

Abstract

Background

It is increasingly acknowledged that service-user satisfaction and experience are fundamental to the achievement of high quality care delivery worldwide. Research in this area identifies a need, to capture the experience of care providers, to expand methodological approaches beyond the survey instrument, and to develop patient-centred approaches that include effective partnerships between professionals, patients and their carers or family members. Evidence highlights the coercive potential of admission in adult acute mental health, and the increased complexity associated with enhancing patient satisfaction and experience in these environments.

Objective

This study aimed to explore the experiences of staff, service-users, and carers with admission in two adult acute inpatient mental health wards.

Methods

A grounded theory (GT) approach was adopted such that theory was developed inductively through data collection and analysis.

Results

A total of twenty-two participants were interviewed, this included: 9 (40%) service-users, 10 (46%) members of staff and 3 (14%) carers. The substantive theory of admission produced was organised across three major categories, namely: *a person-centred beginning*; *building relationships along the way* and *barriers to the service* received. These interrelated factors determine the meaningfulness of the admission and have the power to hinder or facilitate improvement to a service-user's wellbeing and their evaluation of being admitted to an inpatient mental health ward.

Conclusion

The process of admission in an acute inpatient mental health environment can pre-determine satisfaction and experience with services. It is essential that person-centred ideals are maintained from the outset in order to maximise the quality of care received. This includes the implementation of strategies that facilitate involvement

approaches and nurturing positive relationships to improve communication, concordance, shared decision-making and participation with care delivery.

Key Points for Decision Makers

- A service-users experience during admission to an adult acute mental health ward can pre-determine satisfaction with services and inpatient care
- A person-centred approach, recognition of the role of emotion and positive patient / professional relations are key to a positive transition
- An effective person-centred philosophy must be embedded within the heart of an organisation; not exist at a superficial level

Introduction

It is increasingly acknowledged that service-user satisfaction levels are fundamental to the achievement of high quality care delivery worldwide [1, 2]. Research in this area posits the classification of *'patient experience'* as a pillar of quality in healthcare equal in stature to that of clinical effectiveness and patient safety [3-5]. A burgeoning global patient experience movement indicates positive advancement internationally with new ideas continually emerging [6]. Recent trends highlight an increasing global awareness of the need to address the experiences of care-providers to produce the best outcomes for patients; the progressive use of alternative methods to capture patient experience beyond the survey instrument; and an altered perception in the consideration of *'patient-centredness'* to include definitive actions towards developing partnerships with patients and their carers / family members [6, 2].

Despite international research [1, 2, 5-10] highlighting the need to establish *'patient experience'* as an indicator of high quality care a number of challenges are identified. Evidence highlights divergence in both the usage and understanding of the terms *'patient experience'* and *'patient satisfaction'* [11]. Studies report discrepancies between patients' negative perceptions of care quality and subsequent reported satisfaction scores [11-13]. Idvall (2002), for example, found that post-operative patients who scored highly in satisfaction measures had negative perceptions of care during a hospital stay. Participants retrospectively suggested their negative perceptions were associated with the level of pain they endured as an inpatient; despite feeling satisfied with their overall symptomatic reduction at the time of discharge [14]. This demonstrates that the concepts *'patient experience'* and *'patient satisfaction'* are closely related; however they are not necessarily positively correlated.

Patient satisfaction and quality care in UK mental health services

There are a number of distinct challenges associated with improving the satisfaction of patients in complex care settings such as mental health and learning disability services. Increasing fiscal pressures have resulted in a dramatic reduction in the number of inpatient beds within UK mental health services [15]. Reports highlight a 32% decrease in bed numbers between 1987 / 88 and 2009 / 2010 with a consistent subsequent annual decline [16]. In addition, crisis intervention is a current criterion for admission to an acute inpatient ward and during 2014 / 2015, of the 103,840 service-users admitted to mental health and learning disability wards, 19,656 were

detained under the *Mental Health Act (1983; amended 1995 and 2007)* [23, 24]. This is an 8.3% increase on figures recorded for the period 2013 / 2014 [17, 18, 10]. Together these factors have altered the severity of inpatient ward populations and increased the intensity of the ward environment with a consequential impact on staff and service-users [19].

