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SECTIONED UNDER THE MENTAL HEALTH ACT

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SECTIONED UNDER THE MENTAL HEALTH ACT

by Kate Ross

A thesis submitted to the University of Plymouth
in partial fulfilment for the degree of

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Abstract

This project looks at the experience of being sectioned under the 1983 Mental Health Act for acute psychiatric patients. The view is taken that sectioning in itself is a major intervention and hence should be the subject of research scrutiny. The views of two groups of participants, sectioned and informal inpatients, are compared using a variety of survey techniques including standardised questionnaires, structured interviews and open ended questions.

It was found that being sectioned did not have a major impact on patients' experience of hospital treatment or their understandings of mental health issues although the sectioned patients did place less value on the medical aspects of their care and some sectioned patients showed a degree of internality for their health care that was not present in the informal group. Locus of control and transactional analysis were both found to be useful theoretical perspectives from which to examine patients' experiences.

In general, the psychiatric patients who participated in the project valued the human contacts they made in hospital far more than their medical treatment. They also tended to attribute the cause of their psychiatric difficulties to non-medically based models of mental health based on childhood experiences, life events, human relationships and stress.

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This thesis is dedicated to Robbie whose gestation and early weeks were dominated by its production.

Author's Declaration

At no time during the registration for the degree of Doctor of Clinical Psychology has the author been registered for any other University award.

The contents of this bound volume are identical to the volume submitted for the examination in temporary binding except for the amendments requested at the examination.

This study was conducted whilst the author was a Trainee Clinical Psychologist in the South West Region based in Frenchay Healthcare Trust, Bristol.

Signed: Kate Ross
Date: 28th May 1995

Introduction

Under the 1983 Mental Health Act, inhabitants of the British Isles may be detained in psychiatric hospitals involuntarily if it is in the interests of their health or safety or the safety of others to do so. This thesis aims to examine the experience of being sectioned under this act. The introduction will detail the legal context of this experience and what the role and rights of the patient are. A discussion will be made of how current psychological theory can be used to throw light on this experience. Finally, an assessment will be made of the research that has been carried out in this field to date and the methodologies that are suggested.

The Law

The Mental Health Act covers a broad spectrum of situations including the detention and treatment of people who have been tried and convicted under criminal law. However, for the majority of patients, no crime has been committed. This thesis will be concerned solely with patients who have been detained because of their mental state. If these people were not judged to have psychiatric illness, there would be no other reason to detain them.

There are two sections of the act which are of primary relevance to acute psychiatric patients. Section 2 allows someone to be detained for twenty-eight days and is primarily designed to allow for assessment. Section 3 allows someone to be detained for six months during which time they must be offered some form of treatment.

These sections can be brought into force if the patient falls into one of four categories: severely mentally impaired, mentally impaired, having psychopathic disorder or being mentally ill. In the first three cases, the

condition must be associated with "abnormally aggressive or seriously irresponsible behaviour" and there must be reason to suppose that hospitalisation will produce some improvement in the condition. The most widely used category under which people are sectioned is mental illness. This is the only category which is not formally defined in law but is based upon the clinical judgement of a consultant psychiatrist.

If a person is sectioned on the basis of mental illness, this must be because it is judged to be in the interests of their health or safety or the safety of others. The act has been widely interpreted as being appropriate when the patient is perceived as a risk to themselves or others. However, the Mental Health Act Code of Practice (HMSO, 1993) emphasises that someone may be detained solely in the interests of their health and that this includes their mental health. Although factors to be considered are offered, it is not clear how it is to be determined what level of ill health must pertain. This seems one of the most vague parts of the act since, in general, people are free to choose to behave in ways which are risky or detrimental to their physical health and, presumably, this also applies to their mental health up to a point.

A section can be instigated by an Approved Social Worker or the person's nearest relative. The nearest relative can also over-ride the social worker and prevent an application for section unless they are formally "displaced" by a legal proceeding. The Mental Health Act Code of Practice (HMSO, 1993) stresses that it is generally preferable for an Approved Social Worker to make the application.

The Approved Social Worker has overall responsibility for the process of assessment and making an application for section. This must be supported by the assessment of two doctors; an approved doctor (the consultant

psychiatrist) and a doctor who knows the patient well (the GP). It is the role of the doctor to decide whether a person is suffering from a mental disorder and how serious it is.

While they are under section, the patient is obliged to remain in hospital unless granted leave by their consultant. The section need not necessarily run its full time course but should only remain in force as long as this is warranted by the mental health of the patient. A section may be terminated before term if the patient makes a successful application to a Mental Health Tribunal to have the section quashed.

During the first three months of their detention under section, the patient is obliged to accept whatever medication is prescribed for them. They may also be given ECT against their will if a second independent doctor agrees that this is necessary. After this time, treatment may still continue without the patient's consent if a second independent doctor agrees that it is necessary.

The Patient's Rights

The World Health Organisation's declaration on the rights of patients states that:

"Everyone has the right to respect of person as a human being, self-determination, physical and mental integrity, security of person, respect for privacy, respect for moral, cultural, religious or philosophical values." (Carmi, 1991)

Whilst it may be expected that the Health Service as a whole aims to act within these parameters, it is clear that the Mental Health Act allows the over-riding of the patient's rights to self-determination where the establishment deems the patient's judgement to be sufficiently flawed to warrant this. This is backed up, in law, by the doctor's right to

administer non-volitional treatment irrespective of the patient's specific and general beliefs and attitude to medicine and mental health. This is likely to force at least a proportion of patients to conform to treatment regimes which do not reflect their personal goals, particularly since Babiker and Thorne (1993) found that there are often significant discrepancies in the treatment goals of psychiatric patients and their carers.

However, the Mental Health Act also spells out a number of rights that must be afforded to the patient. Many of the rights that are afforded to patients under section relate to information that they must be given. There are also guidelines to ensure that the information is given in a way and at a time that allows the patient to understand it. The sectioned patient must be told about the role and decision of the Approved Social Worker and about the nature of their section. The written information that is given to sectioned patients is shown in Appendix 1. The patient must be given information about their diagnosis and treatment and likely prognosis, side effects, alternatives etc. They must be told that they have the right to withdraw their consent to treatment at any time. The patient must also be told about their right to appeal against their section and the procedure for doing this.

In addition, the sectioned patient has the right to attend their appeal in person if they wish to do so and to have legal assistance at appeal. They may be entitled to legal aid to help with the cost of this. The Mental Health Act Code of Practice also suggests that the sectioned patient should receive respect and consideration for their cultural, ethnic or religious beliefs, that the use of control and segregation should be the minimum necessary for their effective care and treatment, and that the treatment package offered should promote the self-determination and personal

responsibility of the patient.

The rights of informal patients in psychiatric hospitals who make up the majority of admissions are much less clear as the term suggests. This is an interesting legal arrangement since British law treats the informal psychiatric patient as any other health service user and presumes that they are competent to make judgements about the information and treatment that is offered to them without any formal safeguards to ensure this. However, it has been recognised that this need not necessarily be the case. For instance, Ford (1980) states that:

"It seems evident as a clinical matter, that whether a patient comes into hospital voluntarily or involuntarily does not dispose of the quite separate issue of his competence to refuse medication. Some voluntary patients are so needy and so accepting of the doctor's authority that they will consent to any medication at any dosage level and perhaps even to psychosurgery."

In some other countries, even voluntary patients have a formal legal status that affords them certain rights. For example, the admission of a psychiatric patient in the Netherlands (Legemaate, 1991) is considered to be a legal contract between the patient and hospital which confers a number of contractual obligations on the hospital. In Britain, it is necessary for some irreversible procedures to have the second opinion of an independent doctor whether or not the patient consents. However, this only pertains to very rare instances. In general, it seems quite possible that the informal patient may be less well protected and informed than the sectioned patient, particularly if they lack the capacity to assimilate and judge information.

The only right formally ascribed to informal patients under the Mental Health Act seems to be the assertion that "all patients should be given as

much information as possible about their care and treatment" and that informal patients should be told that they have the right to leave hospital. Informal patients naturally retain the common law right to refuse treatment although it is not specified that they have to be informed of this and no written information is given to informal patients. Although any health service user has the right to complain about their care, there seems to be no easy access route for appeal for informal patients, e.g. against involuntary discharge. Under Dutch law, this would be considered a breach of contract except under certain specified conditions.

The Psychological Context

In practice, people who are willing to enter hospital on a voluntary basis are not sectioned. Therefore, a commonality amongst sectioned patients is that they have been obliged to enter and remain in hospital without having chosen to do so. The effect of being sectioned is thus to site the locus of control of the patient's mental health firmly outside the patient. It, therefore, seems pertinent to examine the effect of being sectioned from this theoretical perspective.

As well as locus of control, behavioural theories of motivation, particularly that of "learned helplessness" seem to be relevant to understanding what effect one might anticipate a section to have.

Finally, I wanted to consider how a psychodynamic perspective might account for the roles played in sectioning someone. I have chosen the theory of 'Transactional Analysis' as a vehicle for this because of the clear labelling of messages as coming from parent, adult or child.

Out of the three, learned helplessness is the concept that is currently most widely used within the field of clinical psychology since it was

initially developed in its application to people to provide an explanation of the development and course of depression. Miller and Morley (1986) describe Seligman's theory as 'the expectation that behaviour and reinforcement are unconnected'. This is most evident in the passivity of depressed people who seem unable to motivate themselves to do anything about their unhappiness and sometimes even neglect to do things whose absence is likely to be aversive such as eating or washing. The theory was developed from the observation that if animals are subjected to aversive stimuli which they cannot control, they become passive even in situations which they could influence, i.e. they have learned that they are helpless. This observation has been found to generalise to people, e.g. Donovan (1981) found that mothers of infants who were subjected to inescapable crying were subsequently less proficient at solving a solvable task to terminate crying and were less attentive to the environmental predictors of crying.

How is this likely to apply to sectioned psychiatric patients? The application of the Mental Health Act is that patients are only sectioned if they are not willing to enter hospital on a voluntary basis or, having entered, attempt to leave. The experience of being detained is hence outside the patients volition and control. In addition, their opportunities to chose their method of treatment and daily activities are also likely to be restricted. To what extent can these circumstances be seen as independent of the patient's behaviour and hence likely to lead to learned helplessness. There is, of course, an obligation on the part of those seeking the section to demonstrate that the section is directly related to the patient's behaviour. If they were not disturbed and at risk, the section would not be implemented. However, the fact that the patient has not chosen to go into hospital might indicate that they do not share this assessment. Hence from their perspective, they may indeed feel

powerless either to convince others of their mental good health or to insist upon a treatment regime that is in keeping with their beliefs about health and medicine.

If being sectioned does lead to learned helplessness then it carries risks for the person's future ability to act upon their situation. It may also increase their morbidity for anxiety and depression. It is easy to imagine how a vicious circle could develop where the more frequently a person is brought into hospital, the less able they are to solve everyday problems and the more prone they are to depression making it more likely that they will be perceived to be at risk.

However, it is not reported in the literature that people who have been sectioned subsequently turn up at their GPs complaining of depression. This is perhaps because certain cognitive attributions surrounding the uncontrolled event are thought to be necessary for depression to follow (Miller and Morley, 1986). That is that negative aspects of the event are internal, stable and global; that is the fault of some enduring characteristic of the patient that is likely to have a negative impact on multiple situations. Depending on whether the patient sees their behaviour as a transient aberration or an enduring part of their personality, their attributions may or may not be global and stable. Learned helplessness theory would also suggest that the patient is likely to feel more helpless if they think of the section as their fault, e.g. the result of stupid behaviour, rather than an external fault, e.g. the result of an unfair system. This is a surprising assertion in the light of the information about locus of control that is to follow. Nevertheless, one can imagine that the patient may hold either of these or any number of other beliefs.

The failing of Learned Helplessness theory in this context is that it seems

to deal exclusively with the consequences of being subjected to aversive unavoidable events. It is not necessarily the case that being taken into hospital, being restricted in being allowed out or having to comply with treatment is aversive. The predominant feature is uncontrollability. The theory seems to have little to say about events that may not be aversive and may not be attributed to an internal characteristic but are nevertheless prosecuted upon a person.

Locus of Control is a concept devised by Rotter (1966) and developed from social learning theory. It aims to measure to what extent an individual believes they can control or influence their surroundings and the content of their lives. The hypothesis is that the extent to which people believe they can have an effect on events will be directly reflected in the way they approach and behave in situations. This also applies to social behaviour and the forming of relationships.

Measures of locus of control give an index of a person's internality or externality, that is the degree to which they believe that they themselves have control of events or that events are controlled by external sources. Numerous studies have shown that a high degree of internality is associated with a wide variety of positive personal characteristics and coping mechanisms. In a paper by Smith and Tedeschi (1973), studies are cited that demonstrate an association between internality and self-esteem, trust of others and trust of self. Robert, Zacharchemny and Cohen (1992) also found internality to be associated with self-esteem as well as positive attitudes to authority and adaptive problem solving. Conversely, externality was associated with low persistence and achievement and also with risk-taking and anti-social behaviour. The association between locus of control and achievement has long been of interest in industry and there are many studies from this field confirming the relationship (e.g. Duke and

Nowicki, 1973; Hersch and Schiebe, 1967). Anderson (1977) also reports greater business activity, more task-centred coping strategies and less perceived stress in business people facing financial difficulties who have high internality.

There is also evidence linking locus of control to a number of characteristics pertinent to mental health. Scott and Severance (1975) found internality to be associated with sociability, well-being, responsibility, self-control and tolerance. Externality was associated with hypochondriasis, depression, anxiety, obsessionality and schizophrenic symptoms. This is an interesting report since depression and anxiety were found to be significantly more likely the more the person attributed events as being outside their influence. Lester (1992) also found a significant association between externality and depression and Lester and Sidrow (1988) found suicidal preoccupation to be associated with lower internality. This is contrary to the understanding of the development of depression described earlier by the learned helplessness theory.

So far, it has been described how a person's locus of control is likely to impact on their perception and understanding of events. This is relevant to psychiatric patients because people who attribute responsibility for events to themselves assume they can cause changes in their environment. Virtually all theories of mental health acknowledge that, whatever the root cause of the problem, there is a significant interaction with environmental stress. It would therefore be desirable for patients to be able to examine their lifestyles with a view to identifying sources of stress and to feel able to initiate changes to minimise these stresses. The belief that one can influence the environment to make it more desirable would be indicated by a high internality score. Hence, it makes sense for mental health care systems and interventions to aim to enhance internality.

Importantly, locus of control is thought to be changeable. Anderson (1977) found that people with high internality who experienced success became more internal whilst people with high externality who experienced failure became more external. It has also been found (Robert et al, 1992) that it is possible to increase internality in adolescent inpatients by intervening to increase contingency awareness. The increases were subsequently found to be associated with better outcomes.

Given that locus of control is changeable, how is it likely to be affected by the action of sectioning? This may well depend on whether the section is perceived as a success or failure on the part of the patient. Given that a section carries the clear message that a person is not considered to be an adequate judge of their needs, it is probably more likely to be seen as a failure and thus can be expected to increase externality at least in those who had an external perspective to start with.

The section also very clearly sites the locus of control for the person's mental health care outside the person. The question is whether the accurate perception of not being in control of this area generalises to other situations. Wallston, Wallston, Kaplan and Maides (1976) suggest that experiences encountered in a specific situation are likely to lead to specific rather than generalised expectancies so a shift in locus of control is more likely to be seen in the person's attitude to health rather than to life in general. Nevertheless, it is to be taken seriously if a potential side-effect of sectioning, which is designed to protect a person, is to make them less capable of catering to their own health needs in the future.

The alternative argument to be offered in defense of sectioning is that the section may in itself prevent the person having repeated negative

experiences and failures to adequately manage problems. This combined with the enforced demonstration that there is another way of dealing with the situation may act to prevent the person feeling increasingly out of control and so be supportive of internality.

Since outcome locus of control is a function of the interaction between initial locus of control and subsequent events, it is likely that sectioning may have both the effects described above in different individuals. This would be likely to present as a broader distribution of locus of control scores in sectioned patients and might also be reflected in the distribution tending to be more bi-modal than normal.

It seems that outcome locus of control is an important factor to consider in planning mental health care since it will contribute to future well-being.

The final perspective to be considered in this chapter is that of Transactional Analysis. This is an integrated theory of personal development and interpersonal relations based upon writings by Eric Berne (1964). In essence, it is postulated that each of us has a script by which we lead our lives. In this script are beliefs about what we can expect from other people, what sort of person we are and what our future holds. The script was written during childhood as a result of observing the behaviour and coping strategies of important others and finding solutions to problems that were encountered at the time (Stewart and Joines, 1987).

Alongside the notion of script is that of ego states; parent, adult and child. The adult ego state is the thinker and reacts to the here-and-now without reverting to script. The adult may use aspects of the parent or child in order to respond to situations, i.e. it is appropriate to use

parental influences to care for someone who is ill and to use the childlike quality of our natures to enjoy ourselves. However, if the person responds from a purely parental or child ego state then they have been hooked into a past pattern of behaviour and are likely to be discounting some aspect of the current situation. These ego states can be seen to relate quite closely to the concept of id, ego and superego although therapy is generally more humanistic in nature, emphasising a change in current behaviours and attitudes rather than focusing exclusively on the past.

When a person is caught up in thinking or behaving in a way that reflects the past more than the present, they may unconsciously seek out evidence or set up the situation to confirm the belief they have. E.g. People who have been abused may enter abusive relationships and repeat patterns of being a victim etc. Berne theorised that each person's script has a final destination which is worked towards by repetition of experiences and confirmation of beliefs. For instance, a possible script destination might be "I will go mad". Feeling out of control, having unusual experiences and being a psychiatric patient might all serve to confirm this belief.

One way in which this situation can be prevented from occurring is if the other person in the transaction resists the invitation to enter their script and instead responds from their adult (Petruska Clarkson, 1992). This might well form part of the therapeutic relationship within this discipline. It is possible that therapy will involve the therapist using their parent ego state, e.g. if the client has had some poor parenting experiences and the therapist wishes them to internalise more healthy parental messages then these messages may well be modelled within the therapy room. However, for the therapist to address the current needs of the client, the intervention must take place with the adult firmly in the executive.

When a patient is sectioned, the message that is being conveyed is fairly clearly parental. The person is being told that their judgement is impaired and that they are going to be cared for "for their own good". This does not necessarily mean that the message is an unhealthy one. Psychosis is generally thought of in terms of lack of energy in the adult ego state. I.e. the person is not dealing with their situation with appropriate here and now problem solving. This leaves them very vulnerable since they may not have the resources to debunk persecutory parental messages or to ensure that a childlike desire for excitement and risk is safely controlled. It is sometimes appropriate for others to assume a caring role on behalf of others.

However, the fact that a person is thought to be psychiatrically ill and not responding to their situation in a here-and-now way has additional implications. To approach these people from a parent ego state is an invite for them to respond from child either with dependency or rebellion. This carries risk for two reasons. If they themselves are discounting their ability to solve problems for themselves by reacting in a maladaptive scripty way, then official confirmation that their adult thinking is no good is likely to further that discount. Also, the encouragement to rely on others may encourage a symbiotic or dependent relationship where the person is never truly independent. Parts of the Mental Health Act which invest the nearest relative with considerable powers both to apply for or prevent a section or guardianship seem to be particularly likely to foster dependency. This may well be especially unhelpful where the source of a person's difficulties has been associated with a failure to achieve an independent adult status within their family.

The adult alternative would be to expect them to take responsibility for their actions and offer them support to do so. The risk is that this might

be quite a dangerous step for people who have very little energy in their adult ego state or whose parental messages are destructive. However, where inpatient treatment is seen to be necessary, some consideration would have to be given to the nature of the therapeutic contract to ensure that the person is not simply enabled to take a further step down the road of a "go mad" script.

In the long term, this sort of process might be reflected in the repetition of patterns of behaviour and types of relationship over the years in different situations and with different people. It might be more difficult to measure at any one time. However, a "here and now" or "adult" approach to a situation would involve an assessment of the circumstances and available information according to the person's own priorities and perspective. This would result in an understanding of the situation that was, in some ways, unique and specific to them. A global acceptance or rejection of an offered explanation suggests the person has a low personal capacity for assessing and taking responsibility for the situation. This is suggestive of a "child" response to a perceived parental figure which is either embraced or rebelled against. Both types of response demonstrate a degree of dependency. This would be reflected in the total rejection or acceptance of the model of care being offered and would show up as extreme scores on measures of satisfaction and greater convergence or divergence on understandings of mental health.

None of the three perspectives outlined above comes down firmly on one side of saying that sectioning has a globally good or bad effect on the psychological health of the patient. However, all raise concerns about the potential long-term effects of such a loss of volition. Not surprisingly, the dangers of leaving someone unsupported in a time of crisis are also apparent from all three perspectives. The conclusion that I think can be

drawn from the psychological literature is that sectioning in itself must be considered as an intervention irrespective of what care is then offered to the person. This makes it the proper subject of research looking at outcome and side-effects. It also suggests that, like many treatments, it carries risks in itself that should be weighed when implementation is considered.

Research Background

Given that the Mental Health Act Code of Practice (HMSO, 1993) specifically enjoins the psychiatrist to consider "the impact that compulsory admission would have on the patient's life after discharge", there is surprisingly little available in the literature on this subject. None of the currently available literature addresses the issue of sectioning from within the context of psychological theories of motivation and behaviour described above. Most of the recent studies seem to be born of the trend to regard health service users as customers whose views should be used to shape the service. Nevertheless, despite a rather atheoretical approach, some useful information is provided about the priorities and beliefs of psychiatric patients.

One study that has specifically compared the views of sectioned and informal patients is that of McIntyre, Farrel and David (1989). Patients were asked to rate how helpful they found fifteen aspects of their hospital care. Overall, those aspects that the patients rated most helpful were (in descending order): being free to come and go as they pleased, having visitors, talking to the doctor, talking to the nurse, medication. Obviously not being confined to the hospital and having personal interactions with family and friends as well as health professionals is seen as more important to recovery than formal treatment. This may be of particular pertinence to the sectioned patients who are unlikely to feel

free to come and go. When specifically comparing the sectioned and informal patients, the sectioned patients were found to judge all aspects of their hospital treatment less favourably, particularly the helpfulness of staff and other patients, the value of hospital as an asylum and group meetings on the ward. One might, therefore, expect to find lower ratings of satisfaction amongst sectioned patients and a different pattern of assessment of which factors of hospitalisation are most important to them.

The only other work that has come to light which specifically looks at the experience of sectioned patients is the MSc thesis of Hesford (1992). She interviewed nine people about their experience of being sectioned under the Mental Health Act. She found that there was a great deal of uncertainty and confusion about the process of admission and the rights of patients although each participant had been sectioned at least four times. It would appear that, despite the best intentions of the Act to ensure that patients are fully informed, this information is not easily assimilated by patients. She also found that although two thirds of the interviewees agreed that they had been mentally ill at the time of admission, there was a great deal of reluctance to take the medication that was prescribed. Feelings that were associated with being sectioned were unworthiness, vulnerability, humiliation, fear, anger, hatred, fatalism, negativism and lack of control. One would anticipate that many of these feelings would be associated with lack of self-confidence for patients.

These two papers do suggest that sectioning someone should be seen as an intervention that potentially carries some risks since the outcome for some patients seems to be that they find their experience of hospital less beneficial than informal patients and that admission becomes associated with a number of negative feelings including a sense of personal powerlessness. The importance of the last point is backed up by Davidson

and Strauss (1992) who found that the development of a sense of self was a critical component in the process of recovery from severe mental illness. They define self as a combination of self-efficacy, internal locus of control and self-esteem and suggest that recovery is facilitated where the patient plays an active role in their own improvement. This understanding would be consistent with transactional analytic theory if a sense of self is interpreted as the confidence to act independently from the adult ego state rather than relying on parental messages or past patterns of behaviour. It also clearly reinforces the importance of locus of control in psychiatric health although this is not found to be sufficient of itself. The authors acknowledge the conflict in desiring to hand over control and responsibility to the patient without exposing them to undue risk but also raise the possibility that the process of risk-taking can in itself be a part of self-assessment: people learn from their mistakes.

It seems likely that staff in mental health services might find it very difficult to readjust their expectations of patient and staff roles to such a degree. In a study of the views of psychiatric patients, Myers, Leany, Shoeb and Ryder (1990) excluded statements about the benefits and adverse effects of drug treatments because "technical topics ... require clinical trials for valid inferences" and thus "the patient does not have an adequate basis for testimony".

There have been a number of studies that have looked at what psychiatric patients in general consider to be important. Whalan and Mushet (1990) found that, on admission, the three most desired services were: an explanation of why I feel and behave the way I do; help to get back to doing the things I used to; general advice, understanding and care. The next most desired items were various forms of psychotherapy. Physical treatments, asylum and interpersonal skills training were not rated as

highly desirable. Elbeck and Fecteau (1990) found that the most desired aspects of care for psychiatric patients were: staff and facilities geared to help; genuine staff interest in patients; clearer information from doctor; more explanation by doctor; more time with doctor. Clearly, accurate information and collaborative relationships with staff are things that are highly rated by patients.

The majority of patient-oriented research with psychiatric populations has focused on client satisfaction. Whilst some of these studies have provided useful information, including that cited above, a number of authors question whether satisfaction per se is an adequate measure of people's experience of a service. It has been noted that satisfaction surveys usually result in very high levels of measured satisfaction, typically 70% - 90% (MacGlip, 1991; Stallard and Chadwick, 1991; McAuliffe and MacLachlan, 1992). This does raise the possibility of considerable response bias. Also, such low variability reduces the quantity of information that can be gathered by such means.

What seems to be largely ignored in the literature on patient's views are the philosophical and political questions that are raised by enshrining a particular view of appropriate health care and unreasonable risk in law. There is a growing body of academic and popular literature which challenges the established view of emotional and cognitive distress as illness (Szasz, 1993; Millett, 1990; Johnstone, 1989; Bentall, 1990). There is some recent work which examines mental illness in the wider context of human nature and spirituality (Witztum, Greenberg and Dasberg, 1990) but there seems a dearth of information about the way psychiatric patients view mental illness. One exception to this is Molvaer, Hantzi and Papadatos (1992) who specifically probed attributions of causality in people diagnosed as psychotic for their difficulties. They identified three factors which

accounted for 48% of the data: family relationships (25%), personal inadequacy (13%) and chance (10%). The six main items that made up the first factor were based on life events suggesting that life events are believed by patients to be important in the onset of disorder. Notably missing from the analysis were factors representing biological or genetic explanations for the experienced difficulties. Since these are the models upon which a large proportion of psychiatric training and services are based, they are likely to underpin the standard against which judgements about mental health are made for the purposes of the Mental Health Act. Therefore, one would anticipate a mismatch between what makes sense in terms of detention and treatment from the service perspective and what makes sense from the patients' perspective. It might be very interesting to consider people's beliefs about the nature and cause of mental illness when examining their response to being sectioned.

Since there are sound theoretical reasons for supposing that being sectioned might have an impact on a person's future outlook on life and evidence to suggest that patients can and do form clear opinions about the source of their own difficulties and the sort of care they would like, the stage seems open for a consideration of patients' experiences of being sectioned. The final section of this chapter will consider the ways in which this might be done.

Involving the Consumer

The precise importance of the "consumer" in determining the best mode of delivery of mental health services is an issue that is not unrelated to theoretical understandings of psychiatric health. There are psychological theorists who practise their therapy on the supposition that the patient will naturally tend towards that which is healthy for them and who would presumably also expect the patient to be the best judge of the sorts of

mental health services they require. At the other end of the spectrum are practitioners who believe that the patient is the unfortunate victim of a biochemical disease or imbalance. Therapists in this tradition expect the treatment offered to patients to be the outcome of scientific enquiry demonstrating its beneficial effect and might extend this expectation to mental health services in general. Between these two views is a plethora of other approaches allotting the expert knowledge of what the patient needs to a greater or lesser degree to the therapist or patient. One area of agreement amongst all these theories is the importance of environmental issues to the well-being and prognosis of the patient.

In terms of mental health services, environment should be broadly understood to cover accessibility to services, understanding of services and satisfaction with services as well as more specific details such as accommodation, personnel etc. Since the quality of the environment depends very much on the patient's perception, there is a clear argument for taking the patient's views into consideration in evaluating the quality of the overall service.

Theory apart, there is also a commercial argument for giving the patient a significant role to play in evaluation. Gordon et al (1979, reported in Myers et al 1990) suggested that the British system of health care gave little opportunity for the view of the patient to be influential. One may suppose from this that he thought a nationally organised and freely provided health service created a situation in which the service receiver naturally had little opportunity to express choice.

However, the consumer society is upon us. The Griffiths report (1983) sets the tone by extolling managers to "... ensure that it is central to the approach of management, in planning and delivering services, to ascertain

how well the service is delivered by obtaining the experience and perceptions of patients and the community". The 1989 white paper, "Working for Patients", continued this theme advising that patient satisfaction in the NHS should be routinely monitored using surveys. The most recent and radical document is the patient's charter. For the first time, patients have been given rights to services and the right to claim damages for unsatisfactory service. The concept of tax-payers buying their national services in the market place is also supported by radical changes in the funding and structure of the NHS resulting in comparable services being encouraged to bid against each other, GP's holding money on behalf of their "clients" and the public expecting the health service to be accountable. Since money will follow the patient and people clearly do have opinions about the sort of health care they would like and the sort they have received, it would be social and financial suicide not to be influenced by consumer demand in the evaluation of mental health services.

Having accepted that the consumer has an increasingly important role to play in evaluating Mental Health Services, the question is then how to enable consumer involvement in the evaluation process. This question has two parts: how to establish what consumers want from mental health services, and how to ensure that identified needs and wants get implemented.

The 1989 Department of Health white paper, "Working for Patients", suggests the routine use of surveys to monitor patient satisfaction in the NHS. However, there are a number of critics who argue that routine surveys are not per se guaranteed to achieve anything.

Carr-Hill et al (1989) describes the average health service questionnaire as a generalised 12-item satisfaction questionnaire designed to be machine-

readable and applicable to a variety of services. There are some obvious problems with this approach. Generalised questions can only generate generalised responses so little if any feedback will be available on aspects of the service that are specific to mental health. Also, the global nature of the questions may mask extreme views on a small portion of a particular area of the service. Additionally, the generation of percentage estimates of consumer satisfaction does not tell you much about what it is that people like, dislike or find important. Most questionnaires of this nature do provide space for comments which could inform interpretation of the figures but the machine is unable to read the comments so unless someone else does, this information is lost. The information that can be obtained from a single dimensional scale is obviously limited and Carr-Hill et al (1989) suggest that repeated decision making on the same axis leads respondents to produce repetitive answers. One might also expect that, faced with a scale, respondents will locate the median point of their satisfaction at the median point of the scale irrespective of how generally satisfied or dissatisfied they are. This is not a problem if their answers are considered in terms of the deviation from the individual mean but does mean that the overall figures that are generally produced from summing the results of questionnaires are probably summing dissimilar opinions. Finally, the very regularity of the questionnaire may itself militate against its effectiveness since one would imagine that administrators habituate to the receipt of the information which then loses its impact.

