

**Negotiating Uncertainty: Mental Health Professionals' Experiences of the Mental
Health Act Assessment Process.**

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Doctorate in Clinical Psychology

By

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DECLARATION.

This thesis is an original piece of work that has been submitted in partial fulfilment of the degree of Doctorate in Clinical Psychology. The literature review and research report contained within this thesis have not been submitted for any other degree, or to any other institution.

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WORD COUNT.

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Negotiating Uncertainty: Mental Health Professionals' Experiences of the Mental Health Act Assessment Process.

Laura Skinner, Trainee Clinical Psychologist.

ABSTRACT.

Part one: Literature review.

Aim: A literature review was carried out to explore the current knowledge about how the application of mental health legislation affects both clients and clinicians.

Method: A computerised literature search was carried out using various databases.

Results: Researchers have found that a significant proportion of mental health clients who are placed under mental health legislation experience negative emotional reactions and perceived coercion. However, the relationship between legal status and negative outcomes seems to be mediated by procedural justice. The few studies of clinicians' experiences suggest that applying the legislation can be associated with practical difficulties, stress and pressure.

Discussion: Methodological issues in the existing research are discussed alongside suggestions for further research.

Part two: Research report.

Aim: The current study aimed to explore how mental health professionals experience the Mental Health Act assessment process and how they cope with any effects.

Method: The data from semi-structured interviews with eleven mental health professionals was analysed using the grounded theory method (Pidgeon & Henwood, 1996).

Results: The core category of the generated theoretical model was 'negotiating uncertainty'. Interwoven factors that contributed to uncertainty were legal liability, the pressured context of assessments, external conflict and the tension between incompatible identities. Strategies used to tolerate and contain the uncertainty included internal psychological processes and external support.

Discussion: The clinical implications of the findings are discussed, including the need for increased occupational support for professionals. Suggestions for further research are also provided.

Part three: Critical appraisal.

A reflection on the research process is provided, including issues of ongoing adaptation and overall learning outcomes.

PART ONE

LITERATURE REVIEW

Detainers and Detained: A Literature Review of the Effects of Compulsory Mental Health Legislation on Clients and Clinicians.

The literature review has been written in accordance with the guidelines of the International Journal of Law and Psychiatry (see Appendix 1 for a copy of the guidelines). Referencing therefore follows the American Psychiatric Association guidelines.

Detainers and Detained: A Literature Review of the Effects of Compulsory Mental Health Legislation on Clients and Clinicians.

1. Abstract.

Aim: Mental health legislation exists in some form in most developed countries. The present literature review summarises the current knowledge about how assessments under this legislation affect the clients and professionals who are involved.

Method: A literature search was conducted to identify qualitative and quantitative research studies, using a number of search engines and the snowball method.

Results: Previous research on client samples suggests that involuntary assessment and treatment can be associated with perceived coercion and a range of negative emotions. However, it seems that the relationship between legal status and perceived coercion is complex and may be mediated by procedural justice. Fewer studies have explored professionals' reactions to the legislative process. However, the existing research suggests that this role may be associated with ethical conflicts, stress and pressure. Suggestions for further research are discussed.

Keywords.

Mental Health Act/legislation, service users, mental health professionals, coercion.

2. Rationale for the review.

Coercion exists in various forms in the mental health system, including seclusion and restraint within inpatient settings and the use of access to benefits and threat of involuntary hospitalisation as leverage to enhance compliance (Susser & Roche, 1996). The current literature review is solely concerned with the application of mental health legislation¹ and how this affects clients and the professionals involved. The term ‘client’ will be used throughout this review to describe people who are suffering from mental health problems, the term ‘professional’ refers to clinicians employed in adult mental health or social services departments.

Compulsory assessment or treatment of people with mental health problems, unable or unwilling to consent, is regulated by a legal framework of common law, statute law and the European Convention on Human Rights (Grounds, 2001). Coercive interventions to promote clients’ mental health or prevent harm to others remain controversial (Eastman, 1994). International trends towards enhancing client autonomy have led to legislative reform in many countries, with more stringent commitment criteria and additional safeguards (Kaltiala-Heino, 1996).

The United Kingdom (UK) Government recently announced intentions to reform the current Mental Health Act within the Draft Mental Health Bill (Department of Health, 1983, 2002)². In contrast to the international trend, proposed changes include a broader

¹ Otherwise known as sectioning in the UK or involuntary commitment in the United States.

² These proposals coincide with other changes in the National Health Service, towards increasing community care (as opposed to institutionally based care) and with recent homicides and suicides by former clients of the mental health services (Department of Health, 2002).

definition of ‘mental disorder’³, extension of compulsory powers to the community and changing the role of ‘Responsible Medical Officer’ (RMO) (enacted by consultant psychiatrists) to ‘Clinical Supervisor’, who may be consultant clinical psychologists. Criticism of the Bill has come from various professional, voluntary and service user groups and primary concerns include compatibility with the Humans Rights Act (1998), inclusion of preventative detention and insufficient safeguards (Mental Health Alliance, 2002). Opponents also fear that the proposed changes will widen the net of clients who are eligible for involuntary treatment, potentially driving clients away from services (Roberts, Peay & Eastman, 2002).

Two previous authors have reviewed how clients are affected by being subjected to mental health legislation (Hiday, 1988, 1992; Monahan *et al.*, 1995). However, no such reviews of clinicians’ experiences could be located in the current review. Previous literature reviews were conducted some years ago and predominantly focused on studies in the United States of America (e.g. Hiday, 1988). Some were more narrowly focused and only explored perceived coercion (e.g. Monahan *et al.*, 1995). Given these limitations and the current climate of change within the UK, a re-examination of existing knowledge about how mental health legislation affects clients and clinicians was felt to be very timely.

³ The new definition is ‘any disability or disorder of mind or brain, which results in impairment or disturbance of mental functioning’ (Department of Health, 2002). The definition in the Mental Health Act 1983 is based on diagnostic categories and stipulates that the client’s disorder must be amenable to treatment in order for a compulsory treatment order to be applied.

3. Search strategy.

A comprehensive computerised literature search was carried out, entering the keywords ‘mental health act’, ‘section’, ‘mental health legislation’, ‘coercion’, ‘service users’ and ‘mental health professionals’. The MEDLINE (1966-2006), Psychinfo (1887-2006), Embase (1980-2006), Google Scholar and Web of Science (1970-2006) databases were searched. Snowball sampling was also used to retrieve relevant studies from the reference lists of key papers. The inclusion criteria were relatively broad and included qualitative and quantitative research studies conducted in a wide range of countries to extend the previous reviews. This search identified 67 studies that examined the effects of mental health legislation on clients and 22 studies that focused on professionals’ experiences.

The current search also revealed a significant literature discussing different professionals' views about the legislation, including ethical and practical issues⁴. These articles were excluded from the review on the grounds that they were discursive rather than qualitative or quantitative studies. A significant amount of literature was also revealed on using coercive measures (seclusion, restraint and forced medication) within inpatient settings and clients’ and professionals’ perceptions of inpatient wards. These studies also fell outside the current inclusion criteria as they did not focus on the use of mental health legislation. However, this literature generally indicated that coercive interventions can have various negative psychological and physical effects on clients, including humiliation,

⁴ In brief, opponents of the legislation emphasised power differentials, civil liberties and undesirable social control and supporters stressed the paternalism, beneficence and public protection elements of the legislation (Eastman, 1994).

fear, retaliation, paranoia and anger (Fisher, 1994; Naber, Kircher & Hessel, 1996). In terms of the impact on professionals, studies have found effects that include staff injury, guilt and regret (Brown & Tooke, 1992; Fisher, 1994).

The results of the current literature review are divided into sections. The first discusses the methodological issues in the research, the second describes what is known about how clients react to having mental health legislation applied to them and factors that affect the relationship between clients' legal status and any negative outcomes. The final section reviews how clinicians feel about using the legislation and participating in the process.

4. Methodological considerations in coercion research.

4.1. *Defining coercion.*

Many studies exploring peoples' experiences of mental health legislation focus on perceived coercion. The abstract, subjective nature of this concept poses definition and operationalisation difficulties, leading to questionable validity of measurement tools used to assess it (McKenna, Simpson & Coverdale, 2003). Coercion is multifactorial and reducing this process to limited-response questionnaire items dilutes the explanatory power of existing research. Although early theorists equated legally coerced treatment with perceived coercion, research does not support a direct linear relationship (Monahan *et al.*, 1995). It appears that coercion exists on a continuum and this has led researchers to explore clients' perceptions of their admission, rather than relying on legal status alone (Høyer, 1999).

4.2. *Measuring coercion.*

Methods used to explore clients' perceptions of their admission vary, including qualitative and quantitative designs. Most authors have created their own questionnaires and do not report on reliability and validity. However, the MacArthur Foundation Research Network on Mental Health and the Law⁵ has developed psychometric measures of perceived coercion, including the MacArthur Admission Experience Survey/Interview (AES/AEI), focusing on perceived treatment during admission (Gardner *et al.*, 1993). A Procedural Justice Scale and the MacArthur Perceived Coercion Scale (MPCS) are also incorporated. Studies have found these scales to have sound psychometric properties (Høyer, 1999).

4.3. *Design and sampling.*

Coercion research has been carried out in various settings, including the community and university, forensic and general psychiatric hospitals. Although most studies have been completed in the United States, a limited number have been carried out in Australia, Europe and New Zealand. Interpretation of this research can be complicated, as the legislation differs between countries (Poulsen, 1999).