Existing research identifies a relationship between low levels of patient satisfaction and the presence of coercion during admission to an acute psychiatric ward [20-22]. A study carried out by Iversen et al (2007) found that patients with a *formal legal status* (involuntary admission) and high levels of *perceived coercion*, who also experienced some form of *objective coercion* (use of physical force or restraint / involuntary administration of medication), displayed lower levels of satisfaction with services [21]. This may be unsurprising; nevertheless increased patient satisfaction scores were observed when coercive measures were perceived by patients to restore autonomy [21]. Research further highlights that service-users who are subjected to the *Mental Health Act (1983; amended 1995 and 2007)* [23, 24] may resist efforts to engage in therapeutic discussion and in some cases perceive coercive treatment as unnecessary [10, 25-27].

Evidence suggests that positive relationships are a primary indicator of a positive patient experience in mental health; this includes relationships with staff, other patients, and family and friends [28, 29]. Carers and family members, however, consistently report a lack of involvement with treatment decisions and a disregard for the value of their role in the management of patient care [30, 31]. Carers also encounter difficulties accessing information from mental health professionals who routinely identify the issue of patient confidentiality as validation for carer exclusion [31]. Research further suggests that patient satisfaction levels are positively influenced by the sincere and open communication of staff, and the validation of the patient's perspective by staff members [27, 32]. However, the *Adult Inpatient Survey (2015)* highlighted that 17% of mental health service-users didn't feel actively involved with shared decision-making (SDM) in comparison with 8% of service-users without mental health conditions [33].

Despite cumulative evidence of the need to address patient experience and satisfaction with admission in adult acute inpatient mental health [34], research in this area is predominantly medical-model centric with

considerable oversight to the psychosocial aspects of care delivery [35]. Indeed, Wood & Alsawy (2016), in their systematic review of qualitative evidence, identified just 11 studies carried out between 1995 and 2014 that focused on service-user experience of psychiatric inpatient care. In view of the evidence presented, this research aimed to explore staff, service-user and carer perspectives of admission and inpatient care in two adult acute wards. The authors expect that the enhanced understanding of stakeholder perceptions gained will facilitate the future improvement of existing processes and procedures. It is further anticipated that such improvements will positively impact patient experience and satisfaction, improve patient / carer staff relations and result in better long-term clinical outcomes.

Methods

A *Constructivist* Grounded Theory (GT) approach was selected for its ability to produce a substantive theory that is developed inductively through data collection and analysis [36].

Recruitment and participant selection

Purposive sampling was initially used to identify appropriate research participants. The criteria for participation included: current inpatients with recent (within one calendar month) experience of admission on one of two adult acute inpatient wards; carers or family members of current inpatients; care co-ordinators currently engaged with the service; and staff based on the two adult acute mental health wards. Service-users' who lacked capacity were excluded from the study. Verbal permission was sought in the first instance from the ward manager / nurse-on-duty to approach individual participants regarding research participation. Service-users were approached in person by the researcher and given a verbal explanation of the research and details of participation. Information sheets were given to those interested and a re-visit arranged to ascertain individual decisions. Carer's were identified and recruited in a similar way, whereas staff participants were recruited via morning meetings and through word-of-mouth. Care co-ordinators were identified via the community team and invited to participate by email. Service-users' capacity to consent to participate was determined on the day of the interview and ascertained via a series of direct questions. These included: confirmation of the service-user's ability to understand the aims and objectives of the study and details of participation; acknowledgement and

understanding of voluntary participation and the right to withdraw; understanding of associated disadvantages, risks or benefits; and consent to the use of a recording device.