Not all surveys are as dull and under-achieving as that described above. However, good quality surveys are expensive to administer and there are a number of alternative ways of collecting information. Consumer opinion is often available informally within patient communication systems such as the hospital radio or magazine. Consumers can also be encouraged to vocalise

their opinions by the presence of a complaints box or wishing list. A wishing list has a particular advantage since it encourages people to say what they **do** want. Implementation will always be easier if people come up with positive suggestions rather than just criticisms of what is currently available. The consumer voice can be made louder by the inclusion of patients or patient advocates at decision making meetings. Where this is impractical or inappropriate, it is still possible for staff to comment on patient opinion if they are in the habit of canvassing and recording satisfaction during ward rounds. Where the information gathering is to be carried out by an independent assessor, as in this thesis, standardised questionnaires can be supplemented by more open ended questions that allow patients to voice their individual views.

Although, some people are always more inclined to speak up than others and hence may bias the overall impression so that it is not truly representative, the informal data collection described above is likely to be sufficient to answer the general sorts of question that could have been addressed by a standard survey. Where a more systematic method of data collection is required, critical incident analysis has the advantage of allowing the patient to determine what is of pertinence to them. The patient is asked to construct a retrospective diary of their experience of health care and to note down what was particularly important to them during their stay in hospital and anything that stood out in their memory. This technique requires the employment of trained interviewers who take the patient through each stage of their admission, treatment and discharge probing for notable experiences. This technique does seem to rely on the assumption that what people remember in retrospect is the same as what was important to them at the time. It would be interesting to see a comparison of the information generated this way with what people would record on a daily basis in self-kept diary. In her study, Hesford (1992) interviewed

patients about their memories and understanding of being sectioned and then picked out themes that emerged which she illustrated with specific quotes from the interviews. Whilst this type of research does not allow objective measurement of the proportion of people who think a particular way or the level of satisfaction/distress patients express, it does give a more easily assimilated impression of the types of experience people are likely to describe. For this reason, it is likely to be particularly useful in an area of research that is still in the exploratory stage.

In a study of acute inpatient psychiatric care, Sharma (1992) found that patients and nursing staff rated quite different aspects of the hospital experience as most helpful to the patient. This suggests that the most accurate information does depend on direct access to the patients' views and makes it more likely that a survey will be seen to be worthwhile.

There are a number of points to consider when constructing a survey. Sharma (1992) used two methods of data collection and got different results with each. This highlights the extent to which answers can be predetermined by the nature of the question and shows the need to vary the form and format of questions so that people are not required to measure all aspects of their experience on a single axis. Myers et al (1990) suggest that self-administered questionnaires enable patients to be frank in expressing their views although they also acknowledge that this approach does not allow you to correct any misunderstandings of the question. Their study involved a 45-item questionnaire and they also note that this was too many for easy analysis so many of the items did not get used and that the patients were unable to concentrate on such a lengthy form. They suggest that 20 items should be the limit. Dixon and Carr-Hill (1989) note that information couched in terms of levels of satisfaction or percentages tells you little about what is liked or disliked and suggest that the information

is more likely to result in a specific recommendation if the patients are asked to explain the reasons for their answers. Gutek (1978) suggests that measures of satisfaction should ask about specific aspects rather than the service in general and should employ alternative vocabulary such as happiness and contentment.

The overall structure of surveys can also be very varied. Most surveys designed to elicit consumer feedback are likely to be descriptive but it is also possible that they may wish to explore what the patient wants from the service or test specific hypotheses. Where the service to be measured is acute, the survey design is most likely to be cross-sectional. Services for long-term psychiatric inpatients lend themselves to longitudinally designed studies. It might also be possible to take before and after measures in acute services although one would probably have to take these measures at different times for different patients and so would have to be aware of the effect of other changes that might have happened. Another alternative in acute services would be to canvass one set of patients before a change and another set afterwards. However, one would need enough participants to be certain of representing the entire population before one could be sure that the groups were really comparable so this approach is unlikely to be practical.

This piece of work aims to take a cross-sectional look at the experiences of people on an acute psychiatric ward. Past research and theory suggests that measures of satisfaction and locus of control are likely to be pertinent to this. There is also reason to suppose that an indication of people's beliefs about mental health and their preferred aspects of care will be useful in constructing a holistic picture of their experience. The information above suggests that the use of some survey tools may be useful. This is most likely to be the case if the format of questioning is varied

and patients' particular experiences and reasons are probed. Given the dearth of information in this area, it may also be helpful to include some more qualitative data to ensure that important areas are not missed because their relevance was not immediately obvious.

Summary and Hypotheses

The thesis on which this project is based is that being sectioned can be expected to have an impact on a person's outlook on life and their experience of hospitalisation and treatment. Thus it should be viewed as an active intervention in its own right and be the subject of research scrutiny to assess side effects etc. like any other form of treatment. This may be done by considering the following areas.

Locus of Control: Outcome locus of control is the result of the interaction between initial locus of control and subsequent events. Where being sectioned lowers a person's self-confidence and is associated with greater feelings of hopelessness, then this would be likely to lead to greater externality. Where the imposition of a section prevents what would otherwise be repetitive experiences of failure, then sectioning will be supportive of internality. Hence, the impact on locus of control is likely to differ for different individuals. This is most likely to be evident in measures that are specific to the health care setting.

Hypothesis 1.

That measures of locus of control will be more widely distributed and will tend towards bi-modality in sectioned patients, particularly for measures that specifically probe attitude to health and mental health.

Satisfaction: In past studies, overall satisfaction with mental health services has been found to be lower in sectioned patients. However, a theoretical understanding of satisfaction from the perspective of transactional analysis would lead one to expect that the most pertinent

difference will be found in the distribution of scores with the sectioned patients giving more extreme scores at both ends of the distribution.

Hypothesis 2.

That measures of satisfaction will show more extreme scores, i.e. a broader distribution, in sectioned patients.

Treatment Priorities: Previous studies have found that patients are able to clearly express their preferences for the services they receive and, when invited to do so, often have goals and priorities that differ from the basic philosophy of the service being offered. In particular, collaborative relationships with staff and family seem to be more important in patients' accounts than formal treatment. Additionally, the treatment priorities of sectioned patients have been found to differ from those on informal patients.

Hypothesis 3.

That there will be a mismatch between the treatment options on offer and those most valued by the patients.

Hypothesis 4.

That the priorities of the sectioned patients will differ to those of the informal patients.

Understandings of Mental Health: Past studies have found that there are often differences between the model of mental health underlying the service offered and patients' own beliefs about mental health. In addition, transactional analytic theory would lead one to expect that, where sectioning leads to a discount of adult thinking, sectioned patients are more likely to endorse models of mental health that exactly conform to or exactly oppose the model offered by the service.

Hypothesis 5.

That many patients will have beliefs about mental health that are not matched by the service model.

Hypothesis 6.

That sectioned patients are more likely to have beliefs about mental health that relate directly to the service model, either in acceptance or opposition.

Understanding of Legal Status: There is a legal obligation for the service to give sectioned patients information about their section and to give all patients information about their treatment. Given the "informal" nature of the majority of psychiatric admissions, it seems likely that sectioned patients may well be better informed about their choices and rights than many other patients. However, the limited research available to date suggests that even these patients express a good deal of confusion about the legal procedures relating to their admission and the rights they have. It therefore seems likely that much of the information about status and treatment that one would wish patients to have is not assimilated by patients, whatever their mode of admission.

Hypothesis 7.

That patients will have poor knowledge of both their legal rights and the treatment they are receiving.

Method

The aim of this project was to look at the effect and experience of being sectioned under the 1983 Mental Health Act for non-forensic psychiatric patients. In order to be able to examine this topic in the light of current theory and research, a number of formal measures of locus of control and satisfaction were used. Structured questionnaires were also constructed to look more specifically at mental health services and understandings of mental health. Finally, a more flexible interview approach was used to allow people to explain what they understood of the Mental Health Act and describe their own experiences of admission. An account of the design of the project, the participants involved and the measures used is given below.

Setting and Access

The project was run in the acute psychiatric wards of Blackberry Hill Hospital, Frenchay, Bristol. These wards are located in a separate building and are collectively known as Prichard Clinic. The project ran alongside an Occupational Therapy project evaluating the clinic services and was seen as part as an overall evaluation package. It was initially set up through collaboration between the Head of the Psychology Department, the Nurse Manager for Mental Health and the Consultant Psychiatrist with managerial responsibility for the clinic. Having been organised and approved in this manner, written permission was sought from all the consultants to approach people under their care in the clinic.

Design

Two groups of participants were approached, people who were detained under sections two or three of the Mental Health Act and people who were staying in the clinic as informal admissions. The intention was to use the group

of informal patients as a comparison for the sectioned patients so that the effect of being sectioned could be distinguished from the more general effects of psychiatric disturbance and admission. Since it is likely that people admitted under section are not typical of the general psychiatric population, an attempt was made to match patients in the two groups for age, sex and number of previous admissions.

Inclusion/Exclusion Criteria

The intention was that people should not be approached about the project while they were actively psychotic or if the demand placed upon them was likely to cause distress. People were also avoided if they were thought likely to present a risk to the investigator. Advice from both doctors and nursing staff on the wards was used to make these judgements.

Participants

The participants in this project were sectioned or informal patients who were admitted to Prichard clinic between February and December 1994. Each person in the group of sectioned participants was broadly matched with an informal participant in an attempt to make the groups as similar as possible. The background information that was recorded for participants was their sex, age, number of previous admissions and current diagnosis. The characteristics of the two groups according to these factors is described here.

Age: Each pair of participants was within two years of each others' age.

The mean ages for each group were:

Sectioned participants - 31.3 years

Informal participants - 31.6 years

The range of ages was from 21 to 59 years in both groups. The means are probably younger than the general psychiatric population because many of

the sectioned participants were at the lower end of the age range.

Sex: It was possible to match sex for all but one pair. The distributions of men and women in the two groups were:

Sectioned participants - 12 men, 4 women

Informal participants - 11 men, 5 women

The group of sectioned participants was characterised by being predominantly male. This balance would be unlikely to be reflected in the general psychiatric population.

Previous Admissions: As far as possible, the number of previous admissions was matched within pairs although an exact match was not always achieved. Unless a person had four or more previous admissions in which case they were matched with someone with four or more previous admissions, all the matches differed from each other by not more than one. The overall distribution of admissions is shown in Figure 1.

Number of previous admissions	Zero	One or two	Three or four	More than four
Sectioned participants	5	7	4	0
Informal participants	3	9	3	1

Figure 1: Number of Previous Admissions

Diagnosis: No attempt was made to match participants for diagnosis since the diversity of diagnoses given would have made this an impossible task. However, an account of the diagnoses present within the two groups is given

in Figure 2 so that the similarity of the groups can be assessed. Where more than one diagnosis was recorded for a person, the primary diagnosis only was used to construct this table.

The first seven diagnoses represent some form of psychosis. Eleven of the sectioned participants and ten of the informal participants had a primary diagnosis of psychosis. This suggests that the groups are broadly similar in the severity of their mental health difficulties.

Diagnosis	Sectioned participants	Informal participants
Acute psychosis	1	2
Recurrent psychosis	1	1
Paranoid psychosis	3	2
Affective psychosis	2	1
Drug-induced psychosis	2	2
Psychosis	0	1
Schizophrenia	2	1
Bipolar Disorder	1	1
Hypomania	1	1
Depression	0	2
Huntingdon's Chorea	1	0
None recorded	2	2

Figure 2: Primary Diagnosis

Measures

The main method of data collection used for this project was written questionnaires. Three of the questionnaires used were adapted forms of standard tools. These were Rotter's internal-external locus of control questionnaire designed to measure general attitude to personal influence (Rotter, 1966); Wallston's health locus of control questionnaire which looks specifically at beliefs about what or who enables good health (Wallston, Wallston, Kaplan and Maides, 1976); and Larsen's 8-item client satisfaction questionnaire which is designed for use in health service settings (Larsen, 1979). See Appendix 2.

The reason for amending the standard questionnaires was to make them more readable. The Flesch scores of the original and amended versions are shown in Figure 3. The higher the score, the greater the readability. The scores of the originals were low in many instances, a score of less than 70 means that at least 25% of the population can be expected not to understand the document. There were additional comprehension problems presented by Rotter's I-E which contained American terminology not in common usage in the British Isles. In all cases, the aim in amending the questionnaires was to retain the original meaning of the instructions and items but to make the text easy to read and understand for British English speakers. Although this may have had the effect of making comparison with other studies less reliable, it was hoped that the validity of the information collected would be increased by reducing the incidence of questions being misunderstood or answered at random.

Standard tools were not available to specifically examine the views of psychiatric patients concerning the service they receive and their experience and understanding of mental health issues. Therefore, a questionnaire was constructed expressly for the purpose of this project.

Questionnaire	Flesch Score - Original	Flesch Score - Amended
Rotter's I-E	73.93	80.62
Health Locus of Control	Instructions - 67.08 Statements - 79.10	Instructions - 71.13 Statements - 82.04
Satisfaction Questionnaire	Instructions - 62.29 Statements - 68.56	Instructions - 77.64 Statements - 88.22
Mental Health Questionnaire	N/A	77.33
Introductory Letter	N/A	85.48

Figure 3: Readability of Survey Tools

This questionnaire and all the other questionnaires were given jaunty titles and gathered together into 'Blackberry Hill Project Patient's Pack' which was fronted by a colourful title page and an introductory letter. The entire pack is given in Appendix 2.

The mental health questionnaire was split into two parts so that it would appear less daunting. The first part, titled 'What Do You Think About Prichard Clinic' was concerned with aspects of people's care. It asked what things people had found helpful and unhelpful about the clinic, who had shown the best understanding of their problems, and how important various aspects of their care had been to them. The aim of this part of the questionnaire was to provide information about patients' priorities in terms of their care that could be compared to some of the other research literature about what psychiatric patients consider to be important. An effort was made to vary the format of questions without making their structure overly complicated.

The second part of the mental health questionnaire was titled 'What Do You Think About Mental Health' and asked participants to consider the effect of their problems on themselves and their beliefs about the causes of mental illness. The first question asked people to pick three ways in which they thought they had changed. An effort was made to provide a wide variety of choices to pick from and to include a balance of positive and negative changes. Some items were also included that were specifically intended to probe internality or externality for mental health.

The items that were considered to represent internality were:

- I have learned something about myself
- I have to make some changes in my life
- I'll be able to cope better than before
- I am a stronger person now

The items that were considered to represent externality were:

- I know that the doctors know what is best for me
- I can no longer trust my own judgement
- I realize that mental illness can happen to anyone
- I need someone to keep an eye on me

The second question asked people to identify what they thought were the three most likely causes of mental illness. The choices that people were given to chose from were designed to represent the major models of mental illness in lay terms. The models and their related items were as follows:

1. Psychoanalytic Model - The problems are caused by early childhood experiences
2. Genetic Model - Some people are just naturally more miserable than others

3. Systems Model - The problems are caused by stressful relationships
4. Disease Model - The problems are caused by an illness in your brain
5. Faith Model - The problems are caused by lack of faith in God
6. Behavioural Model - People have problems when they behave in a way that
makes them unhappy
7. Social Degradation Model - The problems are caused by bad living
conditions
8. Social Model - Problems arise because we don't have our family and
friends around to help
9. Cognitive Model - The problems are caused by thinking about things in
a negative way
10. Anti-Psychiatry Model - Mental illness is just a label for people who
behave in an unusual way
11. Stress Model - The problems are caused by the stress of modern living:
people expect too much of themselves.

It was hoped that this question would provide some interesting information about how mental health is conceived outside the psychiatric profession and might also give some sort of indication of how well the care and treatment that is offered to people matches their understanding of what is wrong with them.

The mental health questionnaire and the introductory letter were checked for readability using the same criteria that all written tools should achieve a Flesch score of at least 70. The results of this are shown in Figure 3.

Interview Format

The purpose of the interview was to probe patients' specific knowledge about the Mental Health Act and to allow them to describe their experiences

and views in a more qualitative manner. The overall format was semi-structured. The questions and topics introduced by the investigator are given in Appendix 3. The majority of the questions were open ended inviting the interviewee to consider their personal understanding of a particular topic. Each interviewee was asked to raise topics that they had particularly strong feelings about.

The information gathered during the interviews was recorded in note form at the time so that respondents had the opportunity of looking at the overall account they had given and judging whether it was an accurate reflection of their viewpoint. All the interviews were also recorded on audio tape and these recordings were later transcribed. These transcriptions are given in Appendix 4.

In addition to the interviews, all participants were invited to make additional comments on their questionnaires if they had a point they wished to express.

Procedure

The bulk of data collection, using the written questionnaires, took place once a week in the clinic. Each week the new admissions would be recorded and potential participants would then be approached near the end of their stay in the clinic and asked if they would like to take part in the project. If they agreed, then the investigator would sit in a private room with them and go through the questionnaires. This generally took 45-60 minutes. In some cases, people were discharged unexpectedly and questionnaires were sent to them through the post immediately following their discharge.

The interviews were conducted towards the end of the data collection

period. People who had expressed an interest were invited to come and talk about their experiences in more detail. Each person was offered a choice of interview time and venue so that they could opt to return to the clinic for their interview or be seen at their local health centre.

Special Considerations in Administration

Questionnaire Response Rates: This was not an easy project to run. The original intention was that the written questionnaires should be distributed by postal survey. However, the response rate to this was so poor that face-to-face administration proved much more practical. Nevertheless, it took eleven months to establish a database of sixteen pairs of respondents although over one hundred sectioned patients and many more informal patients would have passed through the clinic in this time. Although not everyone who was approached wanted to take part in the project, the main reason for this low uptake was the fast rate of patient turnover in the clinic. Since data collection only took place once a week, many people recovered and were discharged in the interim.

Interview Response Rates: The response rate for the interviews was a little better despite requiring people to travel to the place of interview and to make themselves available for an appointment. Of twenty people for whom appointments were arranged, five attended for interview.

Behaviour During Administration: In general, actually collecting the data from people was not too onerous although people have widely different tolerances for written questionnaires and this was naturally affected by their general attentional and reading capacity. Nevertheless, remarks threatening the life of the investigator were made on two occasions and two other participants tried to contact the investigator subsequent to taking

part in the project for more amorous reasons. However, no threats were ever carried through. Participants appeared to find the interviews more relaxing and enjoyable and no untoward comments were made during interviews.

Results

As described in the method section, much of the data in this project derived from the use of structured questionnaires. However, information was also collected using open ended questions and interviews. The results of data collection will be presented according to the hypothesis being examined. The qualitative information will be used to illustrate or enrich the information provided by the analysis of the more formal measures.

Hypothesis 1. Measures of locus of control will be more widely distributed and will tend towards bi-modality in sectioned patients, particularly for measures that specifically probe attitude to health and mental health.

Rotter's internal-external locus of control questionnaire was used to measure general locus of control. The distribution of scores for sectioned and informal patients is shown in Figure 4. Scores at the higher end of the distribution indicate a greater degree of externality. It appears from the graph that the means for the two groups are likely to be similar but that the distribution is broader, and hence more extreme, in the sectioned group. The results of formal analysis are as follows:

means: 11.36 for the sectioned patients, 12.21 for the informal patients.

comparison of means: Paired t-test: $t=-0.61$, $df=13$, $p>0.1$.

comparison of variance: F ratio test: $F_{\text{max}}=2.98$, $df=13$, $0.1>p>0.05$.

H_0 = normal distribution: One-Sample Kolmogorov-Smirnov:

Informal Group, $z=0.77$, $df=13$, $p>0.1$, H_0 accepted

Sectioned Group, $z=0.56$, $df=13$, $p>0.1$, H_0 accepted.

comparison of distribution: Two-Sample Kolmogorov-Smirnov: $z=0.76$, $df=13$,
 $p>0.1$.

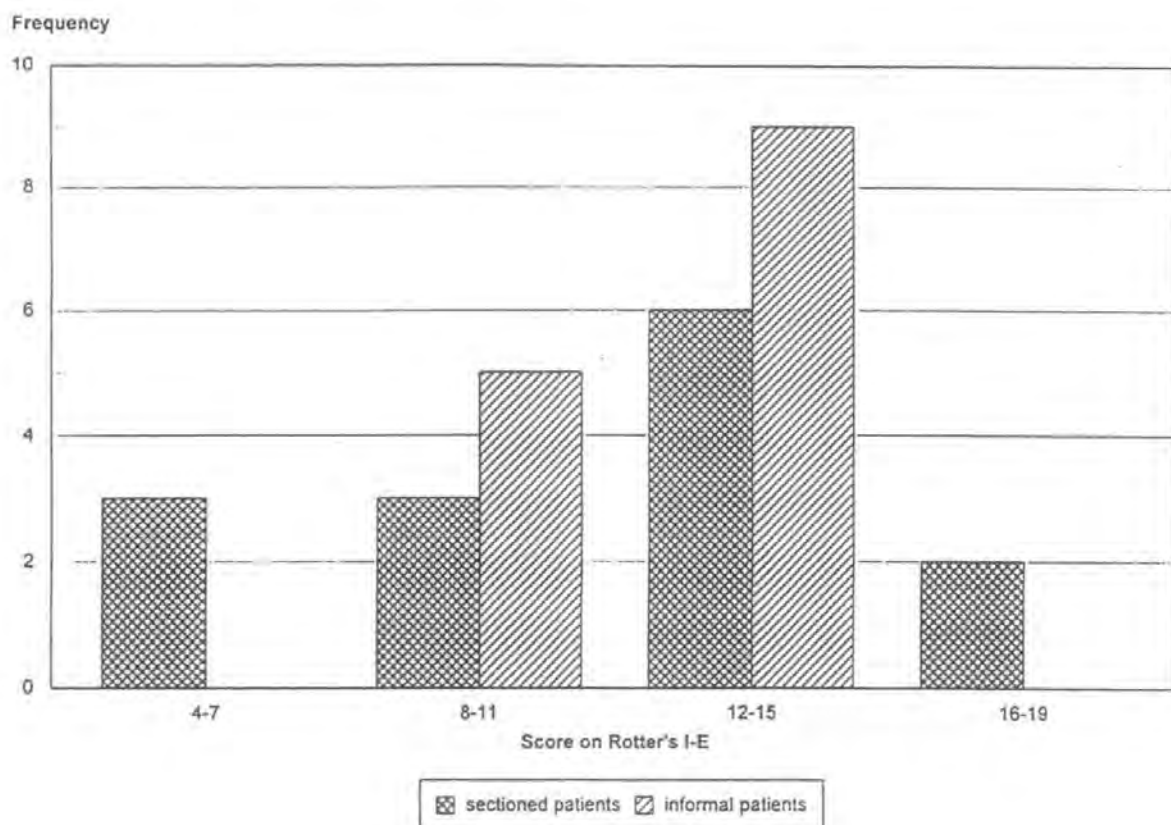


Figure 4: Frequency Distribution of Rotter's Locus of Control

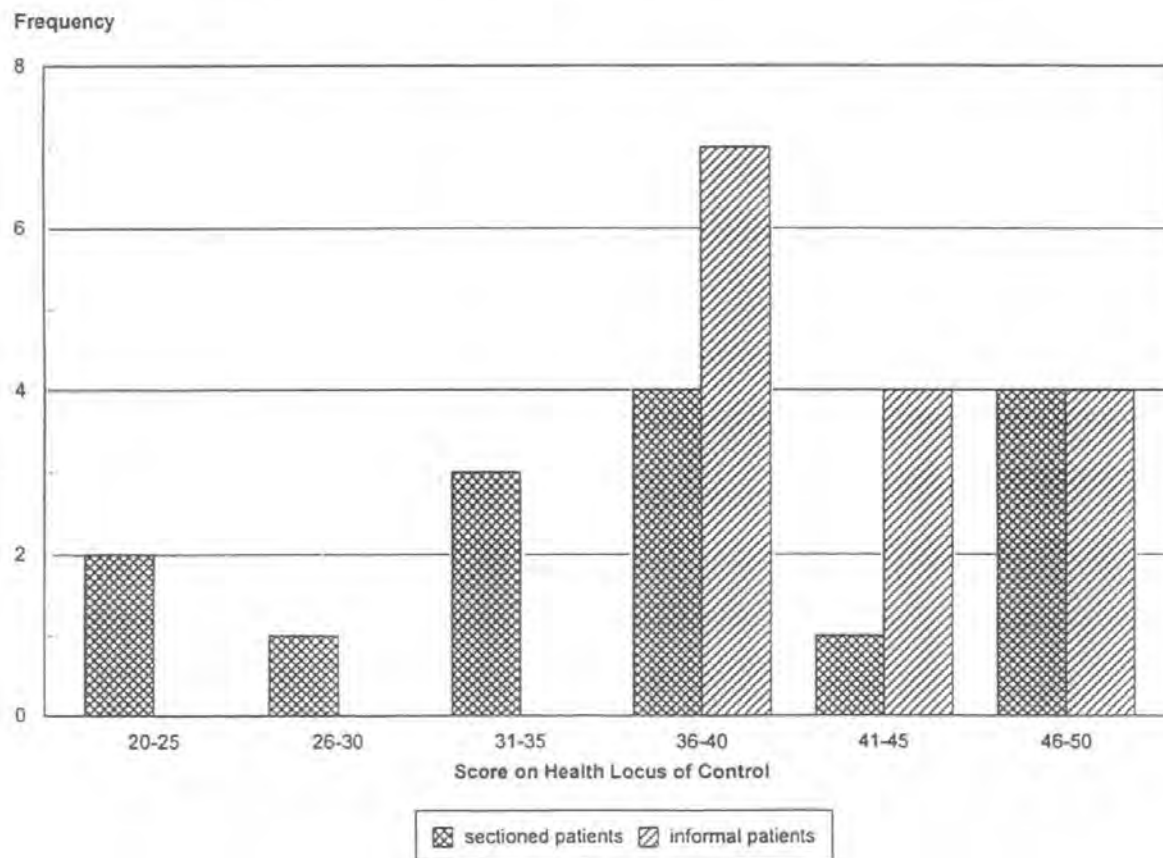


Figure 5: Frequency Distribution of Health Locus of Control

The non-significant t-test confirms that the means do not differ between the two groups for general locus of control and the Kolmogorov-Smirnov tests which are sensitive to the nature of distributions (Siegel and Castellan, 1988) indicate that both distributions are broadly normal and do not differ significantly from each other in shape. The breadth of the distribution is examined by the F-ratio test (Kirk, 1986). Although this test did not reach significance at the 5% level, the result is approaching significance and might well attain significance in a larger group (only 14 pairs completed this measure). Since the greater variance in scores occurs in the sectioned patients, the possibility is raised that sectioned patients give more extreme scores on this measure of general locus of control.

The distribution of scores for health locus of control is shown in Figure 5. Again, the higher scores are associated with greater externality, this time for health issues. It would appear that the mean score is higher among the informal patients indicating a more external attitude in this group. It also looks as though there is a broader distribution of scores in the sectioned group. The results of formal analysis are as follows:

means: 37.47 for the sectioned patients, 41.47 for the informal patients.

comparison of means: Paired t-test: $t=-1.56$, $df=14$, $p>0.1$.

comparison of variance: F ratio test: $F_{\max}=4.07$, $df=14$, $p<0.05$.

H_0 = normal distribution: One-Sample Kolmogorov-Smirnov:

Informal Group, $z=0.73$, $df=14$, $p>0.1$, H_0 accepted

Sectioned Group, $z=0.54$, $df=14$, $p>0.1$, H_0 accepted.

comparison of distribution: Two-Sample Kolmogorov-Smirnov: $z=1.01$, $df=14$,
 $p>0.1$.

Once again, there is no significant difference in the means or distribution

of scores in the two groups. A comparison of the breadth of distribution does show a significant difference for health locus of control, the sectioned patients scores having a significantly higher variance. This difference in variance is wholly accounted for by the sectioned group having more observations in the lower end of the distribution. I.e. there is a degree of internality for health issues that is represented only in the sectioned patients.

The other piece of data collected that relates specifically to locus of control comes from the mental health questionnaire. As part of this questionnaire, participants were presented with a list of ways that they might think they had changed as a result of their difficulties and asked to vote for three of them. The votes cast are shown in Figure 6.

Ways I Have Changed	Sectioned	Informal
a. I have learned something about myself	6	3
b. I know the doctors know what is best for me	4	3
c. I feel anxious now about becoming ill again	2	2
d. I feel confident knowing that the clinic is here to help	4	7
e. I have to make some changes in my life	5	8
f. I can't trust my family any more	0	2
g. I'll be able to cope better than before	4	3
h. I feel more confused than ever	2	0
i. I realize that there are people who care about me	3	3
j. I can no longer trust my own judgement	0	0
k. I realize that mental illness can happen to anyone	8	5
l. I am a stronger person now	5	3
m. I need someone to keep an eye on me	0	1
n. I mustn't expect too much of myself	2	5

Figure 6: Changes Resulting from Mental Health Difficulties

Of these statements, a, e, g, and l represent an internal locus of control whilst b, j, k, and m represent an external locus of control for mental health. Analysis using chi-square indicates that there is no significant difference in the number of votes allotted to internal statements by sectioned and informal patients (Chi-Square=0.48, df=3, $p>0.1$) or in the

number of votes given to external statements ($\text{Chi-Square}=1.15$, $\text{df}=2$, $p>0.1$). Overall, people were more likely to endorse changes reflecting an internal locus of control than an external locus of control (37 and 21 votes respectively). The most commonly voted for statements were e and k suggesting that psychiatric patients do not think that their experiences make them particularly unusual and do expect to take some responsibility for changing their circumstances.

Hypothesis 2: Measures of satisfaction will show more extreme scores, i.e. a broader distribution, in sectioned patients.

Satisfaction was measured using Larsen's client satisfaction questionnaire which gives a general index of satisfaction within a health care setting (Larsen, 1979). The distribution of scores on this measure for the sectioned and informal patients is shown in Figure 7. Scores at the higher end of the distribution indicate a greater level of satisfaction. From the graph, it appears that the mean score in the two groups is broadly similar but the distribution of scores is wider for the sectioned patients and may also tend towards bi-modality. Formal analysis gives the following results:

means: 21.94 for the sectioned patients, 22.38 for the informal patients.

comparison of means: Paired t-test: $t=-0.21$, $\text{df}=15$, $p>0.1$.

comparison of variance: F ratio test: $F_{\text{max}}=3.25$, $\text{df}=15$, $p<0.05$.

H_0 = normal distribution: One-Sample Kolmogorov-Smirnov:

Informal Group, $z=0.73$, $\text{df}=15$, $p>0.1$, H_0 accepted

Sectioned Group, $z=0.62$, $\text{df}=15$, $p>0.1$, H_0 accepted.

comparison of distribution: Two-Sample Kolmogorov-Smirnov: $z=0.71$, $\text{df}=15$, $p>0.1$.