Studies have interviewed clients at different points during the process of involuntary treatment, from shortly after admission to years after discharge. Most studies have implemented cross-sectional designs, without gathering longitudinal data. It is

⁵ This network conducts research relating to mental health legislation, particularly coercion, competency to consent and the association of mental illness and violence.

conceivable that clients' interpretations may vary, given time to reflect. Some researchers have used mental health professionals to administer questionnaires to hospitalised clients, which may have constrained free expression, introducing positive response bias into the results (e.g. Toews, El-Guebaly & Leckie, 1981).

Sample sizes range from five (Johansson & Lundman, 2002) to 331 (Hiday, Swartz, Swanson & Wagner, 1997). Many researchers have interviewed convenience samples from one institution, excluding clients judged as being 'too disturbed' and clients with diagnoses of 'mental retardation' or comorbid substance misuse. Response rates have been low in a number of studies (e.g. Morrison, Bowe, Larkin & Nothard, 1999). These issues may have introduced selection bias, as excluded or refusing clients may have held different views (Kaltiala-Heino, 1996).

The impact of involuntary admission has been explored by comparing voluntary and involuntary clients' views. Research suggests that involuntary clients are more likely to be older, poorly educated, ethnic minority males, who live alone (Nicholson, 1986; Okin, 1986). These differences may have introduced confounding variables into studies that examined, for instance, differential outcomes.

Researchers have also suggested that voluntary admission may occur under coercion, including being delivered to the hospital in official custody and clinicians, family or legal representatives using negotiation, persuasion or threat of involuntary hospitalisation (Lewis, Goetz, Schoenfield, Gordon & Griffin, 1984). This 'quasi formal coercion' blurs the voluntary/involuntary distinction. Furthermore, not all involuntary

clients oppose their admission (Work, 1986). Based on anecdotal evidence, Miller (1980) suggested that clients who are unable to obtain voluntarily sought treatment, may purposefully exhibit behaviours to secure involuntary admission, including 'bizarre' behaviour. Thus, voluntary clients may not be an ideal comparison group against which to measure the effects of involuntary admission (Kaltiala-Heino, 1999). Furthermore, clients' legal status may change during admission, as some voluntarily admitted clients may later be placed on a section and some involuntarily admitted clients might remain in hospital voluntarily after their section has expired (Cuffel, 1992).

5. The effects of mental health legislation: The client's perspective.

This section describes what is currently known about how clients are affected by being placed under mental health legislation. Researchers have explored various outcomes associated with involuntary admission to hospital, including perceived coercion, attitudes towards services, emotional impact and post-traumatic stress disorder and these findings are discussed below.

5.1. *Treatment outcome.*

It has been suggested that involuntary treatment creates oppositional staff-client relationships that are associated with difficulties establishing therapeutic relationships and poorer treatment outcomes for clients (Allen, 1999). Whilst some authors have found that involuntary clients have greater difficulty establishing therapeutic relationships, longer hospital stays, lower satisfaction with their care, less symptomatic improvement and lower

compliance with services on discharge (Leavy, King, Cole, Hoar & Johnson-Sabine, 1997; Szmukler, Bird & Button, 1981), others have found no significant differences or better outcomes (Bindman *et al.*, 2005; Nicholson, Ekenstam & Norwood, 1996). Therefore, although the results are conflicting, some authors have found that clients with involuntary status, particularly when they also perceive their treatment or admission as coercive, have poorer outcomes.

5.2. *Perceived coercion, self-determination theory and the psychology of choice.*

Numerous psychological theories, supported by empirical evidence, emphasise the importance of perceived personal control and self-determination on well-being, learning and motivation (Hartmann, 1964). These theories offer insights into the mechanisms of the negative impact of involuntary treatment that restricts personal control. Self-determination theory proposes that people have basic needs for autonomy and events that constrain autonomy might be perceived as coercive (Deci & Ryan, 1985). This theory hypothesises that perceived coercion undermines motivation and effective performance. Psychological research has demonstrated that choice and self-determination are associated with increased interest and involvement in activities and environments that limit self-determination produce the converse pattern (Koestner & Losier, 1996). If involuntary treatment does indeed remove autonomy, then self-determination theory would predict that this might result in lower motivation for participation in therapeutic activities.

Theorists have hypothesised that when personal control or freedom is restricted, people may react with anger and attempts to reassert personal control, termed

'psychological reactance' (Brehm, 1966). However, with repeated unexpected deprivations of personal control and unsuccessful attempts to change these negative situations, learned helplessness may result (Seligman, 1975). Clients' first experience of involuntary admission may engender reactance (as clients may maintain expectations of control), whereas successive readmissions may produce learned helplessness.

Using various measures, researchers have focused on assessing perceived coercion resulting from involuntary hospitalisation or compulsory outpatient treatment. Most studies have indicated a bimodal distribution, with clients either perceiving their compulsory admission as highly or minimally coercive (Hiday *et al.*, 1997; Høyer *et al.*, 2002). Researchers have found that involuntary clients perceive greater coercion during their admissions than voluntary clients (Cascardi & Poythress, 1997; Hoge *et al.*, 1998; McKenna, Simpson & Laidlaw, 1999; Nicholson *et al.*, 1996; Swartz *et al.*, 1999; Taborda, Baptista, Gomes, Nogueira & Chaves, 2004). However, the percentage of involuntary clients perceiving coercion ranges from 38% (Kjellin & Westrin, 1998) to 100% (Kjellin, Høyer, Engberg, Kaltiala-Heino & Sigurjónsdóttir, 2006). Most researchers to date have found that a substantial minority of voluntary clients also perceive their admission as coercive, ranging from 4% (Kjellin *et al.*, 2004) to 44% (Rogers, 1993). An equally consistent finding is that some involuntary clients do *not* perceive their admission as coercive (Hoge *et al.*, 1997; Iversen, Høyer, Sexton & Grønli, 2002).

A key study by Hiday *et al.* (1997) found that 58% of involuntary clients, discharged from different psychiatric facilities, scored above the MPCCS's midpoint, suggesting they experienced coercion during their admission. Methodological advantages

of this study included a large sample size and low refusal rate, enabling some generalisation of the findings. However, disadvantages included the narrow inclusion criteria and cross-sectional design.

High rates of perceived coercion reported by both voluntary and involuntary clients are of concern in that this may result in lower motivation to engage in treatment (according to self-determination theory). Given that legal status cannot be consistently equated with coercion during admission, research must incorporate clients' subjective perceptions. Factors that may exacerbate perceived coercion are discussed below. Strategies used to reduce these elements may decrease perceived coercion and attenuate any potential impact on therapeutic outcome.

5.3. *Attitudes towards involuntary admission.*

Weinstein (1979) completed a review of clients' attitudes towards psychiatric hospitals, concluding that the quantitative studies indicated that most clients held favourable views, whereas the qualitative studies suggested the opposite. However, he did not distinguish between voluntary and involuntary clients' views, limiting utility in the context of the current review. Other research has illustrated that clients exhibit different beliefs about admission, with expectations ranging from severe optimism to severe pessimism (Goffman, 1961). Längle, Günthner, Stuhlinger, Eschweiler and Foerster (2003) found that 57% of involuntary clients retrospectively identified adverse consequences from their admission, including lowered self-confidence, employment

disadvantages, child custody issues and reduced social networks. Low response rate and the time elapsed since admission may have introduced bias into the results.

Generally, more voluntary than involuntary clients believe that they are ill and in need of hospitalisation, which they anticipate may be beneficial (Linn, 1969; Spence, Goldney & Costain, 1988; Svensson & Hansson, 1994). However, researchers have found that many involuntary and voluntary clients retrospectively perceive admission as necessary, with percentages ranging from 44% (Conlon, Merskey, Zilli & Frommhold, 1990) to 84%⁶ (Iversen *et al.*, 2002). Kaltiala-Heino (1996) found that clients who felt coerced during admission were less likely to anticipate benefits from hospitalisation and were more likely to resist treatment. However, the small university hospital sample, limited diagnostic profile and the number of clients lost during follow-up, may have introduced sampling bias into the study.

An important study by Edelsohn and Hiday (1990) had methodological advantages, as they interviewed a large sample of involuntary clients after their discharge from various hospitals, limiting problems of positive response bias. However, the response rate was low, the constructed scale was not standardised and the varying length of the clients' stays may also have affected their responses. These authors found that 55% of clients were unwilling to be hospitalised, 35% felt it was necessary and 41% believed they were ill.

The above mentioned research suggests that, although some involuntary clients eventually hold positive attitudes towards treatment, many hold negative attitudes that are

⁶ Eighty-four percent of voluntary clients perceived it as necessary, 57% of involuntary clients felt the same.

sustained over time. Theories from social psychology suggest that denial of the need for hospitalisation may serve an ego-defensive function, protecting clients' self-concepts (Katz, 1960). Alternatively, it may protect clients' self-esteem through attribution of negative events to external rather than internal factors (self-serving attributional bias) (Zebrowitz, 1990).

5.4. *Helpful or harmful?*

Generally, a minority of involuntary and voluntary clients regard their admission as 'harmful', ranging from 13% (Gove & Fain, 1973) to 33% (Toews, El-Guebaly, Leckie & Harper, 1984). However, many, including involuntary clients, rate their admission as 'helpful', ranging from 46% (Toews *et al.*, 1984) to 80% (Srinivasan, Soundararajan & Hullin, 1980). Retrospectively, many clients perceive their treatment as helpful, even if initially denying the need for hospitalisation (Gove & Fain, 1977). Furthermore, authors have found that around half of these clients would willingly return to hospital if necessary in the future (Bradford, McCann & Merskey, 1986).