Data collection and analysis

Following receipt of signed informed consent participants were invited to a single private face-to-face interview with the research assistant or project lead ($n = 22$). In order to minimise any potential stress caused to participants interviews were restricted to a maximum duration of 90 minutes, at which point a second interview would be arranged if required. For the purpose of ensuring consistency of data collection a semi-structured interview guide was developed for use during interviews¹. Interview data was audio recorded and transcribed verbatim by the research assistant and NVivo-10 was used to aid data analysis. The *Comparative Analysis* method was utilised during data collection and analysis to ensure an iterative process was adopted [36]. This process involved the initial line-by-line coding of individual transcripts. As data collection and analysis progressed, the process of coding evolved to incident-by-incident within and between transcripts. This led to focused coding which was used to generate conceptual categories and theoretical codes were used to specify possible relationships between those categories. Memos were used to explore the author's ideas about the categories and to delineate relationships between major and minor categories. As conceptual understanding advanced, theoretical sampling was used to identify further participants who could contribute to the emerging theory. This process culminated in the saturation of theoretical constructs and the production of the substantive theory presented within. Member checking and expert checking was used throughout to enhance rigour and ensure respondent and steering group member validation.

Compliance with Ethical Standards

This study was granted ethical approval by the National Research Ethics Service (NRES) Committee East Midlands, UK. As such, all procedures were conducted in accordance with the ethical standards laid out within the 1964 Declaration of Helsinki, and its later amendments. This study was funded by a bequest donation to a charitable fund within the host NHS trust for the conduct of research to enhance service-user experience. The authors declare that they were employed by the host NHS trust to conduct the study discussed in this manuscript. Two of the authors were employed externally on a temporary basis specifically to carry out the research study. The remaining author was the Chief Investigator who maintained a joint role within the NHS

¹ A sample interview guide is available in appendix 1

Trust and a neighboring University. The study was exploratory; hence preconceptions were not made and there were no conflictual benefits with regard to the study outcomes.

Results

Participant Demographics

A total of 22 participants took part in this study. The participant sample consisted of 9 (40%) service-users, 10 (46%) members of staff and 3 (14%) carers.

Service-users

Service-user participants included 5 (55%) men and 4 (45%) women ranging in age from twenty-three to sixty years. Seven (78%) had been formally admitted, while two (22%) were informal admissions. Six (67%) were first-time admissions, two (22%) had been admitted between 2-to-5 times, and one service-user participant had been admitted on multiple occasions over a 20-year period. Four (45%) service-user participants presented with a dual diagnosis as follows: 2 x bipolar affective / personality disorder, 1 x bipolar affective disorder / schizophrenia, 1 x schizophrenia with psychosis. One (11%) service-user participant was diagnosed with a drug induced psychotic disorder, 1 (11%) had a diagnosis of schizophrenia and 3 (33%) were diagnosed with bipolar affective disorder. Seven (78%) service-user participants had been living independently prior to admission while the remaining 2 (22%) were living with a Carer.

Staff members and Carers

Of the 10 staff members who participated 4 (40%) were male and 6 (60%) were female ranging in age from twenty-two to fifty-eight years. Staff participants occupied a variety of roles across a number of disciplines including psychiatry, nursing and occupational therapy. The Carer's sample included 1 (33%) man and 2 (67%) women between the ages of fifty-seven to seventy-five years. All Carer participants had been dealing with the service and ward admissions for many years. All three (100%) were long-term carers of family members with severe and enduring mental illness.

Theoretical Narrative

'A service-user's journey through acute inpatient admission', as illustrated in Figure I, has been organised across three major categories and associated subcategories that are presented in Table I. Service-users who are admitted to acute inpatient wards instantaneously become part of a larger process that through collaborative working focuses on their recovery and re-integration into society. Service-user reflections reveal that their early interactions on the ward are coloured by feelings of fear, paranoia, disinterest and mistrust. Service-users feelings about the rationale and circumstance of admission are re-evaluated over the duration of their admission and inpatient stay. A number of inter-related factors are highlighted by study participants for their contribution to a meaningful admission and overall improvement to patient wellbeing. These include: a person-centred approach; recognition of individual needs and the role of emotion during admission; and positive patient / professional relationships. Barriers exist that negatively impact the service received; however the extent of this impact is not explicitly acknowledged by patients due to illness severity at the time of admission.