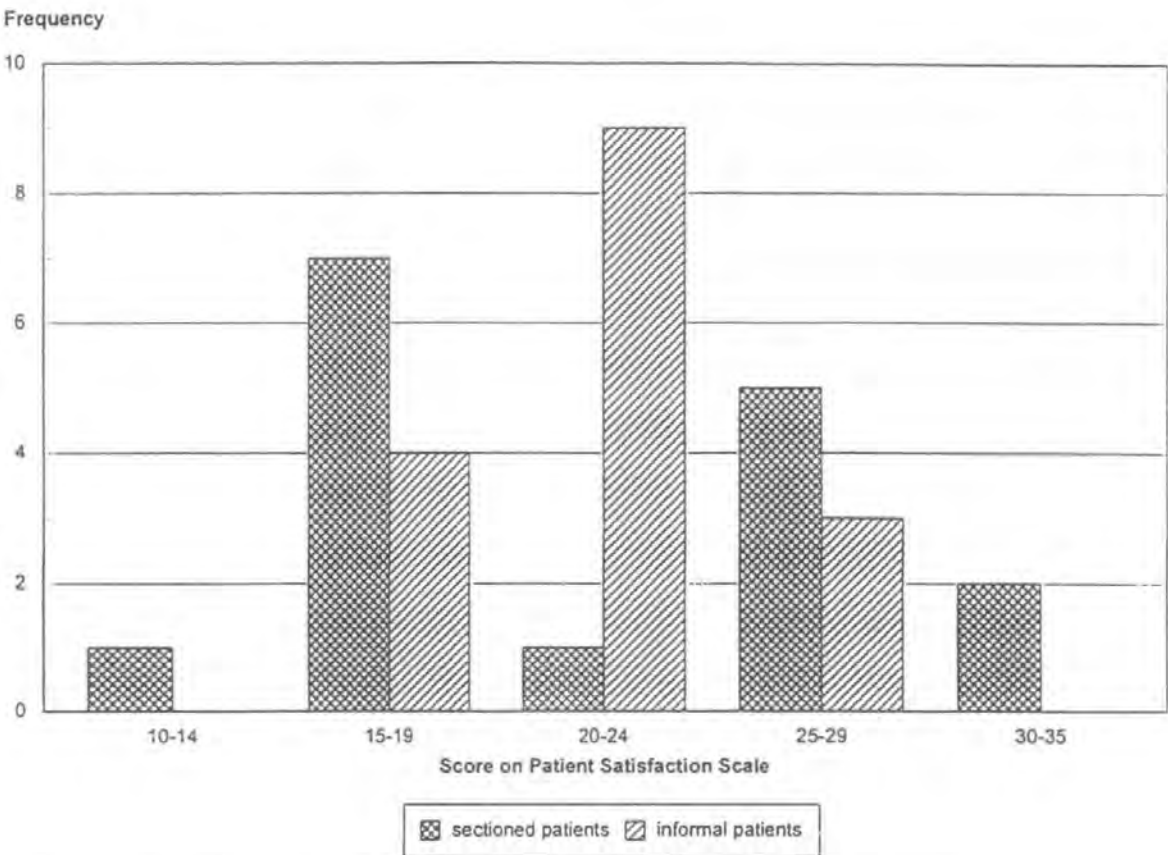


Figure 7: Frequency Distribution of Satisfaction Scores

Since the results of the t-test are not significant, there is no evidence to suggest that the sectioned patients are generally less satisfied than the informal patients. The Kolmogorov-Smirnov tests show that there is also no difference between the nature of the distributions in the two groups. However, there is a significant difference in the variance of the scores. Since the sectioned patients show the greater variance, this supports the hypothesis that sectioned patients give more extreme scores on measures of satisfaction.

Hypothesis 3: There will be a mismatch between the treatment options on offer and those most valued by the patients.

The service offers people inpatient care away from their home and work environments. Privacy and space for quiet contemplation are not generally on offer since bedrooms are typically shared by four and there is no quiet place set aside within the clinic. The one aspect of care that is offered as an individually planned course of treatment is medication and, in some cases, ECT. Other therapeutic activities such as relaxation classes take place within the clinic but these are not built into a care programme, patients chose whether and how often to attend on an ad hoc basis. A small minority of patients are referred for treatment to art therapy. The importance of therapeutic relationships is acknowledged within the clinic by the allocation of a keyworker to each patient. However, the patient is not actually guaranteed any time with this person. Although the keyworker generally takes an interest in the patient's welfare, there are no formal appointments and it is not possible to predict when the keyworker may be available. Hence, the most consistent and regular treatment offered is likely to be medication or ETC.

The aspects of care rated most highly by patients are measured on the

Mental Health Questionnaire by a question asking patients to rate how important various aspects of their care are to them on a scale of 1-4 from not important at all to very important. A mean rating of importance was calculated for each aspect of care which allowed them to be ranked in order of importance according to the means. These rank orders are given in Figure 8 with the most valued aspect of care being given rank 1 and so on.

The three aspects of care rated most highly by patients in general are talking to nurses, having time to think and having visitors. Having time to talk with doctors is rated as comparatively important. However, taking medication comes very low down the patients' list of priorities as does participating in the ward activities which is the other form of treatment generally on offer.

Aspects of Care	Ranks		
	Sectioned	Informal	Total
Talking to nurses	1	2	1
Talking to doctors	7	3	5
Talking to other patients	5	7	6
Time away from home	6	8	7
Having visitors	4	1	3
Taking prescribed medicine	8	6	8
Days out of the clinic	3	4	4
Joining in ward activities	9	9	9
Having time to think	2	4	2

Figure 8: Patients' Priorities for Care

A number of the items covered in this question were clearly of issue to the patients and frequently arose in response to some of the more open ended questions. The comments that arose on these topics are given in Appendices 5 to 13.

Many comments were made about the relationship with nursing staff (See Appendix 5) with a large number of people saying that talking to staff had been helpful to them. No-one seemed to find attention from staff unpleasant or intrusive. Where complaints were voiced, it was generally that there was not enough staff time available so that people didn't have the opportunity to talk when they wanted to. This was attributed to a number of causes by different people: under-staffing, staff resources being absorbed by too much paperwork, and lack of interest on the part of staff. In general, it seems that the keyworker system provided by the service is valued by patients but that this system does not guarantee adequate access to staff time from the patients' point of view.

The comments made about relationships with doctors are given in Appendix 6. Again, a large number of people felt that they had been helped by talking with doctors and this seemed to be particularly true where the person considered that the doctor had listened well and really understood their situation. It seemed to be time spent talking through ideas rather than medical expertise that people said they valued. Conversely, some people felt not well listened to by the doctors. An awareness of the powerful position of the doctors was apparent in some comments both in terms of being obliged to take the doctor's advice on medication and the doctor being the access route for other services. One aspect of medical care that was commented on adversely was the rapid changeover of medical staff which mitigated against continuity in therapeutic relationships. Although psychiatric practitioners are increasingly aware of the importance

of the doctor-patient relationship and care supposedly takes place within multi-disciplinary teams, there is still a strong sense of limited access to the psychiatrist who wields overall decision-making power

People had a mixed response to their experiences with other patients (See Appendix 7). A large number of people felt that they had been helped by talking with other patients. The general impression was that these interactions were more social and practical than therapeutic although a few felt that patients had helped them directly with their psychiatric difficulties. However, there were also a large number of comments suggesting that the presence or behaviour of other patients was sometimes difficult, upsetting or frightening. The distress felt by others also affected people, for instance when someone committed suicide. The service does not seem to capitalise on the potential of patients to help each other. Although some care is delivered in groups, these are largely structured as a professional delivering advice and skills training to several people at once rather than as a co-therapeutic milieu.

Time away from home did not crop up as often in people's comments as some other issues (See Appendix 8). When it did, people seemed to value being in hospital as a place of safety and a place of sanctuary from their normal sources of stress. This seemed to be particularly true when their home life was characterised by stressful family relationships. This feature of inpatient treatment is largely appreciated by service personnel although there is no medium for interacting with the family as a whole in order to resolve conflict.

Very few people commented on the impact of having visitors (See Appendix 9). For those that did, visits from close family and friends were seen as entirely positive, and for some people, were the one thing that kept them

going. The service does profess to welcome visitors although the facilities provided are very poor. For instance, there are no tea making facilities and no private space where people can talk with their visitors.

A large number of comments were made about the medical treatment people received (See Appendix 10). These seemed to be equally balanced between those who thought their medication had been a positive help and those who had negative experiences of taking drugs or ECT. There was also a certain amount of ambiguity represented in the comments. Some people seemed to feel that their treatment had caused changes that in some respects had helped them to cope but they were not sure that these changes or ways of coping were quite what they would have wished for. People did seem to have a general awareness of the possibility of experiencing side effects from taking medication but seemed to find it difficult to obtain detailed information about drugs. The general impression was that decisions about medication resided with the medical staff rather than the patients. Those people who were well-informed about their treatment seemed to have used sources of information other than the clinic staff. There is a clear conflict for the service in fulfilling their obligation to provide people with details of their treatment and having the time to explain what may be quite technical information. Conflict also seems to arise in locating who should decide what is best for the patient, the patient themselves who is in distress but knows their own priorities best, or the medical staff who may feel that their experience allows them to make judgements about what is best when the patient is poorly placed to do so.

Very few people made comments about days when they had been out of or had leave from the clinic (See Appendix 11) although a number of the sectioned patients commented on how frustrating it was not to be able to go out when they wanted to. In general, the service encourages people to visit home

as soon as they seem able to cope in order not to foster dependency.

Although ward activities came bottom in the ranking of the importance of various aspects of care, it was something about which people clearly felt very strongly (See Appendix 12). A number of people said that they had found the relaxation classes etc. that are provided useful but the overwhelming brunt of opinion was that there simply were not enough activities provided, that being in hospital was boring and that boredom and lack of opportunity for enjoyment was actually an impediment to good mental health. Some people clearly felt that some types of activity such as art and drama could be directly linked to helping people cope. It was also raised that the ward activities did not follow any course or plan and were not tailored to help with the specific difficulties of different types of mental health problem. The lack of suitable activities on the ward has been partly addressed recently by the appointment of an occupational therapist who provides what there is. However, this arrangement clearly is not sufficient from the patients' point of view.

A number of people made comments relating to the clinic's role in terms of providing time and space away from their usual environment (See Appendix 13). Some people valued this as an opportunity for thinking and life review although an equal number seemed to value it as a break from having to think too much. The overall impression was that the notion of a place of sanctuary was valued. No adverse comments were made about lack of contact with other aspects of society. This aspect of the hospital experience could be enhanced by the service if it were possible to set aside quiet space on the ward. All rooms which are not in use for some scheduled activity are currently kept locked.

As well as those aspects of the clinic that were specifically probed by the

questionnaire, the comments that people chose to make highlighted several other factors that were obviously important in their experience of the clinic. Key amongst these were the food provided at the clinic and the environment -within the clinic itself.

Comments made about the catering are given in Appendix 14. Not all the comments were negative although the balance was on the negative side. Opinion seemed to depend largely upon how much regular helpings of shepherd's pie were appreciated! Particular problems that were raised were lack of reliable provision for vegetarian diets and lack of access to drink-making facilities. The attention of a member of staff had to be sought even to procure a drink of water. It is generally recognised by the staff that good health and good nutrition are linked and that the lack of catering facilities that the patients can use is less than optimal. Nevertheless, the facilities available mean that patients are entirely dependent on the hospital catering which is often inadequate, are limited in their access to a hot drink which most of us would consider a fairly basic comfort, and are reduced to a very dependent role in getting a drink at all.

The environment within the clinic aroused quite a large number of comments (See Appendix 15), particularly about things that had displeased people. Lack of security of belongings was something that had upset a good number of people. People also did not like having to move rooms and having to share rooms. A number of the facilities were thought to be inadequate, no easy access to a telephone, not enough televisions or bathrooms, and people generally did not like places and facilities being locked. The nature of the facilities presented particular difficulties for some people. This was particularly true for some of the elder respondents. One person was unable to use the bath or get down the stairs to the laundry and another was

embarrassed at having to ask for the toilet to be unlocked during the night. Apart from these specific complaints, many people commented that the building itself was shabby and poorly maintained. A number of suggestions were made re redecoration and renewing of the furniture in order to make the place more attractive and more comfortable. Clearly the service is not measuring up to the expectations of the patients in this respect. Whilst resources may largely determine whether the clinic is suitably housed and the quality of the furniture, the lack of even lockable bedside cupboards does suggest a scant regard for the privacy and security of patients' belongings and hence for the individual needs of the patients. It is also not surprising that people find it degrading if they have to ask to go to the toilet or are unable to use the facilities unaided. These factors seem to undermine any desire to encourage self-confidence and self-respect.

Hypothesis 4: The priorities of sectioned patients will differ from those of informal patients.

The ratings of importance of each of the aspects of care listed in Figure 8 was compared for the sectioned and informal patients using the Wilcoxon t statistic for paired samples. None of these individual analyses reached significance at the 5% level indicating that there were no differences between the groups in the absolute ratings of importance for any of the aspects of care.

(Talking to nurses:	t = 11, N=8, p > 0.1
Talking to doctors:	t = 17, N=9, p > 0.1
Talking to other patients:	t = 15, N=9, p > 0.1
Time away from home:	t = 24, N=11, p > 0.1
Having visitors:	t = 7.5, N=6, p > 0.1

Taking prescribed medicine:	$t = 27, N=11, p > 0.1$
Days out of the clinic:	$t = 21.5, N=9, p > 0.1$
Joining in ward activities:	$t = 16, N=8, p > 0.1$
Having time to think:	$t = 10, N=8, p > 0.1$

Although the individual ratings of importance were broadly similar, the orders of importance that were derived from these rating were slightly different for the two groups (See Figure 8). Four of the top five aspects of care are the same for the two groups: talking to nurses, having visitors, time to think and days out of the hospital. However, talking to doctors appears in the top five of the informal patients but this is replaced with talking to other patients for the sectioned participants. Human contacts are obviously seen as vitally important by both groups. However, more medical aspects of care (Talking to doctors, taking medication) are seen as comparatively less important than other aspects of care by the sectioned group.

Hypothesis 5: Many patients will have beliefs about mental health that are not matched by the service model.

People's beliefs about the causes of psychiatric ill-health were primarily measured by a question on the Mental Health Questionnaire which gave people a variety of possible causes and asked them to vote for the three they thought most likely. The number of votes allocated to each possible cause allowed the plausibility of the offered causes to be ranked. These rankings are given in Figure 9.

Although the service doesn't specifically specify what model it adheres to, the fact that the clinic is managed by psychiatrists and that the only individually tailored treatments offered are medical suggests that the

		Rankings	
Reasons for Mental Illness	Sectioned	Informal	Total
a. Early childhood experiences	1	2	2
b. Some people are just naturally more miserable than others	10	11	10
c. Stressful relationships	3	1	1
d. An illness in your brain	7	7	8
e. Lack of faith in God	8	9	9
f. People have problems when they behave in a way which makes them unhappy	11	9	10
g. Bad living conditions	4	4	4
h. No family and friends around to help	5	6	5
i. Thinking about things in a negative way	8	5	6
j. Its just a label for people who behave in an unusual way	5	7	7
k. The stress of modern living. People expect too much of themselves.	2	2	3

Figure 9: Patients' Beliefs about Mental Illness

staff adhere primarily to the Disease model represented by statement d. The use of long-term medication and the provision of individual relaxation

training rather than life-style planning or problem solving suggests that they are also influenced by the Genetic Model and the Behavioural Model, represented by statements b and f respectively. One may suppose that patients are more likely to understand what the service is aiming to do and to feel that this addresses their needs if they share the service model, i.e. if they view their difficulties as the result of a disease process or as being inherent in their make-up or the way they behave.

The three models chosen as most plausible by patients in general were the Systems Model, concentrating on stressful relationships, the Psychoanalytic Model, focusing on early experiences, and the Stress Model, looking at current sources of stress. The next most popular models were those focusing on the persons social situation, both in terms of their material living conditions and their social support networks. The Disease Model came eighth out of eleven in terms of plausibility, just after the Anti-Psychiatry Model (Statement j)! The Genetic and Behavioural Models fared even worse, coming joint bottom. Interestingly for psychology, the Cognitive Model (statement i), whilst more popular than the Disease Model, also did not have immediate salience to the majority of people, coming only sixth out of eleven.

People were also given the opportunity to comment on what they thought had given rise to the particular problems that had resulted in them coming to the clinic. The comments they made are given in Appendix 16. A number of factors emerged as important contributors to people's difficulties. The four most prominent ones were:

Financial and work-related stress

Life events -bereavement, loss of relationships, change of circumstances

Early history leading to chronic difficulty in coping

Search for meaning in life - existential/spiritual crisis.

These factors do broadly correspond to the psychoanalytic and stress models picked out as most important in the formal questioning. The existential or spiritual nature of people's difficulties was not picked up by the formal questioning, possibly because the statement designed to tap this was too narrow in referring to God. Neither the questionnaire nor the service models allowed for the importance of life events in the development of acute psychiatric distress whilst this factor is described as highly pertinent by the respondents in this study.

Hypothesis 6: Sectioned patients are more likely to have beliefs about mental health that relate directly to the service model, either in acceptance or opposition.

Consideration of this hypothesis is again based on the information presented in Figure 9. As described above, the models of mental health that are apparent in the service provision are the disease model, the genetic model and the behavioural model. If sectioning has the effect of leading the patient to be dependent on others' account of things, then one would expect to find that they were more influenced by these models in their beliefs about mental health than the informal patients. However, the three reasons chosen as most plausible by both sets of patients are a, c and k, none of which relate to the service model. Therefore, it seems that the most prominent beliefs of neither group of patients relate to the service model.

Those statements which are endorsed by the service model are b, d and f. Statement j is also related to the service model in that it directly opposes it. Statements b and f appear in the three least plausible causes of mental illness for both the sectioned and informal patients. Both groups gave the same ranking to statement d. The only statement where

there seems to be a small difference between the rankings was statement j which represents the Anti-Psychiatry model. This was thought to be slightly more plausible by the sectioned patients although it was still half-way down their list of likely reasons. It does not appear that patients are strongly influenced by the models of mental health implicitly presented by the service or that sectioning has much effect upon this influence.

Hypothesis 7: Patients will have poor knowledge of both their legal rights and the treatment they are receiving.

There is an obligation for health professionals to give their patients information about their treatment and the terms of their hospitalisation.

What is being examined here is not what information has ever been given to the participants but what information they have retained and can therefore make use of. The extent of patients knowledge was judged according to whether they were able to produce answers to direct questions about various aspects of their hospitalisation and treatment.

As has already been described earlier, the comments many of the patients made about their medication whilst showing a general appreciation of the possibility of side effects did suggest that patients find it difficult to obtain detailed information about their treatment. The knowledge that patients have was examined in greater depth during the interviews when questions were specifically directed at what people knew about the law, procedures and treatment. The answers people gave to these questions are shown in Appendix 17.

Five people participated in the interviews. Participants with an H code are informal patients and participants with a P code are sectioned

patients:

H27 is a 30 year old woman with two previous admissions, diagnosed with recurrent psychosis

H41 is a 32 year old man with three previous admissions, diagnosed with psychotic thinking

H50 is a 27 year old woman with no previous admissions and no recorded diagnosis

P21 is a 25 year old man with no previous admissions, diagnosed with paranoid delusions

P18 is a 33 year old woman with two previous admissions and no recorded diagnosis.

The interviewees' knowledge of the Mental Health Act is summarised in Figure 10. This information is presented separately for the sectioned and informal patients since the sectioned patients ought, by law, to have been presented with this information in a way they can understand. Interviewees' knowledge of their own psychiatric condition and treatment is summarised in Figure 11. All the interviewees are considered together in this case since all patients have a right to be told this information.

As regards admission procedure, three of the five interviewees felt that they had made the decision about admission and all five felt that the decision made had been the right one. Four of the five knew whether they were informal or sectioned patients. One of the informal patients was not sure. In general, people seemed quite clear about their admission.

Re knowledge of the Mental Health Act, all five interviewees had heard of sectioning. Four out of the five, including both the sectioned patients knew that it involved restrictions about leaving the hospital and one of the sectioned patients knew that it meant that you could be forced to take

Information Held by Patient	Informal	Sectioned
Had heard of sectioning	3/3	2/2
Knew status, informal or sectioned	2/3	2/2
Knew a section restricted the right to leave the hospital	2/3	2/2
Knew a section could carry the obligation to take medication	0/3	1/2
Thought sectioning a good idea	3/3	2/2
Could describe the criteria for sectioning	1/3	0/2
Knew it was the role of an Approved Social Worker to apply for a section	0/3	0/2
Could describe the rights of a sectioned patient	0/3	0/2
Had heard of appealing against a section	1/3	2/2

Figure 10: Patients' Knowledge of the Mental Health Act

medication. All five interviewees thought that sectioning was a good idea in some circumstances although the three informal patients thought they would have felt worse if they had been forced to come into hospital. The interviewees were generally unclear about the criteria that led to a section. One of the informal patients knew that the patient must be considered to be at risk or risky to others. Both the sectioned patients thought it was to do with being psychotic. Nobody knew about the role of the social worker in the sectioning procedure. The general consensus was that patients who are under section don't have any specific rights although one of the informal patients thought they had the right to be treated

humanely. Three people, including the two sectioned people, had heard of the possibility of appeal. Of the two sectioned people, one did not know how to make an appeal and the other did not think it was worthwhile because she assumed that her opinion would count for less than that of the doctor.

Information Held by Patient	
Could remember being told their diagnosis	2 out of 5
Had explanation for psychiatric condition	1 out of 5
Knew what medication they were taking	4 out of 5
Was aware of potential side effects	3 out of 5
Was aware of alternative treatments	0 out of 5

Figure 11: Patients' Knowledge of their Psychiatric Condition and Treatment

In terms of people's psychiatric condition, all five interviewees felt that the best explanation they had been offered had come from a doctor. However, only two people remembered being told their diagnosis and one of these said that he didn't understand what had been said to him. Only one person could produce an explanation of the cause of their condition and one other person had been told that they were "ill".

As regards treatment, four of the five interviewees knew the names of the drugs they were taking although only one of the sectioned patients had any clear ideas about what the drugs were specifically for. Both the sectioned patients thought that the decision about treatment rested with the doctor. Interestingly, so did two of the informal patients with only one patient saying that they had the right to make the final decision. When asked about risks, two of the informal patients and one of the sectioned patients

showed an awareness of side effects but nobody seemed to think of these as potentially damaging, the impression was that side effects were regarded as a temporary nuisance. No-one could recall any discussion of alternative treatments that might be available.

Discussion

The format of this discussion will follow that of the results section by considering each of the experimental hypotheses in turn. This will be followed by a section in which the overall implications and theoretical understandings suggested by the results are drawn together and considered in terms of the literature from which they derived. The conclusions that can be made from this will then be summarised.

Hypothesis 1: Measures of locus of control will be more widely distributed and will tend towards bi-modality in sectioned patients, particularly for measures that specifically probe attitude to health and mental health.

It was argued in the introduction that sectioned patients would have more broadly and more bi-modally distributed scores on measures of locus of control. This was because a section might be expected both to reinforce externality in people who saw it as a failure and were initially inclined towards externality and to reinforce internality where its use prevented repeated experiences of failure and enforced an appreciation of the possibility of alternative coping strategies. It was also suggested that this effect would be most apparent in the arena in which the section was experienced, i.e. health.

No differences were found in the mean scores for any of the measures of locus of control suggesting that sectioning does not have a global effect of increasing internality or externality. Also, the shape of the distribution of scores was not found to be significantly different for any of the measures so bi-modality was not apparent in the sectioned group.

However, the distribution of the scores tended to be broader in the

sectioned group on Rotter's measure of general locus of control and was significantly broader on locus of control for health issues. This would tend to support the hypothesis that sectioning reinforces and hence makes more extreme the person's tendency to internality or externality. However, examination of the raw data shows that the broader distribution of locus of control for health in the sectioned patients can be accounted for by more extreme scores in the internal range of the distribution. Since internality is associated with positive prognosis and coping abilities, this evidence does not suggest that change in locus of control should be seen as a potential risk of sectioning. This cannot be attributed to the insensitivity of the measures used since differences in distribution were found between the groups. Indeed, a more plausible explanation of these findings may be that locus of control has not changed at all but that people who have extreme confidence in their own judgement and ability to problem solve may be less persuaded by the opinions of others and hence more likely to enter hospital under section in times of crisis.

No differences were found between the groups in their locus of control for mental health issues although all patients were more inclined to agree with statements indicating an internal understanding of their situation. The most commonly agreed with statements were:

I have to make some changes in my life

I realize that mental illness can happen to anyone

These statements suggest that patients feel that change is possible and do not feel overly stigmatised by their experiences.

Hypothesis 2: Measures of satisfaction will show more extreme scores, i.e. a broader distribution, in the sectioned patients.

The rationale of this hypothesis was that if, following transactional

analytic theory, sectioned patients are dependent on rejecting or accepting the views offered to them rather than using their own thinking capacity to form an independent opinion, they will tend to answer more extremely on measures of satisfaction. This hypothesis was contrary to past findings which suggest that sectioned patients are generally less satisfied with services than informal patients.

In fact, the measure of satisfaction did show that there was no difference in the mean satisfaction recorded for the two groups but that the sectioned patients' scores had a broader distribution than those of the informal patients. This is interesting because it suggests a willingness on the sectioned patients' part to give answers which do not centre the median at the same point as other respondents. The literature surveyed in the introduction suggested that measures of satisfaction were often uninformative because people tended to site the mid-point of their response range in the same place irrespective of their overall level of satisfaction.

It also suggests that, according to the theory that generated the hypothesis, there is a tendency by sectioned patients to rely on accepting or rejecting the view of the service rather than forming their own opinions. Within transactional analytic theory, this means they are employing less adult energy to think for themselves. The question then arises of whether this is a feature of people who become sectioned or a result of the section. This question is very difficult to answer in a cross-sectional study. However, the diagnoses given to the patients within the sectioned and informal groups were very similar as was described in the method section. There were equal numbers of people diagnosed as psychotic which is the diagnosis typically associated with low adult energy. Therefore, the possibility exists that the observed difference is a result

of the sectioning procedure. If this were the case, it must be considered as a potentially negative side effect and interventions to encourage independent adult thinking would be appropriate as an antidote.

Hypothesis 3: There will be a mismatch between the treatment options on offer and those most valued by the patients.

This hypothesis was based on past research in psychiatric settings which identified mismatches between service provision and patient priorities. In the clinic where this project was carried out, the treatments most commonly on offer were medication, ward activities led by an occupational therapist, and some discussion time with the keyworker who was a member of the nursing staff. However, the results of this project showed that the aspects of care most valued by the patients were talking to nurses, having time to think, and receiving visitors.

There is a match between the patients' value for time talking to nurses and the provision of a nursing keyworker. The comments made by the patients also suggested that the keyworker system was valued. However, these comments made it clear that the system did not guarantee that adequate time would be available and many patients wanted more access to nursing time than was available.

Patients seemed less enthusiastic about the other main forms of treatment on offer. Taking medication was ranked eighth out of eleven in terms of its importance to patients. The comments made about medication suggested some ambiguity in people's attitude towards it. Many people felt that it had helped them cope in some ways but there was a sense that they were uncertain whether it was really the sort of help they wanted.

Ward activities were ranked as the least important aspect of care on offer. This is interesting because the comments made by patients suggested that ways of usefully passing time was something about which people felt very strongly. The vast majority of people thought there was not enough to do on the ward and some complained that boredom was actually an impediment to good mental health. It therefore seems surprising that people thought what was on offer was of such little importance. It suggests that the activities that are available are not meeting the need for interest and occupation that people are voicing. This may be because the activities that are available are rather narrow in their scope and loose in their structure. The failure to incorporate non-medical interventions into the individual care plan does seem to make them less pertinent to the patients. It also seems likely that there is simply not enough time given to structured activities. This was one area in which many patients seemed to have positive and imaginative suggestions about what they would like to be provided suggesting that the service could benefit from some consumer involvement.

It would also be possible for the service to enhance the other two aspects of care rated as most important by patients, having time to think and receiving visitors. Whilst, at face value, these items may seem to be independent of what the service provides, the lack of any private space for patients and the lack of any reserved quiet areas on the ward actually mean that patients may not be able to enjoy these aspects of their care to the full. In this sense, the service cannot be said to be meeting the priorities of the patients.

Two other aspects of care cropped up as being of vital importance to the patients and inadequately met by the service. These were the ward environment and the catering arrangements. There was a commonality about

the complaints to be made in these areas (failure to provide vegetarian food, lack of access to drink making facilities, tatty surroundings, no security of belongings, inadequate facilities for elderly/disabled patients, the need to announce one's intention to use the toilet) in that they suggested a lack of regard for the patient's individuality and tended to foster dependent behaviours. Again, the importance of consulting the consumer is apparent from these complaints. Self-respect and independence are important factors in mental health and yet the salience of the catering facilities and ward environment was only apparent in the comments freely offered by patients.

Hypothesis 4: The priorities of the sectioned patients will tend to differ from those of the informal patients.

This hypothesis was based on previous findings with psychiatric patients (McIntyre et al, 1989) that sectioned patients placed less value on staff, other patients, asylum and ward activities. In the current study, no differences were found in the absolute ratings of importance given to any of the aspects of care by the sectioned and informal patients.

However, absolute ratings are probably less informative than the comparative importance of the aspects of care to the groups of patients. The top five aspects of care for the two groups were broadly similar. Four out of the five most valued aspects of care were the same for the two groups suggesting that being under section does not make a huge difference to the perception of the care received. The top five choices for both groups of patients were dominated by time spent with other people - nurses, doctors, visitors, other patients - suggesting that human contacts and the quality of relationships are essential to the experiences of all patients. Other valued features were having days out of the clinic and having time

to think.

Talking to doctors and taking medication was rated as comparatively less important by the sectioned patients than by the informal patients suggesting that there is a tendency for patients under section to have less value for the medical aspect of their care. It is not possible to say whether this is a result of being sectioned or whether it was a distaste for medical care that led to their initial reluctance to enter hospital. However, it makes it more likely that sectioned patients who are obliged to take medication are being forced to comply with a regime of health care that is not in keeping with their personal priorities. This suggests that the provision of some choice in the type of treatments available so that non-medical alternatives could be offered might well be of value.

Hypothesis 5: Many patients will have beliefs about mental health that are not matched by the service model.

The World Health Organisation declaration on the rights of patients (Carmi, 1991) declares that everyone has the right to respect for their philosophical values. Although this declaration is not enshrined in the Mental Health Act, it is a pertinent point because by defining in law the circumstances under which a person's right to self-determination may be withdrawn, a certain understanding of mental health is adopted. It is reasonable to suppose that a person's reaction to hospitalisation and treatment will depend very much on whether what happens to them seems to make some logical sense from their point of view and whether it accords with their own understanding of mental health issues and treatment values.

In this study, the causes of psychiatric ill-health most commonly endorsed by the patients were stress in relationships, early childhood experiences

and stress in living conditions. These causes were related to the systemic model of mental health, the psychoanalytic model and the stress model respectively.

Additionally, many people made comments about the specific cause of their own problems. Some of these comments reinforced the models that had already been chosen. For instance, financial and work-related difficulties relate to the stress model and early history relates to the psychoanalytic model. Additional importance factors that arose in people's comments were life events, particularly relating to loss of relationships which might be considered to related to the systems model, and existential or spiritual crisis.

Importantly, the disease and behavioural models, which are the modality in which treatment is offered, came very low down on the rating of plausibility given by patients. This suggests that there is a mismatch between patients' understandings of mental health and the treatments they are offered. It is also consistent with the results of Hypothesis 3 which showed that talking to people and having time to think were valued much more than medication. It is perhaps the opportunity to discuss relationships and lifestyle issues that leads people to place such high value on talking to nurses.

Given that patients do seem to have clear ideas about the root causes of their difficulties and that these seem most frequently to relate to specific incidents, stresses or relationships, it is also understandable that patients attitude to medication was found to be ambiguous and that some people felt that it was not the sort of help they had expected or wanted.