Lucksted and Coursey (1995), however, found that 43% of their sample reported being less willing to enter hospital when needed after involuntary treatment and 27% felt that coerced admission negatively affected their relationships with professionals and their mental health. However, half the sample retrospectively felt it had been in their best interests. The survey used by these authors was non-standardised and there were missing responses to all of the questions. The participants were current service users and did not

include those clients who may have experienced involuntary treatment and subsequently avoided services.

In summary, although some authors have found that involuntary admission may result in negative attitudes about the admission and services, others have found that many clients perceive it positively, especially retrospectively. As in other areas of coercion research, further clarification of the impact of involuntary admission on subsequent attitudes is required.

5.5. *Personal integrity and self-identity.*

Studies have found that many voluntary and involuntary clients perceived infringements on their rights to self-determination and felt personally violated during admission (Eriksson & Westrin, 1995; Kjellin *et al.*, 1993; Johansson & Lundman, 2002; Sallmén, Berglund & Bokander, 1998). However, the Swedish commitment criteria during these studies were extremely broad, therefore the samples may not be representative of involuntary clients in other countries.

Potential effects of admission on self-identity have not been extensively studied. Toews *et al.* (1984) found that involuntary clients retained a high self-image, comparable to voluntary clients' scores. However, Rooney, Murphy, Mulvaney, O'Callaghan and Larkin (1996) found that 46% of involuntary clients experienced reduced self-esteem, fear and bewilderment during their admission. Generalisation of these results is limited by a

small sample size, uneven numbers of involuntary and voluntary clients and low response rate.

Compulsory admission may be incongruent with individuals' schemas or attributions about themselves, others and the world, thereby necessitating schema change (Janoff-Bulman, 1985). Researchers have theorised that clients may internalise the stigma and labelling associated with involuntary admission (Deegan, 1993). Winick (1995) discussed the possible effects of incompetency labelling (often a prerequisite for involuntary treatment). He suggested that labelling may result in stigmatisation, self-blame and reduced self-esteem via internalising attributions of deviancy. Psychological theories, including social identity theory, suggest that self-concept is largely socially determined, shaped by others' reactions to the individual (Mead, 1934). Winick (1995) suggested that damaged self-concepts resulting from labelling by others, combined with involuntary treatment, may reduce clients' perceived personal control. One consequence of reduced opportunities for control is learned helplessness, resulting in lowered motivation, self-efficacy and depression (Seligman, 1975). Studies discussed below suggest that clients may experience negative emotional reactions to admission. Further research incorporating measures of self-efficacy, learned helplessness and depression may shed further light on the impact on self-identity of admission to psychiatric hospital.

5.6. *Emotional impact.*

Few studies have explored the emotional impact of involuntary admission. Authors have speculated that admission may result in various emotions, including anxiety,

depersonalisation, abandonment, alienation, mistrust, humiliation, depression and reduced self-esteem, all of which may affect the building of therapeutic alliances (Beveridge, 1998). The few studies that included measures of anger suggest that approximately half of all involuntary clients experience anger after their admission (Lucksted & Coursey, 1995; Rooney *et al.*, 1996; Spence *et al.*, 1988). Studies have found that clients who perceive coercion are more likely to feel angry or frightened (McKenna *et al.*, 1999; Shannon, 1976). A minority of voluntary clients also feel angry about their admission (Spence *et al.*, 1988).

In a postal-survey of voluntary and involuntary clients, Morrison *et al.* (1999) found that 68% scored 50 or above on a scale of 100, asking how scared they felt during admission. The majority of clients also reported feelings of sadness and anger during admission. The impact of legal status is unclear, as this was not reported. Caution is required when interpreting these results given the low response rate and small sample. Some clients were retrospectively describing admissions, which occurred up to nine years previously. Emotional reactions were assessed by single questions, which may be less reliable than multiple items (Nicholson, 1996).

In a study of discharged involuntary clients, Joseph-Kinzelman, Taynor, Rubin, Ossa and Risner (1994) found that most clients described panic, anger, fear, hopelessness and confusion associated with admission. However, the small sample size, non-standardised interview schedule and payment for participation may limit generalisation. Shaw, McFarlane and Bookless (1997) developed their own measure of distress associated with admission and found that half of the sample experienced distress. Social

consequences, including losing contact with friends, family and fear of losing custody of children, were cited as distressing. However, the questionnaires were administered by clinicians to clients who were still hospitalised, which may have affected the information they were willing to disclose.

Research by the MacArthur Network has found that clients often hold mixed feelings about coerced admission, with coexisting sadness, anger, fear and relief (Gardner & Lidz, 2001). Similarly, Edelson and Hiday (1990) found that 46% of their sample rated involuntary hospitalisation as depressing, 41% as unpleasant, 29% as degrading and 27% as embarrassing. Whilst one fifth felt that hospitalisation harmed their social relationships, approximately half found it helpful, suggesting that emotional reactions may be mixed. Although the evidence is limited, research suggests that involuntary hospital admission may be associated with strong negative emotions, which clearly requires further investigation.

5.7. *Post-traumatic stress disorder (PTSD).*

It has been hypothesised that the stress experienced during hospital admission may fulfil diagnostic criteria for PTSD (Deegan, 1993). Studies have found that 35% to 52% of clients fulfilled the criteria for PTSD after being discharged from hospital (McGorry *et al.*, 1991; Morrison *et al.*, 1999; Priebe, Bröker & Gunkel, 1998; Shaw *et al.*, 1997). However, involuntarily admitted clients were no more likely than voluntary clients to suffer from PTSD⁷. All of these researchers measured PTSD symptoms in small samples of clients, some of whom were interviewed up to 13 years after their admission. PTSD symptoms

⁷ In fact, one study found that involuntarily admitted clients were *less* likely to suffer from PTSD (Morrison *et al.*, 1999).

may have been related to events following discharge rather than their hospitalisation experience. It is also unclear which aspect of hospitalisation (e.g. admission, forced medication, seclusion, restraint or other aspects) led to traumatic reactions. Therefore, although such studies suggest that admission/treatment may be experienced as traumatic, involuntary admission does not seem to be associated with more extreme trauma.

5.8. *Positive reactions.*

Some evidence suggests that clients may perceive positive aspects of admission, including relief, protection, companionship, security, support, hope and the chance to recover without everyday pressures (Farnham & James, 2000; Work, 1986). In a study of curative factors during admission to maximum-security hospital, Vartiainen, Vuorio, Halonen and Hakola (1995) reported that a third of clients found the hospital's restriction and isolation to be helpful. Positive attitudes may also be associated with the social situation before admission, as clients from socially disadvantaged areas may be more likely to perceive admission as respite (Linn, 1969). Caution is therefore required in automatically concluding that restricting personal freedom will be construed negatively.

6. *Moderating/mediating influences of perceived coercion.*

Research on the determinants of perceived coercion has led to an increased understanding of factors that influence clients' negative perceptions of admission. However, most studies correlate clients' reports of one aspect of admission with their reports of another, without corroborating this with data from other sources, such as

clinicians or relatives. However, there are some exceptions to this and these are discussed later in the current review.

6.1. Demographic factors.

Theorists have suggested that client demographic variables may affect perceived coercion (Lidz *et al.*, 1995). However, most studies have indicated that demographic variables are not associated with treatment attitudes (Iversen *et al.*, 2002; Lucksted & Coursey, 1995; Poulsen, 1999). Exceptions include research findings that females and more highly educated clients perceive more coercion (Hiday *et al.*, 1997; Rain *et al.*, 2003; Sallmén *et al.*, 1998). Studies have also found that clients from ethnic minorities perceive significantly less coercion during admission and report fewer negative pressures than Caucasians (Hoge *et al.*, 1998; Lidz *et al.*, 2000). However, the reverse pattern has also been found (Bindman *et al.*, 2005). Finally, two studies suggest that married clients perceive less coercion than single clients (Hiday *et al.*, 1997; Swartz *et al.*, 1999). These limited, conflicting findings require further study.

6.2. Clinical factors.

Authors have found an association between mental health diagnosis and perceived coercion. Studies suggest that clients with schizophrenia perceive admission as more coercive (Längle *et al.*, 2003; McKenna *et al.*, 1999). However, others have found no such association (Poulsen, 1999; Swartz *et al.*, 1999). Some researchers have found that psychiatric inventory scores do not correlate with clients' attitudes (Adams & Hafner,

1991). However, others have found that clients who are more ‘disturbed’ according to these assessments feel more coerced, make less favourable evaluations of sectioning and perceive greater violation of personal rights (Längle *et al.*, 2003; Linn, 1969; Weinstein, 1979). Evidence for the association of clinical status and attitude towards commitment remains equivocal to date in the literature.

6.3. *The role of procedural justice.*

The process of compulsory treatment varies with the type of legislation applied and differing practices between countries (Riecher-Rössler & Rössler, 1993). Studies have shown that the procedures surrounding the use of mental health legislation can influence clients’ subsequent attitudes towards treatment (Hiday, 1992; Lucksted & Coursey, 1995). Therapeutic jurisprudence is an interdisciplinary approach that researches the therapeutic or anti-therapeutic consequences of mental health legislation (Winick, 2003). A growing literature from this field now suggests ways of maximising the therapeutic consequences of applying mental health legislation (Drogin, 2000).

Procedural justice theory hypothesises that maximising procedural justice may minimise feelings of coercion during involuntary admission/treatment, enhancing acceptance, therapeutic outcomes and psychological well-being (Sydeman, Cascardi, Poythress & Ritterband, 1997). This theory hypothesises that satisfaction with outcome and perceived fairness in decision-making are positively influenced by ‘voice’ (opportunity to present personal opinions), ‘validation’ (having those opinions seriously considered), receiving information, lack of deceit, being treated with respect and positive evaluations of

the motivations of other actors ('good faith') (McKenna, Simpson & Coverdale, 2000). It is likely that procedural justice influences self-respect and trust in decision-makers (La Fond & Srebnik, 2002). Satisfaction with decision-making will also be influenced by prior expectations about events and beliefs regarding perceived personal entitlements (McGovern & Hemmings, 1994). Unfortunately, the lack of a standardised measure of procedural justice and problems defining and operationalising this abstract concept complicates the interpretation of research in this area (Høyer, 1999).

Research with non-clinical and clinical populations provides some support for the mediating influence of procedural justice on perceived coercion. Social cognition research has consistently found that people given voice and validation (termed 'process control') perceive greater procedural justice, fairness and satisfaction with decisions, regardless of its impact on the decision ('outcome control') (Sydeman *et al.*, 1997). Process control serves instrumental functions, enabling people to influence what happens to them by voicing their views and non-instrumental or value expression functions (Lind, Kanfer & Earley, 1990). Research suggests that procedural justice affects acceptance of authority, as opportunities for voice imply that the authorities regard people as equals (Lind, Kulik, Ambrose & Park, 1993). However, it is questionable whether studies carried out on general or student populations generalise to clients with mental health difficulties in the context of decisions that potentially restrict their freedom.

Further support for the role of procedural justice during involuntary treatment comes from a study demonstrating that mental health involuntary clients were able to perceive procedural justice in videotaped mock commitment hearings (Cascardi, Poythress

& Hall, 2000). However, the use of videotaped hearings may limit ecological validity. Researchers have found that perceived coercion during involuntary admission is correlated with voice and validation (McKenna, Simpson, Coverdale & Laidlaw, 2001; Swartz *et al.*, 1999), deceit (Bennett *et al.*, 1993; Shannon, 1976), provision of information (Rogers, 1993), process inclusion (Iversen *et al.*, 2002) and all aspects of procedural justice considered independently (Cascardi & Poythress, 1997).

The MacArthur group found that perceived respect, dignity and fairness were associated with lower perceived coercion (Lidz *et al.*, 1995). However, the cross-sectional design and interviewing clients within the hospital introduced possible response bias and limited the conclusions about the long-term influence of procedural justice on admission perceptions. In a study of clients whose hearings took place in the Broward Mental Health Court in Florida⁸, Poythress, Petrila, McGaha and Boothroyd (2002) found that these clients perceived less coercion and greater respect, fairness, voice and satisfaction than clients whose hearings took place in normal courts. However, whilst procedural justice predicted outcome satisfaction, perceived coercion did not. This may have been a result of the uniformly low perceived coercion scores and low variability of scores in the Mental Health Court group.

Qualitative research has also suggested that feeling excluded from the admission proceedings is associated with perceived coercion (Bennett *et al.*, 1993). Empirical studies have suggested that more voluntary than involuntary clients perceive procedural justice

⁸ Mental Health Courts are currently being set up in many areas of the USA. The majority of these courts only hear cases in which the defendant has a mental illness and has committed a non-violent crime. Many Mental Health Courts employ principles of therapeutic jurisprudence during hearings, to minimise coercion and maximise therapeutic outcomes for clients.

during admission (Cascardi & Poythress, 1997; McKenna *et al.*, 2001). Längle *et al.* (2003) found that approximately half of involuntary clients felt their admission lacked opportunities for voice and validation and that their physician was not acting to protect them from harm. Whilst the literature provides strong support for the association between procedural justice and perceived coercion, the direction of causality in the relationship remains unclear. Should further research support this association, this has training implications for the professionals involved in future mental health legislation, including clinical psychologists. Future professional training should emphasise the importance of meaningfully involving clients in the decision-making process surrounding involuntary admissions, including listening to their views and treating them respectfully.

6.4. *Negative pressures.*

Perceived coercion has consistently been associated with ‘negative pressures’, including threats or force by family, police or clinicians prior to and during admission (Monahan *et al.*, 1999; McKenna *et al.*, 1999). Studies have suggested that such negative pressures applied by clinicians have the greatest impact on increasing perceived coercion (Lidz *et al.*, 2000). Studies have also found that negative pressures during admission are higher amongst involuntarily admitted clients (Cascardi & Poythress, 1997). However, direction of causality remains unclear. It may be that negative pressures result in perceived coercion, resulting in clients resisting admission. Conversely, negative pressures may be applied as a consequence of clients resisting, resulting in heightened perceived coercion.

6.5. *Positive pressures.*

Researchers have suggested that persuasion and inducement to accept treatment⁹ (also called ‘positive pressures’ in the literature) are perceived differently from threats and force, which have negative consequences attached to failure to comply (Susser & Roche, 1996). Interestingly, studies have not found positive pressures to be associated with perceived coercion (Hoge *et al.*, 1997; Lidz *et al.*, 1995). Furthermore, clients may positively interpret persuasion as an effort to include them in decision-making (Bennett *et al.*, 1993).

The source of the persuasion may also influence its impact, as researchers have found that persuasion by family members resulted in low perceived coercion, whereas the same persuasion by admitting clinicians exhibited a trend towards increasing perceived coercion (Cascardi & Poythress, 1997). These findings suggest that force or threats during involuntary admission to hospital should be replaced with persuasion, as this may reduce clients’ perceived coercion and therefore improve treatment outcome.

6.6. *Locus of control.*

Research has suggested that individuals vary in their beliefs about the factors that control their destiny (Rotter, 1966). People with an internal locus of control believe they have the greatest influence, whereas those who are externally controlled believe that luck or others’ actions are more influential (Levenson, 1974). The current review revealed a

⁹ E.g. an offer or promise of a desirable outcome in exchange for compliance.

scarcity of studies considering the association of locus of control and experience of compulsory hospital admission, yet it seems intuitive that general attributional style may influence perceptions of admission. Ross (2003) speculated that depressed clients, with internal loci of control, might attribute the negative consequences of involuntary admission to personal deficits. Conversely, paranoid clients may attribute negative effects to external causes, potentially exacerbating their wariness of professionals.

Clients with an external locus of control may see events as primarily related to external influences, therefore negative perceptions of admission may be lower. In support, Sallmén *et al.* (1998) found that clients with external loci of control reported significantly less perceived coercion than internally controlled clients (22% compared to 84% respectively). The authors concluded that clients requiring situational control reacted more negatively to coercive treatment, which may have implications for treatment outcome. However, the study was restricted to one Swedish rehabilitation centre and a relatively small sample. Additionally, the measure of coercion was not tested for psychometric soundness. Cascardi and Poythress (1997) included a psychometrically valid measure of locus of control in their study and did not find any correlation between locus of control and perceived coercion. However, interpretation of this requires caution, as voluntary clients in the sample had initially been detained involuntarily. Further research is necessary to explore the issue of locus of control.

7. Stability of clients' accounts.

Stone's 'thank-you' theory proposes that clients who initially oppose involuntary admission, may later feel grateful if it improves their mental state (Stone, 1975). Studies have found that some clients show increased recognition of the necessity of involuntary hospitalisation and less negative perceptions of hospital, even at intervals of one week after admission¹⁰ (Edelsohn & Hiday, 1990; Kaltiala-Heino, 1996; Toews *et al.*, 1984). Spence *et al.* (1988) found that, although most involuntary clients initially perceived their admission as coercive, unnecessary and harmful, their responses were more positive and closely resembled those of voluntary clients fifteen days later. However, the researchers asked clients to recall their admission opinions retrospectively. Furthermore, sample size was limited, restricting generalisation.

Perceived coercion during admission, however, does not seem to change over time, even when clients retrospectively accept the necessity of forced treatment (Bindman *et al.*, 2005; Gardner & Lidz, 2001; Hoge *et al.*, 1997). A frequently cited study by the MacArthur Foundation used the MPCCS to interview 267 voluntary and involuntary clients within two days of admission and again four to eight weeks following their discharge. Gardner *et al.* (1999) found that 52% of clients who denied the need for hospitalisation at admission, retrospectively believed that admission was necessary. However, perceived coercion and procedural justice did not change, suggesting that clients do not retrospectively hold more positive attitudes towards their admission.

¹⁰ Research suggests that changes in perceptions of admission and treatment may be related to treatment outcome, as clients with symptomatic improvement hold more favourable views at discharge (Beck & Golowa, 1988; Naber *et al.*, 1996).

There are a number of plausible competing explanations for apparent attitudinal changes, including general improvements in mood or fear of further involuntary treatment. Understanding attitudinal change may be informed by cognitive dissonance theory (Festinger, 1957). Clients that initially oppose and anticipate little benefit from admission, yet subsequently gain symptomatic relief, are faced with two inconsistent cognitions, potentially resulting in dissonance. It is possible that changes in clients' attitudes after time are related to motivation to reduce dissonance.

Further studies have found that clients' attitudes towards hospitalisation do not change significantly between admission and discharge or post-discharge (Toews, El-Guebaly, Leckie & Harper, 1986). The limited number of studies employing longitudinal designs, the conflicting findings and methodological limitations in existing studies, suggest that further research is necessary to clarify the stability of clients' perceptions. However, the findings to date suggest that perceived coercion remains stable over time.

8. Reliability of clients' accounts.

One issue in coercion research is whether mental health clients' accounts accurately reflect events surrounding admission. Authors have speculated that the passage of time since admission, denial, wish to gain freedom, social desirability, impression management, phenomenon of 'yea-saying' and severity of psychiatric symptoms, may impair clients' recall or perceptions of coercive events, thus limiting the reliability of reports (Carr-Hill, 1992; Weinstein, 1979).

Few studies have explicitly explored the reliability of clients' reports. However, the MacArthur group has developed a method for determining the 'most plausible factual account of events' (MPFA)¹¹. Studies employing this method have found that clients' accounts of coercive events generally have closer association with the MPFA than reports from clinicians or relatives (Lidz *et al.*, 1997, 1998). Using less sophisticated methods, other authors have found that the accounts of people involved in admissions differ in important respects. Hoge *et al.* (1993) found that family members and clinicians reported greater pressure during admissions than did clients. However, the small sample size necessitates caution when interpreting the statistical analysis.

Further studies have found low concordance between clients' and relatives' reports (Eriksson & Westrin, 1995) and lower perceived coercion amongst family members than clients and clinicians (Hoge *et al.*, 1998). Other studies have found that clients reported significantly more coercive measures than those recorded in case notes (Kjellin & Westrin, 1998; Poulsen & Engberg, 2001). Clearly, differential personal costs and consequences associated with admission, the influence of professional training and individual differences in sensitivity to external controls may affect people's perceptions of the admission (Westrin, 1997). The literature suggests that people involved in admission may have differing perceptions of events and further research is necessary to clarify the factors influencing these perceptions. Furthermore, studies do suggest that clients' accounts of actual events may be relatively reliable (Lidz *et al.*, 1997, 1998).

¹¹ Data collected using the AEI from multiple parties is triangulated with data from written records, using a detailed coding procedure.

9. Clinicians' reactions.

There is an extensive literature on professionals' views of the ethics of compulsory care (Diamond, 2002; Roberts *et al.*, 2002). Generally, these studies have suggested that professionals view mental health law as a valuable and/or necessary tool, whilst retaining some concerns about the purpose, utilisation and functioning of the legislation (Bhatti, Kenney-Herbert, Cope & Humphreys, 1999; Franklin, Pinfold, Bindman & Thornicroft, 2000). Other studies have suggested that many professionals prefer to avoid involuntary detention or feel that it infringes on clients' rights, threatens the therapeutic relationship and risks stigmatising clients (Mears & Worrall, 2001; Swartz, Monahan & Swanson, 2003).

Research has also focused on professional decision-making concerning involuntary admission, including ethical conflicts and the influence of clinicians' cognitive and emotional reactions towards clients (Bagby, Thompson, Dickens & Nohara, 1991; Lepping, Steinert, Gebhardt & Röttgers, 2004). Qualitative studies have explored clinicians' reactions to implementing coercive interventions within inpatient settings (Brown & Tooke, 1992). Generally, studies have found that although professionals value having a means to control dangerous clients, coercion conflicts with their therapeutic ideals, resulting in negative feelings, regret and a desire to implement less restrictive alternatives (Olofsson, Gilje, Jacobsson & Norberg, 1998; Olofsson, Jacobsson, Gilje & Norberg, 1999).

The current review found relatively few studies that specifically explored professionals' psychological or emotional reactions to implementing mental health legislation. Authors have theorised that committing clients to mental health treatment against their wishes may result in relief, guilt, anxiety, frustration and discomfort (Beveridge, 1998). Olofsson *et al.* (1999) used qualitative methods to explore physicians' experiences of using coercion in a general psychiatric clinic, including the use of involuntary admissions. The physicians' narratives revealed that using coercive interventions was motivated by the fear of clients, legal implications and pressure from nursing staff. Most physicians felt that coercion may harm clients psychologically or physically, which contradicted their wish to care for them, resulting in moral burden and conflict with clients. Respondents often used coercion to comply with legislation requirements when personally disagreeing with it, leaving them feeling constrained in their choices. Most respondents wanted to reflect on their actions with the client and colleagues. The Swedish setting, governed by differing legislation and the focus on physicians' experiences of particular instances of implementing coercion may limit generalisation. However, the findings suggested that coercive practice can have negative effects on clinicians and further studies have found that professionals encounter ethical conflicts or unpleasant emotional reactions when implementing coercion (Alexius, Berg & Aberg-Wistedt, 2002; Kjellin *et al.*, 1993; Westrin, 1997).

Some studies of stress/burnout in professional groups involved in mental health legislation have explicitly referred to the impact of legislative duties. These studies have found that feeling pressured to use the MHA, when personally disagreeing with this view was experienced as stressful (Smith & Nursten, 1998). Others have found that

professionals experience the whole process as stressful, particularly through feeling physically vulnerable, misunderstood by others and the conflict of wanting to collaborate with clients, yet feeling responsible for controlling them (Reid *et al.*, 1999). Some professionals felt that *not* sectioning was more risky and anxiety-provoking (Reid *et al.*, 1999).

Marriott, Audini, Lelliott, Webb and Duffett (2001) carried out a qualitative study of a range of professionals involved directly or indirectly with the MHA. The authors found that psychiatrists, acting as RMOs for detained clients, felt burdened with the associated responsibility, which could result in defensive practice. Other professionals interviewed felt they had insufficient comprehension and knowledge about aspects of the legislation. Despite the adequate sample size, the authors did not provide an extensive explanation of the analytic techniques used to explore the data or any steps taken to increase the rigour of the analysis.

Two studies have explored approved social workers' (ASWs) experiences of the mental health legislation in Northern Ireland (Campbell *et al.*, 2001; Manktelow *et al.*, 2002). Both studies found various problems encountered in fulfilling the ASW role, including trying to organise transportation, coordinating other professionals, fears for their personal safety and difficulty accessing supervision. Although both studies had large samples, which increased the representativeness and generalisation of the results, some of the ASWs were employed in specialities where mental health legislation was not largely utilised (e.g. child-care or health departments), which may have affected their experiences.

Evans *et al.* (2005, 2006) examined the impact of legislative duties on ASWs in England and Wales, in a multi-method study comparing their working patterns and scores on a comprehensive battery of standardised and non-standardised questionnaires with social workers, without approved status. The authors found that the ASWs spent an average of 25 hours per week dedicated to statutory duties. The MHA assessments often required considerable time (average 6.9 hours) and frequently ran into unsocial hours and the ASWs felt this sometimes resulted from the actions of other people. Many of the social workers were suffering from psychological distress/stress and wished to leave their posts. Strengths of these studies included the large sample size and range of geographical authorities who participated. However, the cross-sectional design limits the conclusions about causality that can be extrapolated from the findings. Although the study did not address the ASWs' specific feelings about the MHA process, it provided strong evidence that this role can have adverse effects, including reduced job satisfaction and high burnout levels.

In the qualitative analysis of contributors to stress as part of the same study, Huxley *et al.* (2005) found that aspects of the ASW role were perceived negatively, such as the paperwork, associated overtime and feelings of being at risk. However, one participant highlighted positive aspects of the role, including the challenge, opportunity to use numerous skills, autonomy and satisfaction of helping clients. It remained unclear whether any of the other participants shared these views. The qualitative data was analysed using a computer program and the authors did not provide a clear description of the methodology used, their epistemological position or how issues of reflexivity were incorporated into the

study. Legislative duties were only one of several factors considered as potential contributors to stress or satisfaction in the study.

Other researchers have found that mental health clinicians can have negative feelings (e.g. frustration, anger, dislike) towards clients with severe symptomology, particularly when psychotic and violent (Brown, 1980; Gillig, Hillard, Deddens, Bell & Combs, 1990). Despite many clients who are assessed under the mental health legislation presenting in this way, the potential influence of such emotional reactions during assessments under the mental health legislation has not yet been explored in the literature. Negative evaluations of clients may reduce any dissonance associated with using coercion and this hypothesis requires further investigation. The limited amount of literature to date indicates that clinicians may experience a range of negative effects when using mental health legislation and other coercive interventions, including ethical conflicts and stress. However, this is a relatively new area of research and further studies are needed to advance our understanding of the nature and extent of these responses.

10. Conclusions and suggestions for further research.

Despite methodological variability in design, research has gone some way towards establishing the effects of mental health legislation on those affected by it. The existing research suggests that involuntary hospitalisation can have negative effects on clients' psychological well-being, including perceived coercion, negative emotional reactions and pessimistic attitudes towards services. However, these effects appear to be mediated by procedural justice and negative pressures during admission.

In terms of future research, remaining questions include: the relationship between clients' perceived and actual coercion; and the mediating role of demographic/clinical variables, treatment history, relationship with the coercer and the context of the admission on perceived coercion. Questions also remain about the affective and psychological consequences of compulsory treatment. Research incorporating validated measures of learned helplessness, locus of control, PTSD and emotional responses would provide valuable information about the possible relationship between involuntary admission and negative emotional effects.

Research so far indicates that clients may have mixed feelings about hospitalisation. These may fluctuate rapidly or change gradually over time (Essex *et al.*, 1980). Future research using repeatedly administered measures is necessary to chart these changes and any influencing factors. Existing research has studied the effects of single forms of coercion whereas in reality, clients often experience multiple forms (Lucksted & Coursey, 1995). Future research therefore needs to address the differential effects of combined coercive interventions.

Methodological and ethical difficulties in designing prospective randomised control trials of involuntary treatment remain a problem in coercion research. However, future studies implementing longitudinal designs with repeated measures of clients' attitudes and emotions would provide information to inform remaining questions. Studies comparing clients' subjective reports with others' reports and objective events surrounding admission, including coercive events, communication and decision-making are needed. Given difficulties defining and measuring coercion, the use of multiple qualitative and

quantitative measures is advised (Monahan *et al.*, 1995). Research using the same measures in multiple settings will enable generalisation, as coercive events may vary in different contexts. Future studies should consider the impact of previous admissions on perceptions, as authors have suggested that repeated admissions may result in desensitisation and increased acceptance of coercion (Allen, 1999).

There is much more to learn about the emotional impact on professionals involved in using mental health legislation. Further qualitative studies yielding in-depth information would provide valuable insights, as quantitative attitudinal measures may not capture the full range and complexity of responses. The limited amount of literature suggests that mental health clinicians may have various reactions to using coercion, including ethical conflict, stress and concerns about damaging therapeutic relationships. It is unclear how clinicians' emotional reactions to clients influences their affective reactions to implementing involuntary treatment. Further research of the possible interactions between these factors is needed.

Given geographical variations in legislation, replications of studies exploring admission perceptions and mediating factors are needed in the UK, as research has mainly been conducted in the USA (Rogers, 1999). In light of proposed legislative UK reforms and research indicating that both clients and clinicians may have negative reactions to the legislation, further research on the impact of these reactions on the therapeutic alliance and treatment outcome are critical and timely. The importance of the therapeutic alliance for positive treatment outcome is firmly established (Department of Health, 2001). Rooney *et al.* (1996) found that a quarter of involuntary clients reported sustained negative attitudes

towards their therapist. Given proposals for clinical psychologists to assume key roles in coerced treatment, studies investigating the impact of perceived coercion on the therapeutic alliance will provide valuable information on any potential impact of psychologists' new roles (as 'Clinical Supervisors') on the efficacy of clinical work.

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PART TWO

RESEARCH REPORT

Negotiating Uncertainty: Mental Health Professionals' Experiences of the Mental Health Act Assessment Process.

The research report follows the general style of the British Journal of Clinical Psychology.

Referencing therefore follows British Psychological Society guidelines.

1. ABSTRACT.

Aim.

A number of professional groups currently have implicit and/or explicit responsibilities within the UK mental health legislation, including approved social workers, psychiatrists and community psychiatric nurses. Research evidence suggests that clinicians within these professional groups suffer from high levels of psychological distress. This study aimed to explore how participating in the Mental Health Act (MHA) assessment process affects the professionals involved.

Method.

Eleven mental health professionals were interviewed using a semi-structured Interview Schedule focused on their experiences of using the MHA and how this role affects them. The interviews were analysed using the grounded theory method, which generated a final theoretical model (Pidgeon & Henwood, 1996).

Results.

The core category of the final model was 'negotiating uncertainty'. Many interwoven factors contributed to inherent uncertainty within the MHA assessment process, including the pressured context of the assessments, internal conflict generated by competing/incompatible identities, liability and conflict with others. The participants used a range of strategies to contain the inevitable uncertainty, including internal psychological processes (denial, detachment, normalisation) and external support.

Discussion.

The study's results are discussed within the context of relevant psychological theories. The clinical implications of the findings are outlined, particularly the need for increased organisational support for these professionals and further research to extend the current findings.

2. INTRODUCTION.

Few research studies have focussed on professionals' experiences of using the Mental Health Act (MHA) (Department of Health, 1983). The current climate of legislative reform in the United Kingdom (UK) and changes to the professionals who currently have legal duties, highlights the importance of further research in this area. Studies that have explored stress, burnout and mental health problems in health/social care professionals and their experiences of using the MHA are reviewed. This introduction argues that further exploration of the impact of legal duties on professionals is extremely timely, given the potential for a wider range of professionals to acquire statutory duties if the new Mental Health Bill is passed (Department of Health, 2002).

2.1. An era of reform: Changes in services and mental health law in the UK.

Mental health legislation exists to enable the compulsory assessment and treatment of clients with mental health problems, who refuse to accept treatment voluntarily (Hatfield & Antcliff, 2001). Mental health law has generated decades of philosophical and ethical debate, a comprehensive review of which is beyond the scope of the current study¹². In 2002, the UK Government announced intentions to reform the MHA. Proposed changes included a broader definition of mental disorder, compulsory community treatment and changes to the professionals with legal duties. This Bill has been widely criticised¹³ (Eaton, 2004). Within the 1983 Act, all compulsory treatment must take place

¹² These issues, including self-determination versus paternalism, risks of criminalising clients and potential human rights conflicts are discussed in Clark (1998) and Parrish (1993).

¹³ Critics fear that the new legislation may increase the numbers of clients who are eligible for compulsory treatment and may also increase already overstretched professionals' workloads.

within inpatient settings. Recent government documents, including *The NHS plan* (Department of Health, 2000) and *The National Service Framework for Mental Health* (Department of Health, 1999), have shifted mental health care into the community, leaving many believing the current legislation to be outdated (Howlett, 2001). Authors have suggested that these changes have also resulted in increased expectations with decreasing resources, a 'blame culture' and decreased professional autonomy, engendering demoralisation (Coid, 1994; Salter, 2003).

2.2. Professionals involved in the MHA.

Numerous professional groups have prescribed roles within the MHA and the main ones that will be focused on are approved social workers (ASWs), psychiatrists and community psychiatric nurses (CPNs). When a client is assessed under the current MHA, they must be interviewed by three professionals, one ASW and two medical professionals¹⁴. This assessment focuses on whether the client fulfils the legal criteria for the application of the MHA. If all three professionals feel that the client's presenting problems fulfil these criteria, the ASW can then decide whether to apply a section of the MHA in order to compulsorily assess/treat the client or whether to pursue an alternative intervention option. The ASWs' statutory duties include: considering less restrictive alternatives to hospitalisation; exploring risk issues; and making applications for compulsory hospital admissions (Sheppard, 1993). Conflicts or tensions between the ASW role and that of a generic social worker have been highlighted (Campbell *et al.*, 2001). Obstacles to ASWs fulfilling their envisaged advocacy role include: the dominance of the

¹⁴ For most types of section.

medical model; limited community resources; and the dual responsibilities towards clients and the public (Lloyd, King & Chenoweth, 2002). Medical professionals also have key legislative responsibilities. To make the final MHA application for most types of section, the ASW must have two signed medical recommendations. Other professionals and the clients' families will often play parts in the process, including requesting or attending the assessments.

Research indicates relatively high rates of vacancies, turnover and retirement from ill-health within the ASW and psychiatric professions (Huxley & Kerfoot, 1994; Royal College of Psychiatrists, 2004). Some authors have suggested that the stress associated with statutory duties, including the risk of encountering aggression, may be a disincentive to continue the role (Nolan, Dallender, Soares, Thomsen & Arnetz, 1999). Important to these findings is the research into the psychological well-being of these professional groups that is reviewed below.

2.3. Stress and burnout in professionals involved in the MHA.

Many studies suggest that mental health and social care professionals suffer from higher stress rates than other professional groups (Bennett, Evans & Tattersall, 1993; Collings & Murray, 1996; Luck, 2000). To some extent, these studies may also underestimate the prevalence of stress¹⁵ (Hale, 1997). Negative outcomes associated with stress include: reduced social functioning; absenteeism; shorter life expectancy; inability to

¹⁵ Health professionals may be reluctant to disclose their distress, preferring to avoid the shame, stigma and potential negative effects of disclosure (Forsythe, Calnan & Wall, 1999; Symons & Persaud, 1995).

switch off from work; low self-esteem; reduced quality of care¹⁶; and personality changes (Kivimäki *et al.*, 2001; Melchior, Bours, Schmitz & Wittich, 1997). However, within reasonable limits stress can have motivating and energising effects (Cournoyer, 1988).

Prolonged exposure to stress may result in ‘burnout’¹⁷ (Freudenberger, 1974). Burnout is hypothetically characterised by emotional exhaustion (fatigue, irritability and anxiety), depersonalisation (cynicism and distancing) and low personal accomplishment (lowered self-efficacy and increased guilt) (Maslach, Schaufeli & Leiter, 2001). It may be accompanied by headaches, gastrointestinal disorders and sleep problems (Arches, 1991; Kilfedder, Power & Wells, 2001). Behaviourally, manifestations may include increased avoidance of work, lowered efficiency and increased alcohol or substance use (Roberts, 1997; Tillett, 2003). Cognitively, burnout may affect attention levels, memory and decision-making (Edwards, Burnard, Coyle, Fothergill & Hannigan, 2000). Emotionally, professionals may feel more irritated and depressed (Rathod, Roy, Ramsay, Das & Birtwistle, 2000).

Between 8% and 60% of professionals within psychiatry, social work or community nursing have been found to suffer from burnout¹⁸ (Benbow & Jolley, 2002; Evans *et al.*, 2005; Pajak, Mears, Kendall, Katona & Medina, 2003). However, evidence that these rates are higher than comparison samples remains equivocal (Korkeila *et al.*, 2003). Direct comparison of these studies is complicated due to the use of different comparison groups and cut-off points.

¹⁶ Authors highlight this association is largely anecdotal rather than empirically supported (Coffey, 1999).

¹⁷ Some authors suggest that burnout requires further conceptual clarification and may not be a distinct phenomenon (Gibson, McGrath & Reid, 1989). However, others have shown that burnout is a separate construct to both stress and depression (Maslach *et al.*, 2001).

¹⁸ According to total scores on the Maslach Burnout Inventory (MBI).

Some studies have found that health professionals' depersonalisation sub-scale scores fall within or below the normal range (Carson, Bartlett & Croucher, 1991; Onyett, Pillinger & Muijen, 1997¹⁹). However, others have found elevated levels (Edwards *et al.*, 2000; Fagin, Brown, Bartlett, Leary & Carson, 1995). Depersonalisation has major implications for the helping professions, as negative attitudes towards clients are likely to detrimentally affect the quality of care and therapeutic relationships (Webster & Hackett, 1999). High emotional exhaustion has consistently been found in psychiatrists (Benbow & Jolley, 2002), community mental health team professionals (Walsh & Walsh, 2002; Webster & Hackett, 1999), CPNs (Edwards *et al.*, 2000) and social workers (Onyett *et al.*, 1997; Siefert, Jayaratne & Chess, 1991). However, some authors have found normal or low rates (Gibson *et al.*, 1989).

Mental health and social care professionals have been found to report high personal accomplishment (Evans *et al.*, 2006; Onyett *et al.*, 1997). However, others have found low personal accomplishment scores in social workers (Gibson *et al.*, 1989), CPNs (Carson *et al.*, 1991) and consultant psychiatrists (Pajak *et al.*, 2003). Interestingly, studies have found that many professionals experiencing high stress/burnout continue to report high satisfaction and accomplishment (Dallender, Nolan, Soares, Thomsen & Arnetz, 1999; Prosser *et al.*, 1996). Paradoxically, for some individuals, despite the emotionally draining aspects of their statutory roles, working within health or social services may still remain personally fulfilling.

¹⁹ Although this study found the reverse was true for consultant psychiatrists, who exhibited higher than average levels of depersonalisation.

2.4. Correlates of stress and burnout.

Research suggests that organisational factors have more influence on occupational stress than personality factors or client characteristics (Duquette, K rouac, Sandhu & Beudet, 1994). However, individual coping style, idealism, type A personality, external locus of control, low self-esteem, anxiety proneness, perfectionism and working with ‘difficult’ or aggressive clients have been associated with stress (Burnard, Edwards, Fothergill, Hannigan & Coyle, 2000; Caughey, 1996; Leiter & Harvie, 1996; Pines & Maslach, 1978).

Role conflict and ambiguity²⁰ have been found to be significantly associated with stress (Heim, 1991; Mears *et al.*, 2004). However, there are positive aspects of such role conflict, including energising effects and reduced boredom (Jones, 1993). Research has found that role conflict/ambiguity is high in social workers and health professionals (Balloch *et al.*, 1999). It is likely that most professionals pursuing such careers may be motivated to help, care for and promote clients’ self-determination (Acker, 1999; Wilhelm, Diamond & Williams, 1997). Using the MHA to compulsorily treat clients may therefore conflict with this ‘helping’ ethos. Jayaratne and Chess (1984) added to this by suggesting that legislation requirements may also conflict with departmental or professional policies, thereby creating conflict. Therefore, MHA assessments may contribute to role conflict and associated stress.

²⁰ Role ambiguity is characterised by uncertainty about one’s role, responsibilities and others’ expectations (Balloch *et al.*, 1998). Role conflict is characterised by two or more separate parts of one’s role being contradictory or incompatible (Jones, 1993).

Overwork/workload is also reported as a contributor to stress (Prosser *et al.*, 1997; Tyrer, Al Muderis & Gulbrandsen, 2001). As MHA assessments frequently take place out of hours, often in addition to other duties, they may contribute to high workloads. Studies have highlighted that psychiatrists and social workers often work overtime (Dallender *et al.*, 1999; Kennedy & Griffiths, 2001). Perceptions of limited autonomy or control over one's working life, particularly combined with high demands, has been consistently associated with burnout (Arches, 1991; Knapp, Harissis & Missiakoulis, 1981). Studies have found that social services and mental health professionals report limited perceived control over their work (Dallender *et al.*, 1999; Gibson *et al.*, 1989). Since MHA assessments take place under a prescribed legislative framework, this would limit professional autonomy. In addition, these assessments often occur during crises, when demands and emotional charge may be high, thereby adding to the stressful context of the process.

Further factors associated with stress that may be salient during the MHA process, include: professional conflict; threat of violence; decision-making responsibility; feeling unable to solve clients' problems; limited time; and extensive paperwork (Benbow & Jolley, 2002; Manktelow *et al.*, 2002; Parry-Jones *et al.*, 1998). Interacting with distressed or angry relatives has also been associated with stress and is often present during MHA assessments (Fothergill, Edwards & Burnard, 2004; Rathod *et al.*, 2000).

Numerous factors have been found to mediate between stress risk factors and burnout, including: the amount/quality of supervision; supportive colleagues/managers; positive feedback; and personal factors, including: 'hardiness'; time-management skills;

enthusiasm; and relaxation techniques (Littlewood, Case, Gater & Lindsey, 2003; Pines & Masalch, 1978). Low levels of perceived support from colleagues or management have been found amongst health and social care professionals, which may have contributed to the high levels of stress/burnout found in these groups (Balloch *et al.*, 1998; Dallender *et al.*, 1999). Therefore, professionals involved in the MHA process often exhibit high levels of stress/burnout, particularly emotional exhaustion. During the MHA process, it is likely that they encounter several stress risk factors. In addition, they report low levels of factors that may buffer against these organisational stressors, such as consistent supervision and high professional autonomy.

2.5. Methodological issues.

Various methodological issues must be considered when interpreting some of the research evidence on stress/burnout in professionals engaged in the MHA process. Some researchers designed their own measures without providing data on reliability or validity (e.g. Prosser *et al.*, 1997; Rathod *et al.*, 2000). Several authors assessed complex constructs, including job satisfaction and stress, using single questions that may not have adequately captured the complexity of the concept (e.g. Collings & Murray, 1996; Siefert *et al.*, 1991). Many researchers used self-report measures to assess multiple factors, which may have increased the shared error variance, producing spurious or inflated associations (e.g. Acker, 1999; Burnard *et al.*, 2000). Self-report measures can also be vulnerable to response bias and demand characteristics (Barlow, Hayes & Nelson, 1984).

Problems such as low response rates, focusing on one area or team or completion outside the UK, where legislation and service climate differ, limit the generalisation of some studies (e.g. Burnard *et al.*, 2000; Reid *et al.*, 1999). Most researchers sampled professionals who were still in post. The most severely distressed professionals may have left their jobs, resulting in underreporting of problems or biased samples. Additionally, many researchers used a cross-sectional design, preventing conclusions regarding cause and effect relationships. Some studies were carried out in the 1980s or 1990s and given recent organisational changes in mental health services, the findings may no longer be relevant. However, the consistently high levels of stress/emotional exhaustion in mental health/social care professionals that have been found across these studies strengthens the evidence. In addition, a number of well-designed studies using standardised questionnaires with large samples have also been completed and have found similar results (e.g. Edwards *et al.*, 2000; Onyett *et al.*, 1997). Therefore, there is strong evidence that stress levels are elevated in these professional groups. However, the findings concerning depersonalisation and personal accomplishment remain equivocal.

2.6. Mental health and occupational role.

Studies have found that mental distress, as measured by the General Health Questionnaire (GHQ), is high in the professionals who are involved in the MHA (Balloch *et al.*, 1998; Holmes, 1997). Evans *et al.* (2006) found that 47% of UK mental health social workers scored above the GHQ-12 threshold indicating 'caseness'. Similar percentages have been found for other mental health professionals involved in the MHA (23%-72%) (Carson *et al.*, 1991; Caughey, 1996; Edwards *et al.*, 2000; Evans *et al.*, 2005; Wall *et al.*,

1997). However, interpretation of these studies is complicated, as different researchers have used different versions of the GHQ and different cut-off scores.

High rates of anxiety, depression and suicidal intent/attempts have also been found, using alternative measures of professionals' mental health (Bennett *et al.*, 1993; Hawton, Clements, Sakarovitch, Simkin & Deeks, 2001²¹; Jones, Fletcher & Ibbetson, 1991). However, others found that the suicide rates did not differ from the rate found amongst the general population (Frank & Dingle, 1999). There is some evidence that alcohol and substance misuse is elevated, particularly among psychiatrists and other doctors (Holmes, 1997; Tillett, 2003). The cross-sectional nature of these studies makes it difficult to conclude whether these problems were present before the professional entered their career or were precipitated by the role.

2.7. What are the effects of involvement in MHA assessments?

Authors have highlighted the importance of exploring contributors to stress amongst social workers and others, to facilitate the development of effective stress reduction/management interventions (Lloyd *et al.*, 2002). However, research into professionals' experiences of using the MHA as a potential contributor is limited. The existing research can roughly be divided into studies of professionals' attitudes or experiences of the legislation.

²¹ Female psychiatrists only, compared to other medical specialists and the general population.

2.7.1. Attitudinal studies.

Researchers have generally found that professionals view mental health law as valuable and/or necessary to enable treatment of those in need (Franklin, Pinfold, Bindman & Thornicroft, 2000; Kumasaka & Stokes, 1972; Wood, Rosenthal & Khuri, 1984). However, some professionals also held concerns, including: the rigidity of the criteria; the role of the nearest relative; and limited alternatives for treatment without detention (Marriott, Audini, Lelliott, Webb & Duffett, 2001; Roberts, Peay & Eastman, 2002). Other studies have suggested that many professionals prefer to avoid involuntary detention, as they feel it infringes on clients' autonomy and jeopardises the therapeutic relationship (Kullgren, Jacobsson, Lynöe, Kohn & Levav, 1996; Swartz, Monahan & Swanson, 2003).

2.7.2. Experiential studies.

Some studies have researched professionals' experiences of using a range of coercive interventions, including mental health legislation. Using coercion was generally associated with distress and conflict with clients (Olofsson, Jacobsson, Gilje & Norberg, 1999; Smith & Nursten, 1998). Psychiatrists, acting as responsible medical officers for detained clients, have also been found to feel burdened by this responsibility (Marriott *et al.*, 2001).

Evans *et al.* (2005, 2006) examined the impact of statutory duties by comparing the working patterns, burnout levels, job satisfaction and health status of ASWs with social workers without approved status. The authors highlighted that ASWs frequently faced physical threats during MHA assessments, which often took place out of hours. Despite

these additional duties, the ASWs received *less* supervision than their non-approved counterparts. The ASWs felt undervalued, were more willing to leave their posts and reported lower job satisfaction. Their GHQ scores²² and total MBI burnout scores were significantly higher than the non-ASWs. The strengths of these studies included the large sample sizes who participated and the range of geographical authorities studied. These studies therefore provided good evidence that the MHA process can have some adverse effects on professionals.

Reid *et al.* (1999) found that ASWs described role conflict as difficult more frequently than other professionals, particularly in reference to the MHA in their qualitative study. The ASWs described MHA assessments as stressful and characterised by a conflict between collaborating with clients and minimising risk. They also felt their personal safety was sometimes jeopardised and that others occasionally misconstrued their roles. The ASWs felt that deciding *not* to section was often anxiety-provoking. However, the sample only included three social workers and the authors did not report in detail any strategies used to increase the rigour of the data analysis. Quantitative studies have also found that conflict between caring and control in the ASW role can generate stress (Thompson, Stradling, Murphy & O'Neill, 1996).

In another qualitative study, Huxley *et al.* (2005) found that the paperwork, stress, overtime and risk associated with the ASW role were perceived negatively. However, one participant highlighted positive aspects, including the opportunity to use different skills

²² Their GHQ scores indicated that 65% could be suffering from minor psychological problems and 52% scored four or more, suggesting they may be suffering from a psychological disorder.

and role satisfaction. The authors do not clarify how many others shared this view. These researchers concluded that:

'The data suggest, for the first time to our knowledge, that carrying statutory responsibilities, while viewed as positive by many workers, raises stress levels.' (Huxley *et al.*, 2005).

In summary, researchers have found that mental health professionals exhibit high levels of stress, burnout and psychological distress, including anxiety and depression. The few studies that have specifically explored professionals' views and experiences of using the MHA, suggest that it can conflict with professionals' other roles and may generate pressure, administrative burden and stress. Given the limited research in this area and the prospect that other professional groups may acquire similar roles under future legislation, the current study was designed to add to the knowledge base about professionals' experiences of the MHA process.

3. METHOD.

3.1. The research question.

The research questions explored in the current study were:

1. How do professionals experience their involvement in the Mental Health Act (MHA) assessment process?
2. How do professionals cope with any effects of participating?

3.2. The research design.

Few research studies have specifically investigated professionals' experiences of the MHA assessment process. Given that this area has not been extensively explored and that complex, multifaceted experiences, thoughts and emotions were likely to be involved, qualitative research methods were felt to be most appropriate (Barker, Pistrang & Elliott, 1994; Turpin *et al.*, 1997).

3.2.1. Grounded theory.

The grounded theory methodology was selected to guide the current study, as it accentuates the meaning or significance that people attribute to their experiences (Glaser & Strauss, 1967). This methodology ultimately aims to generate abstract theory, which goes beyond description (Glaser, 2002a; Goulding, 1998). The theory is discovered, developed and verified through systematic data collection and analysis. It is a non-linear or 'iterative'

methodology, whereby data collection and analysis have reciprocal relationships and are largely conducted concurrently.

Many texts offer detailed guidelines of the grounded theory method (see Charmaz, 1995; Strauss & Corbin, 1998). The current research was informed by the procedure/philosophy outlined by Pidgeon and Henwood (1996). The grounded theory approach is inductive and encourages researchers to generate theory, without theoretical preconceptions or hypotheses (Coyne, 1997). Therefore, the literature review proceeded in an ongoing parallel process to data collection and analysis rather than preceding it, to ensure that the analysis remained grounded (Rennie, Phillips & Quartaro, 1988).

3.3. The researcher's position.

The grounded theory method is compatible with different epistemological frameworks along a realist/constructionist continuum (Madill, Jordan & Shirley, 2000). The current researcher approached this study from a critical realist epistemological stance. Broadly, this position suggests that there is an external reality, encapsulated within people's ideas and interpretations of their experiences (Guba & Lincoln, 1994). Therefore, through research, researchers can learn, at least partially, about this reality. In the context of the current study, the researcher therefore assumed that participants had conscious access to most of their experiences of the MHA process. However, it was acknowledged that participants may choose to present this knowledge in a certain way or only partially, according to the research context and their assumptions about how this information may be interpreted or used.

Grounded theory writers emphasise the possible influence of researchers' attitudes, experiences, beliefs, culture and training on the research process. Early ideas about researchers being entirely objective and analysing from a 'blank slate' position have largely been rejected (Charmaz, 1990). The researcher's reflexivity, awareness and articulation of their position and how this may have affected the research process incorporates this issue into the research (Greenhalgh & Taylor, 1997).

The current researcher had previously worked within an inpatient forensic setting, providing therapeutic interventions to clients who were sectioned. Many clients expressed strong views about the MHA and sectioning and this was a prominent narrative on the unit. Clinical care was provided within the context of adhering to legislative guidelines, which raised the researcher's awareness of the impact of the MHA process on clients, clinicians and their relationships.

In terms of the research context, the current researcher was on a part-time, psychodynamically informed clinical placement within an adult community mental health team, during the study. The researcher occasionally worked in a shared office, where discussions of using the MHA and the perceived problems with this were commonplace.

3.4. Methodological rigour.

It is generally accepted that traditional scientific quality criteria, including reliability and validity, are not appropriate for evaluating qualitative research, without

modification²³ (Cutcliffe & McKenna, 1999). Although there is no consensus about appropriate quality criteria, numerous researchers have proposed some standards (see Corbin & Strauss, 1990; Elliott, Fischer & Rennie, 1999; Greenhalgh & Taylor, 1997; Henwood & Pidgeon, 1992; Mays & Pope, 2000; Morse, Barrett, Mayan, Olson & Spiers, 2002). Suggested alternative criteria for qualitative research are ‘trustworthiness’, including the transferability, relevance²⁴ and credibility of the research, internal coherence and ‘fit’ of the theory with the original data (Glaser, 2002b; Stiles, 1993).

In the current study, the researcher’s engagement/immersion with the data was increased through personally transcribing every interview. A research diary was kept throughout the process, constructing an audit trail (Henwood & Pidgeon, 1992). This included memos recording general reflections, doubts and methodological/analytic decisions, which assisted theory development. Issues of the researcher’s reflexivity were also included, to protect against her biases clouding the analysis too significantly (Charmaz, 1990).

The credibility of the analysis was increased through the researcher’s supervisors and the members of a qualitative research group²⁵ open coding some of the original data. The similarities with the researcher's own analysis suggested that others formed similar interpretations and that the analysis was remaining grounded (Barbour, 2001). The researcher's supervisors read several transcripts, versions of the final write-up and explored

²³ However, some authors contest this (Morse *et al.*, 2002).

²⁴ This refers to whether the study explored issues, which were meaningful to the public or professional groups (Mays & Pope, 2000).

²⁵ The researcher regularly attended a qualitative research group with her peers and an external facilitator with experience of qualitative research methods, throughout the research process. This provided a forum where ideas were shared.

the final theoretical model. They fed back that the theory fitted the original data well.

Although the researcher considered using respondent validation, it was decided that the participants may not recognise their original accounts within the results, given that the analysis became increasingly conceptual over successive coding procedures (Morse *et al.*, 2002).

The use of strategies within the grounded theory method also provided checks on the theory's fit and coherence, including using verbatim quotes to illustrate the final categories (Barker *et al.*, 1994; Charmaz, 1995). The constant comparison method also ensured that categories that had not proved meaningful across participants' accounts were discarded, which protected against the researcher's biases extensively colouring the analysis (Cutcliffe, 2000). Negative/deviant cases are those that initially appear inconsistent with the majority voice and have been proposed as tests of the comprehensiveness and explanatory power of the theory (Henwood & Pidgeon, 1992, 1995; Pope, Ziebland & Mays, 2000). The current sample of participants described a range of experiences of the MHA process. