right to make poor decisions (Mental Capacity Act, 2005). To account for risks that are too great, or decision-making being hindered (considering capacity), advance statements should be used to ensure the persons’ wishes are considered though they might not be able to engage in such choices at that moment.

Safety plans are used often as an intervention themselves to help the person develop insight into and strategies to work with their risks (Higgins et al., 2015). Tighter integration with current risk assessments or the shared process described above could reduce power imbalances by elevating the person’s ownership of parts of their risk profile, making them joint partners in risk reduction not just decision making. There would undoubtedly be anxieties about this, and it challenges medical models of ‘care’, but it can also reduce restrictions, and for many increased ownership could serve as a therapeutic recovery-oriented goal. Without appropriate support it can feel like decision making, shared or otherwise, has failed in the face of serious incidents. Post-incident reviews can play an important part helping the person to revisit their decisions and consequences, and helping the staff continue to empower them.

The discourses show that many people experience risk in similar ways, but very few discuss sharing risks with each other. A therapeutic group with clear aims of sharing and validating the persons’ subjective experience of risks, especially fears of the ward environment, could increase trust and collaboration. Having experts by experience co-facilitate such a group would further shift staff perspectives on risk, while demonstrating to service users that the system does hold their subjective experience in mind as a key part of such discussions.

Interventions at the Team Level

Interventions at this level should be aimed at supporting teams' holistic understanding of the person and their risks, increasing the visibility of relational dynamics that influence risks, and making meaningful use of the experiences of service users.

Relational dynamics can be unspoken or unrecognised in busy inpatient teams. To challenge the framing of behaviours within constructs of illness and symptomology, increasing staff knowledge of relational frameworks could offer another useful perspective. The results suggest that service users' actions are often aimed at moving from powerless to powerful, or from controlled to in control. Cognitive Analytic Therapy (CAT) offers formulation frameworks well suited to exploring such 'reciprocal roles' and the consequent actions of somebody subject to them (Ryle, 1991). Using CAT as a model for staff reflective practice could have specific aims of exploring a team's feelings towards the work and people, and the service users perspective in turn, as well as the higher level abstractions of what individual acts represent – for example a restraint may feel necessary, but it is also an act of violence and an exercise of power. None judgementally mapping that is a powerful tool to increase insight and alter behaviour. A staff team collectively understanding that violent incidents could have been influenced by relational dynamics may understandably find ways to address them in their environments. Formulation of individual problems is often done with the individual in the context of a therapeutic intervention. Team formulations by comparison can helpfully draw on the experience of the entire MDT to conceptualise a person's problems, integrating a range of perspectives to generate collaborative solutions

Positive therapeutic relationships are known to reduce risks to service users (Markham, 2021). Co-producing an explicit ward ethos which embeds key basic interventions such as fostering relationships could reduce risks. Performance is often monitored through key performance indicators (KPIs), which can to some staff feel detached from real world effects. Fortunately, service user feedback is a frequently employed KPI (Chambers et al, 2014) and questions about therapeutic relationships could feedback the relative success of staff on this measure. This could be regularly evaluated to understand both service user and staff perspectives of success.

The power of the system and staff groups could be rebalanced with increased service user involvement at different levels. Recruiting peer support workers who have a lived understanding of the difficulties faced by those on the ward would foster better relationships with service users and would naturally shift staff perspectives on how they work with people.

Decisions about the ward (for example changes to the design of the environment) could be made within committee meetings, the committee being made up of a mix of staff, current service users, and people who have previously been admitted. Representatives from this group could also be involved in staff recruitment and co-production/facilitation of groups on the ward such as the previously mentioned recovery groups or suggested risk-based group.

Interventions at the organisational level

Organisational interventions should in the first instance form a statement of intent from the organisation that signals to all within it the intention to work in a certain way. Thoughtful co-produced policies can effectively communicate the intent and accompanying strategies can outline how such changes will be operationalised. A specific aim here should be increasing meaningful service user involvement at the highest level of decision making and in all policy creation.

To operationalise positive risk taking, policies should be designed to empower individual practitioners to make such decisions, and incident reviews should instil a sense of safety through reflective enquiry that doesn't aim to assign blame. The newly introduced Patient Safety Incident Response Framework (*PSIRF*) could be a helpful tool to achieve this, with its aim to increase transparency in organisations, as well as operationalising learning and improvement based on investigations (NHS England, 2022).

Service user groups have largely been influential in shifting the traditional paternalistic models of psychiatry in favour of coproduction and a focus on service user experience. The inclusion of those who can experientially reflect the voice of those using service users at every level of organisations, from the Board through the wards will ensure those experiences are captured, and the negative effects of not acknowledging those experiences, as suggested in these results, can be reduced. NHS Trusts are often in states of transformation with varying aims and catalysts. Making changes within models such as Appreciative Inquiry and with service users having equal voices at all stages of the process can ensure organisations are designed with an eye on power imbalance and restrictive practices (Wright & Baker, 2005).

Recommendations for future research

The current research suggests that a ‘risk formulation’ approach would more readily incorporate service users’ views on risk and safety. Furthermore, service users suggested that risk from others is a prominent risk factor to consider, particularly on inpatient wards. Future research should consider how risk formulation compares to current risk assessment practices and whether this more individualised approach encourages service users to talk more openly about risk from others, in comparison to other techniques. Clinicians may want to consider changing their approach to risk assessment to ensure risk from others is explored fully with service users, research could also evaluate the process of this.

Participants’ accounts demonstrated different response to risk that seemed to show a change in levels of sophistication in response to ‘playing the game’ within the system. The current research did not consider which factors may influence this, for example, more experience of detention in these settings may lead service users to adapt their responses as their knowledge of the requirements of the system upon them increases. This should be considered in future explorations of service users experiences of detention, to identify any factors that influence experiences that could be supported in clinical settings.

The participants accounts also suggested that there may be gender difference in terms of how service users respond when they perceive they are threatened in inpatient environments. Further research may wish to specifically explore the role of gender and risk, triangulating participant experiences with staff experiences and observations of such incidents. This would help to identify any strategies that can support individuals who respond in different ways.

Conclusions

This research suggests that service users accounts of ‘risk’ and ‘safety’ whilst detained under the MHA are informed by discourses describing issues pertaining to: power and control, identity as a ‘good’ or ‘bad’ patient, varying levels of ‘involvement’ in their care and coercion from the system. The current research is one of a very limited number of studies which consider the views of service users who are detained under the MHA. Furthermore, it is one of few studies which considers service users’ perspective of their own risks and the concept of safety in inpatient environments. The research has clear clinical implications for the way views of service users can inform risk assessment processes to reduce overall levels of risk, and why this is important. Future research should consider how risk formulation compares to current risk assessment practices, to inform clinical practice in this area.

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APPENDICES

APPENDIX A: DATA EXTRACTION TOOL

Domain	
Author and year of publication	
Location	
Setting	
Sample and characteristics	
Design	

APPENDIX B: DATA EXTRACTION TOOL 2

Domain	
Author and year of publication	
Main aims	
Main findings	
Outcomes	
Clinical Implications	

APPENDIX C: METHANOGRAPHY EXAMPLE

Study name	Key concepts	Group
Kaminskiy et al 2021	SU Involvement Shared Decision Making Risk Assessment Systemic challenges Therapeutic relationships	

APPENDIX D: EMAIL TO KEY AUTHOR

Cartwright, Claire- 08/11/2022
emma.kaminskiy@aru.ac.uk
Dear Dr Kaminskiy,

I am a third year doctoral student on the Liverpool Dclin programme. I am currently conducting a systematic review in to the experiences of 'shared decision making' in adult mental health services from the perspectives of service users and staff.

I have come across many of your articles during my searches and have enjoyed reading all of your published work on this topic. I am contacting you as you are an expert in the area and was wondering whether you were aware of any publications or unpublished works which I may not be aware of in relation to the topic.

Any support or advice would be greatly appreciated.

Best wishes,

Claire.

Claire Cartwright
Trainee Clinical Psychologist
Doctorate in Clinical Psychology
University of Liverpool
Whelan Building
Brownlow Hill
Liverpool
L69 7ZX

My current working days are Wednesday, Thursday and Friday (PM).

APPENDIX E: AUTHOR GUIDELINES FOR BMC

Preparing your manuscript

The information below details the section headings that you should include in your manuscript and what information should be within each section.

Please note that your manuscript must include a 'Declarations' section including all of the subheadings (please see below for more information).

Title page

The title page should:

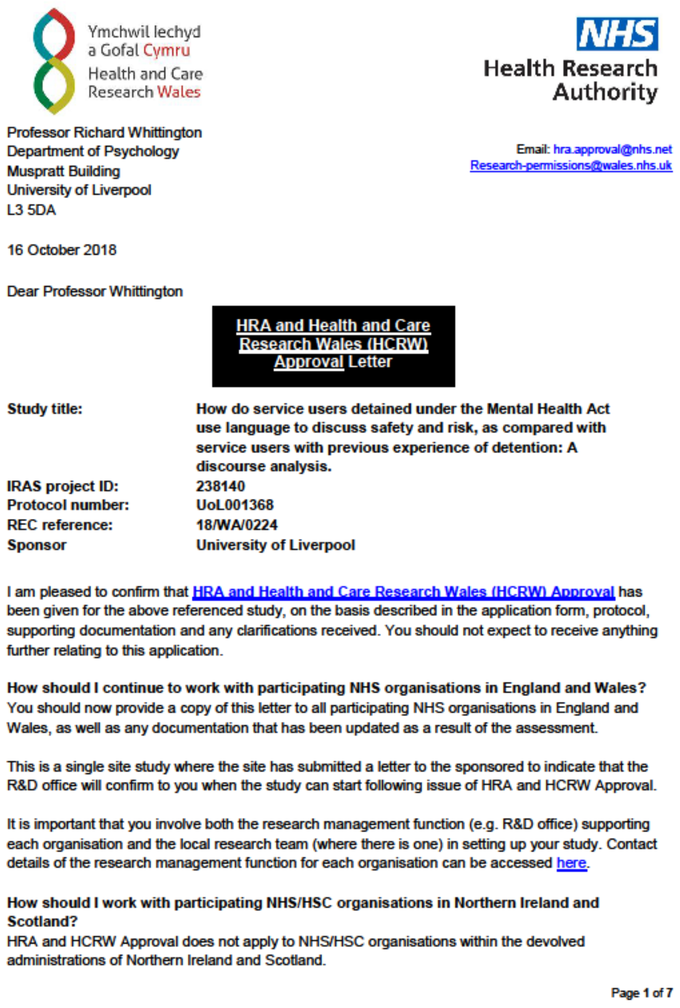
- present a title that includes, if appropriate, the study design e.g.:
    - "A versus B in the treatment of C: a randomized controlled trial", "X is a risk factor for Y: a case control study", "What is the impact of factor X on subject Y: A systematic review"
    - or for non-clinical or non-research studies a description of what the article reports
- list the full names and institutional addresses for all authors
    - if a collaboration group should be listed as an author, please list the Group name as an author. If you would like the names of the individual members of the Group to be searchable through their individual PubMed records, please include this information in the “Acknowledgements” section in accordance with the instructions below
    - Large Language Models (LLMs), such as ChatGPT, do not currently satisfy our authorship criteria. Notably an attribution of authorship carries with it accountability for the work, which cannot be effectively applied to LLMs. Use of an LLM should be properly documented in the Methods section (and if a Methods section is not available, in a suitable alternative part) of the manuscript.
- indicate the corresponding author

Abstract

The Abstract should not exceed 350 words. Please minimize the use of abbreviations and do not cite references in the abstract. Reports of randomized controlled trials should follow the CONSORT extension for abstracts. The abstract must include the following separate sections:

- **Background:** the context and purpose of the study
- **Methods:** how the study was performed and statistical tests used
- **Results:** the main findings
- **Conclusions:** brief summary and potential implications
- **Trial registration:** If your article reports the results of a health care intervention on human participants, it must be registered in an appropriate registry and the registration number and date of registration should be stated in this section. If it was not registered prospectively (before enrollment of the first participant), you should include the words 'retrospectively registered'. See our editorial policies for more information on trial registration

APPENDIX F: APPROVAL LETTER FROM HRA



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Professor Richard Whittington
Department of Psychology
Muspratt Building
University of Liverpool
L3 5DA

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

16 October 2018

Dear Professor Whittington

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**How do service users detained under the Mental Health Act use language to discuss safety and risk, as compared with service users with previous experience of detention: A discourse analysis.**
IRAS project ID:	**238140**
Protocol number:	**UoL001368**
REC reference:	**18/WA/0224**
Sponsor	**University of Liverpool**

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales?
You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

This is a single site study where the site has submitted a letter to the sponsored to indicate that the R&D office will confirm to you when the study can start following issue of HRA and HCRW Approval.