Hypothesis 6: Sectioned patients are more likely to have beliefs about mental health that relate directly to the service model, either in acceptance or opposition.

This hypothesis derived from transactional analytic theory. As has already been discussed, a potentially adverse effect of sectioning might be to reduce the energy a person puts into their adult ego state and hence to reduce their capacity for problem solving. If this were the case, they would be less likely to develop their own understandings of mental health issues and more likely to be dependent on the service for their views. This dependency might manifest either as a total acceptance of the views represented by the service or a total rejection.

In fact, the three most prominent beliefs about the causes of psychiatric illness were the same for the sectioned and informal patients. As described above, they do not relate to the service model which offers treatments based on disease oriented and behavioural understandings of psychiatric illness. This suggests that neither the views of sectioned nor informal patients are greatly influenced by the service. The sectioned patients were also no more or less likely to pick the genetic, behavioural or disease models of mental health as plausible. The only difference between the two groups of patients was that more of the sectioned patients thought that the anti-psychiatry model was plausible (represented by the statement; mental illness is just a label for people who behave in an unusual way). Since this model is in direct opposition to the main thrust of service provision which is based on the belief that there is something wrong with patients, this belief could be considered to be a childlike rejection of a parental message and hence to indicate some dependency on the source of that message. On the other hand, it may well be that a tendency to view their experiences as unusual rather than abnormal makes

people less likely to want to have treatment for those experiences and hence more likely to be sectioned. In any event, support for the anti-psychiatry model still placed it fifth out of eleven for the sectioned patients, only two places above its position for the informal patients.

Hypothesis 7: Patients will have poor knowledge of both their legal rights and the treatment they are receiving.

The Mental Health Act goes to some lengths to ensure that patients are fully informed both about their legal position and the procedures surrounding sectioning and about their condition and treatment. Nevertheless, the information that is available on the subject (Hesford, 1992) suggests that many people do not retain this information. This finding was largely backed up by the results of this study although people did seem to know a lot more about some aspects of their care than others.

People generally seemed clear about their admission and happy with the decision to be admitted. Most people were also aware of whether they were admitted as sectioned or informal patients. However, knowledge about the criteria leading to a section or the role of the Approved Social Worker was very scant, even among the sectioned patients. In many ways it is not surprising if people are more aware of the practical details of what has happened to them than the details or why and how this has come about. It is of some concern that one of the informal patients did not know whether she was under section or informal. This suggests that either she has not been told that she has the right to leave the hospital or she has forgotten it. It is clearly not adequate to assume that people will realize that they have the right to make their own decisions unless they are specifically informed that they can. This is reinforced by the fact that the majority of the informal patients thought that it was the doctors who

had the right to make the final decision about what treatment they received.

Again people were generally aware of the practical implications of being under section in terms of having to stay in hospital and having to take medication. There was less awareness of appeal procedures and no knowledge of the rights of sectioned patients. Not surprisingly, the sectioned patients were more likely to be familiar with the terms of a section than the informal patients.

Many of these rights of sectioned patients pertain to being given information. Ignorance of these rights means that people did not know that they had the right to details of their diagnosis, treatment, prognosis and possible alternatives. One must therefore question whether they were in a position to understand and discuss their health care in such a way as to make their personal preferences clear. It seems likely that they were not since the majority of all patients did not know what their diagnosis was and could not remember having received any explanation of what had caused their difficulties. People were much more familiar with the details of their treatment since most people knew what drugs they were taking and were aware of the possibility of side effects. However, it is again questionable whether people had enough information to be able to draw their own conclusions since only one person had any clear idea about what the drugs were supposed to do. Also, whilst people had heard of side effects, they seemed to have the impression that there was inevitably nothing to worry about. No-one seemed aware that these could present potentially serious long-term health risks. It is possible that this could be attributed to a preference on the part of patients to trust decisions about treatment to trained medical personnel. However, many of the comments that were made about medication suggested that people had difficulty obtaining

the information they would have liked about their treatment.

It therefore seems clear that although people pay attention to and remember the details of what they can observe happening to them including the drugs they take, they either are not told or do not remember more abstract information. This should be of concern since they have a legal and moral right to be fully informed. How this situation might be tackled is less clear. Under the terms of the Mental Health Act, medical staff are obliged to keep a record of whether sectioned patients have been told about their section. This information is also supplied to the patient in writing. It is of note that the sectioned patients did seem to have quite good recall of this information suggesting that people might be better informed if the procedures for imparting information were generally more formalised. It would probably place a great burden on staff time if this were done by word of mouth but it should be a relatively simple matter to produce standardised fact sheets about common conditions and treatments and about the range of therapeutic interventions that are available within the health service. However, there is also a legal obligation for sectioned patients to be informed about the role of the Approved Social Worker and no-one had retained this information. Since the Approved Social Worker initiates the section, at a time when the person is likely to be very disturbed or distressed, this may well highlight the difficulty for patients of assimilating information when their thoughts are anyway confused. It may well be more realistic to allow patients a routine re-assessment of their care plan midway through their hospital stay rather than expecting them to be able to assert or know their own wishes at the start.

One thing that was of note regarding the experience of being sectioned was that all patients thought that the provision of the possibility to section people was a good idea. Although the respondents were a self-selected

sample and there were some patients who passed through the clinic during the data collection period who did feel angry about their section, the overwhelming majority of people seemed to feel that being sectioned had been for the best. Frustrations seemed to be limited to day-to-day annoyances such as not being able to go out when they wanted to. Thus, despite the findings described above about mismatches between service provision and patients priorities and despite the enforced removal of their free will, a retrospective and holistic consideration of the experience did not appear to assess it as aversive.

Learned Helplessness

Of the theories chosen within which to examine the experience of being sectioned, learned helplessness is the one most widely applied to the field of clinical psychology. Despite this, there are no standardised tools available to assess the degree to which a person exhibits this attribute. Nevertheless, the possibility that sectioning might lead to the development of learned helplessness is an important issue because of its association with depression and impaired coping. However, according to Abramson's revision of the theory (Miller and Morley, 1986), it is only relevant to consider the concept of learned helplessness if the consequence of an event is aversive and is understood to be the result of internal, stable and global characteristics of the person. As was explained in the discussion of hypothesis 7, it is not the case that the majority of people seem to regard their experience of being sectioned as aversive.

Notwithstanding the obvious limitations of the terms of the theory, it would still be of concern if people exhibited behaviours that were akin to the passivity and lack of self-confidence associated with learned helplessness. However, figure 4 in the results section shows the attributes that people make about themselves following their

hospitalisation. Statements that might be associated with learned helplessness are those that suggest lack of faith in oneself and lack of hope for the future. Such statements are:

I feel anxious now about becoming ill again

I feel more confused than ever

I can no longer trust my own judgement

I need someone to keep an eye on me

I mustn't expect too much of myself

In fact, the sectioned patients identified with these statements slightly less than the informal patients (6 and 8 votes respectively) and these statements generally appeared in the bottom 50% of those selected. Therefore, there is no suggestion that sectioning leads to helpless forms of behaviour nor that learned helplessness is widespread among the patients in general.

Locus of Control

The measures of locus of control employed for this study did prove to be sensitive to differences between the informal and sectioned patients. However, it was expected that if sectioning led to changes in locus of control, this would be exhibited by more extreme scores at both ends of the distribution for sectioned patients and a tendency towards a bi-modal distribution on measures of locus of control. No bi-modality was found and although the sectioned patients did have more broadly distributed scores on these measures, this was limited to more extreme scores only at the end of the distribution representing internality. It was therefore speculated that higher internality might be a feature of people that made them more likely to be sectioned rather than a result of the sectioning. However, the expectation that a change in locus of control would lead to a bi-modal distribution was based on the assumption that some people would experience being sectioned as a failure. In fact, the results discussed under

hypothesis 7 suggest that sectioned patients are rather better informed than their informal counterparts and generally view their section as having had a positive or successful outcome. This raises the possibility that the results may be due to a change in locus of control with sectioning being supportive of internality. In any event, since internality is associated with positive outcomes, low morbidity and good coping, there is no evidence to suggest that change in locus of control is a potentially adverse effect of sectioning (although some evidence that it might be a benefit).

Transactional Analysis

From a psychodynamic perspective, it was suggested that a potential risk of sectioning might be to discourage people from using their own thinking ability to problem solve. In terms of transactional analysis, this would be expressed as them having low adult energy. Although measures of ego states do not exist, it was argued that this would be demonstrated by the person globally accepting or rejecting what was offered by the service. The sectioned patients did show more extreme scores on a measure of satisfaction with the service. This would be more consistent with a childlike response to a parental measure than a measured adult assessment. The possibility that sectioning fosters a degree of dependency and may impair future problem solving is thus lent some weight. Neither the informal nor the sectioned patients who took part in the study seemed to have much affinity with models of mental health represented by the service suggesting that there is no great dependency on the service view for understandings of mental health. Interestingly, many people did feel that early childhood experiences and family relationships were central to their problems which would be in keeping with a psychodynamic perspective.

Research Considerations

Following evidence discussed in the introduction that responses to surveys

vary according to the format of the questions, a number of methodologies were employed in this thesis. These all turned out to be useful in their own way.

The standardised measures of locus of control and of satisfaction did prove to be sensitive enough to detect differences between the patient groups. However, these differences would have been missed if the means only had been considered showing the need to consider the distribution of scores as well as their means.

The mental health questionnaire and the structured interview that were written specifically to probe issues that were of interest in this project also were useful both in allowing a consideration of psychological theory and in providing useful data about people's views and knowledge.

However, despite this variety of research tools, it was notable that some interesting factors came to light solely through examination of the comments people made spontaneously or in response to open-ended questions. These comments would not have been sufficient in themselves either to make a theoretical analysis of the data or to quantify patients' priorities highlighting the need for different types of data to complement each other.

The major difficulty encountered in drawing conclusions from this project was the cross-sectional design of the study. This inevitably meant that doubt existed about the cause of any differences that were found. Although steps were taken to make the patient groups as similar as possible, individual differences naturally existed although the use of statistical analysis allowed a judgement about what was error variance and what variance represented a genuine difference between the groups. More important was the fact that it is reasonable to suppose that people who

become the subjects of a section have certain characteristics that are more common to them than to others, e.g. a dislike of hospitalisation. This makes it very difficult to tell what features of this group pre-existed the section and what features were caused by the section.

The most obvious way of avoiding this difficulty would be to use a longitudinal design. However, whilst it would be possible to assess the stability of the differences discussed in this project by repeated sampling of the populations after admission (and possibly discharge), a longitudinal study of the effect of sectioning would require measures to be taken before and after admission. This would present some practical difficulties since the nature of a section is that it is usually planned and executed within a very short time period at a time when the subject of the section is unlikely to welcome or be able to participate in research.

One option would be to follow people who were already known to the service on the off-chance that some of them would become sectioned. However, this would be very costly in research time since the population would need sampling over years during which there would be massive participant attrition. It would also limit the research to people who have chronic mental health difficulties making the participant population unrepresentative since a substantial number of sectioned patients have very short term contact with psychiatric services often beginning with the section.

The other alternative is to make the results of cross-sectional research more reliable by increasing the number of participants. This seems most likely to be facilitated if measures that are specifically designed for use with psychiatric patients are developed and standardised. The problem would still exist of deciding which features of the sectioned population

were due to peculiarities of the population and which to the effect of the section but at least reliable information would then exist about the special needs of this group of patients.

Summary and Conclusions

Viewed as a whole, the data from this project does not suggest that sectioning makes a major difference to people's experiences of hospital treatment. Although the breadth of distributions differed on some measures of locus of control and satisfaction, there were no differences in any mean scores suggesting that the populations of informal and sectioned patients were not vastly different. There was some suggestion that sectioned patients valued the medical aspects of their care less than the informal group although the priorities of both groups were similar and focused on spending time with other people and having time to think.

From a theoretical perspective, learned helplessness proved too narrow a concept to adequately examine the experience of being sectioned and no attributes suggestive of learned helplessness were detected in the sectioned patients. Locus of control seemed to have the most face validity as a theoretical base since the predominant feature of a section is the withdrawal of control from the patient. However, there was no evidence that sectioning led to greater externality in sectioned patients and hence no reason to suppose that it had an adverse effect on locus of control. The suggestion, derived from transactional analytic theory, that sectioning might lead to greater dependency and less problem solving ability was given some support from the data on client satisfaction although other measures of dependency failed to back this up. Hence, both locus of control and a more psychodynamic perspective were found to have something to offer.

Considering the sectioned and informal patients as a single group, patients

generally seemed quite positive believing that change was possible. The understandings of mental illness subscribed to by patients were based on early experiences, life events, relationships, day-to-day sources of stress and the need for an existential or spiritual understanding of their place in the world. Patients did not generally identify with medical understandings of mental health and their attitude to medication, whilst not negative, was ambiguous. Patients generally wished to have more time available for talking about their problems with nursing staff and more constructive things to do whilst on the ward. It also seemed that some patients might value being offered treatment alternatives that were non-medical. The biggest source of patient dissatisfaction was in basic services such as food and accommodation. Many weaknesses were identified in these services which were contrary to the development or maintenance of self-respect and independence. It is also seemed that improved methods of informing patients need to be found since it is likely that many patients do not have sufficient information to make fully informed decisions about their treatment and care.

Appendix 1: Written Information for Sectioned Patients

Information about Section 2

Mental Health Act 1983 Leaflet 6
Section 2

Name _____

Your hospital doctor is _____

Date of admission _____

Your rights under the Mental Health Act 1983

Why you are being held

You are being held in this hospital/mental nursing home on the advice of two doctors. You can be kept here for up to 28 days (4 weeks) so that doctors can find out what is wrong and how they can help. You may also be given any treatment you may need while you are kept here. You must not leave before the end of the 28 days unless a doctor tells you that you can. If you try to leave before then the staff can stop you, and if you do leave you can be brought back. You can be held in this way because of Section 2 of the Mental Health Act 1983. These notes are to tell you what that means.

After 28 days you can only be kept in hospital if your doctor thinks you need to stay longer and makes new arrangements (under Section 3 of the Mental Health Act). If your doctor is thinking of doing this he will talk to you about it towards the end of the 28 days, and you will be given a further leaflet to explain your rights.

If you want to leave

Your doctor will tell you when he thinks you are well enough to leave hospital. If you want to go before the end of the 28 days and before he says you are ready, you will have to get the agreement of either

- the hospital managers; or
- the Mental Health Review Tribunal

If you think you should be allowed to leave hospital you should talk to your doctor. If he thinks you should stay, but you still want to leave, you can ask the hospital

managers to let you go. You should write to them to ask them to do this. Their address is

The Tribunal

You can also ask the Mental Health Review Tribunal to decide if you can leave hospital. You can ask the Tribunal to look at your case by writing to them or sending them a form which the hospital can give you. The Tribunal's address is

You must write to the Tribunal in the first 14 days (2 weeks) of your stay in hospital. If you need help writing the letter or filling in the form your social worker or the hospital staff will help you.

There are usually three people on the Tribunal – a lawyer, a psychiatrist (doctor) and a third person who is not a doctor. All these people will come from outside the hospital.

If you ask the Tribunal to look at your case they will probably ask to see you and your doctor. If the Tribunal see you, they will be able to make sure that they have full details of your case, and you will be able to tell them yourself why you want to leave hospital. You may not have to see the Tribunal if you do not want to but you can insist on seeing them if you want. The doctor from the Tribunal will want to talk to you in any case. The Tribunal will listen to what you and your doctor say, and to what everyone else says, and then decide if you can leave hospital.

You can also ask someone, including a solicitor if you wish, to help you to ask the Tribunal to look at your case and help you put your views to the Tribunal. Because of the legal advice and assistance scheme this solicitor's help may be free or it may only cost you a little. The Tribunal office or social worker will tell you how to find a solicitor or other help if you ask them.

Your treatment

You are being kept in hospital to make sure that you get the medical treatment you need. Your doctor will talk to you about any treatment he thinks you need. In most cases you will have to accept his advice except in the case of certain treatments.

- If your doctor wants you to have certain very specialised and rare treatments he *must* have your agreement and he must get another doctor's opinion on

the treatment that he wants you to have. You can withdraw your agreement at any time. The other doctor will have to talk to other staff who are involved in your case, including a nurse. The law protects you in other ways too. If your doctor wants you to have one of these treatments he will explain all this to you.

- If your doctor feels that you need to have ECT (electro convulsive therapy, sometimes called electric or shock treatment) and you agree, he can go ahead with the treatment. But if you do not agree, unless it is an emergency, he must first ask a doctor from outside the hospital to see you. This other doctor will talk to you and to other staff who are involved in your case, including a nurse, about the treatment and decide whether you need it. If the second doctor says you should have this treatment you will be given it.
- If at first you agree that your doctor may give you ECT but later you change your mind you should tell your doctor that you no longer agree to this treatment. He will then have to ask a doctor from outside the hospital to see you to decide whether you need to go on having it. Again, he will talk to other staff.

If you have any questions or complaints

If you want to ask something, or to complain about something, talk to the doctor, nurse or social worker. If you are not happy with the answer you may write to the hospital managers. If you are still not happy with the reply you are given you can ask the Mental Health Act Commission to help you. You can also write to the Commission even after you have left hospital.

The Mental Health Act Commission

The Commission was set up specially to make sure that the mental health law is used properly and that patients are cared for properly while they are kept in hospital. You can ask them to help you by writing to them at

MENTAL HEALTH ACT COMMISSION

MAID MARION HOUSE

56 HOUNDS GATE, NOTTINGHAM NG1 6BG

Your letters

Any letters sent to you will be given to you. You can send letters to anyone except a person who has said that he does not want to get letters from you. Letters to these people will be stopped by the hospital.

Your nearest relative

A copy of these notes will be sent to your nearest relative who we have been told is

If you do not want this to happen please tell the nurse in charge of your ward or a doctor. Your nearest relative can write to the hospital managers to ask them to let you leave. The managers will need at least 72 hours (3 full days) to consider such a request, so that your doctor can consider whether you should leave or not.

If there is anything in this leaflet you do not understand, the doctor or a nurse or social worker will help you. If you need help in writing a letter you should ask one of them, or a relative or friend.

Information about Section 3

Mental Health Act 1983 Leaflet 7
Section 3

Name _____

Your hospital doctor is _____

Date of admission _____

Your rights under the Mental Health Act 1983

Why you are being held

You are being held in this hospital/mental nursing home on the advice of two doctors. You can be kept here for up to 6 months so that you can be given the treatment and care that you need. You can only be kept in hospital for longer than 6 months if your doctor thinks you need to stay. If your doctor thinks you should stay longer he will talk to you about this towards the end of the 6 months.

You must not leave unless a doctor tells you that you can. If you try to leave before then the staff can stop you, and if you do leave you can be brought back. You can be held in this way because of Section 3 of the Mental Health Act 1983. These notes are to tell you what that means.

If you want to leave

The doctor will tell you when he thinks you are well enough to leave hospital. If you want to go before the end of the 6 months, or before he says you are ready, you will have to get the agreement of either

- the hospital managers; or
- the Mental Health Review Tribunal

If you think you should be allowed to leave hospital you should talk to your doctor. If he thinks you should stay, but you still want to leave, you can ask the hospital managers to let you go. You should write to them to ask them to do this. Their address is

The Tribunal

You can also ask the Mental Health Review Tribunal to decide if you can leave hospital. You can ask the Tribunal to look at your case by writing to them or sending them a form which the hospital can give you. The Tribunal's address is

You can apply to the Tribunal any time in the next 6 months and if you withdraw your application you can apply again. If you need help writing the letter or filling in the form, your social worker or the hospital staff will help you.

There are usually three people on the Tribunal – a lawyer, a psychiatrist (doctor) and a third person who is not a doctor. All these people will come from outside the hospital.

If you ask the Tribunal to look at your case they will probably ask to see you and your doctor. If the Tribunal see you, they will be able to make sure that they have full details of your case, and you will be able to tell them yourself why you want to leave hospital. You may not have to see the Tribunal if you do not want to but you can insist on seeing them if you want. The doctor from the Tribunal will want to talk to you in any case. The Tribunal will listen to what you and your doctor say, and to what everyone else says, and then decide if you can leave hospital.

You can also ask someone, including a solicitor if you wish, to help you to ask the Tribunal to look at your case and help you put your views to the Tribunal. Because of the legal advice and assistance scheme this solicitor's help may be free or it may only cost you a little. The Tribunal office or social worker will tell you how to find a solicitor or other help if you ask them.

If you have not applied after 6 months, the hospital managers will apply for you. If your doctor advises that you need to stay in hospital for a further 6 months you will be able to apply again. After that you can apply every year you are still kept in hospital under the Mental Health Act.

Your treatment

You are being kept in hospital to make sure that you get the medical treatment you need. Your doctor will talk to you about any treatment he thinks you need. In most cases you will have to accept his advice except in the case of certain treatments.

- If your doctor wants you to have certain very specialised and rare treatments he *must* have your agreement and he must get another doctor's opinion on the treatment that he wants you to have. You can withdraw your agreement at

any time. The other doctor will have to talk to other staff who are involved in your case, including a nurse. The law protects you in other ways too. If your doctor wants you to have one of these treatments he will explain all this to you.

- If your doctor feels that you need to have ECT (electro convulsive therapy, sometimes called electric or shock treatment) and you agree, he can go ahead with the treatment. But if you do not agree, unless it is an emergency, he must first ask a doctor from outside the hospital to see you. This other doctor will talk to you and to other staff who are involved in your case, including a nurse, about the treatment and decide whether you need it. If the second doctor says you should have this treatment you will be given it.
- If at first you agree that your doctor may give you ECT but later you change your mind you should tell your doctor that you no longer agree to this treatment. He will then have to ask a doctor from outside the hospital, to see you to decide whether you need to go on having it. Again, he will talk to other staff.
- Your doctor will talk to you about any medicine or drug treatment he thinks you need. You must accept the treatment for the first 3 months that you are kept in hospital under the Mental Health Act. (If you are not given any medicines or drugs at first, the 3 months only begins when your doctor starts to give you them.) If after 3 months your doctor wants you to carry on having any drug treatment or medicine he must, except in an emergency, get your agreement first. If you agree he can continue the treatment. But if you do not agree, he must ask a doctor from outside the hospital to see you. This other doctor will talk to you and to other staff who are involved in your case, including a nurse, about the treatment and decide whether you need it. If the second doctor says you should have this treatment, you will continue to be given it.
- If when the 3 months is up you at first agree that your doctor can carry on giving you any medicine or drug treatment but later you change your mind, you should tell your doctor. He will then have to ask a doctor from outside the hospital to see you and decide whether you need to go on having it. Again, he will talk to other staff.

If you have any questions or complaints

If you want to ask something, or to complain about something, talk to the doctor, nurse or social worker. If you are not happy with the answer you may write to the hospital managers. If you are still not happy with the reply you are given you can ask the Mental Health Act Commission to help you. You can also write to the Commission even after you have left hospital.

The Mental Health Act Commission

The Commission was set up specially to make sure that the mental health law is used properly and that patients are cared for properly while they are kept in hospital. You can ask them to help you by writing to them at

Your letters

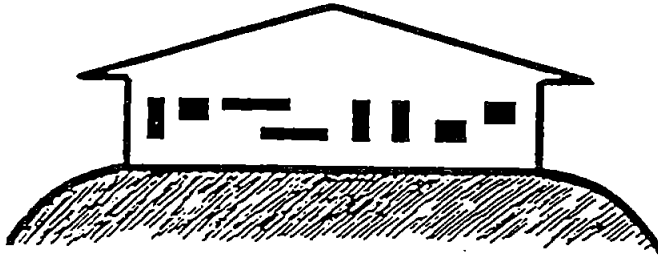
Any letters sent to you will be given to you. You can send letters to anyone except a person who has said that he does not want to get letters from you. Letters to these people will be stopped by the hospital.

Your nearest relative

A copy of these notes will be sent to your nearest relative who we have been told is

If you do not want this to happen please tell the nurse in charge of your ward or a doctor. Your nearest relative can write to the hospital managers to ask them to let you leave. The managers will need at least 72 hours (3 full days) to consider such a request, so that they can get a report from your doctor. Only one request will be considered in any one period of 6 months. If your doctor reports that you should not leave, your nearest relative can ask for a Tribunal to look at your case.

If there is anything in this leaflet you do not understand, the doctor or a nurse or social worker will help you. If you need help in writing a letter you should ask one of them, or a relative or friend.



BLACKBERRY HILL PROJECT PATIENTS PACK

THANK YOU FOR YOUR HELP

If you have any questions, please contact KATE ROSS
by telephoning 0272 656061 and asking for the
psychology department.

BLACKBERRY HILL PROJECT

The aim of this project is to find out what its like to be a patient in the Prichard Clinic. We want YOU to tell US what you think about the clinic. We also want to know if being under a section makes a difference to how people feel about their treatment. What do YOU think?

Who will know what I said?

The information from the project will be given to the clinic managers so they know what people find most helpful. However, they will be given a general picture. No-one will be told your name or exactly what you said and your name will not appear in any reports. To help keep your identity secret, the project is being run by a separate department. Taking part will not make any difference to your treatment and care.

Taking Part

We hope that lots of patients will take part in the project so that we get a true picture of life at Prichard. If you would like to take part, please sign your name below.

Name: _____

Yes, I am willing to answer some questions about Prichard Clinic.

Yes, it is OK to write to me in 3 months to ask a few more questions.

Yes, I would like to be interviewed so I can explain my point of view.

(please tick)

What Do YOU Think About the Your Stay in Hospital?

Please answer all the questions. There are no right or wrong answers. I am interested in your honest answer about what you think now.

What things have been helpful during your stay at the Clinic?

- a. _____
- b. _____
- c. _____

Is there anything that was not helpful?

- a. _____
- b. _____
- c. _____

People who come to the Prichard Clinic have a wide variety of different problems. Tick the person who best understood the problems that you arrived with.

- a. a friend
- b. one of the nurses
- c. one of the patients
- d. a doctor
- e. me
- f. someone in my family
- g. nobody
- h. someone else (who? _____)

Please show how important the following things were to you during your stay in the clinic by circling a number from 1 to 4. 1 means not important at all and 4 means very important.

Not important at all 1	Slightly important 2	Quite important 3	Very important 4
a. Talking to nurses		1 2 3 4	
b. Talking to doctors		1 2 3 4	
c. Talking to other patients		1 2 3 4	
d. Having time away from home		1 2 3 4	
e. Having visitors		1 2 3 4	
f. Taking prescribed medicine		1 2 3 4	
g. Having days out of the clinic		1 2 3 4	
h. Joining in with the ward activities		1 2 3 4	
i. Having time to think		1 2 3 4	

Was there anything else that was important to you during your stay in the clinic?

How Can WE Stay Healthy?

Instructions: Please show whether you agree or disagree with the following statements by circling a number from 1 to 6. 1 means you strongly disagree and 6 means you strongly agree. There are no right or wrong answers and no trick questions.

STRONGLY DISAGREE	DISAGREE	MILDLY DISAGREE	MILDLY AGREE	AGREE	STRONGLY AGREE
1	2	3	4	5	6

- | | | | | | | |
|---|---|---|---|---|---|---|
| 1. If I take care of myself, I can avoid illness. | 1 | 2 | 3 | 4 | 5 | 6 |
| 2. Whenever I get sick, it is because of something I've done or not done. | 1 | 2 | 3 | 4 | 5 | 6 |
| 3. Good health is largely a matter of good fortune. | 1 | 2 | 3 | 4 | 5 | 6 |
| 4. No matter what I do, if I am going to get sick I will get sick. | 1 | 2 | 3 | 4 | 5 | 6 |
| 5. Most people do not realize the extent to which their illnesses are controlled by chance. | 1 | 2 | 3 | 4 | 5 | 6 |
| 6. I can only do what my doctor tells me to do. | 1 | 2 | 3 | 4 | 5 | 6 |
| 7. There are so many strange diseases around that you can never know how or when you might pick one up. | 1 | 2 | 3 | 4 | 5 | 6 |
| 8. When I feel ill, I know it is because I have not been getting the proper exercise or eating right. | 1 | 2 | 3 | 4 | 5 | 6 |
| 9. People who never get sick are just plain lucky. | 1 | 2 | 3 | 4 | 5 | 6 |
| 10 People's ill health results from their own carelessness. | 1 | 2 | 3 | 4 | 5 | 6 |
| 11 I am directly responsible for my health. | 1 | 2 | 3 | 4 | 5 | 6 |

How Satisfied are YOU?

Please help to improve our services by answering some questions about your stay at Prichard. I want to know your honest answers whether they are good or bad. Please answer ALL the questions. Circle the answer you most agree with.

How would you rate the quality of care you received?

Excellent Good Fair Poor

Did you get the kind of care you wanted?

Not at all Not really Mostly Yes, all the time

To what extent did the clinic meet your needs?

Almost all my needs Most of my needs Only a few of my None of my needs
have been met have been met needs have been met have been met

If a friend were in need of similar help, do you think they should go to this clinic?

No, never I don't think so I think so Yes, they should

How happy are you with the amount of help you received from the clinic?

Quite Not sure or a Fairly Very
Unhappy bit unhappy Happy Happy

Did the care you received help you to deal more better with problems?

It helped It helped It really It seemed to make
a great deal a bit didn't help things worse

Overall, how happy were you with the care you received?

Very Fairly Not sure or a Quite
Happy Happy bit unhappy Unhappy

Would you use the clinic in the future?

No, never I don't think so I think so Yes, I would

What Do YOU Think About Mental Health?

When they are recovering from mental problems, people often think they have changed in some way. Tick THREE of the following that most apply to you.

- a. I have learned something about myself.
- b. I know that the doctors know what is best for me.
- c. I feel anxious now about becoming ill again.
- d. I feel confident knowing that the clinic is here to help.
- e. I have to make some changes in my life.
- f. I can't trust my family any more.
- g. I'll be able to cope better than before.
- h. I feel more confused than ever.
- i. I realize that there are people who care about me.
- j. I can no longer trust my own judgement.
- k. I realize that mental illness can happen to anyone.
- l. I am a stronger person now.
- m. I need someone to keep an eye on me.
- n. I mustn't expect too much of myself.

Are there any other ways in which you have changed?

What is it that made you change?

Different people have different ideas about the reasons for mental illness. Which of these reasons make the most sense to you? Tick the THREE you most agree with.

- a. The problems are caused by early childhood experiences.
- b. Some people are just naturally more miserable than others.
- c. The problems are caused by stressful relationships
(in marriage, with the children, at work, etc).
- d. The problems are caused by an illness in your brain.
- e. The problems are caused by lack of faith in God.
- f. People have problems when they behave in a way which makes them
unhappy.
- g. The problems are caused by bad living conditions
(unemployment, poor housing, lack of money, etc).
- h. Problems arise because we don't have our family and friends around to help.
- i. The problems are caused by thinking about things in a negative way.
- j. Mental illness is just a label for people who behave in an unusual way.
- k. The problems are caused by the stress of modern living.
People expect too much of themselves.

What caused the problems that led you to stay in the Prichard Clinic?

What helped?

What Do YOU Think About Life?

Here are some pairs of sentences. For each pair, please pick the one that you think is most often true. There are no right or wrong answers. Circle a or b to show which one you think is the case.

1. a. Many of the bad things in people's lives are due to bad luck.
b. People's misfortunes are due to the mistakes they have made.
2. a. One reason why we have wars is because people don't take enough interest in politics.
b. There will always be wars, no matter how hard people try to prevent them.
3. a. In the long run, people get the respect they deserve in this world.
b. A person's worth often goes un-noticed no matter how hard he or she tries.
4. a. The idea that teachers are unfair to school children is nonsense.
b. Most school children don't realize how much their marks are affected by chance.
5. a. Without the right chances, one cannot be an effective leader.
b. Clever people who are not leaders have not taken advantage of their opportunities.
6. a. No matter how hard you try, some people just don't like you.
b. People who can't get others to like them don't know how to get along with others.
7. a. I often find that what is going to happen will happen.
b. Trusting to fate is not as good as deciding to do something definite.
8. a. If you work hard enough, there is rarely such a thing as an unfair exam.
b. Often exam questions are so different to lessons that studying is a waste of time.
9. a. Becoming a success is a matter of hard work, luck has nothing to do with it.
b. Getting a good job depends on being in the right place at the right time.
10. a. The average person can have an effect on government decisions.
b. This world is run by the few people in power and there is not much most of us can do about it.
11. a. When I make plans, I am almost certain I can make them work.
b. It is not wise to plan too far ahead because many things are a matter of luck.
12. a. In my case, getting what I want has little to do with luck.
b. Often, we might just as well decide what to do by tossing a coin.
13. a. Who is the boss depends on who was in the right place first.
b. Getting people to do the right thing depends upon ability, luck has little to do with it.

14. a. In world affairs, most of us are the victims of forces we cannot control.
b. By taking part in political and social affairs, people can control world events.
15. a. People don't realize how much their lives are controlled by chance.
b. There really is no such thing as luck.
16. a. It is hard to know whether or not a person really likes you.
b. How many friends you have depends on how nice a person you are.
17. a. In the long run, the bad things that happen to us are balanced by the good ones.
b. When people have bad luck, it is because they are stupid or lazy.
18. a. With enough effort, we can wipe out political corruption.
b. People do not have much control over the things politicians do.
19. a. Sometimes I can't understand how teachers arrive at the marks they give.
b. Children's school marks depend on how hard they work.
20. a. I have little influence over the things that happen to me.
b. I do not believe that chance or luck plays an important role in my life.
21. a. People are lonely because they don't try to be friendly.
b. There's no point trying too hard to please people, if they like you, they like you.
22. a. What happens to me is my own doing.
b. Sometimes I feel that I don't have enough control of my life.
23. a. Often, I can't understand why politicians behave the way they do.
b. In the long run we are all responsible for bad government.

Appendix 3: Interview Schedule

Admission

Who decided you should go to the Prichard clinic?

Looking back, do you think this was a good idea?

First Impressions

What were your first impressions of the clinic?

When you first walked in, what did you think, feel?

How were you greeted?

Patient Status

Were you a voluntary/informal patient or under section?

What does being under section mean?

What difference does this make to your care or treatment?

Would you have felt differently if you had chosen/been forced to go to the clinic?

Mental Health Act

Do you think it is a good idea to section people when they are very disturbed?

Do you know who can be put under section?

Who is it that sections people?

If you are under section, what rights do you have?

If a section seems unfair, is there anything you can do about it?

Patient Goals

What did you hope to achieve in the clinic?

Did the staff understand these hopes?

Did the staff have the same hopes as you?

Did you achieve what you wanted?

General Information

What were you told about how the ward ran?

Who told you this?

Who gave you the best explanation of your difficulties?

What did they say?

Treatment Information

What was your treatment?

Who told you the most about your treatment?

What was the purpose of your treatment?

Were there any risks?

Were there any alternative treatments that could be tried?

Who had the right to make a final decision about which treatment to give you?

Experiences

What things stand out most in your memory from being in Prichard?

Can you remember times when you laughed? felt sad? felt angry?

Are you happy with the treatment you received?

What do you think others could learn from your experiences?

Improvements

What would you like to change at Prichard to make the clinic better?

Was there any information you would have liked that you didn't get?

Is there any message you would like to give the staff?

If you were the Health Minister and could do anything you wanted, what care would you provide for people with difficulties like yours?

The Long Term

Do you think your experiences have changed you in the long term?

In what way?

Do you think this is a good or bad thing?

What difference does having been a psychiatric patient make to people?

Appendix 4: Interview Transcriptions

H27 Interview : 20th July 1994

Me: Let me just check there's some tape going through. OK. I've got a number of things that I'd like us to chat about and get your experience of. I just wondered if you have any burning issues that you would like us to know about?

H27: I'd like to talk about the building.

Me: OK.

H27: Yes, I'd like to talk about the building and the suitability of it and all that and the interior decor and everything. And the other thing I'd like to talk about is that sometimes, quite often in fact, nurses aren't available.

Me: Right. How do you mean?

H27: Well, you might want to talk to a staff nurse and you go and ask them and they say "Later, I'm busy at the moment". And on a number of occasions they said "Oh yes, we promise we'll see you before the end of the shift" and they haven't done.

Me: Right. Why do you think that is?

H27: I don't know. I suppose they are busy but I think the time should be made for everybody who wants it. They should divide their time more equitably between whoever they're dealing with.

Me: Were there specific times when you knew that you could, that you would definitely have some space for you to talk to a nurse?

H27: No, there never was.

Me: So it was just luck of the draw if you managed to catch someone.

H27: Yes. Because when I was at Ham Green you had a keyworker and you saw that keyworker, if they were on a full week's stint of shifts, you saw them every night. You saw them every time they were on.

Me: Where's Ham Green?

H27: It used to be - its now Southmead Hospital. They've got a lovely new building up there.

Me: Did you not have a keyworker at Prichard?

H27: Yes but you didn't always see them. One of my keyworkers was Pauline and she's the best nurse there. I was very lucky to have her. She did try to see me as much as she possibly could when she was on. I'm not knocking Pauline because she was very good.

Me: So does it seem as though the nurses at Prichard were busier than at Ham Green?

H27: Yes, they appear to be busier. Whether they are or not I don't know.

Me: Well, that was what I was asking really. Are they actually busier or did they seem less interested in taking time with people?

H27: My gut feeling is that they're less interested in talking to people.

Me: OK, well that's a good point. I'm glad you brought it up. Was there anything else you wanted to say about that?

H27: Not really.

Me: Well, what about the building because you were going to tell me something.

H27: Well, its a terrible shabby building. I think its atrocious that people should be expected in this day and age to go to a building like that. They've got so much better facilities in Southmead. My boyfriend is ill and he really needs to go to hospital but he won't go to Prichard. I said "If you were in Southmead's area, would you go there?", and he said yes he would.

Me: What has Southmead got that Prichard hasn't?

H27: Well, its brand new for a start.

Me: I thought that Prichard was new.

H27: No.

Me: Because three years ago when I was first here, Prichard was in temporary accommodation on one of the wards because I thought they were building a new building. Perhaps not.

H27: They must have redecorated then. Its not very nice at all.

Me: Well, no. I've seen the building and because I thought it was new, I was fairly surprised they built it that way. So what else?

H27: I think its the lay-out, its very square isn't it? And the quality of the carpets.

Me: Is there carpet? There's no carpet in the corridor is there?

H27: There's carpet in the smoke room and the bedrooms.

Me: What about the bedrooms, how do they compare with Southmead?

H27: They're not as nice because in Southmead you get you're own little room. They're a bit small but you get you're own room.

Me: And you like that?

H27: Yes.

Me: Is there anything else?

H27: I don't think so.

Me: I was just wondering about the living room.

H27: Its very grotty. Well, you'd expect the smoke room to be grotty in a way but the smoking room at Southmead isn't grotty. They haven't been punished for their sins.

Me: I wonder how they keep it from not being grotty.

H27: It was new when I saw it. Still, if you give people a nice room, they're going to look after it I think. I wonder how long, I'm sure that Southmead will stay nice for quite a long time.

Me: Did they have ... I'm just wondering if they had some sort of air extractor or something. Because if people do smoke a lot in one place then things do get stained don't they?

H27: There is an air extractor at Prichard but its not a very nice room.

Me: Do you think that, probably the building has to stay like it is so you've got that room in that shape. If you suddenly became manager of Prichard, what would you change in what way. You know, if you had a limited budget so you could probably do bits and bobs with the furniture but you couldn't knock the whole place down and start again.

H27: I might put some more comfortable and some newer chairs in. Give it a lick of paint. New curtains.

Me: Has it got curtains?

H27: Yes, horrible ones.

Me: Its obviously something you've noticed.

H27: Yes.

Me: OK. Is it ok to move on?

H27: Yes.

Me: I want to take you right back to the first day that you went into Prichard for this recent admission. Who decided that you should go to Prichard.

H27: I did, really.

Me: Right.

H27: I had to battle with the GP to send me up there with a letter.

Me: Because?

H27: Because he didn't know the procedure of admission.

Me: Really?

H27: Yes, he didn't think he had the power to refer me.

Me: That's strange isn't it? So obviously you've changed GP's now.

H27: No. He was one of the locums.

Me: Oh right.

H27: I only moved area. I haven't changed my GP.

Me: Now that you've had the admission and come out, do you think it was a good idea?

H27: Yes.

Me: OK. Well, we've talked a bit about the building already so perhaps we've covered some of this but that first time you walked in, what were your first impressions of Prichard?

H27: I had been there before on a visit.

Me: Because you thought you might want to go there or because you ...

H27: No, visiting someone.

Me: Right.

H27: But I thought it was a safe place to be actually.

Me: That was your initial over-whelming feeling was it?

H27: Yes.

Me: Just as you walked through the door, you say you were feeling that it was safe, what was the emotion around that?

H27: Well, I was very distressed as well.

Me: And did arriving at Prichard make a difference to that feeling?

H27: Well, I was hopeful that I'd get admitted to hospital.

Me: So when you walked in, you still weren't sure if you'd be admitted?

H27: Yes.

Me: You must have had to organise all that yourself. How did you go about that?

H27: I went to the GP. My support worker from St. Marks came along with me and gave me support in the GP's office and we got the GP to write a letter of referral. I think he was more aware than I was what was the matter, he was quite good.

Me: Did he come with you to Prichard?

H27: No, my boyfriend did.

Me: So did you just arrive with a letter? Were they expecting you?

H27: No.

Me: And did you get admitted there and then?

H27: Yes.

Me: Who was it you saw?

H27: I don't know. Some lady. Dr. Nereli was there. He was very good.

Me: Right. Who first greeted you when you walked in?

H27: I think the ward clerk.

Me: And how did she greet you?

H27: Very officious. Very stern, not very sympathetic.

Me: Do you think that that's because you weren't expected, it took people by surprise? Is that true for most people that the first person they meet is the ward clerk?

H27: I don't know.

Me: Were you an informal patient?

H27: Yes.

Me: Do you know what it means to be under section?

H27: Yes. I've never been under section.

Me: What is that?

H27: It's when the mental health act can be used to restrain you from going outside the hospital.

Me: Do you know if it makes a difference to your, well not yours. But people who are under section, does that make a difference to their care or treatment?

H27: I think they get more care and treatment.

Me: Do you think if you had been brought in under section, you'd have felt differently about going to Prichard?

H27: If I'd been brought in not wanting to go there, it would have seemed an awful place.

Me: Even though you might have got some extra care?

H27: Yes. Generally, the sectioned people are a bit naughty and so get more attention.

Me: So they get the attention by...

H27: Yes.

Me: And is that attention that they welcome? Because earlier, you were saying that you'd have liked to be able to speak to the nurse when you wanted to so that was attention that you want. Is the attention that the sectioned people get attention that they want?

H27: I think if they want attention, they get it. People tend to get more attention if they're being violent. Obviously they would, it'd be silly if they didn't. But.

Me: Have you ever been tempted to be violent in order to not be ignored?

H27: No. But I know that's the way you do get attention.

Me: What do you think about the mental health act? Do you think its a good idea to section people when they're very disturbed?

H27: Yes.

Me: Why?

H27: For their own safety and the safety of others.

Me: Do you know who it is that can be sectioned?

H27: I'm not really sure about it. Well, people who are a danger to themselves and a danger to other people.

Me: Who can section people?

H27: The police have to be involved, and a psychiatrist. And a GP? I'm not sure.

Me: If a person is under section, what rights do they have?

H27: Well, they've got all the rights to be treated humanely. They've got a right to appeal. I don't know. I've never been sectioned so...

Me: No, but I'm interested to know what people know about it. OK, well you've already answered the next question, if a section seems unfair what can you do? You can go to appeal.

H27: Yes.

Me: OK. I'd like to ask you a bit more about your experiences in the clinic. What did you hope to achieve by going to Prichard?

H27: I hoped to get through a very rough period in my life; and some time out really.

Me: Did the staff there understand what it was you were hoping to achieve?

H27: Yes.

Me: Do you think that the staff had the same hopes that you had? Were they aiming for the same thing?

H27: I think they were aiming for whatever I wanted.

Me: So it sounds as though at some time, even though people weren't always available when you wanted them, at some time you had managed to communicate quite well.

H27: Yes.

Me: How did you manage that?

H27: By asking if I could speak to someone. And then if you got hold of someone... Normally it was Pauline, my keyworker. She was very good about talking to me.

Me: Did you achieve what you wanted? Did it help you get through that rough patch?

H27: Yes.

Me: So, although its quite a shoddy place in many ways, you did get something positive out of it?

H27: Yes.

Me: What information were you given about how the ward ran?

H27: I was given a booklet.

Me: A booklet.

H27: It was quite good but it was more a list of rules and regulations in some ways.

Me: What about the sort of information that isn't really rules and regulations? Stuff like what ward activities are on and where the tea and coffee's kept, stuff like that?

H27: There isn't that information. I think I asked someone to show me round and she showed me where the tea and coffee was.

Me: Was that a member of staff?

H27: Yes.

Me: So what was it that she didn't mention, the ward activities?

H27: Well, half the time I was there, we didn't have an OT anyway.

Me: Oh right.

H27: And if you wanted to know what the ward activities were, you had to look on the board.

Me: Who was that who showed you round then?

H27: I can't remember.

Me: Who was it who gave you the best explanation of the difficulties and problems that you'd gone in with?

H27: Stella Bardsley. She was the SHO for a while but she left. She was only there a couple of weeks.

Me: What did she say?

H27: She was just very good at explaining my problems to me. Explaining what I told her back. She was very good at giving advice.

Me: I realize that some of this may be private so don't answer if you don't want to but I'm interested to know the sort of advice and explanations that she gave you.

H27: It's quite private really.

Me: OK. But she was someone you felt was very understanding?

H27: Yes.

Me: Did you have any formal treatment?

H27: Yes, I had quite a number of tablets and then I went on to injections.

Me: Do you know what it was that you were taking?

H27: The tablets were sulperide and the injection was dipixol. That's what I'm on now and it's agreeing with me quite well.

Me: Who told you the most about your treatment?

H27: Dr. Bardsley.

Me: Did she explain what the purpose of your treatment was?

H27: No.

Me: Are there any risks in your treatment?

H27: Don't know.

Me: Were there any alternatives to the treatment you ended up on that could have been tried?

H27: Don't know.

Me: Who had the right to make the final decision about what treatment you would receive?

H27: The doctors.

Me: What would have happened if you had disagreed or can't you imagine doing that?

H27: Well you see, I wasn't at all happy with the first ones I was on, Sulperide, they were awful things. It's only by chance that I got moved off them.

Me: How do you mean, by chance?

H27: Dr. Watts thought that I was on the dipixol injection and he said to Stella something about the injection. And I said "What about this injection? I'm not on it." I said that I would like to be on the injection. She said "Would you like to be on the injection?" and I said that yes I would like to. I know other people who've been on it and it doesn't have too many side effects so that's why I got onto the dipixol.

Me: So you never complained about the sulperide, that you didn't like it?

H27: No.

Me: What are the things about your stay in Prichard that stand out most in your memory?

H27: Quite a nice time sun-bathing.
 Me: OK. Were there times there when you laughed?
 H27: I had a good laugh with some of the patients.
 Me: Were there things that happened that made you feel sad?
 H27: No, not really.
 Me: Was there anything that happened that made you feel angry?
 H27: They moved my bed without telling me when I came back from weekend leave. And some of my stuff was gone.
 Me: Anything else that made you angry?
 H27: Yes, not being able to speak to certain nurses.
 Me: What, because they were just never available?
 H27: They weren't there.
 Me: Did you ever get your stuff back ?
 H27: No.
 Me: So it was gone for good. Sounds as though there is some sort of issue around the security of people's belongings. If you had anything that was precious to you, was there any way of ensuring that it was safe?
 H27: No.
 Me: Alright. Are you happy now with the treatment that you received there?
 H27: Yes.
 Me: Having gone through that experience of being in Prichard, what do you think people could learn from your experience?
 H27: What, new people going in there?
 Me: Yes.
 H27: I'm not sure.

Me: Ah-ha, now improvements. We've done some of this about what you would like to change in Prichard. Given that you'd like to change some of the furniture, what else might you change to make the clinic better?
 H27: I'd make it more modern.
 Me: Like what?
 H27: Like I said, make it a more modern building.
 Me: OK. I'm just wondering if there's something about the way the staff worked?
 H27: Yes, there is something about the way the staff worked. there needs to be more organisation on the part of the staff.
 Me: Was there any information that you would have liked that you didn't get?
 H27: I would have liked more information about my drugs.
 Me: Anything else?
 H27: I can't think of anything else.
 Me: What message would you like to give the staff?
 H27: Stop pen-pushing, going around faffing around with pens in your hand and doing all your paperwork. Get into the living room and the smoke room and talk to the patients.
 Me: If you were the minister for health in the government and you could do anything you wanted, what would you provide to care for people who've got difficulties a bit like yours?
 H27: I'd provide more day hospitals. More local day hospitals like the day centre they've got at Southmead. I'd make sure the patients had better meals. One of the things that annoyed me about Prichard was that you could only get tea and coffee at certain times. I think you should be able to get it all the time.
 Me: Why was it you could only get it at certain times?
 H27: Well, you have it at ten o'clock in the morning and three in the afternoon and eight o'clock in the evening.
 Me: Could you not just go and make your own?
 H27: No.
 Me: So what could you do if you were thirsty?
 H27: You had to ask for a drink of water.

Me: You had to ask for a drink of water?
H27: Yes.
Me: So you couldn't just go and get one?
H27: No. Because to get in the kitchen you had to ask.
Me: Right. Yes I can see why you might want to change that.
H27: Yes, because at Ham Green we could do whatever we wanted and nobody drank too much tea you know.
Me: What's drinking too much tea?
H27: Well, everybody was just nice and you could go and make tea. It was lovely. Ham Green was lovely, very good. They've shut it down now.
Me: Oh, has it been shut down? Why has it been shut down?
H27: They've build a new building on the site.
Me: And is that not the same?
H27: I haven't been there. But I'm stuck in Easton so I can't go back to Ham Green.
Me: Is there anything else you'd do if you were this amazingly powerful health minister?
H27: Did I say spend more money on the wards?
Me: You said make them look better so ...
H27: Yes. Put more staff on.

Me: Do you think that your experiences have changed you in the long run?
H27: Yes.
Me: In what way?
H27: Less confident.
Me: Is that something to do with the particular difficulties you've had or to do with the hospital?
H27: To do with the difficulties I've had.
Me: What about going into hospital. Has that changed you?
H27: Yes, my first experiences of it horrified me, that was in London.
Me: Do you think you still carry some of that?
H27: The scars, yes. I was just emotionally torn to bits there.
Me: And yet you've chosen to come back to Prichard as a voluntary patient. And in fact you have achieved what you wanted to achieve.
H27: I had good experiences at Ham Green didn't I.
Me: So Ham Green made all the difference?
H27: Yes, and Gloucester House day centre.
Me: Do you think that just having been a psychiatric patient makes a difference to how people feel?
H27: Yes.
Me: In what way.
H27: Well there's a stigma that's attached to it.
Me: Are there any times when you're more aware of that than others?
H27: When you go for jobs.
Me: Do you have to declare?
H27: On medical forms, yes.
Me: How so you feel about that? Does it make a difference to you whether someone's been a psychiatric patient?

H27: No, it doesn't.

Me: Ok. I've come to the end of all my questions. Is there anything you wanted to ask me before you go?
H27: Yes. What is this all about. I mean is it an ongoing thing or what?
Me: Well, its not ongoing for ever but it will take a while. Lets see, I started in February and I should be finished actually collecting the information by November. The reason I'm doing it is that as part of my training I have do some research. And the reason that I'm doing this research is because I was interested in what difference it makes to

people being sectioned and what people's actual experiences are in a psychiatric clinic. There's a lot of information like ... all the different professions have their different information. So psychiatrists will tell you their opinions of what people need and nurses will tell you what they think people need, what their view is. Just recently, say in the last five years, we've realized that there is an extra group of people who might have something to say about that who are the people who actually use the service. But in psychiatric services, there's not a lot about what psychiatric patients say they want and what they think it happening. So that's the point really, to get that extra point of view. And also a personal interest in what difference it makes to people if the care they are given is given against their will. Does that answer your question?

H27: Yes.

Me: OK. I've tried to write it down pretty well as you said it but if you want to have a quick look through then feel free.

H41 Interview : 22nd July 1994

Me: I'll be asking you some questions this afternoon. Is there anything that you particularly wanted to say about Prichard?

H41: No, not really. Its not so bad really.

Me: Good. Well, if anything does crop up that you'd like to mention then just say so and we can talk about that. I'd like to ask you first of all about your most recent admission to Prichard. Who was it that decided you should go to Prichard?

H41: I decided myself. I phoned the police because I thought that my life was being threatened or suicide or I was being controlled by a police computer, a sort of cosmic police computer. And I phoned the police and they said to go and talk to your doctor. Then I phoned the Samaritans just for a chat. That was about it really. I felt that something outside of myself was telling me "its time for you to go into hospital". I seem to go in every year. Its like a guide.

Me: So are you happy now with your decision to go into hospital?

H41: Yes, it seems to work out for the best every time.

Me: This is not your first admission to Prichard then?

H41: No, I've been in three or four times.

Me: Can you remember back to what your first impressions of the clinic were?

H41: I suppose I was a little bit apprehensive the first time I went in. Fearful of what might happen to me in there. I didn't know what to expect, that was the first time. Since then, I've been happy to go in there.

Me: This most recent time, can you remember the day that you were admitted, that you actually walked into the clinic? Can you remember that, walking in?

H41: It was in the evening, I can remember that.

Me: And what did you think as you walked in there?

H41: That anything might happen.

Me: And was that a hopeful feeling or a scary feeling?

H41: Scary.

Me: Who did you first meet when you walked in? How were you greeted?

H41: The first time I went?

Me: No, this most recent time.

H41: Oh, most recently. I can't remember. I remember seeing the doctor but I don't remember who greeted me.

Me: Right, but there was a doctor there ready to speak to you was there?

H41: Yes.

Me: Did you go in as an informal patient or under section?
H41: Informal.
Me: Do you know what being under section means?
H41: Not entirely, no.
Me: Have you got any ideas what it might mean?
H41: Just for your own safety, to protect you and to stop you from leaving the hospital if you're a danger to yourself.
Me: So if you're under section you can't leave the hospital. Does it make any difference to your treatment at all?
H41: I don't think so. I'm not too sure.
Me: You know that if somebody is under section, they can be brought into hospital against their will, they can be made to come in?
H41: Yes.
Me: Do you think you would have felt differently if you had been forced to go into hospital rather than being able to chose.
H41: Yes, I would.
Me: In what way?
H41: I'd have felt as if it was wrong that I should be put under that.

Me: Do you think it is a good idea to section people who are very disturbed?
H41: Yes, I do.
Me: Why?
H41: Because they're a danger to themselves more than anything.
Me: Who is it that can be put under section?
H41: I don't know.
Me: Do you know who it is that sections people?
H41: No, I don't, no.
Me: Its alright about not knowing - a lot of people don't but part of the reason for asking these questions is to find out what people in general know about the Mental Health Act. If you or somebody is under a section, what rights do they have?
H41: I don't know.
Me: Have you got any ideas about the rights you'd have anyway as a patient?
H41: No.
Me: If someone were to be sectioned and they thought their section was unfair, is there anything they could do about it?
H41: I don't know.

Me: OK, let me ask you a little bit more about your own experiences. What did you hope to achieve by going to Prichard this last time?
H41: Well, I saw it as ... in a way it was showing me I was still sick. It was a way of justifying my claiming sickness benefit. It wasn't a punishment or anything, it was more like keeping me sick. Because I felt that I was guided into the hospital by something mysterious.
Me: And is that how you feel now as well?
H41: I don't see it as something internal to me. I see it as something external to me, the sickness. Like a sort of protection from getting into trouble.
Me: It sounds like something personal that is protecting you. I'm just trying to think of external influences like teachers or the doctors, but this sounds more personal than that.
H41: Yes. Its like a computer, that's the effect it has on me. As if I'm being controlled, like a robot. But, I have free will.
Me: So its a computer that makes suggestions rather than absolutely demands your obedience.
H41: Yes.
Me: So you went into hospital because you had this idea, or you'd been given this idea that it was the right thing to do.
H41: Yes.

Me: Did the staff understand that?

H41: I don't know if they understood, they didn't say. They just took notes and that was it.

Me: What do you think the staff were hoping for in terms of treating you? What were they hoping to achieve?

H41: Perhaps getting a break away from my parents at home. I don't know really.

Me: OK. While you were in Prichard, do you think you did achieve what you wanted? Did it serve the purpose that you wanted it to?

H41: Its like a sort of token motion, a token movement on my part. A sort of bowing down to authority which I see this computer as being a symbol of authority. Like if I go into hospital, I'm not fighting against it. Its a sort of masculine sort of computer, like a Father.

Me: I'm still not quite clear. I understand that you're saying that its the computer that drives you to go into hospital and that when you do do that, it demonstrates that you respect that authority. What I don't understand is whether you think its a good thing to show it that respect.

H41: Well, I treat it like a God.

Me: Right, so you think it deserves to be respected?

H41: Yes.

Me: Right, that makes it clear. That's a very good description, thank-you.

Me: Let me ask you a bit about the ward. What were you told about how the ward ran? Were you given any information about that?

H41: I can't remember.

Me: How did you find out then?

H41: Well, I was told that I had to say if I was going out, that sort of thing.

Me: How did you find out about meal times or ward activities?

H41: They just said at the time, anyone interested in relaxation etc.

Me: Who was it who told you that you had to say if you were going out?

H41: I think it was Andy.

Me: Yes, I know him. Who gave you the best explanation of the difficulties that had made you decide to go to Prichard.

H41: Can you say that again?

Me: Yes. Out of the staff at Prichard or it might have been a patient, who was it who gave you the best explanation of what was going on for you?

H41: I don't think I was given any idea of what was going on.

Me: I was just thinking that your idea of having a computer, that's not something that happens to everyone.

H41: No.

Me: I wondered if anybody had talked to you about that or explained to you why you might experience that and other people don't.

H41: I think its because I was always scientific. That's how I rationalize what's happening to me. I think its probably nonsense. I think its something I don't understand but that's how I rationalize it. I don't really believe in a computer.

Me: So when you talk about it, do you talk about it that way because its just the easiest way to explain it?

H41: Well, my psychosis took the form of an electric, you know, it was a physical, a sort of scientific sort of feeling, a reaction to what was happening. Science fiction. That's what it was.

Me: So its a sort of dual thing between experiencing a computer but also realizing that the computer doesn't exist.

H41: Well, all through my life, I've always been rational, even through my illness. That's how I rationalize it. I don't really believe that there is a computer powerful enough to have that effect. I think its a blind alley to start thinking about aliens and everything. Like science fiction.

Me: So it sounds as though you've got another explanation as well which is that you've got an illness and its called psychosis. Who gave you that explanation?

H41: I discovered it for myself.

Me: Psychosis is quite a technical term though.

H41: Oh yeah, that was the doctor, obviously, Dr. Metcalfe.

Me: So, how does Dr. Metcalfe explain what psychosis is?

H41: I think he might have tried to but I didn't understand. Its caused by stress or something.

Me: OK, I'd like to ask you about your treatment. What was your treatment when you were in Prichard?

H41: Just medication - chlorpromazine. The first time I was in there, I attended Glencraft but after that I didn't.

Me: Just chlorpromazine was it?

H41: Chlorpromazine and dipixol injections.

Me: Who told you the most about your treatment?

H41: Dr. Metcalfe.

Me: Do you know what the purpose of your treatment was?

H41: Well, it was to sort of hold back the psychosis.

Me: Were there any risks involved do you know?

H41: Well they say that chlorpromazine has side effects but I've never noticed that. I've never had them.

Me: Do you know what sort of side effects are associated with chlorpromazine?

H41: No.

Me: Do you know if there were any alternative treatments that could have been tried to the ones that you actually had?

H41: I suppose there are sort of new age therapies and things like that; faith healing.

Me: Were any alternatives discussed.

H41: No.

Me: Who had the right to make the final decision about what treatment you would receive?

H41: Who had the right?

Me: Yes.

H41: I suppose I did.

Me: So if you had disagreed with the doctor, you could have said so?

H41: Yes.

Me: What are the things that stand out most in your memory about your most recent stay at Prichard?

H41: I was becoming a bit agitated by a couple of people who were in there. They seemed to be uncooperative and they frightened me a bit. They were sort of drug addicts and heroin addicts and that. They frightened me. I can't say I've really enjoyed ever being in Prichard. I thought it was necessary.

Me: I was going to ask you if you can remember any times there when you laughed?

H41: Yes, there was one bloke there I sort of, who I did have a few drinks with in the pub. We had a laugh. But nobody else really.

Me: Were there any things that happened while you were there which made you sad?

H41: No, I don't think so.

Me: Were there any things that happened while you were there which made you angry?

H41: No.

Me: Are you happy now with the treatment that you received there?

H41: Yes.

Me: What do you think that other people could learn from your experiences?

H41: That life is to do with how one believes about life, the effect it has on one is to do with belief. So if I believe that there's a computer then I'm going to treat everything else with that in mind. Whereas, if I believe in God, I'm going to treat everything else ... Its the human search for order in the world you know. Meaning.

Me: What would you like to change at Prichard to make the clinic better?

H41: I don't know really.

Me: Is there any information you would have liked to have that you didn't get?

H41: No, not really.

Me: Is there any message that you would like to give to the staff?

H41: Thank-you.

Me: Alright, imagine that you were health minister right? That you were in charge of all provision and you could pretty well decide what you wanted and arrange the money accordingly. What sort of services would you provide for people like yourself?

H41: I think I'd provide more activities for the patients apart from trying to get people back into work situations. More leisure activities. Possibly drama or something like that which would help the patients of they were interested.

Me: Anything else that you'd do?

H41: No, not really.

Me: Do you think that your experiences have changed you in the long term?

H41: Yes, very much so.

Me: In what way?

H41: I suppose I have a tendency to treat life a bit like a game now, a dangerous game in some ways.

Me: What does that mean, like a game?

H41: Well, as if everything was acceptable now, in life was acceptable. Not really being against anything.

Me: Is that because you're very tolerant or because you're naive?

H41: Naive.

Me: Do you think that's a good or a bad thing?

H41: Well its not Christian because you'd obviously be against certain things if you're a Christian. In a sense its realistic, in my position.

Me: What difference do you think having been a psychiatric patient makes to people.

H41: Well, it may stop you getting work, finding a partner, something like that. They might not like the fact you've been a psychiatric patient. Lots of ways really.

Me: You were saying just now about it not being Christian. Have you been a Christian at some point?

H41: Catholic.

Me: Is that something that's changed? Or have you just adapted the way you are a Christian to suit the situation?

H41: Yes. I'm not against. I'm not a fundamental Christian, I'm not against a lot of things. I don't see it as a war against Satan.

Me: I've just about come to the end of my questions. Did you have any questions you wanted to ask me?

H41: No, not really.

Me: Are there any comments you wanted to make about what its been like for you or what you think it might be like for other people?

H41: I just find that there are most people just sitting around all day smoking, not doing anything. Like I say, Glencraft which is what they provide is geared up to getting people back to industrial rehabilitation. There's no real leisure, not much fun really. There's no real fun. I think there should be more enjoyment of being in hospital.

Me: OK. That's been really helpful. Thank-you.

H50 Interview : 22nd July 1994

Me: I've got a number of questions I'd like to ask you, but this interview is really about your thoughts so is there anything you'd particularly like to say about your care here?

H50: I'm not really sure.

Me: If there are things that seem important to you as we go through or you just remember, then that's fine and we can talk about those.

H50: OK.

Me: The first thing I wanted to ask you about was your admission here. Who decided that you should go to Prichard?

H50: My consultant, Dr. Seymour.

Me: So had you been seeing him as an outpatient?

H50: Yes, just a few times, a couple of times.

Me: Looking back now, do you think that was a good decision?

H50: What, to be admitted to hospital?

Me: Yes.

H50: I suppose so.

Me: I suppose so doesn't sound very definite. Do you think there were there some advantages and some disadvantages?

H50: Could be. I'm not very sure really.

Me: Is this the first time you've stayed at Prichard?

H50: Yes, the first time.

Me: The first day that you got here, what were your first impressions of the clinic when you walked in?

H50: I didn't really think about it really.

Me: Can you remember the first day you got here?

H50: Yes, I came at the end of March and then I had about an hour with the doctor who asked me questions and things? I didn't think much about it really.

Me: Is that when you were admitted?

H50: Yes.

Me: And what happened was that you had an hour with the doctor?

H50: Yes. And he asked me all the questions.

Me: When you first walked in through the door, you must have first of all seen the entrance hall out there mustn't you. There's the reception on one side and so on. What did you think as you walked in.

H50: I felt a bit nervous.

Me: Right. Any other thoughts? What did you think it looked like?

H50: Just an ordinary place really.

Me: Right. Do you remember the very first person who spoke to you as you came in? Who greeted you as you came in?

H50: I can't remember. I know the doctor was there.

Me: Did you come with someone?

H50: I came with my Dad.

Me: And did you have to report to the ward clerk or reception or was the doctor already waiting for you at the door?

H50: I suppose there was someone there. I can't really remember. I suppose we must have let someone know that we were here but I just can't remember.

Me: Did you come in as a voluntary, an informal patient or did you come in under section?

H50: I don't know. I don't think I came in under section. Not to my knowledge.

Me: What does being under section mean?

H50: I'm not really sure about being under section.

Me: Have you got any ideas what that means?

H50: I don't know if you sort of like have your own room or something like that.

Me: What does that happen do you think?

H50: I suppose to get better I suppose.

Me: Is there anything special about sectioned people?

H50: I suppose you just have someone who like gives the close eye I suppose?

Me: What other differences does it make to their care or treatment?

H50: Just keep a close eye on you and protect their interests.

Me: Did you know that when people are sectioned, that's a legal procedure that they can be brought into hospital for treatment whether they want to or not and mainly used when they didn't want to come. Did you know that?

H50: I don't know.

Me: I don't think you were brought in under section.

H50: I saw the doctor who said "You come in" but I don't think it was under section at all.

Me: Do you think you would have felt differently if you had been brought here under section?

H50: I think so.

Me: In what way?

H50: I don't know if I would have felt in a worse state. It would be rather daunting.

Me: How were you feeling when you first came in ?

H50: Not too bad I suppose, not too bad.

Me: I want to ask you a little bit more about sectioning and the Mental Health Act. I'm interested to know what people know about it. Do you think Its a good idea to section people when they're very disturbed?

H50: I think so. It protects them, you know.

Me: Do you know who can be put under section?

H50: What do you mean?

Me: I mean, what people can a section be applied to.

H50: Can be applied to. I don't think I understand the question.

Me: Well, most people who come here aren't sectioned and some are. Do you know what it is about the person that means they get sectioned?

H50: I suppose they must be in a really poor state, not in control of themselves.

Me: Do you know who it is that sections people? Whose job is it to do that?

H50: I suppose the staff, someone in charge, the manager. You have managers here don't you?

Me: Well, there are a variety of managers in the health service. It can be a bit confusing. Do you mean the manager of the hospital or do you mean the nurse manager who manages the ward? Chris manages the ward.

H50: Yes, the ward manager.

Me: Do you know, if you're under section, what rights do people have?

H50: What rights they have. I don't think they have any say in it really because they're too ill to think about it.

Me: Is that different to how it is for people like you who come in voluntarily?

H50: Its just there's more of a choice really. I don't know whether you can be discharged if you want to get discharged but your not really ready for it.

Me: So can you do that? If you want to be discharged?

H50: I think so yes. Cos there was a lad here who wanted to be discharged and they let him go but he's back again so it wasn't a good idea really.

Me: If somebody is under section and they think its unfair, is there

anything they can do about it?

H50: I suppose they can ask one of the staff and challenge it I suppose.

Me: When you came here, what did you hope to achieve by coming to this clinic?

H50: Just get better.

Me: In what way?

H50: To feel more myself again.

Me: Did the staff here understand those hopes of yours?

H50: I think so.

Me: Do you think the staff here had the same hopes as you. Do you think they were aiming for the same things?

H50: Hopefully, but I'm not sure. I feel a bit uncertain about that.

Me: Do you think they might have been aiming for something different?

H50: Could be.

Me: What sorts of things do you think the staff might be aiming for in your treatment?

H50: To feel fit again I suppose. That's all I can think of.

Me: Do you think you are achieving what you wanted? You said you wanted to get better and to feel more yourself.

H50: I'm not really sure at the moment. I feel a bit vague about it.

Me: When you got here, what were you told about how the ward ran?

H50: Well, I was mentioned from Dr. Foss that they wanted to check or change the medication and she did, and my Dad asked how long will it take and she said about five days. They were not sure in my case how long it will be but its been quite a long time now. Like I came at the beginning of March and hopefully, I'm leaving in the first or second week of August. I'm just waiting for accommodation for me now.

Me: Did anybody give you any general information about how the ward ran? Like what time the meals were and where the laundry was and what was going on, that sort of thing?

H50: No, I don't think so.

Me: Right. How did you find that out then?

H50: I suppose just day to day I found out different things. I did ask what time meals were and they sort of said um ... I'm not really sure really. You sort of find out yourself really.

Me: Who, while you've been here, has given you the best explanation of your difficulties?

H50: I suppose the doctors really, who were in charge.

Me: Which doctor?

H50: Dr. Foss.

Me: I don't know him, Dr. Foss?

H50: She's a female.

Me: Oh Dr. Foss is a woman. Right. And she's the person who has given you the best explanation?

H50: Well, I don't know if it was the best explanation but she's been there to support me I suppose. I haven't seen her for a while so its a bit difficult really.

Me: What has she told you about your difficulties?

H50: Just that I'm a bit unsure about things.

Me: Anything else?

H50: I wish she could be here now but she's not.

Me: Where is she now?

H50: She was going to leave and work on another grade of being a doctor. I feel there should be someone who should like, stay here and not leave. For continuity. I don't think that seems to be happening. There's like big change over and I've seen quite a few consultants. Its been a bit difficult. I think there should be continuity.

Me: Right.

H50: For the patient's sake really. Because its difficult to get better, I

think.

Me: Did anybody explain to you why you might been feeling a bit unsure about things and what the feelings are about?

H50: I'm not really sure really. I feel a bit vague about it. I wish there was more support.

Me: What has your treatment been?

H50: Well, sort of changing the tablets over because I was on the same drug for four or five years. I did have injections but they've stopped that now and they've increased the dose in the morning times. I'm on about ten tablets a day now, but my Father found out that its a very mild dosage. I've got a social worker now as well, at last!

Me: What is it that you're taking.

H50: Oh gosh! I'm taking vitamin B6 and oxytetracycline and I'm not sure about the other medication. I'm not sure of the names. But I think some tablets I've got to make you a bit more happier and the other tablets to calm you down a bit.

Me: And what about your social worker? Is that a man or a woman?

H50: A woman, she's quite nice.

Me: What does she do for you?

H50: She just finds me accommodation and I think, talks about problems that I have.

Me: Is that good?

H50: Yes, its not too bad. Like I was really upset yesterday.

Me: And she was around was she?

H50: Yes. I'm feeling a bit upset today really. I'm not very good.

Me: There's a lot to remember isn't there?

H50: Yes.

Me: Who's the person who's told you about your treatment?

H50: I suppose the doctors.

Me: The doctors. And you've had quite a variety haven't you?

H50: Yes. Its a bit too much really. You only see them a couple of times and then you change to another consultant. It isn't really fair. It doesn't help you to get better.

Me: Of all those doctors that you have seen, has anybody told you what the purpose of your treatment is?

H50: Purpose of treatment? I don't think so, no. I feel very vague about all this.

Me: Yes, that's the impression I was getting. Are there any risks to the treatment you are taking?

H50: Any risks? Well I suppose ... I don't think so, I hope not. Do you mean like any side effects?

Me: Yes.

H50: Well, I did have something, a sort of blackout. When my period started I couldn't see for quite a few minutes and felt awful. But that was the beginning of treatment. My eyes went a bit funny as well, I think you get that as well, blurred vision. When I had an injection I had a side effects tablet to stop the side effects but I still did. Just a little bit.

Me: Were there any alternatives to the treatments you've been given that could have been tried?

H50: There might be. I don't know if its in my case.

Me: Who has the right to make the final decision about what treatments are given to you?

H50: I suppose the doctors are in charge.

Me: Do you know what would happen if you disagreed with your doctor or can't you imagine that happening?

H50: I suppose if I did, it might be a different treatment that I'm having. I don't know what it would be like really. I don't know if they would agree with me if that were the case. They have their certain feelings

and that's it really.

Me: Ok. What things stand out most in your memory from the time you've been here?

H50: Its been a bit unpleasant really. Its not the right place to be.

Me: You don't think its right for you?

H50: I just don't think its - its rather daunting really to come to a big place like this if you haven't been in these places before.

Me: Can you remember any times here when you've laughed?

H50: A little bit I think.

Me: When's that happened?

H50: Just recently.

Me: Yes. In what situations?

H50: I was with somebody and I didn't feel to bad.

Me: A member of staff, a ...?

H50: It was a patient.

Me: Has there been anything that's happened here that has made you sad?

H50: I think the people and the building. Like the patients - its not very nice people to mix with. They can make you upset and they have really.

Me: Has there been anything that's happened here that's made you angry?

H50: I don't think so. Or there might be something to do with the patients that made me cross.

Me: Can you remember being cross at any time?

H50: A patient wanted to borrow something, like one of my possessions, and I said no and she called me some names like selfish cow and I just stood up for myself but it wasn't very nice that you're put in that position.

Me: No.

H50: You're trying to get better and then you have to ...

Me: Its good you could stand up for yourself really.

H50: Yes, so that was well done.

Me: Are you happy with the treatment that you received here?

H50: Not really. I don't know if, I suppose it might, I'm not really sure. I'm a bit vague about it really.

Me: What do you think others could learn from your experience?

H50: Just don't let the place get you down, really. You might not be getting discharged but some people definitely get discharged.

Me: Have you got any ideas about what they should do to try and stop the place getting them down?

H50: Try and be strong-willed really, But that could be quite difficult if you're ill. I think it could be done.

Me: What would you like to change here to make the clinic better?

H50: A bit more staff really. Like, I haven't got my own keyworker. It would be something to have the same person to talk to. I had a keyworker in Prichard two but I haven't seemed to have one here, no-one's mentioned it.

Me: Are there any other things you'd change?

H50: A bit more organisation I think. So the place was more organised. It could be improved. First of all, I think just more staff really. Just make it a bit different.

Me: Was there any information you would have liked to have had that you weren't given?

H50: I was given a leaflet that I found in my room. I wasn't there so they just dropped it in. It tells you about the place. I think that should happen in the beginning but I'd been here a few weeks. I didn't get that or anything, the leaflet or information, in Prichard two.

Me: If you could give a message to the staff, what would that be?

H50: Spend a bit more time with me and the other patients.

Me: If you were the health minister in charge of it all and you could do whatever you like, what service would you provide for people with your

difficulties.

H50: Make it a much better place and bigger I think. It used to be like all wards and there's only this one now and the secure unit.

Me: I'm surprised you said bigger because you were saying before that it's a bit daunting coming to a place that's so big.

H50: Oh, I can't remember what I said.

Me: But you like to come to a big place do you?

H50: Not really. I'm not really thinking straight.

Me: Well, that's alright. People often think different things at different times. You don't have to think the same thing all the time. What other things, if you could, what other things would people like you find useful?

H50: I'm not really sure. I suppose more opportunities.

Me: That sounds good. What sort of opportunities might be helpful to people?

H50: A bit more facilities really. In the health authority. More groups and things, a sports centre or something, a swimming pool.

Me: Do you think your experiences have changed you in the long run?

H50: Not really. I suppose it might have some effect, being in a place like this.

Me: What sort of effect do you think it might have.

H50: To cope more with life when I leave hospital.

Me: That sounds like quite a good thing.

H50: I can't remember it.

Me: You were saying you thought you might be able to cope more.

H50: In like the big world hopefully. I don't know if it will but it could be a chance to cope with people more.

Me: So do you think your overall experience has been a good or a bad thing?

H50: I suppose it puts it into perspective really.

Me: I don't really know what that means. What do you mean?

H50: It puts you in touch with your feelings, in touch with reality. That there's more to life than this place.

Me: What difference do you think having been a psychiatric patient makes to people?

H50: That sounds horrible, like psychiatric patient. Rather daunting. I wouldn't really like to call myself that horrible name. I think the name should change really.

Me: I've just about come to the end of all my questions. Have you got any other comments you'd like to make.

H50: I'm not sure really. I think I'd like it to change a bit. It needs a change and stop that name "institution" because that could put you off. It would put me off.

Me: What, even being called a hospital?

H50: I don't know about hospital but it needs a pleasanter name, not institution because that could put you right off.

Me: I bet.

H50: It's not a very nice thing to be in.

Me: Anything else?

H50: I don't think so.

Me: Well, thank-you very much for your time.

P18 Interview : 27th July 1994

Me: What I wanted to talk to you about ... It's all part of a project asking patients what they feel about things, what's happened to them and so on. I wanted to talk to you about your last admission when you came in under section.

P18: Right.

Me: The other thing is that if you've got stuff that you'd particularly like to say, about the conditions or the care here, or about that then do because this is an opportunity really.

P18: Right.

Me: Is there anything you want to say to kick us off that you feel quite strongly about?

P18: I think the staff here are immensely good. They care for you as well. They're just very good.

Me: Anything else?

P18: No.

Me: OK. Well, we'll start at the beginning. Can I take you back to when you were brought in last time under section. Who was it that decided that you should come to Prichard that time?

P18: I think it was my doctor.

Me: Is he a GP?

P18: Yes, the GP.

Me: How did you arrange that then?

P18: She arranged it through contact with here.

Me: Right. And presumably at that time, you weren't very keen to come.

P18: Not the first time I wasn't, no. I didn't know what I was expecting.

Me: Right. Looking back now, do you think that that was a good decision?

P18: Yes, definitely. Definitely.

Me: OK. Was that your first stay here then, that admission?

P18: My first stay here was just before Christmas. Is this your office?

Me: No, this is the OT's office. But one of the OTs is on holiday and the other one is downstairs doing a group so I borrowed it. I don't have an office here because I don't actually work in the clinic. Other than coming in to do this project, I'm not a member of the staff.

Me: Can I take you back then to when you first walked in through the door here. What were your first impressions?

P18: Dreadful. I wouldn't actually say that the place was home sweet home when I first entered here. There are all different patients with all different problems which I'd never come across before.

Me: Anything else?

P18: No.

Me: Do you remember that first day when you were walking in?

P18: Yes I can.

Me: Do you remember what you thought as you walked in? Do you remember what your first thought was?

P18: Yes, the place itself. Its very strange, the atmosphere was all hickledy pickledy. You don't know what to expect do you?

Me: No, you don't. How were you feeling then?

P18: Me?

Me: Yes.

P18: What, now?

Me: No, that first day when you first walked in.

P18: Oh, I was bad.

Me: What is that?

P18: I wasn't at all well.

Me: Could you describe what your strongest emotion was? Were you anxious, were you very unhappy or very angry? Do you see what I mean?

P18: Just anxious and very unhappy.

Me: Right so you came in under section didn't you?

P18: Not the first time, no.

Me: Not the first time.

P18: I think it was about the third time I came in, my third admission.

Me: The third admission. So that time, you hadn't wanted to come in.

P18: No.

Me: Are you glad now that you did?

P18: Oh, I'm glad I came in because it really helped.

Me: Right. What does being under section mean?

P18: It means that you have to take your medication that's prescribed. You can't go home and come back when you want to, you have to stay until they say. Basically, just abide by the rules really.

Me: What sort of a section did you come under?

P18: Section 5(2) first of all. Then a section 3.

Me: Do you think being under a section makes a difference to your care or treatment?

P18: I think it does, yes, because you're restricted aren't you? It's hot in here isn't it?

Me: Yes, shall I open a window?

P18: Yes please.

Me: Do you think you felt differently then, when you had to come here under section? Do you think that made a difference to how you felt coming here than when you'd come before?

P18: I think so, yes.

Me: Right. What difference did it make?

P18: Well, obviously I realized I had a problem and I had to get over my problems.

Me: You think you did realize that when you came here under section?

P18: Yes.

Me: Right. Were there any other differences you found?

P18: No.

Me: Do you think it's a good idea to section people when they're very disturbed?

P18: I think so, yes.

Me: Do you know who can be put under a section?

P18: Do I know?

Me: Yes, who can be put under a section?

P18: (something inaudible ending with the following question) Do you mean?

Me: Sort of, I don't know. What do you mean?

P18: What do you mean?

Me: Well, what I'm saying is, who can be sectioned? Who can a section be applied to? Because not everyone who comes comes under a section so why is a section applied to some people and not to others?

P18: There's different reasons isn't there?

Me: Like?

P18: Some people are sectioned because they're psychotic. Others aren't.

Me: So is that what makes the difference?

P18: Yes.

Me: Who is it that sections you? Whose job is it to actually carry out the procedure?

P18: Dr. Watts.

Me: When you're under a section, what rights do you have?

P18: You don't have much rights.

Me: Do you have any rights that you can think of?

P18: No, not really.

Me: If a section seems unfair. Say you've been put under a section and you think it's unfair, is there anything you can do about it?

P18: Well you can appeal against it. But I don't see the point, it's a waste of time.

Me: Why is that?

P18: Well the doctors have got more power than you haven't they?

Me: So you think that if you did appeal, they'd have more influence than you'd have?

P18: Yes.

Me: I want to ask you a bit about your personal experience here. What did you hope to achieve by coming to this clinic?

P18: To get better.

Me: And what does getting better mean for you? How would you know if you were better?

P18: Obviously by taking the medication, and talking to the staff. Just trying to get yourself well really.

Me: In what way are things different when you are well to when you are ill?

P18: (long pause)

Me: Do you understand the question?

P18: No.

Me: Well, what changes in between you being ill and you being well. What is it that is different in you?

P18: I don't know, you just change don't you?

Me: That's true but people might change in different ways depending on how they want to be. In what way do you change?

P18: I change when I have the medication.

Me: Well, let's say I had a cold. When I was ill I'd have a runny nose and a headache and sore eyes. Then when I got well, my nose wouldn't be runny and I'd feel quite energetic and fit and I wouldn't feel sore in the eyes. So when you're well, can you describe what you feel like that's different to when you're ill?

P18: How you feel?

Me: Yes.

P18: I can't answer that question.

Me: OK. Fair enough. You said you came here hoping to get better. Did the staff here understand what you were hoping to do?

P18: I think so.

Me: Did they have the same hopes as you. Were they hoping for the same thing as you?

P18: I should think so.

Me: And when you've come here, have you achieved what you'd hoped to and got better?

P18: Yes.

Me: OK. I'd like to know now a bit about the information you've been given while you've been here. What have you been told about the way the ward runs?

P18: We were told about it the first day we came. We were shown around - places that we could smoke, the bathroom, the showers. Given a cup of tea when you first arrived.

Me: Who was it that showed you round.

P18: Andy.

Me: Who gave you the best explanation of your illness?

P18: Dr. Nerehi.

Me: And how does he explain it?

P18: Well, he explained that I was ill. He said I needed to come to hospital for a while. Mind you, I was on a section then.

Me: Did he tell you what your illness was or what your treatment was or anything like that?

P18: No, he never told me that.

Me: Did anyone say that to you.

P18: Yes, they said that I was psychotic and had depression.

Me: Did anyone give you any idea why that might be?

P18: They said it was psychosis.

Me: Have you any idea what causes that?

P18: Not a clue.

Me: What sort of treatment have you had?

P18: Medication.

Me: Do you know what medication?
P18: Procyladine, lofepramine.
Me: What was that?
P18: Lofepramine with an L, Lofepramine. Its like chlorpromazine.
Me: Right. Whose given you the most information about your treatment?
P18: Nobody really.
Me: Do you know what the purpose of your treatment was?
P18: Because of my problem I had.
Me: Are there any risks involved in your treatment?
P18: No.
Me: Do you know if there were any alternative treatments you could have had?
P18: No.
Me: No there weren't or no you don't know?
P18: I don't know.
Me: Who had the right to make the final decision about what sort of treatment you should have?
P18: Dr. Watts.
Me: Does he make the decision all the time whether you're under a section or not or does it change between the two?
P18: No, he makes the decision.
Me: What do you think would happen if you didn't agree with taking something that he wanted you to take?
P18: I think it would cause a problem because on a section I have to take it. You don't really have any say.
Me: What about when you're not on a section?
P18: I suppose you can be ignorant and not take it can't you, but at the same time it helps so you benefit from it.

Me: What things stand out most in your memory from your time in Prichard?
P18: My illness.
Me: Have there been times here when you've laughed?
P18: Yes.
Me: Can you remember any times when you have laughed. What sort of circumstances were they?
P18: Laughing with a bloke called Clive whose got quite a good sense of humour.
Me: Was he a member of staff or a patient?
P18: A patient. I don't see him any more. He's gone out of the system.
Me: Do you ever, I mean you meet people here and some of them you like and some of them you don't. Do you ever find that you stay in contact and make friends on a more long term basis?
P18: No, I'm not really interested.
Me: So you just sort of come and go?
P18: Come and go, yes.
Me: Has anything happened here that has made you feel sad?
P18: No, not really.
Me: Has anything happened here that's made you feel angry?
P18: No.
Me: Are you happy with the treatment you've received?
P18: Yes.
Me: What do you think other people could learn from your experiences?
P18: Well, they can't really learn because they're different cases aren't they? So its a bit difficult to say.
Me: There isn't any general message that you might like to share with people who were coming here for the first time?
P18: I suppose so, yes.
Me: So if someone wanted a bit of advice about coming here, what would you say?
P18: It depends what they want.

Me: So you don't have any general message from your experiences.
P18: No.

Me: What would you like to change at Prichard to make the place better?
P18: Make it a bit more homely.
Me: Like? How would you do that?
P18: I can't think.
Me: So you'd just like it to look more homely, maybe change some of the furniture or something like that.
P18: Oh yes, I'd change the furniture. I'd have a three piece suite or something to lounge on.
Me: So something to lounge on.
P18: And some beanbags. Because the chairs we sit on are not very relaxing.
Me: Yes.
P18: Neither are these chairs.
Me: That's true. I don't know why they're like this, maybe its so we stay awake!
P18: So you're a psychologist are you?
Me: I am, yes. Is that OK?
P18: Yes.
Me: Is there any information that you would have liked to get while you were here that you didn't get? Anything that you'd have liked to have been told more about?
P18: No.
Me: Is there any message that you'd like to give the staff?
P18: Not really.
Me: If you were the Health Minister, you know the person in the budget who has the power and arranges the money in the budget and everything. If you were the Health Minister and you could do what you wanted, what sort of service would you provide for people with problems like yours?
P18: Better food, definitely better food. The quality of food here is terrible.
Me: Anything else?
P18: No.
Me: If you had the power to arrange things any way you wanted?
P18: Arrange for me to go home. No, not really. It's a difficult choice isn't it.
Me: It can be but its an invitation to just let your imagination run riot and think of what you'd have if you could.
P18: There again, I'd make it a bit more like home and put wallpaper up and decorate the place, not just slap paint on the walls.

Me: Do you think your experiences have changed you in the long run?
P18: What, being on medication and all that's happened to me?
Me: Yes.
P18: I think I've changed a lot.
Me: In what way?
P18: Well, a lot more calmer. I think a lot better. I'm a bit more sociable, whereas before I wasn't at all sociable.
Me: Any other ways you've changed?
P18: My personality's helped a bit. I'm not so gloomy, I'm a lot more bouncy.
Me: So they sound like quite positive things. Is that the way you see it, that the changes have been a good thing?
P18: Yes.
Me: Do you think it makes a difference to people having been a psychiatric patient?
P18: I think it helps because you walk out a different person don't you?
Me: Yes. Once people do walk out, do you think the knowledge that they've been a psychiatric patient makes a difference to them or to other

people?

P18: I shouldn't think so.

Me: OK. Is there anything else you'd like to say?

P18: Not really, no.

Me: Well, we've come to the end of the interview. Did you have any questions you'd like to ask me?

P18: No.

Me: Well, thank-you for your time.

P21 Interview : 22nd July 1994

Me: Who decided that you should come to this clinic?

P21: Myself.

Me: You decided.

P21: Yes.

Me: Looking back on that now, do you think that was a good decision?

P21: Yes, it was a good decision. Yes.

Me: Is this the first time that you've been here?

P21: Yes, the first time?

Me: When you first came, what were your first impressions?

P21: Well, sort of mixed feelings really. I didn't know what it was all about and initially I thought I was coming to a place a bit like the old Glenside used to be. It was a bit intimidating to start with but then I knew I was in good hands as well like so it was like an initial settling in process really.

Me: That first day, the first time you walked through the door here, what did you think?

P21: I don't know. Its sort of a strange feeling really. There's no bad feelings about it. I thought it was just like a mini hospital really - that's how it came across, people here to help you and sort of ... it wasn't too bad really. Its like a place where you're going to get help so that was a good feeling.

Me: Do you remember who the first person was who greeted you as you came in?

P21: I think it was Bryan, I think. Bryan was the person who was very helpful to start with, ... and John Holloway as well, he was one of the people I saw to start with.

Me: How were you greeted when you first came in?

P21: It was good, yes. It was a nice welcome really.

Me: Were you an informal patient or under section?

P21: I was informal to start with.

Me: And were you then under section?

P21: Yes, then under section. I sort of misbehaved (laughs).

Me: And are you informal again now?

P21: Informal again now, yes.

Me: What does being under section mean?

P21: Well, it means basically that they can keep you here at their will. There's a section two which is 28 days you're allowed to, well you've got no choice but to stay on the ward and you're under doctors and nurses orders really. And the section moves up. As the severity of the section moves up, it goes up in numbers like 2, 3, 4, 5 and so forth. So basically the higher the section, the higher the seclusion really. When you're under section, you're kept here against your will.

Me: Apart, from having to stay here, does it make a difference to your treatment or your care?

P21: It probably makes the staff more aware of the situation. If they know you're on a section then obviously they're going to treat you slightly

differently. In my case now, I'm informal and basically I can come and go as I please and that's OK. Once you show signs that you're doing OK and you're being more independent with your life then they do let the tightening of the strings down and its a case of ... its obviously a lot better if you're informal rather than being under section. I can understand the sectioning process. Obviously some people need to be kept against their will because of the fact, well they're a danger to themselves and ... I don't know if they could be a danger to other people but certainly they could be a danger to themselves.

Me: So you think that under some circumstances, it is a good idea that people should be sectioned?

P21: I think it is because I don't think people are in control of their lives and under a section gives the whole set up for them to detain people and in the long run, its for the best.

Me: You first came here as an informal patient. If you had been forced to come in when you were first being admitted by being sectioned, do you think you'd have felt differently about coming here?

P21: Possibly, yes. Possibly in terms of, if I didn't want to come in and I was sectioned against my will, I can understand the feeling of wanting to leave and not be in this environment. I can understand the disagreement that a lot of people feel against being sectioned.

Me: Do you know who a section can be applied to? Who can be sectioned?

P21: Anybody. Anybody can be sectioned?

Me: Do there have to be any particular circumstances to allow that?

P21: No. I think its obviously if the consultant or a doctor or nurse thinks you're not in control of your life, ... in terms of, you could be going through an acute illness. Like the typical sort of one is a psychotic illness and while you're not in control of your senses, there's self violence there or violence to other people, ... and I think its important that the section is there really because generally, it gives the staff more control and in the long run it does help you. It sort of keeps the shutters on any problems getting worse.

Me: Who is it that sections people? Whose job is that?

P21: I think its the consultants and the doctors.

Me: While you're under a section, what rights do you have?

P21: To be honest, I'm not brilliantly sure with the section procedure. All I know is that a section two means that you're kept against your will for 28 days. I'm not so sure of the other rights and regulations. I've just browsed through the Mental Health Act, all I've done is just browse at that. Particularly, its not really interested me because I basically knew my situation and I knew what my position entailed and I think in my case that it all worked out fairly well. I can't really tell you what other people have gone through because I can understand that a lot of people's cases are different. There are different sections and there are different people and they react probably to different situations, but my situation always seemed to work out quite well really. At the time, it could be a kind of cooling off period which I needed and it worked out well.

Me: If somebody considers that their section is unfair and they don't agree with it, is there anything they can do?

P21: I'm not really sure. I think they could appeal but I'm not sure of the procedure and I'm not certain of what steps they could take. You see, I don't know who they appeal to really if they wanted to appeal. I'm not quite sure of the procedure you can go through.

Me: OK. I want to ask you a bit about your goals and things. What did you hope to achieve when you first came here?

P21: I think basically that a change of environment was essential at the time and I think that to be in a position where you're given 24 hour

treatment. There's always someone around for 24 hours of the day which gives you that kind of security that you need at a particular time.

Me: Did the staff here understand what it was that you were hoping for when you first came here?

P21: Basically, they wanted to try and help me in terms of my situation. Obviously, medication was the main one. They were helping me by experimenting with drugs and medication. Yes, I think that in a lot of ways, me being voluntary was essential because I needed to come in when I did. I think it was essential that I was here when it was in the worst times so it was helpful that I was actually in a secure place and it was good that you can actually go through these different thoughts and feelings and come out the other end intact.

Me: Sounds as though you're pretty pleased with the outcome and you've achieved what you wanted to?

P21: Oh yes. I think in my situation, I've achieved what I needed to. I needed basically a rest really, from the hurly burly and the long working hours of society. It gets you in a sort of, a relaxed and helpful environment. That's what I wanted to achieve and it has happened.

Me: When you came here, what information were you given about how the ward ran?

P21: Not much really. No, the paperwork was non-available. I do believe now that they've got a little leaflet that they hand out to you, to new patients which gives them the actual goings on in Prichard one.

Me: So how did you find out about things?

P21: Basically, going on spec every day really. And if I was in a position where someone would tell you what was going on then you just follow in with the crowd. Like the activities I've done were pottery, art, we had various meetings like relaxation meetings. relaxation tape in a group of people was quite interesting because you're quite relaxed, you're laid on these massive beanbags. You're just laid out and slide into comfort. Yes, its quite interesting. So basically, you sort of took it on spec by the day. There's not planned organisation for the next day or a few days ahead. I must say that there's a scheme now where the staff write up the activities in the dinner room. You can actually look up to the board and see what the day brings and the activities are put on the board. Its your choice to attend if you want to. Visually, you can see what's happening, now, which is helpful.

Me: What about the problems that made you decide to come here. Who gave you the best explanation of those?

P21: I think, I remember talking to Bryan the charge nurse who was ... he gave me some good advice. But the main one I think was Dr. Nereli. Dr Nereli was the main one who spent time, was the one who was spending more time and explaining the things I was going through, ... and eventually I come round to his way of thinking which was what turned out to be the best advice given.

Me: So what did he say?

P21: He basically spoke to you and he listened as well and you could tell he was experienced in terms of letting time take its course really. Honestly, I was rebellious and I didn't trust anybody at the time, and I think basically, he spent the time and energy needed to convince me that things were going to get better and ... he was someone you could knock some ideals against and he basically listened and, with the medication, it was a course of recovery. He'd listen and give that chance and one day things were going to get better and that was right.

Me: What treatment have you been offered here?

P21: Medication is the main one. And as I said, I spoke to Bryan and Ben Nereli.

Me: What do you call him, Ben or Dr. Nereli?

P21: I can him Ben now, yes. He's a good doctor. Initially You're a bit wary of everybody but you get to know that he's there to help you and you can get better as the days go on.

Me: So what medication do you take?

P21: I've been on chlorpromazine and procycladine which is quite interesting because chlorpromazine was invented in 1949. I've been looking into it and its a very old drug and its still widely used today so its amazing that that kind of drug has gone on for so long and its helped a lot of people as well. They're still waiting for a wonder drug to come out I think. It would be nice to have a pill that anyone could take and feel instantly brilliant. We need something new now in society. It seems to be never ending, society. The whole rush of life.

Me: So who gave you the most information about your drugs? It sounds as though you've ended up knowing quite a lot about them.

P21: Yes. To be honest a lot of the patients, a particular patient I'm quite friendly with, she knew a lot about the drug situation and she give me a lot of information. So, interaction with patients is quite useful.

Me: What was the purpose of your treatment with drugs. Do you know what they're for?

P21: Well yes, chlorpromazine is a mild tranquillizer which keeps you down. I think its used for sort of hyper people, people who are hyperactive, over-active and I think it helps mentally to calm yourself down and it does the job. I'm not sure if its a mild tranquillizer but I know it is a tranquillizer.

Me: What about the other one, procycladine?

P21: Just to stop the side effects, procycladine. Its to stop the side effects of the chlorpromazine. Because the side effects are usually physical like, physically functions going wrong and eyeballs locking and staring so it helps clear that. Without side effects. Its like to stop the side effects of the uncontrollable eye movements and going sideways. It gives that, the procycladine counteracts the chlorpromazine.

Me: You were told about the side effects were you?

P21: Yes, well sort of. I was told you need to take procycladine to stop the side effects. My step-Mum's a nurse anyway so she sort of gives me the up-dated information.

Me: That's useful! Were there any alternatives to that treatment. Any alternative treatments that could have been tried?

P21: Not as far as I know. I just took it for granted that I was given medication to help my position and that's what happened.

Me: Who had the right to make the final decision about what treatment you would take?

P21: Dr. Owen. He was the person I was first associated with.

Me: If you had a disagreement with the treatment you were offered, what do you think would have happened then?

P21: I don't know. Obviously, I could demand not to take the medication but that didn't enter my mind. I just thought that the consultant and the doctor were trying to help me and I trusted them with the medication.

Me: What things stand out most in your memory from the time you've spent here?

P21: Basically, it was a nice place in terms of, its nice to know that these places do exist because it is an alternative to struggling on on the outside. Obviously its essential you know that these places exist so that you can come here and be helped. Things can only get better while you're staying here. The staff are doing their job. I think that they do a good job in terms of their funding and financial situation. They're doing their best with the resources they've got and sometimes I think that they're understaffed and very stretched. That can only be

government policy and obviously Virginia Bottomley takes a lot of the rap for that. I think it would be nice to see if there was more money ploughed into the NHS to update the system and get more help and opportunity for people to get better and move on and be happy with their lives.

Me: Have there been times here when you've had a laugh?

P21: Yes, cos I like having a joke as well and I sort of laugh and joke with the staff. Its good because they've enjoyed it as well and its nice to affect the atmosphere a bit really. I like a joke so we've had some funny times. I'm quite involved with football and football activities which is quite good. In fact, I think the staff are doing a good job with the resources. There's not much resources there and they seem to be doing the best they can with the material they've got. I think one of the biggest problems is that everybody is chucked in the same boat here which can get difficult as time goes on. Like there's all different types of acute illnesses and there are drug takers here as well who are not obviously mentally ill but they're just here for drug-taking and I think that suffers. People who need the time and energy are not really given it because its needed in other areas so the people who need it most can sometimes suffer and not have that kind of backing and support at a critical time. I mean that they're tied with a lot of sort of duties and other areas and it could suffer for the people who need it most.

Me: Has there been anything that's happened while you've been here that's made you feel sad?

P21: Yes, there was one case just recently that a lad who was here for a few days committed suicide which was a sad occurrence. I can't place him at the moment, people said I must have seen him cos he played the guitar but I can't place the face. Apparently, he left here and committed suicide so obviously that was one of the saddest things really and I think everybody tends to think they could have done more or could have helped him in any other way. But basically, it boils down to, the fact that if someone is that determined to commit suicide they will. I don't think there's anything to stop a person doing it.

Me: Has there been anything that's happened while you've been here that's made you angry?

P21: No, not really. Only sort of ... no, I don't think there is. I haven't had a feeling of any anger. I could feel angry in some people's situations, for them. On a personal level, I haven't found anything to be angry much at.

Me: What do you think other people could learn from your experiences?

P21: One of the best things I could pass on as information is: there's always tomorrow and there's always a chance that you'll get better, and I think with medication the way it is nowadays, I think there's a good chance to get better. I think being in a place like this, it does change your values and views on life in terms of trying to look forward and trying to enjoy life. You try and be positive about your life. I think you can only get better with the counselling and with the medication. I mean, it does help you. And I think, if you're positive about yourself, if you trust the medication and the staff. there's only one way to go and that's forward and up and hopefully on to a healthier future.

Me: I was going to ask if there's anything you'd like to change about Prichard to make it better.

P21: I think its going to be hard unless there's the finances there to move on. I think they're trying to do the best they can with the resources they've got. Its really hard to think what else they could do to help the situation. The only thing I could suggest is that more counselling would be nice. It would be nice to have that one-to-one counselling

when you most need it. Because some people get very depressed, it would be nice to know there's someone there ready and available to talk to. That is available but I think that should be pronounced more to know that there is someone there all the time. I think there's a lot of paperwork involved and that seems to bog down the doctors and nurses and consultants when there could be vital personal one-to-one or personal areas which could be more important than all this paperwork they seem to have got to go through with.

Me: Is there any information that you would have liked that you didn't get?

P21: No, I think this leaflet gives you the basics of what Prichard one is all about. In my case, I don't think there's much more you can do in terms of, ... you're here for a purpose and I think you know why you're here and you know that you're here to get better and here to move on and I think it's essential to know that and there's not a lot else you can put down on paper.

Me: Is there any message that you would like to deliver to the staff?

P21: Yes, I think that they're doing a fine job. In terms of the resources they've got and the staffing levels they've got, they're doing the best they can and it's a good job they're doing. I think that the whole structure of the NHS and for the money they get paid, they're doing a damn good job.

Me: You mentioned Virginia Bottomley earlier. If, just imagine for a minute that you were the health minister and you were in control and could sort it out however you thought best, what sort of service would you offer to people who have problems like yours?

P21: I think I would make more money available for mental health. That is the central factor. Obviously there's money available for medication but I think that there should be more money available for new buildings, new structures, ... and a new sort of criteria as well. Which would be a new bill on mental health. It all boils down to the training of individuals, the training of the staff and the resources that the staff have got. Obviously the time and money as well. It's an essential part of staffing levels and morale is essential as well. A new mental health act bill. Basically where the staff stand, the doctors and consultants. I think it would be a better overall structure. At the moment, the government with health policy are cutting corners. Remember it always used to be Glenside and it used to be full up with patients. They're all gone now because it costs less to put a mental health patient in the community than in a structured environment here. They know that by putting a patient into the community, into society, they're saving a hell of a lot more money than they would in a structured environment like this. That's why they're cutting the corners. And I do wonder sometimes, what happened to the patients who used to be here? Certainly, they can't get all healthy and well in the space of a week. Yes, I do wonder where they've all gone to and what's happened to them. All I can think of is that they moved into the community to save the money. Most of mental health patients need that environment where they're secure and they're protected from society because I think that initially they need the protection and the security of an organised environment like Prichard one. Instead of being out in society trying to survive on the little monies they've got and all the pressures of life itself. All the pressures of society in the 90's, I think a lot of people with mental problems cannot cope with that and by forcing them out into the community, it doesn't help them. I think what would help them would be more an environment like Prichard one and two but with more buildings, more structure, and more policy for the mental health patients. You see, it does boil down to money really. The money the government waste on other sectors is wrong and I think it's still a stigma. Mental health is a stigma which people are afraid of and I think they're afraid to look into it more and afraid

to plough more money in. Not only the government but society as a whole are afraid of patients in the community and it certainly is a stigma and that is a shame.

Me: Partly I think you've answered this question already but I'll ask it in case there's anything else you want to say. That is whether you think your experiences have changed you in the long term? You were saying something about being much more positive.

P21: Yes, it changes your values and it changes your whole outlook on life. It gives you the chance to think you've got to change your life in some way. You easy slip into a rat race situation where you work long hours and your social life revolves around alcohol and the pressures of life are great now for people. It should be so easy to have a family, a house and a car. But nowadays, in this society, that's almost impossible to have the basic necessities of life because financially the ways and means of money are partially out of control. I think that there's a lot more pressure now on people in the nineties than there ever will be and there'll be more mentally ill people now in life as we go on than ever before because there's more stress and pressure on people now. That is a shame because I think that the decency of people is gone. People are very selfish and people will do anything to get on top. You're just trampling over somebody else in the same world. I think people have got the attitude, as long as I'm OK, who gives two hoots about anyone else. That is a shame now I think. A lot to do with that is the corruption of money. People are so money orientated, all they think about is where they're going to earn money and how they're going to earn it. They don't mind who they step on to get money and I think it is corrupting society. People are very money orientated which brings a selfish environment in which people are living these days. You read papers now and it always seems to be bad news. There's always articles on someone being raped and someone being killed or stabbed or brutally murdered. I don't know. I just to tell people, like family and relatives, in their day was is like this? I can understand some of it going on but it seems to be, society seems to be getting out of control. I think people are very frustrated and very angry at life and society and the government takes a lot of the blame for that. Morale is very low in this country and we're suffering for that. We're suffering the government, politics, obviously our sport is suffering. All areas of Great Britain are suffering. I think there's less opportunity for people now than there ever has been and you can tell that by redundancies everywhere in life. Its putting a strain on people and there's more people going to have more stress now that there ever has been in life.

Me: So do you think that the changes that you've made while you've been in the clinic, do you think that's a good thing?

P21: Well yes. I think it gives you the belief that you know there's always help, that's the important thing. The worst thing that could be would be to be mentally ill and there's no help and there's no chance to help yourself. With the Mental Health Act, if it was changed into a more publicity, in terms of more finances, more public notice, more help. I don't know. There's got to be a lot of people in the community, in society now who need help and don't know how to get it and there's no structure for help for them. I know there's community nurses but they're very thin on the ground. There's a lot of people; old people with frail minds, youngsters, middle-aged people, and they're all in trouble and they don't know either the next step to getting help or they're too afraid. They're too frightened to know what to do or they basically don't know how to get help and that's the people who are suffering. I mean, the people here, that's the people who are going to get help and are going to get better. Its the people outside who are

going to suffer and that's why the suicide rate is escalating all the time. There isn't the structure to help them. It would be nice to know if there were Mental Health Teams in the community. I know they're trying to now but they're very thin on the ground. You get probably one community nurse and so forth. It would be nice to know if there was a squad of nurses, doctors, consultants who could go out as a team and help people out in the community. I know that happens to some extent but there's a lot of pressure on doctors and consultants because they're overloaded with patients. ... I think they would say themselves, if there was more money available, there'd be a lot less people struggling and breaking down under the stress of their situation. I think the problem is that a lot of the damage is done for a lot of people out there before they know that there's teams available that can help them. It all boils down to money. The doctors and consultants need good money to do a job like this. That's where all the problems are occurring. I wouldn't be surprised if they privatised the mental health service. I don't know what would happen then. In the states, they won't help you at all unless you hand over money. I think that would be a bad thing. The government now is squeezing the mental health act into one little ball. They're chucking everyone in the same boat, as I said earlier. You've got acute illnesses, you've got people who've had break-downs, you've got people who've got acute mental illness and people who've got depression and you've got drug takers as well, they're not mentally ill but they're drug addicts - you could say that was a form of illness - and they're all in the same boat. If you've got kind of a section of group, it would be nice to have a section of depression, manic-depression, mentally ill people in terms of nervous breakdowns, with different people and then the drug users. If you were all in a structure with like, this group is for this and this group is for this, then you've got all the doctors and consultants to deal with that case and I think it would be a lot better. Its everybody swimming in the same boat, if you see what I mean, and everybody just sort of chucked in the sea and everyone's just fighting for themselves, not knowing that if people were divided into sections, it would give the nurses, the doctors and the consultants more leeway to know exactly what they're dealing with rather than looking at it on spec. Who's got what problem and the situation they're in, that is the biggest problem. I should think that everybody's coated with the same brush here and that's where the problems occur. People need more help, like person A needs more help than person B, but person A is going to get the same help as person B so that where the problem comes in. If there were different structures like say A B C group, they would know exactly how to deal with it and know say, this person's a manic-depressive rather than a schizophrenic. I think there's vital time lost diagnosing people when they could be diagnosed straight away and put in various sections; like this group is for this problem and that group's for that problem. I think that make it a lot better. They're all chucked in the same situation and I think that's where the problems do occur. Like I said, person A needs more help than person B but they're going to get the same amount of help because the thing is not being diagnosed straight away and there's no situation where you can say: this is the manic-depressive area, this is the schizophrenic area. People are just struggling around in the same environment which is a shame. Medication and the actual treatment suffers itself because its taking this long for doctors to diagnose this person's problem. If it was diagnosed straight away, after intensive talk then treatment and medication: this person's a manic-depressive and they should be in this section and this person's a schizophrenic and should be in this section. Then you'd know the structure. Then you could know that this doctor and consultant and nurse are on the manic-depression section and

this doctor, nurse and consultant are on the schizophrenic section. If there was that kind of structure, I think people would get better quickly and they get diagnosed quicker than they are at the moment chucked in to the same area. You cope with so many acute illnesses and drug addict people that it is hard to deal with all that in one rather than nine units, sections.

Me: I have one more question for you which is; what difference do you think it makes to people knowing that they've been a psychiatric patient?

P21: I think in terms of people who want to work and go out into the community to find work, I think to mention you've been a psychiatric patient, a mentally ill patient is going to do you no good at all. The stigma about mental health people is wrong. To be honest, being mentally ill, in any of the forms we discussed earlier is not going to do you any good at all. For later life, especially career wise, there's not going to be much chance if you say your life story for the last however many months or years as a person who is struggling with their mental health. The stigma now about mentally ill people is bad because people are scared and frightened because I don't think they know what its all about. I think doctors and consultants are struggling with the real reason behind mental health, I think nobody really knows. It happens, its either a breakdown or a schizophrenic problem but people don't know how it occurred and they don't know how to really deal with it. People are scared of that. They'd rather let it alone than touch it. It is the stigma of the 90s. For many many years, people have had diseases like the black plague and various illnesses but I think mental health is the worst because its an illness that alienates you. It secludes you. Its a lonely illness. A lot of people are alone and scared out there and people don't know how to help them. They leave them alone and the illness will get worse if its not treated quickly. The only good thing that could come out of having a bout of mental illness or depression or whatever is it gives you the chance to know that you could see the danger signals straight away this time. Trying to get on with your life and struggle in society, struggle with your own illness, people can see the danger signs so they can try and get treatment straight away. Once they come into an environment like Prichard, they know that the environment is there for them to go back to if they have this trouble. That is one good thing that could come out of it that you know that there's a structure there to help you and you are invited to come back if you feel under pressure and under stress. That's one thing that people on the outside, in society, struggle with because they don't think there's any help there and they find it hard to find help because they're suffering and mentally ill. I can understand them being locked away in their homes for weeks on end and months on end being ill. There's not the structure there to worm them out and help them. They get worse and worse without treatment and I think its essential to know that places like this exist to get the treatment straight away which will help in the long term.

Me: OK. I've just about come to the end here. Are there any other comments you'd like to make. We've covered a lot.

P21: No, not really.

Me: Well, thank-you very much for your time.

P21: That's alright. As long as it helps. As long as people in the future will be getting more help because I do worry about the structure of the mental health act. I think people are being left unattended. If there were big teams of doctors who were out in the community, they could spot the illnesses straight away. They could bring people in and help them. A lot of people out there don't know how to get help. It makes their condition worse. Without counselling and medication, people will

get worse.

Me: Is there anything you wanted to ask me before you go.

P21: No, I think we've covered everything! We've gone right through the top and bottom of it. They're doing the best job they can. If there were a whole new structure from the government, it would put people in an easier position. If they knew exactly what they were doing and what kind of structure they were in, it would help them. It's still a stigma. People are frightened and scared. And in terms of parents with children with mental health problems, they're frightened as well because they don't know what to do with it. They're trying to do their best. The parents and families are struggling out there when, if there was a governing body, when a person who becomes ill they know exactly where to go and what group to put them in. It would be nice for a doctor to diagnose his problems and then to move them into, like we said before, a depression section or a manic-depression section or a schizophrenic section. If there were those kind of set-ups available, it would be a lot easier rather than getting the person and chucking them in the situation where people suffer from all different illnesses. That's where the problem occurs. One mental health illness is different to another. People suffer different symptoms and different acute illnesses and that's where the problem is. That's why time is lost to diagnose a person's problem when it should be diagnosed out in the community straight away. They would know how to bring a person from the community into a health environment and know exactly what treatment this person needed rather than chuck them all in the same boat with them getting worse and then try to administer medication and counselling. It could have been done in the first stages. The first stages of any mental illness is critical.

Me: So do you feel really that there was a time before you came here when, if there'd have been someone sympathetic around, they could have given you help earlier?

P21: I was OK in my case. My Mum was good. She saw as soon as I was in trouble and basically knew who to contact and get on with it. So I was OK and I knew myself that help was available so I went through those lanes. But there's people out there who don't know what to do and they're left for weeks and months on end with no help available and they could be suffering. If there was a structured team in the community, they would know exactly what to do. If there was a national campaign that the government provided to the public to know that if anyone's under mental health problems or nervous problems, schizophrenia problems, they know who to contact, what organisation to contact and how to cope with it. If you ask a lot of people, if you go out now in the community and ask people: if your son or husband or wife was mentally ill what would you do?, a lot of them would say, "I wouldn't know what to do" because what organisation do we go through? I think that it's a danger that it's not widely advertised enough that this is available if you're mentally ill. That's why people get worse because there's nowhere to turn. Even now, I'm just learning about community doctors and community consultants now working but it's a very thin line and they can't cover the whole of Bristol and we're not even talking about any of the country. Bristol alone is very thin on doctors and consultants and nurses who can be called out straight away and deal with the problem in its infancy. The dangers are that people get worried and afraid and scared. People who are suffering get worse and worse. I think that if there was a governing body or a helpline that we all knew about. If we could get in contact with that straight away, and people would come out and help you straight away ... but that costs money. It costs money for transport.

Me: But then again, it might also save money at the other end if people didn't get so bad.

P21: Yes, it would be nice to have a man, a sort of team of doctors and nurses to go out in a team. To be like the mental health team. You'd know there was a team out in your area and if you felt mentally ill ... say like they do in libraries. In libraries, you can go up to pick a library book. It would be nice to know you can go and have a talk with somebody, say a doctor or nurse who can deal with a mental health problem. It would be nice to know that. It would be nice to go into the centre and there would be a mental health wagon there that people could sort of ...

Me: Like a drop-in?

P21: Yes, like a mobile drop-in. You could go and think, "Gor, I've been struggling for a while and I didn't know how to get in contact with anybody" and suddenly they see a mental health wagon or helpline and you could go in there and get some counselling straight away. The stigma of that is, I could imagine people. You could just imagine a mental health wagon in town and who is going to walk in those steps. They're going to be frightened they're going to be seen by their boss or some friends. They're going to sneak up there and think, "I hope no-one knows I might have mental health problems". Its a stigma and we're scared of it. We're scared to let people know. And we're scared to let people come in and help us because we're scared that people will find out and it could ruin people's lives and jobs.

Me: Funny though isn't it because the truth is that most people, some time in their lives need someone else to help them out.

P21: Oh they do, yes. I think we all need friends and people. But that could be normal problems like a love life problem or a job problem or a little problem that a bit of help from friends can pull us through. But when you're talking about mental health, its a totally different environment you're in and its a feeling that not many friends can help you. It boils down to important qualified consultant psychiatrists and medication, that's the only way you're going to help in a mental health problem. The basic sort of problems that we all suffer like losing a job or losing a love life or something like that, we're going to bounce back from it because we've probably got friends around us. It could start from that and the other problems getting bigger but I do think that there's a case for like normal people's problems and mental health problems. I think that the mental health people need the help straight away. It would be nice. It'll never happen. We'll never have a wagon out there saying "Instant Counselling for Mental Health Problems". I don't see that ever happening. Its locked away, hidden away. It seems that a lot of people are afraid and embarrassed to find help. They know that it will cause a lot of problems financially, job wise and relatives and friends might look at them differently. I think that is the growing problem. People can't cope and they're too afraid to find help because the consequences could be quite bad for them. That is the problem. But who knows? One day it might turn out right. One day we might get rid of Virginia Bottomley and get a new person.

Me: Oh yes. She's not going to be there for ever.

Appendix 5: Comments on Relationships with Nursing Staff

When asked what things were helpful at the clinic:-

"Seeing old friendly faces, patients and staff."

"Staff" (x 4)

"Staff very helpful"

"Helpful staff - if you get in a state, they'll come along and calm you down"

"Some of the nurses will chat to you-the two keyworkers help."

"Staff on this ward have more time for you than the Maples"

"I think the staff are doing a good job"

"Talks with nursing staff and doctors"

"Talking to members of staff"

"The staff talking with you"

"The keyworker system"

"The attitude of some staff"

"The staff very helpful"

"The nursing staff were helpful"

When asked what was not helpful at the clinic:-

"The staff - don't follow by the rules"

"Some people's attitudes - staff and people here"

"Having to wait to talk to nurses"

"Allowing my emotions to become out of control before the staff attempt to approach me"

"When I wanted help, they didn't want to. They carried on with the handover"

"Not much encouragement from staff"

"Night staff"

"Some staff members - in job for not entirely honest reasons, haven't got the heart for it, cold"

"I've never been told who my keyworker is"

When asked what was important to them:-

"Trying to communicate with staff - I find it hard to express myself"

When asked what had caused them to change while at the clinic:-

"Care from nurses"

"Get to change mental image of self - realize this through talking with my named nurse"

When asked what had caused their psychiatric problems:-

"Nurse not knowing what was on my mind"

When asked what had helped with the problems:-

"Some of the nurses"

"Talking to staff with my problems"

"Communication and understanding"

"Having people around that would listen and try and respond thoughtfully"

Comments that were made spontaneously:-

"The staff are all very pleasant"

"The staff could do a bit more - tend to sit around and talk to each other."

Don't do an awful lot. I'd like them to socialize with patients more, to be in the common room etc."

"The staff are hardly around and busy doing something important"

"They're not provided with enough staff"

"Quite a lot of the time, there are more patients around than staff and the staff lock themselves away in the office. It doesn't seem right - they're not paid to chat in the staff room. I enjoy a good conversation and the patients aren't always up to it. I wander around looking for someone to talk to and then I go to my room because there isn't anyone."

"Train receptionists to deal appropriately with people who ring up and ask for help."

Comments that arose during the interviews:-

"The other thing I'd like to talk about is that sometimes, quite often in fact, nurses aren't available. ... Well, you might want to talk to a staff nurse and you go and ask them and they say, "Later, I'm busy at the moment". And on a number of occasions they said "Oh yes, we promise we'll see you before the end of the shift" and they haven't done. ... I suppose they are busy but I think the time should be made for everyone who wants it. They should divide their time more equitably between whoever they're dealing with. ... One of my keyworkers was P and she's the best nurse there. I was very lucky to have her. She did try to see me as much as she possibly could when she was on. I'm not knocking P because she was very good. ... They appear to be busy. Whether they are or not, I don't know. ... My gut feeling is that they're less interested in talking to people."

"There needs to be more organisation on the part of the staff. ... Stop pen-pushing, going around faffing around with pens in your hand and doing all your paperwork. get into the living room and the smoke room and talk to the patients."

"(I'd like) a bit more staff really. Like I haven't got my own keyworker. it would be something to have the same person to talk to. I had a keyworker in Prichard 2 but I haven't seemed to have one here, no-one's mentioned it. ... A bit more organisation, I think. So the place was more organised. It could be improved. First of all, I think just more staff really. ... (I'd like the staff to) spend a bit more time with me and the other patients."

"The staff are doing their job. I think that they do a good job in terms of their funding and financial situation. They're doing their best with the resources they've got and sometimes I think that they're understaffed and very stretched. ... Cos I like having a joke as well and I sort of laugh and joke with the staff. Its good because they've enjoyed it as well and its nice to affect the atmosphere a bit. ... I think the staff are doing a good job with the resources. There's not much resources and they seem to be doing the best they can with the material they've got. I think one of the biggest problems is that everybody is chucked in the same boat here which can get difficult as time goes on. ... People who need the time and energy are not really given it because its needed in other areas so the people who need it most can sometimes suffer and not have that kind of backing and support at a critical time. I mean, they're tied with lots of duties and other areas and it could suffer for the people who need it most. ... The only thing I could suggest is that more counselling would be nice. It would be nice to have that one-to-one counselling when you most need it. Because some people get very depressed, it would be nice to know there's someone there ready and available to talk to. That is available but it should be pronounced more

to know that there is someone there all the time. I think there's a lot of paperwork involved and that seems to bog down the doctors and nurses and consultants when there could be vital personal one-to-one or personal areas which could be more important than all this paperwork they seem to have got to go through with."

"I think the staff here are immensely good. They care for you as well. They're just very good."

Appendix 6: Comments on Relationships with Doctors

When asked what things were helpful at the clinic:-

"The doctors and nurses are friendly"

"A talk with the sympathetic ear of the psychiatrist"

"Doctors"

"Doctors and nurses try to be helpful but I always argue with the doctor about taking pills and injections"

"Talks with nursing staff and doctors"

"Help from doctors and nurses"

"Dr. O has helped me to think twice"

"My doctor, she's got everything arranged for me including physiotherapy for my back and shoulder and hopefully a social worker to find me somewhere to live"

"Helpful medical staff"

When asked what was not helpful at the clinic:-

"Lack of communication between doctors - 2 weeks before I saw a doctor"

"I can only say that the doctors just really didn't listen, so long as I was taking the pills they were happy"

When asked in what way they had changed while at the clinic:-

"I have to start taking notice of what the doctor says in here cos if I went to the GP, I wouldn't take the pills"

When asked what had caused them to change while at the clinic:-

"Myself and the doctors"

"Talking to doctors"

"Got to take notice of the doctors in order to get out of this place. If I went to my GP, I would listen to what he said and then make up my own mind"

"Care from doctors"

"Being cared for by the doctor and going through my whole life with her right back to being a baby - it helped her to understand my situation"

When asked what had caused their psychiatric problems:-

"The doctor wanted to change my tablets to get me better once and for all"

Comments that were made spontaneously:-

"The doctors just don't believe me. They say "Just relax and rest. I think you're definitely going on all right"."

"I never get to see a doctor or very rarely - he's always so busy. I would like psychotherapy to help with anxiety but I've heard nothing about it"

Comments that arose during the interviews:-

"The main one I think was Dr.N. Dr.N was the main one who spent time, was the one who was spending more time and explaining the things I was going through. And eventually I came round to his way of thinking which is what turned out to be the best advice given. He basically spoke to you and he listened as well and you could tell he was experienced in terms of letting time take its course really. Honestly, I was rebellious and I didn't trust anybody at the time, and I think basically he spent the time and energy needed to convince me that one day things were going to get better and ...

he was someone you could knock some ideals against and he basically listened and, with the medication, it was a course of recovery. He'd listen and give that chance and one day things were going to get better and that was right."

"I don't know if it was the best explanation but she's (the doctor) been there to support me I suppose. I haven't seen her for a while so its a bit difficult really. She was going to leave and work on another grade of being a doctor. I feel there should be someone who should like, stay here and not leave. For continuity. I don't think that seems to be happening. There's like big change over and I've seen quite a few consultants. Its been a bit difficult. I think there should be continuity."

"S.B (gave the best explanation). She was the SHO for a while but she left. She was only there a couple of weeks. She was just very good at explaining my problems to me. Explaining what I told her back. She was very good at goving advice."

Appendix 7: Comments on Relationships with Other Patients

When asked what things were helpful at the clinic:-

"The patients have been very helpful, very good - helped with the washing machine etc."

"Patients"

"Talking to other patients"

"Patients sharing the same sort of problems as myself - not everyone has the same problems"

"General chat to patients"

"Other patients"

"People"

"Chatting to other patients"

"Making friends with other patients"

When asked what was not helpful at the clinic:-

"The people can get you down a bit, the patients more. Someone upset me - it didn't help. You have to try and cope with that."

"Too many drug addicts and criminals. Some clients aggressive and upcooperative."

"A few patients who swear a lot, who don't behave."

"Needs more supervision of patients - incidents could be stopped sooner."

"Other patients" (x 2)

When asked what was important to them:-

"There are lots of people here - its very different to being at home."

When asked in what ways they had changed while at the clinic:-

"I think more of myself and respect other people's views more"

"I get more bad-tempered at times, more aggressive. Some days I seem to snap people's heads off, especially if I don't get much sleep."

When asked what had caused them to change while at the clinic:-

"Listening to what other people have to say"

"Care from patients"

When asked what had helped with the psychiatric problems:-

"The patients and some of the nurses"

"Chatting to people"

"Talking about it"

"Talking"

Comments that arose during the interviews:-

"I had a good laugh with some of the patients"

"I was becoming a bit agitated by a couple of people who were in there. They seemed to be upcooperative and they frightened me a bit. They were sort of drug addicts and heroin addicts and that. They frightened me."

"I think the people and the building (make me sad). Like the patients - its not very nice people to mix with. They can make you upset and they have really. ... Or there might be something to do with the patients that made me cross. A patient wanted to borrow something, like one of my

possessions, and I said no and she called me some names like selfish cow and I just stood up for myself but it wasn't very nice that you're put in that position."

"There was one case just recently that a lad who was here for a few days committed suicide which was a sad occurrence. I can't place him at the moment, people said I must have seen him cos he played the guitar but I can't place the face. Apparently, he left here and committed suicide so obviously that was one of the saddest things really and I think everybody tends to think they could have done more or could have helped him in some other way. But basically, it boils down to the fact that if someone is determined to commit suicide they will."

"I haven't had a feeling of any anger. I could feel angry in some people's situations, for them. On a personal level, I haven't found anything to be angry much at."

"(good times were) Laughing with a bloke called Clive whose got quite a good sense of humour. A patient. I don't see him anymore. He's gone out of the system."

Appendix 8: Comments made about the value of Time Away From Home

When asked what things were helpful at the clinic:-

"Space"

"Getting away from everything"

"Time away from family and friends so I realized the people I was mixing with were no good for me"

When asked what was important to them:-

"Being away from the place I was living"

When asked what had caused them to change while at the clinic:-

"Being in hospital"

When asked what had caused their psychiatric problems:-

"I needed a place of my own"

"I felt hurt that Mum and Dad sent me out of the house"

"We had a big argument over a stair carpet and they decided to get me in here"

"Difficult to say. I was home from work and got worse and worse"

When asked what had helped with the problems:-

"In past visits, the fact that I can go somewhere to get well and when well resume my place in the community as before. As I can be totally unrealistic and would not be accepted when out in the community."

"Getting away"

"Change of environment. Getting away from parents."

"Being able to live away from my parents."

Comments that were made spontaneously:-

"I'm going back to the same situation which caused the illness and I'm left to deal with it on my own."

Comments that arose during the interviews:-

"I think that a change of environment was essential at the time and I think that to be in a position where you're given 24 hour treatment. There's always someone around for 24 hours of the day which gives you that kind of security that you need at a particular time."

"(The staff were aiming for) perhaps getting a break away from my parents at home."

"I hoped to get through a very rough time in my life and some time out really."

Appendix 9: Comments made about Having Visitors

When asked what things were helpful at the clinic:-

"Unrestricted visiting time"

"Friends and people"

"Visitors, family"

"Visits from family and friends"

When asked what was not helpful at the clinic:-

"Limited visiting hours"

When asked what was important to them:-

"I couldn't have managed without my wife - very important to see her."

"My friends"

When asked what had caused them to change while at the clinic:-

"Care from family and friends"

When asked what had helped with the problems:-

"Family and friends"

"Only my family coming in"

"Love - my wife and immediate family"

Appendix 10: Comments made about Medical Treatment

When asked what things were helpful at the clinic:-

"Medication" (x 3)

"Tablets"

"Meals and medication at regular times"

"Obviously the medication"

When asked what was not helpful at the clinic:-

"The reaction I got when informing general nursing staff that the amount of medication I was on was too strong"

"Don't like having injections, hate having them, have been having them since 1976 to keep me stable."

"Enforced medication - two injections against my will"

"All the tablets"

"Filled up with pill and walking around like a zombie. I don't like taking pills and I'm a coward about injections."

"Too much emphasis on drugs and not enough on talking problems through."

When asked what had been important to them while at the clinic:-

"The treatment"

When asked in what way they had changed while at the clinic:-

"Never recovered from having ECT in 1979"

When asked what had caused them to change while at the clinic:-

"ECT put me back on the road but I wonder if it was the right road."

"Medication"

"Drugged up makes it worse. Makes you find it difficult to think."

"The system and the drugs given to patients."

When asked what had helped with their problems:-

"Medication" (x 2)

"The treatment"

"The tablets get me stabilised - I've stopped over-reacting to feelings and thoughts."

Comments that were made spontaneously:-

"More information on drugs and what they do to you. Need information to make correct decisions."

"Maybe (would recommend service to friends) though depending on extent of illness, taking therapeutic drugs is not always a good idea due to dependency."

Comments that arose during the interviews:-

"Well you see, I wasn't at all happy with the first ones I was on, Sulperide, they were awful things. Its only by chance that I got moved off them. Dr.W thought I was on the dipixol injections and he said to S something about the injection. And I said, what about this injection? I'm not on it. I said that I would like to be on the injection. She said "would you like to be on the injection?" and I said that yes I would like to. I know other people who've been on it and it doesn't have too many

side effects so that's why I got on the dipixol."

"I would have liked more information about my drugs."

"(My treatment is) sort of changing the tablets over because I was on the same drug for 4 or 5 years. I did have injections but they've stopped that now and they've increased the dose in the morning times. I'm on about 10 tablets a day now but my Father found out that its a very mild dosage ... I'm taking vitamin B6 and Oxytetracycline and I'm not sure about the other medication. I'm not sure of the names. But I think some tablets I've got to make you a bit more happier and the other tablets to calm you down a bit ... Any risks? Well, I suppose ... I don't think so, I hope not. Do you mean like any side effects? ... Well, I did have something, a sort of blackout. When my period started I couldn't see anything for quite a few minutes and felt awful. But that was the beginning of treatment. My eyes went a bit funny as well, I think you get that as well, blurred vision. When I had an injection I had a side effects tablet to stop the side effect but I still did. Just a little bit."

"I've been on chlorpromazine and procycladine which is quite interesting because chlorpromazine was invented in 1949. I've been looking into it and its a very old drug and its still widely used today so its amazing that that kind of drug has gone on for so long and its helped a lot of people as well. They're still waiting for a wonder drug to come out I think. It would be nice to have a pill that anyone could take and fell instantly brilliant ... (My source of information was) to be honest, a lot of the patients, a particular patient I'm quite friendly with, she knew a lot about the drug situation and she gave me a lot of information. So, interaction with patients is quite useful ... Chlorpromazine is a mild tranquillizer which keeps you down. I think its used for sort of hyper people, people who are hyperactive, over-active, and I think it helps mentally to calm yourself down and it does the job. I'm not sure if its a mild tranquillizer but I know its a tranquillizer ... Just to stop the side effects, the procycladine. Its to stop the side effects of the chlorpromazine. Because the side effects are usually physical like, physical functions going wrong and eyeballs locking and staring so it helps to clear that ... I was told you need to take procycladine to stop the side effects. My Step-Mum's a nurse anyway so she sort of gives me the up-dated information."

Appendix 11: Comments made about Having Days Out from the Clinic

When asked what things were helpful at the clinic:-

"Being allowed out in the days"
"Home leave"

When asked what was not helpful at the clinic:-

"Not being allowed out in the days"
"Not being allowed to do what I want to do, I don't want to be here at all"
"Its frustrating if you're not allowed out"

When asked what was important to them:-

"Arranged outings - stress relief"
"Daily trips and outings"

When asked in what ways they had changed while at the clinic:-

"I appreciate being at home more. Being in hospital was an experience"

When asked what had helped with the problems:-

"Going home and having a rest and a cup of tea and a bath"

Appendix 12: Comments made about Ward Activities

When asked what things were helpful at the clinic:-

"Art therapy, sport, chess"

"Relaxation"

"I enjoyed the art therapy and table tennis"

"The relaxation classes and groups downstairs are a big help"

"All the groups have something to offer"

When asked what was not helpful at the clinic:-

"Boredom" (x 3)

"Lack of organised activities"

"Most of the classes don't run or are not good. Gets boring very quickly."

When asked what was important to them:-

"Art therapy"

"Chess and club house"

Comments that were made spontaneously:-

"The clinic has a need for arranged stress and boredom relief out of the clinic other than visitors, e.g. organised social activities."

"They give you tablets and write what's on on the board but it isn't enough. Need some video games or some decent books."

"You're put in a bedroom and left to fend for yourself. There needs to be more things to do. It can be really boring - every day the same."

"You can only use weights on a Monday unless a staff member is free to supervise."

"Its not very nice - its just the atmosphere. It seems withdrawn and dated. You should be given some serious activities really, maybe even a training course."

"Lack of things to do to pass the time. Lack of staff around to join in - they don't see it as part of their role. Its depressing - there's nothing to do and you've got to be there. Its contrary to the idea of getting well."

"Its very boring in here - just left to sit and watch TV. There needs to be more going on and to get everybody involved."

Comments that arose during the interviews:-

"(It would be useful to have) I'm not really sure. I suppose more opportunities ... A bit more facilities really. In the health authority. More groups and things, a sports centre or something, a swimming pool."

"I think I'd provide more activities for the patients apart from trying to get people back into work situations. More leisure activities. Possibly drama or something like that which would help the patients if they were interested ... I just find that there are most people just sitting around all day smoking, not doing anything. Like I say, Glencraft which is what they provide is geared up to getting people back to industrial rehabilitation. There's no real leisure, not much fun really. There's no real fun. I think there should be more enjoyment of being in hospital."

"Well, half the time I was there, we didn't have an OT anyway. And if you wanted to know what the ward activities were, you had to look on the board."

"(most memorable aspect of stay) Quite a nice time sun-bathing."

"If I was in a position where someone would tell you what was going on then you just follow in with the crowd. Like the activities I've done were pottery, art, we had various meetings like relaxation meetings. Relaxation tape in a group of people was quite interesting because you're quite relaxed, you're laid on these massive beanbags. You're just laid out and slide into comfort. Yes, its quite interesting. So basically, you sort of took it on spec by the day. There's not planned organisation for the next day or a few days ahead. I must say that there's a scheme now where the staff write up the activities in the dinner room. You can actually look up to the board and see what the day brings and the activities are put on the board. Its your choice to attend if you want to."

"I should think everybody's coated with the same brush here and that's where the problems occur. People need more help, like person A needs more help than person B, but person A is going to get the same help as person B so that's where the problem comes in. If there were different structures like say A B C group, they would know exactly how to deal with it and know, this person's a manic-depressive rather than a schizophrenic."

Appendix 13: Comments Made about Having Time to Think

When asked what things were helpful at the clinic:-

- "Relax a bit, take things easy"
- "Peacefulness of grounds"
- "Its been helpful being here"
- "The security and safety aspect. Felt safe being there."

When asked what was Important While at the Clinic:-

- "Just being able to relax and not worry about day-to-day things"
- "The beautiful grounds"
- "Allowed to sleep"
- "Having time off work. Being in a low stress environment."

When asked in what way they had changed while at the clinic:-

- "I enjoy life more, more relaxed. I think less deeply about life."
- "I think I have become more realistic about the future and my role in it"

When asked what had caused them to change while at the clinic:-

- "Thinking less deeply, enjoying simple pleasures"
- "Time to think about things. The environment provided has so many different situations and people that you analyse where you fit into things more."
- "Greater self-awareness. Understanding me."

When asked what had caused their psychiatric problems:-

- "Too much work, not enough relaxing."
- "Too much stress and overwork, caused by lack of good sleep."

When asked what had helped with their problems:-

- "Stopping work and listening and being direct"
- "Think should concentrate on causes - by talking about it you can understand things you've never even thought about."
- "Isolating the stress causing things in my life"
- "Rested a bit. Got away from it all."
- "Time"
- "I've been here quite a time"

Comments that arose during the interviews:-

"I think it was essential that I was here when it was in the worst times so it was helpful that I was actually in a secure place and it was good that you can actually go through these different thoughts and feelings and come out the other end intact ... I needed basically a rest really, from the hurly burly and long working hours of society."

"I do wonder sometimes, what happened to the patients who used to be here? ... Most of mental health patients ... I think that initially they need the protection and the security of an organised environment like Prichard 1. Instead of being out in society trying to survive on the little monies they've got and all the pressures of life itself ... I think a lot of people with mental problems cannot cope with that and by forcing them out into the community, it doesn't help them."

Appendix 14: Comments about Food

When asked what things were helpful at the clinic:-

"Food, also a good choice of food."

"I like the shepherd's pie. I could have shepherd's pie every day."

"Good meals. The cooks are very talkative and laugh."

"Nice food, wide selection."

"Food and warmth."

When asked what things were not helpful at the clinic:-

"Food, money, rules."

"I ordered a pizza which never came."

"The food. I have a special diet and there's not always something available. I have to provide quite a lot myself."

"No access to make coffee."

Comments that were made spontaneously:-

"Not eating enough - you lose weight. Kitchens (provide) not enough food."

"The food - its tacky, doesn't taste nice, always the same. It fills you up if you like shepherd's pie. Should have a monthly rota, not fortnightly. The vegetarian food doesn't always come down."

Comments arising from the interviews:-

"I'd make sure the patients had better meals. One of the things that annoyed me about Prichard was that you could only get tea and coffee at certain times. I think you should be able to get it all the time. (Q) Well, you have it at 10 o'clock in the morning and 3 in the afternoon and 8 o'clock in the evening. (Q - can't you make your own?) No. (Q - what if you are thirsty?) You have to ask for a drink of water ... Because to get in the kitchen you had to ask."

"Better food, definitely better food. The quality of food here is terrible."

Appendix 15: Comments made about the Ward Environment

When asked what was helpful at the clinic:-

"Access to coffee bar, library, craft room."
"Privacy in dormitories."

When asked what was not helpful at the clinic:-

"Rules - no ground rules stated."
"Not allowed to bring in own electrical equipment."
"I can't get in the bath and there's no chair for the shower. The stairs are a problem."
"There's a kleptomaniac in here."
"Only one television - have to put up with whatever's on. Only two bathrooms."
"Too much like an army prison."
"Having belonging's stolen. Being moved from room to room."
"The way the telephone is organised - all patients' phonecalls go through to P1. Also, you have to go downstairs to make calls. I think often patients on P2 don't get their calls."
"I don't like the toilets being locked at night - the bathrooms should be kept open."
"I don't like places being locked and out of bounds but they have to be."

When asked what was important while at the clinic:-

"Asked to be moved because I was in a room with a girl trying to get off heavy drugs - couldn't sleep."

Comments that arose spontaneously:-

"Decorate, put in flowers, make it beautiful. Make the seats more tidy. Make a big table so people could eat together."
"Put locks on cupboards in bedrooms so could lock stuff up - had loads of stuff go missing from room. Should have own key for room and own room. Wouldn't have to worry where anyone goes. More privacy."
"Get a telephone on P2. Paint the walls and skirting boards."

Comments that arose from the interviews:-

"Make it a bit more homely ... I'd change the furniture. I'd have a three piece suite or something to lounge on. And some beanbags. Because the chairs we sit on are not very relaxing ... I'd make it a bit more like home and put wallpaper up and decorate the place, not just slap paint on the walls."

"Well, its a terribly shabby building. I think its atrocious that people should be expected in this day and age to go to a building like that ... I think its the layout, its very square isn't it. And the quality of the carpet. (Q) There's carpet in the smoke room and the bedrooms. They're not as nice because in Southmead, you get your own little room ... Its very grotty. Well, you'd expect the smoke room to be grotty in a way but the smoking room in Southmead isn't grotty. They haven't been punished for their sins ... I might put some more comfortable and some newer chairs in. Give it a lick of paint. New curtains."

"(I was angry when) They moved my bed without telling me when I came back from weekend leave. And some of my stuff was gone."

"I'd make it a more modern building."

Appendix 16: Comments about the Cause of People's Problems

- "Nurse not knowing what was on my mind"
- "Lost my girlfriend - relationship finished"
- "Depression and stress which ultimately led me into a fantasy world"
- "Too much work, not enough relaxing"
- "Didn't listen to what other people were thinking or saying"
- "Financial - house repossessed, child support agency. Overwork. Break-up of relationships. Loss of faith in self."
- "Isolated in school. Sent to a boarding school at age 4. Darkest kid in a military school so outcast, even my brother ignored me. Loss of support when parents died - used relationships to compensate so break-up hard to cope with."
- "Money worries. Things not looking right. Worries about heart."
- "Lack of sleep - I was mentally and physically exhausted. Guilt for the way I've acted towards my wife. Got no feelings at the moment - can't cry, can't laugh. Got no physical sensations - can't feel heart beat."
- "The doctor wanted to change my tablets to get me better once and for all."
- "Being difficult to live with"
- "My Gran's death and my Auntie and Uncle's death. Auntie died of lung cancer. My Auntie dies in January and my Gran in February and I can't get over it."
- "Lots of people took me for granted. Maples just didn't agree with me - made things worse."
- "Stress - money problems, pressure of work, pressure at home."
- "I hit a little boy cos he kept calling me names. The whole street called names. Told him to stop and he didn't. Told him I'd hit him and he didn't stop. So I hit him. Horrid little boy, didn't tke no notive of anyone. Someone was going to hit him one day."

- "Basically just ill"
- "Hearing voices, very restless and very tearful."
- "Lack of faith in God, (even hatred), and thinking in a negative way. Desperately trying to make sense of life, looking for order in the universe. This led to psychosis."
- "Looking into the meaning of life: e.g. religion, politics, superstition, etc."
- "Because they thought I was having delusions."
- "An anxiety attack and I went a bit haywire on Maples West."
- "Southmead Hospital WSM ward, the police and the government."
- "Having no friends or family to support me."
- "I needed a place of my own."
- "Too much stress and overwork, caused through lack of good sleep."
- "Mentality, depression, very miserable. Felt hurt that Mum and Dad sent me out of the house. My brain runs away with me. I get blanks and think I'm younger than I am."
- "Glastonbury festival. Flashbacks."
- "I have had two mental breakdowns now, first was caused by me having an abortion and not coming to terms with it, this time I don't know the cause of."
- "My Brother died in a car accident."
- "I have a spiritual problem not a mental one."
- "Lack of self-respect is an important factor. I'm usually relatively depressed, I have been for most of my life. So when an opportunity arises to be happy, I can't take the pressure. Not liking myself. Doing things which make me unhappy. Its a cycle of despair. To do with childhood experiences and compounded by stress."
- "I was trying to jetison various inhibitions that I felt were detrimental to my mental make up. I went a bit too far and some friends/family realized that I needed help."

- "We had a big argument (wife and him) over a stair carpet and they decided to get me in here. My family reported me and that's the reason I'm in here."
- Described history of abuse from early childhood and throughout entire school career, subsequent changes of job, trying to come to terms with and live by the Bible, relationship difficulties. (The precise quote and the details of abuse are withheld on request.)
- "Business is closed down - I've been told I couldn't run a business. Also I've not had a proper holiday - I've worked myself out."
- "Over a 2-3 year period, I lost my job, went to a stressful job straight away, lost my car, relationships, a baby. I couldn't cope with it in the end."
- "Difficult to say. I was home from work and got worse and worse."

Appendix 17: Patients' Knowledge of their Status and Treatment

Who decided you should go to Prichard?

H27 - I did. Had to instruct locum GP how to make a referral. Supported by worker from St. Marks.

H41 - I did. Felt an outside influence (cosmic police computer) was saying it was time to go into hospital.

H50 - The consultant, Dr. Seymour

P21 - I did. (Was admitted as an informal patient and subsequently sectioned).

P18 - The GP.

Was that a good decision?

H27 - Yes

H41 - Yes

H50 - I suppose so.

P21 - Yes

P18 - Yes

Did you come in under section or as an informal patient?

H27 - Yes (an informal patient).

H41 - Informal.

H50 - I don't know. I don't think I came in under section. Not to my knowledge. I saw the doctor who said "you come in" but I don't think it was under section.

P21 - Informal to start with. Then under section. I sort of misbehaved.

P18 - Not the first time, no. I think it was about the third time I came in (that I was under section).

What does it mean to be under section?

H27 - Its when the Mental Health Act can be used to restrain you from going outside the hospital.

H41 - Not entirely (sure what it means). Its just for your own safety, to protect you and stop you from leaving the hospital if you're a danger to yourself.

H50 - I'm not really sure about being under section. I don't know if you sort of have your own room or something like that.

P21 - Well, it basically means that they can keep you here at their will. There's a section 2 which is 28 days when you're allowed to, well you've got no choice but to stay on the ward and you're under doctors and nurses orders. And the section moves up. As the severity of the section moves up, it goes up in numbers like 2, 3, 4, 5 and so forth. So basically, the higher the section the higher the seclusion. When you're under section, you're kept here against your will.

P18 - It means that you have to take your medication that's prescribed. You can't go home and come back when you want to. You have to stay until they say. Basically, just abide by the rules.

What difference does it make to care and treatment?

H27 - I think they get more care and treatment. Generally, the sectioned people are a bit naughty and so get more attention.

H41 - I don't think so, I'm not too sure.

H50 - I suppose you have somebody who gives the close eye. Just keep a

- close eye on you and protect their interests.
- P21 - It probably makes the staff more aware of the situation. If they know you're on a section then obviously they're going to treat you slightly differently.
- P18 - I think it does, yes (make a difference), because you're restricted aren't you.

Would you have felt differently under section?

- H27 - If I'd have been brought in not wanting to go there, it would have seemed an awful place.
- H41 - Yes, I would. I'd have felt it was wrong that I should be put under that.
- H50 - I don't know if I would have felt in a worse state. It would be rather daunting.

Is sectioning a good idea?

- H27 - Yes. For their own safety and the safety of others.
- H41 - Yes, I do. Because they're a danger to themselves more than anything.
- H50 - I think so. It protects them you know.
- P21 - I think it is because I don't think people are in control of their own lives and a section gives the whole set up for them to detain people and in the long run, its for the best.
- P18 - I think so, yes.

Who can be sectioned?

- H27 - Well, people who are a danger to themselves and a danger to other people.
- H41 - I don't know.
- H50 - I suppose they must be in a really poor state, not in control of themselves.
- P21 - Anybody. Anybody can be sectioned. (Q) I think its obviously if the consultant or a doctor or a nurse thinks you're not in control of your life ... in terms of, you could be going through an acute illness. Like the typical sort of one is a psychotic illness and while you're not in control of your senses, there's self-violence there or violence to other people.
- P18 - There's different reasons isn't there. Some people are sectioned because they're psychotic. Others aren't (and therefore aren't sectioned).

Who sections people?

- H27 - The police have to be involved, and a psychiatrist. And a GP? I'm not sure.
- H41 - I don't know.
- H50 - I suppose the staff, someone in charge, the manager. You have managers here don't you? The ward manager.
- P21 - I think its the consultants and the doctors.
- P18 - Dr. Watts.

What rights do you have under section?

- H27 - Well, they've got all the rights to be treated humanely. They've got the right to appeal. I don't know. I've never been sectioned so ...
- H41 - I don't know.
- H50 - What rights they have. I don't think they have any say in it really

- because they're too ill to think about it.
- P21 - To be honest, I'm not brilliantly sure with the section procedure. All I know is that a section 2 means you're kept against your will for 28 days. I'm not so sure of the other rights and regulations.
- P18 - You don't have much rights.

What can you do about an unfair section?

- H27 - They've got a right to appeal.
- H41 - I don't know.
- H50 - I suppose they can ask one of the staff and challenge it, I suppose.
- P21 - I'm not really sure. I think they could appeal but I'm not sure of the procedure and I'm not certain of what steps they could take. You see, I don't know who they appeal to really if they want to appeal. I'm not quite sure of the procedure you can go through.
- P18 - Well, you can appeal against it. But I don't see the point. Its a waste of time. (Q) Well, the doctors have got more power than you haven't they?

What did you hope to achieve?

- H27 - I hoped to get through a very rough period in my life. And some time out really.
- H41 - Well, I saw it as ... in a way it was showing me I was still sick. It was a way of justifying my claiming sickness benefit. It wasn't a punishment or anything, it was more like keeping me sick. Because I felt that I was guided into hospital by something mysterious.
- H50 - Just get better. To feel more myself again.
- P21 - I think basically that a change of environment was essential at the time and I think that to be in a position where you're given 24 hour treatment. There's always someone around for 24 hours of the day which gives you that kind of security that you need at a particular time.
- P18 - To get better. (Couldn't define what 'better' meant)

Did the staff understand these hopes?

- H27 - Yes.
- H41 - I don't know if they understood, they didn't say. They just took notes and that was it.
- H50 - I think so.
- P18 - I think so.

What did the staff want?/ Did they want the same as you?

- H27 - I think they were aiming for whatever I wanted.
- H41 - Perhaps getting a break away from my parents at home. I don't know really.
- H50 - Hopefully, but I'm not sure. I feel a bit uncertain about that. (Q) To feel fit again I suppose. That's all I can think of.
- P21 - Basically, they wanted to try and help me in terms of my situation. Obviously, medication was the main one. They were helping me by experimenting with drugs and medication.
- P18 - I should think so.

Did you achieve what you wanted?

- H27 - Yes.
- H41 - Its like a sort of token motion, a token movement on my part. A sort of bowing down to authority which I see this computer as being a

- symbol of authority. Like, if I go into hospital, I'm not fighting against it. Its a sort of masculine sort of computer, like a Father.
- H50 - I'm not really sure at the moment. I feel a bit vague about it.
- P21 - Oh yes. I think in my situation. I've achieved what I needed to. I needed basically a rest really, from the hurly burly and long working hours of society. It gets you in a sort of, a relaxed and helpful environment. That's what I wanted to achieve and it has happened.
- P18 - Yes.

What were you told about how the ward ran?

- H27 - I was given a booklet. It was quite good but it was more a list of rules and regulations in some ways. (Q) There isn't that information. I think I asked someone to show me round and she showed me where the tea and coffee was. And if you wanted to know what the ward activities were, you had to look on the board.
- H41 - I can't remember. I was told that I had to say if I was going out, that sort of thing. (Q) They just said at the time, anyone interested in relaxation etc.
- H50 - I suppose just day to day I found out different things. I did ask what time meals were and they sort of said um ... I'm not really sure really. You sort of find out for yourself really.
- P21 - Not much really. No, the paperwork was non-available. I do believe now that they've got a little leaflet that they hand out to you, to new patients which gives them the goings on in Prichard one. (Q) Basically going on spec every day really. And if I was in a position where someone would tell you what was going on then you just follow in with the crowd. So basically you sort of took it on spec by the day. There's not planned organisation for the next day or a few days ahead. I must say that there's a scheme now where the staff write up the activities in the dinner room. You can actually look up to the board and see what the day brings and the activities are put on the board. Its your choice to attend if you want to. Visually, you can see what's happening now which is helpful.
- P18 - We were told about it the first day we came. We were shown around - places that we could smoke, the bathroom, the showers. Given a cup of tea when you first arrived.

Who told you this?

- H27 - I can't remember - a member of staff.
- H41 - I think it was A.
- P18 - A.

Who gave you the best explanation of your difficulties?

- H27 - S B. She was SH0 for a while but she left. She was only there a couple of weeks.
- H41 - I don't think I was given any idea of what was going on. (Q) Oh yeah, that was the doctor obviously, Dr. M.
- H50 - I suppose the doctors really, who were in charge. Dr. F. Well, I don't know if it was the best explanation but she's been there to support me I suppose. I haven't seen her for a while so its a bit difficult really.
- P21 - I think, I remember talking to B the charge nurse who was ... he gave me some good advice. But the main one I think was Dr. N. Dr. N was the main one who spent time, was the one who was spending more time and explaining the things I was going through, ... and eventually I came round to his way of thinking which was what turned out to be the

best advice given.
P18 - Dr. N.

What did they say?

- H27 - She was just very good at explaining my problems to me. Explaining what I told her back. She was very good at giving advice.
H41 - I think he might have tried to (explain psychosis) but I didn't understand. Its caused by stress or something.
H50 - Just that I'm a bit unsure about things.
P21 - He basically spoke to you and he listened and you could tell he was experienced in letting time take its course really. Honestly, I was rebellious and I didn't trust anybody at the time, and I think basically he spent the time and energy needed to convince me that things were going to get better and ... he was someone you could knock some ideals against and he basically listened and, with the medication, it was a course of recovery. He'd listen and give that chance and one day things were going to get better and that was right.
P18 - Well he explained that I was ill. He said I needed to come into hospital for a while. Mind you, I was on section then. (Q) Yes, they said I was psychotic and had depression. (Q-cause) Not a clue.

What was your treatment?

- H27 - I had quite a number of tablets and then I went on to injections. The tablets were Sulperide and the injection was dipixol. That's what I'm on now and its suiting me quite well.
H41 - Just medication - chlorpromazine. The first time I was in there, I attended Glencraft but after that I didn't. Chlorpromazine and dipixol injections.
H50 - Well, sort of changing the tablets over because I was on the same drug for four or five years. I did have injections but they've stopped that now and they've increased the dose in the morning times. I'm on about ten tablets a day now, but my Father found out that its a very mild dosage. I've got a social worker now as well, at last! (Q) Oh gosh! I'm taking vitamin B6 and oxytetracycline and I'm not sure about the other medication. I'm not sure of the names. But I think some tablets I've got to make you a bit more happier and the other tablets to calm you down a bit.
P21 - Medication is the main one. And as I've said, I spoke to B and Dr. N. I've been on chlorpromazine and procycladine which is quite interesting because chlorpromazine was invented in 1949.
P18 - Medication. Procycladine, Lofepamine. (Q) Lofepamine with an L, its like chlorpromazine.

Who told you the most about your treatment?

- H27 - Dr. B.
H41 - Dr. M.
H50 - I suppose the doctors.
P21 - To be honest a lot of the patients, a particular patient I'm quite friendly with, she knew a lot about the drug situation and she gave me a lot of information. My step-Mum's a nurse anyway so she sort of gives me the up-dated information.
P18 - Nobody really.

What was the purpose of your treatment?

- H27 - No (I don't know).

- H41 - Well, it was to sort of hold back the psychosis.
H50 - Purpose of treatment? I don't think so, no (nobody told me). I feel very vague about all this.
P21 - Chlorpromazine is a mild tranquillizer which keeps you down. I think its used for sort of hyper people, people who are hyperactive and I think it helps mentally to calm yourself down and it does the job. I'm not sure if its a mild tranquillizer but I know its a tranquillizer. Just to stop the side effects, procycladine. Its to stop the side effects of the chlorpromazine.
P18 - Because of my problem I had.

Were there any risks?

- H27 - Don't know.
H41 - Well, they say that chlorpromazine has side effects but I've never noticed that. I've never had them.
H50 - Any risks? Well I suppose ... I don't think so. I hope not. Do you mean like side effects? Well, I did have something, a sort of blackout. When my period started I couldn't see for quite a few minutes and felt awful. But that was the beginning of treatment. My eyes went a bit funny as well, I think you get that as well, blurred vision. When I had an injection, I had a side effects tablet to stop the side effects but I still did. Just a little bit.
P21 - Well, sort of. I was told you need to take procycladine to stop the side effects.
P18 - No.

Were there any alternative treatments that could be tried?

- H27 - Don't know.
H41 - I suppose there are sort of new age therapies and things like that, faith healing. (Q - were these discussed) No.
H50 - There might be. I don't know if its in my case.
P21 - Not as far as I know. I just took it for granted that I was given medication to help my position and that's what happened.
P18 - No. I don't know.

Who had the right to make a final decision about what treatment you have?

- H27 - The doctors.
H41 - I suppose I did.
H50 - I suppose the doctors are in charge.
P21 - Dr. O.
P18 - Dr. W.

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