Figure I: A figure to illustrate a service-user's journey through acute inpatient admission

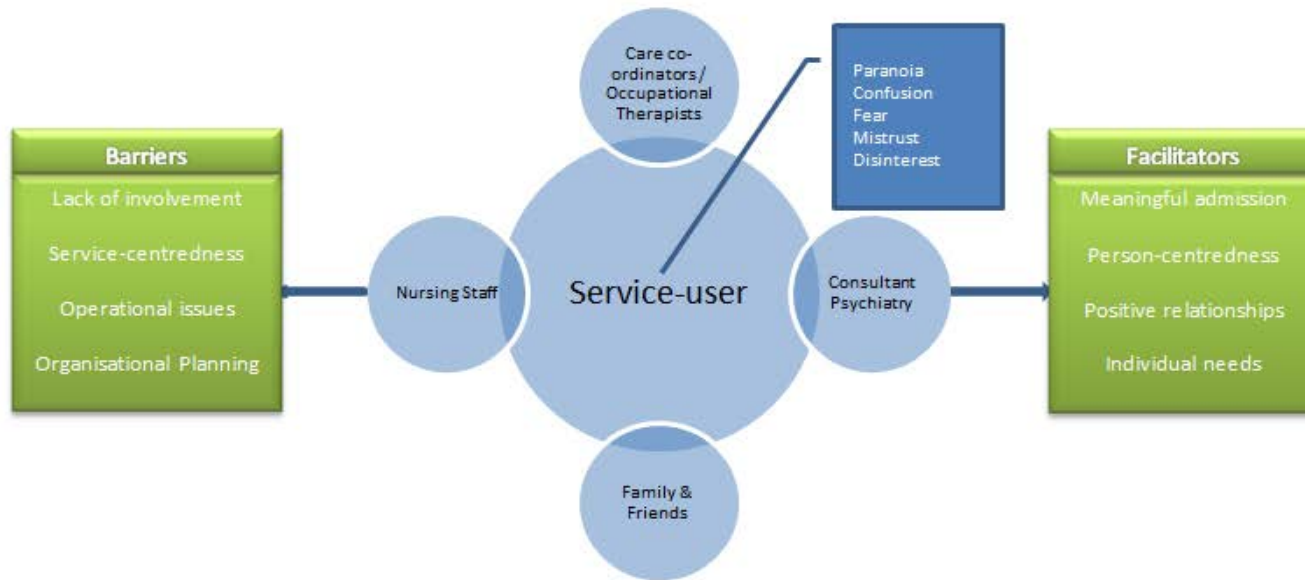


Table I: A table to illustrate the major categories and associated subcategories derived from interview data

No.	Category	Subcategory	Codes (general)
1	<i>A person-centred beginning</i>	<i>Admission: a process and a philosophy</i>	<ul style="list-style-type: none"> • The purpose of the admission interview and formulation meeting • Issues of power • Prioritising goals • Empowerment
		<i>The right of choice</i>	<ul style="list-style-type: none"> • Take ownership or leave it to the professionals • Advocacy services to help build trust
		<i>A positive transition</i>	<ul style="list-style-type: none"> • Medication Resistance • Reasons for non-compliance and exploring alternatives • Improvement to SU well-being as a result of taking medication
2	<i>Building relationships along the way</i>	<i>The essence of positive relationships</i>	<ul style="list-style-type: none"> • Collaborate and build rapport • Confidence, trust and mutual respect • Feeling safe and looked after • Personal interactions and making friends
		<i>The role of emotion</i>	<ul style="list-style-type: none"> • Paranoia causes self-isolation and mistrust • Anger as a path to isolation • Disinterest and demotivation affects information processing and person-to-person engagement
		<i>Nursing staff, consultant, and patient relations</i>	<ul style="list-style-type: none"> • The key-nurse as advocate • Nursing staff care and are easy to talk to • Consultants are more watchful and formal • Nursing staff are more readily available than consultants
3	<i>Barriers to the service received</i>	<i>Service-user and carer involvement</i>	<ul style="list-style-type: none"> • Service-users are expected to co-operate • Involvement with care planning doesn't happen • Service-users don't understand • Carer's feel undervalued and overlooked
		<i>Staffing, out-of-hours admissions, and bed management</i>	<ul style="list-style-type: none"> • The majority of admissions are out-of-hours • Staffing levels and bed management impact care quality and provision • Carer's and service-user's feel unsupported

A person-centred beginning

Admission: a process and a philosophy

The admission interview is predominantly a therapeutic undertaking that imbues a philosophy of relaxation and collaboration, providing service-users with the time and space needed to understand what is happening and explore their thoughts and feelings. This ensures that service-users '*understand that they have somebody there that understands their needs completely*'. The 72 hour formulation meeting provides a review of the assessment to-date and is used to get '*everyone on the same page*'. Initially the service-user is expected to '*wait outside while the professionals are meeting*', which potentially creates '*a power imbalance and a sense of formality*' despite being a collaborative undertaking. The importance of finding '*out what they want to achieve, rather than what we want to achieve*' was emphasised by one member of staff who talked about not always knowing '*what's best for the person, but if you dig deep enough, you can find out what they want*' which '*will give them the motivation to hopefully get better*'.

The right of choice

Some service-users decline the invite to attend the formulation meeting while others '*want to take ownership*' of their recovery and '*feel in control of what they are doing*'. One service-user recalled feeling surprised when her care co-ordinator showed up for her formulation meeting as she hadn't been made aware and resultantly felt ill-prepared '*my care co-ordinator and my support worker came onto the ward and I was like "what are you doing here".....that wasn't the best to be fair because I wasn't prepared*'. Service-users propose the use of advocacy services to provide a better opportunity to '*build up a level of trust*' with someone prior to participating in formal meetings.

A positive transition

When first admitted to the ward some service-users resist taking their medication as they believe it's either '*not working*', it needs to be re-evaluated or they'd like to explore available '*alternatives*'. In some cases a service-users condition may have worsened and therefore a re-assessment of the prescribed medication is required. However, others might be non-compliant due to dissatisfaction '*with the side-effects*' of their medication or because '*they don't want to be seen as somebody who has an illness that needs medication forever*'. The

importance of exploring the reasons for non-compliance is recognised and members of staff willingly consider available alternatives. Service-users recognise the improvement to their overall outlook and experience of the ward once their *'medication has kicked in.....the first three days were a blur, but by the end of the week I could see more clearly'*.

Building relationships along the way

The role of emotion

Service-users who are admitted to acute wards commonly experience confusion, paranoia, and mistrust. For example one service-user explained how she *'thought everyone was out to get me...so I just stayed in my room and it took a while to get through to me'*. Another discussed how paranoia caused her to withhold information in the belief that this would keep her safe *'I felt if I was to tell them what was going on they would probably have killed me straight away'*. Anger and aggression have a similar impact as expressed by one service-user who didn't *'think anyone wanted to approach'* her because she *'was very angry'*. Some service-users are fearful of being surrounded by psychotically ill people while others feel intimidated by noise on the ward. Feelings of disinterest and de-motivation are also common among service-users and can adversely affect both their ability to process information and willingness to engage with staff and other service-users.

The essence of positive relationships

A positive patient / professional relationship and in particular the need for *'building rapport with the client'* is considered one of the *'most important things'* a member of staff will do as part of their role in acute mental health. In order to ensure that a service-users *'journey is the best experience it can be'* this relationship must begin collaboratively and imbue a sense of confidence, trust and mutual respect. For example the importance of ensuring the service-user trusts that *'you're going to get them well and you're going to get them home and out of the hospital'* is highlighted. Service-users *'feel looked after'* and grateful for the care they receive and appreciate even the smallest gestures such as a member of staff *'saying hello even if they are busy'*. Some service-users regard staff members so highly that they consider them friends and would be reluctantly dishonest with them as *'this would be about lying to your friends really'*.

Nursing staff, consultant and patient relations

Nurses play a key role in a service-users journey through acute inpatient care and in particular it is the responsibility of the key-nurse to represent the service-user. Service-users value the caring nature of nursing staff and in the absence of their key-nurse are generally content with the fact that *'there is always someone else to speak to if needed'*. Relations between service-users and ward consultants are mostly positive albeit slightly more formal. Service-users feel listened to, respected and suggest that ward consultants *'don't play God like some do'*. They are *'a bit more watchful sometimes'* as they need to be more attuned to the types of behaviour expected of people with severe and enduring mental illness. Nursing staff are also easier to talk to because they are more regularly available *'and try and speak to you all the time'* whereas *'doctors obviously only see you once or twice a week'*.

Barriers to effective practice

Service-user and carer involvement

The importance of service-user / carer involvement is recognised; however some staff members conceptualise shared-decision making in terms of the level of co-operation that can be attained when engaging with service-users...*'a certain amount of empowerment would literally go to their head and it could cause problems on the ward'*. Furthermore, staff members suggest that service-users are fully involved in care planning, despite these being formulated at *'night-time when the service-user is asleep'*. Service-users themselves feel involved, albeit they *'don't really understand what's going on'* and feel that staff members merely seek information *'so they could make a plan'*. Carer's feel the value of their role is not acknowledged and at times their involvement with patient care *'is more of an afterthought'*. In addition, carers feel distressed when they do not receive sufficient information and suggest *'...all those things are important, but they are not spelled out'*.

Staffing, out-of-hours admissions, and bed management

The optimal time for ward staff to *'receive ward admissions and be organised enough'*, is between the hours of 10.30am to 5pm; however the majority of patients are admitted outside of these hours. Members of staff overwhelmingly feel that *'there is just not enough of us to do it effectively and then be able to spread yourself to other patients as well'*. In the past *'patients were used to longer admissions, longer spaces between reviews and*

now the pressure is very much on reducing the number of bed days'. Carer's feel that 'it goes pear shaped at the weekend when there's nobody to help'. This has a negative impact on service-user experience and satisfaction. Indeed one service-user discussed not being notified of the key-nurse for up to twelve days, while another discussed being admitted for a number of days before having 'the opportunity for significant one-to-one contact'.

Discussion

The aim of this study was to explore stakeholder perspectives of the process of admission in adult acute mental health. The results highlight that it is essential that a service-user's earliest interactions on a ward are person-centred. The findings suggest that service-users should experience a sense of collaboration with professionals and be allowed time and space to explore their thoughts and feelings about admission and identify goals for their immediate care. However, despite the best intentions of staff to ensure a person-centred approach is adopted the findings suggest that the service-centred nature of delivery can detract from this, resulting in service-users, carers and family members feeling actively excluded from this process. Research in this area suggests that the implementation of involvement is particularly challenging and potentially more complex than translating more general research practices [36]. In order to ensure that implementation is effective, a culture shift and the establishment of robust leadership strategies that facilitate involvement approaches is required [37].

The findings also revealed the significance of emotion during admission when considering person-centred approaches to care. The service-users in this study experienced an array of emotions that contributed to difficulties communicating and processing information, willingness to participate in meetings, and building relationships with staff and other service-users. Consistent with research in this area the study findings identify positive relationships as key to a positive patient experience and highlight confidence, trust and mutual respect as essential components. The findings further highlight that nurse / patient interactions are more positively received by service-users than consultant encounters. It is therefore suggested that nurturing nurse / patient relationships would facilitate positive working alliances, with the potential to improve communication, concordance and participation with care delivery. It is further suggested that each admission is treated as unique and pitched at a level appropriate to the service-user's emotional capacity at the time of admission.

The demands of service delivery had an observable impact on patient experience and satisfaction in the present study. In particular out-of-hours admissions decreased quality and prevented one-to-one contact for extended time periods. The findings collectively indicate that the current provision of care does not reflect person-centred ideals; rather it prioritises the routines and practices of the service [38]. Nevertheless, service-user participants in the present study were satisfied with the care received; highlighting a dissonance between patient experience and satisfaction consistent with existing research in this area [11, 12, 13, 39]. The limitations associated with the present study include the development of a context specific theory typical of grounded theory studies and the requirement of staff to consent to patient participation which may inadvertently lead to bias. More specifically it is possible that participants were selected due to their favourable view of the ward, its environment, and staff.

Conclusion

The process of being admitted to an acute inpatient mental health ward can pre-determine satisfaction and experience with services and inpatient care. The findings of this study suggest that it is essential that a person-centred approach is adopted from the outset in order to maximise the quality of care received. Despite recognition of person-centred ideals among staff members in this study, these were not translated to the practice setting. Rather, a superficial representation of a person-centred philosophy was evident within cultures and practices that are inherently service-centred. It is reasonable to conclude that the immediate implementation of strategies that facilitate involvement approaches is required, as well as the nurturing of positive relationships to improve communication, concordance and participation with care delivery.

References

1. Staniszewska, S., & Churchill, N. (2014). Patients' experiences in the UK: Future strategic directions. *Patient Experience Journal*, 1(1), 140–143.
2. Wolf, J. A. (2016). Patient experience: Driving outcomes at the heart of healthcare. *Patient Experience Journal*, 3(1), 1–4.
3. Department of Health. (2010). Transparency in outcomes – a framework for the NHS Government response to the consultation.
4. Doyle, C., Lennox, L., & Bell, D. (2013). A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. *BMJ Open*, 3(1), 1–18.
5. Institute of Medicine. (2001). Crossing the quality chasm: a new health system for the 21st century. *Iom*, (March), 1–8.
6. Wolf, J. A. (2015). A Report on the Beryl Institute Benchmarking Study State of Patient Experience 2015 : a Global Perspective on the Patient.
7. Department of Health. (2015). NHS Constitution for England. *The NHS Constitution Establishes the Principles and Values of the NHS in England*.
8. Francis R. (2013). *Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry*. London: Stationery Office.
9. NHS National Quality Board. (2011). NHS Patient Experience Framework. *Department of Health*.
10. NICE. (2011). Service user experience in adult mental health services (QS14).
11. Grøndahl, V. A., Wilde-Larsson, B., Karlsson, I., & Hall-Lord, M. L. (2012). Patients' experiences of care quality and satisfaction during hospital stay: a qualitative study. *European Journal for Person Centered Healthcare*, 1(1), 185–192.
12. Jenkinson, C., Coulter, A., Bruster, S., Richards, N., & Chandola, T. (2002). Patients' experiences and satisfaction with health care: results of a questionnaire study of specific aspects of care. *Qual Saf Health Care*, 11(4), 335–339.
13. Kroenke, K., Stump, T., Clark, D.O., Callahan, C.M. & McDonald, C.J. (1999). Symptoms in hospitalized patients: outcome and satisfaction with care. *American Journal of Medicine*, 107, 425-431.
14. Idvall, E. (2002). Post-operative patients in severe pain but satisfied with pain relief. *Journal of Clinical Nursing*, 11, 841-852.
15. The Commission on Acute Adult Psychiatric Care (2015). *Improving acute inpatient psychiatric care*

- for adults in England. Interim report.* London: The Commission on Acute Adult Psychiatric Care.
16. The Kings Fund. (2015). Mental health under pressure, 30. Retrieved from http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/mental-health-under-pressure-nov15.pdf
 17. Health and Social Care Information Centre. (2015a). Inpatients formally detained in hospitals under the Mental Health Act 1983 , and patients subject to supervised community treatment , Annual figures , October 2012, (October), 1–35.
 18. Health and Social Care Information Centre. (2015b). Mental Health Bulletin. *Community Care*, (March), 2003–2008.
 19. Champion, J. & Fitch, C. (2012) *Guidance for the commissioning of public mental health services*. Joint Commissioning Panel for Mental Health, 1-58. www.jcprmh.info/resource/guidance-for-commissioning-public-mental-health-services/
 20. Bindman, J., Reid, Y., Szmukler, G., Tiller, J., Thornicroft, G., & Leese, M. (2005). Perceived coercion at admission to psychiatric hospital and engagement with follow-up. A cohort study. *Social Psychiatry and Psychiatric Epidemiology*, 40(2), 160–166.
 21. Iversen, K. I., Høyer, G., & Sexton, H. C. (2007). Coercion and patient satisfaction on psychiatric acute wards. *International Journal of Law and Psychiatry*, 30(6), 504–11.
 22. Kjellin, L., & Wallsten, T. (2010). Accumulated coercion and short-term outcome of inpatient psychiatric care. *BMC Psychiatry*, 10(1), 53.
 23. Hamilton, J. R. (1983). Mental Health Act 1983. *British Medical Journal (Clinical Research Ed.)*, 286(6379), 1720–1725.
 24. Department of Health. (2007). Mental Health Act 2007, 1–173.
 25. Gilbert, H., Rose, D., & Slade, M. (2008). The importance of relationships in mental health care: A qualitative study of service users' experiences of psychiatric hospital admission in the UK. *BMC Health Services Research*, 8(1), 92.
 26. Lidz, C. W., Mulvey, E. P., Hoge, S. K., Kirsch, B. L., Monahan, J., Eisenberg, M., ... Roth, L. H. (1998). Factual sources of psychiatric patients' perceptions of Coercion in the hospital admission process. *American Journal of Psychiatry*, 155(9), 1254–1260.
 27. Lorem, G. F., Hem, M. H., & Molewijk, B. (2015). Good coercion: Patients' moral evaluation of coercion in mental health care. *International Journal of Mental Health Nursing*, 24(3), 231–240.

28. The Independent Commission on Acute Adult Psychiatric Care. (2016). Old Problems, New Solutions: Improving Acute Psychiatric Care for Adults in England, 1–136.
29. Wood, L., & Alsawy, S. (2016). Patient experiences of psychiatric inpatient care: a systematic review of qualitative evidence. *Journal of Psychiatric Intensive Care*, 12(1), 35–43.
30. Rapaport, J., Bellringer, S., Pinfold, V., & Huxley, P. (2006). Carers and confidentiality in mental health care: considering the role of the carer's assessment: a study of service users', carers' and practitioners' views. *Health & Social Care in the Community*, 14(4), 357–65.
31. Wilson, L. S., Pillay, D., Kelly, B. D., & Casey, P. (2015). Mental health professionals and information sharing: carer perspectives. *Irish Journal of Medical Science*, 184(4), 781–790.
32. Sheehan, K. A., & Burns, T. (2011). Perceived Coercion and the Therapeutic Relationship: A Neglected Association? *Psychiatric Services*, 62(5), 471–476.
33. Care Quality Commission. (2016b). NHS Patient Survey Programme 2015 adult inpatient survey Statistical release.
34. Care Quality Commission. (2016a). Better care in my hands.
35. Baguley, I., Alexander, J., Middleton, H., & Hope, R. (2007). New ways of working in acute inpatient care: a case for change. *The Journal of Mental Health Training, Education and Practice*, 2(2), 43–52.
36. Charmaz, K. (2006). *Constructing Grounded Theory: a practical guide through qualitative analysis*. London: Sage.
37. Eassom, E., Giacco, D., Dirik, A., & Priebe, S. (2014). Implementing family involvement in the treatment of patients with psychosis: a systematic review of facilitating and hindering factors. *BMJ Open*, 4(10).
38. Draper, J., & Tetley, J. (2013). The importance of person-centred approaches to nursing care. *The Open University*, accessed @ <http://www.open.edu/openlearn/body-mind/health/nursing/the-importance-person-centred-approaches-nursing-care>
39. Otani, K., Waterman, B., Faulkner, K.M., Boslaugh, S. & Dunagan, W.C. (2010). How patient reaction to hospital care attributes affect the evaluation of overall quality of care, willingness to recommend, and willingness to return. *Journal of Healthcare Management*, 55, 25-27.