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed here.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

Page 1 of 7

APPENDIX G: INFORMATION SHEET AND CONSENT FORM

CONSENT TO CONTACT FOR RESEARCH PURPOSES

TITLE: How do service users detained under the Mental Health Act use language to discuss safety and risk, as compared with service users with experience of detention: A discourse analysis

SPONSOR: University of Liverpool

INVESTIGATORS: Professor Richard Whittington, Dr Beth Greenhill, Dr Claire Iverson and Claire Cartwright (Student researcher)

You are being invited to give consent for a member of this study team to contact you at some time in the future to invite you to participate in a research study.

Are you willing to learn more about the above project? (Circle one)

YES NO

If yes, you will be contacted at a later date. Please include your contact information below.

☐ Telephone: ______________________________

☐ Email: ______________________________

You authorise your health service provider to disclose your name and ward you're currently staying on to the research team for the purpose of being contacted to learn more about the research study.

This consent is effective immediately. Your consent to be contacted can be revoked by you at any time.

You will be provided with a Participant Information Sheet.

Patient's Signature: ______________________________

Date: ______________

Clinician's Name: ______________________________

Consent Form

UNIVERSITY OF LIVERPOOL

How do service users detained under the Mental Health Act use language to discuss safety and risk, as compared with service users with previous experience of detention: A discourse analysis.

Please Initial Box

1. I confirm that I have read and understand the information sheet (version number 4, dated 03/06/2020) for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason. ☐
3. I agree to take part in the above study. ☐
4. I agree to the interview being audio recorded. ☐
5. I agree to the use of anonymised quotes in publications. ☐
6. I am aware that the researcher will be required to inform my care team or GP if I disclose any previously unknown or immediate risks. I agree to provide the researcher with the contact details for a professional involved in my care prior to the interview. ☐

Age:

Which of the following best identifies your gender (please circle):

Male Female Non-Binary Other

Do you give consent for your data to be included in the final study (please circle):

Yes No

______________________ ______________ ______________

Name of Participant Date Signature

______________________ ______________ ______________

Name of Researcher Date Signature

APPENDIX H: POSTER ADVERTISING

Version 2- 27/05/2020

Research Recruitment
Perspectives of Risk and Safety

What the research is:

At present there is very little research on people's experience of being detained under the Mental Health Act and being perceived as a risk to themselves or others. This research aims to develop and understand of those first hand experiences

Who we're looking to recruit:

Participants will have experience of being detained to a mental health ward under the Mental Health Act, but will have been out of hospital for longer than 12 months. Participants may still be accessing mental health services or will be only in touch with their GP. Unfortunately, we are not able to recruit people who are currently subject to a community treatment order.

What's involved:

Participants will be required to have a 1:1 interview either over telephone or on Zoom or Skype.

All participants will receive a £10 Love2Shop voucher as reimbursement for their time.

If you are interested in participating please email:

cdowlin@liverpool.ac.uk

for further information

APPENDIX I: TOPIC GUIDE FOR INTERVIEWS

Proposed Interview Schedule

1. How do you think risk issues might contribute to people being detained under the Mental Health Act?

2. What is your understanding of how risk contributed to you being detained?

Prompts- Have you perceived yourself to be a risk to yourself- What is your experience of this?
Have others perceived you to be a risk to yourself- What is your experience of this?
Have you perceived yourself to be risk to or from others- What is your experience of this?
Have others perceived you to be a risk to or from others- What is your experience of this?

3. . Who did you talk to about your risks

4. . When you were on the ward who did you think was the most important person to talk to about your risks?.

5. How easy was it to talk to staff about your risks?- non-inpatient group

6. Why did you talk to staff about your risks?

7. What were your thoughts about talking about risk whilst you were detained?-

8. Do you think that staff saw your risks the same way you did?

9. Did you talk to anybody else about your risks aside from staff on the ward?-

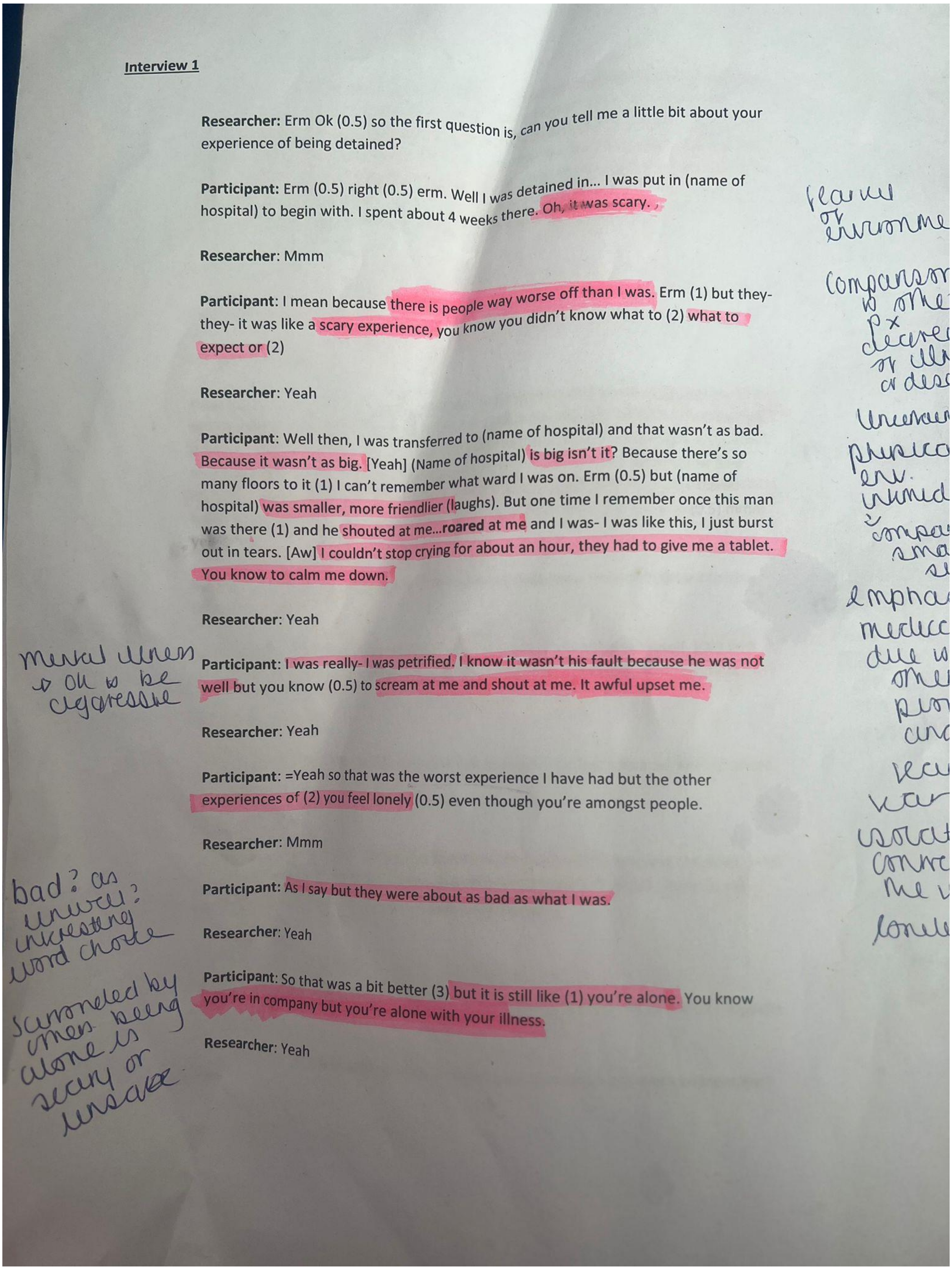
Prompts- Other service users? Family? Friends?

10. Were you involved in any risk assessments or plans? What was your experience of this?

11. What was your understanding of how to keep yourself and others safe from any risks?

12. Has anybody ever supported you to think about this? What was your experience of this?- How were you involved?

APPENDIX J: DISCOURSE DEVELOPMENT



Interview 1

Researcher: Erm Ok (0.5) so the first question is, can you tell me a little bit about your experience of being detained?

Participant: Erm (0.5) right (0.5) erm. Well I was detained in... I was put in (name of hospital) to begin with. I spent about 4 weeks there. Oh, it was scary. ,

Researcher: Mmm

Participant: I mean because there is people way worse off than I was. Erm (1) but they- they- it was like a scary experience, you know you didn't know what to (2) what to expect or (2)

Researcher: Yeah

Participant: Well then, I was transferred to (name of hospital) and that wasn't as bad. Because it wasn't as big. [Yeah] (Name of hospital) is big isn't it? Because there's so many floors to it (1) I can't remember what ward I was on. Erm (0.5) but (name of hospital) was smaller, more friendlier (laughs). But one time I remember once this man was there (1) and he shouted at me...**roared** at me and I was- I was like this, I just burst out in tears. [Aw] I couldn't stop crying for about an hour, they had to give me a tablet. You know to calm me down.

Researcher: Yeah

mental illness
→ ok to be
aggressive

Participant: I was really- I was petrified. I know it wasn't his fault because he was not well but you know (0.5) to scream at me and shout at me. It awful upset me.

Researcher: Yeah

Participant: =Yeah so that was the worst experience I have had but the other experiences of (2) you feel lonely (0.5) even though you're amongst people.

Researcher: Mmm

bad? as
unwell?
interesting
word choice

Participant: As I say but they were about as bad as what I was.

Researcher: Yeah

surrounded by
others being
alone is
scary or
unsafe

Participant: So that was a bit better (3) but it is still like (1) you're alone. You know you're in company but you're alone with your illness.

Researcher: Yeah

fearful
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APPENDIX K: REFLECTIVE STATEMENT

Appendix ** Reflective Statement

My interest in this topic area began when I was working as a bank nursing assistant on inpatient wards and acting as a carer for a family member with a diagnosis of Schizophrenia. I was always interested in the concept of 'risk' and how much service users were involved in decisions about risk whilst detained on inpatient wards. As a family member I was remember not feeling as though we could be involved in talking to an inpatient team about 'risk' as this was viewed as the role of the nursing staff. As an assistant psychologist I was fortunate enough to work within a service with a keen interest in embedding human rights in healthcare and was involved in a project which developed a human rights-based risk assessment for adult mental health service users. I worked with a clinical supervisor with a keen interest in human rights and continued this work with her when I became a trainee clinical psychologist.

I have always had a keen interest in the experiences of marginalised communities in accessing mental health services which I think guided my decision to explore the perspectives of people who had been detained as they have the most restrictions placed upon them by the mental health system. I am also interested in how social factors such as gender and social class inform people's experiences of mental health services.

During my time working on this project, I became a service user of secondary mental health services myself following perinatal mental health difficulties. This experience really changed my perception of 'risk' and 'safety'. As a service user I became acutely aware of the risk assessments which may be being completed about me and was anxious about these processes, wondering what they may mean for me. I completed half of my interviews with participants following this experience and I feel this informed my approach to the analysis and discussion. I am hopeful that I will be able to continue this work and hope that it will benefit from my own personal experiences.

APPENDIX L: DISCURSIVE CONSTRUCTIONS

Discursive Constructions

Discourses	Subdiscourses	Illustrative examples
Power	-power and control of 'risk decision makers' - deprivation of liberty - lack of autonomy and shared decision making - physically restrictive environments	"I've saw loads of assaults happen in there I'm not even messing **I've seen staff members hitting patients with a fucking pool cue** and I'm not even messing I've seen that shit happen"- P2 "The system is not as squeaky clean as it likes to fucking think"- P2 "The manager, the one in charge because he or she would know everything wouldn't they"- P1 "It'll be the people who have made the decisions doctors maybe erm or psychiatrists who deal with you"- P1 "I thought ohhh (2) I want to go out (0.5) you know. It is thingy on your freedom isn't it?"- P1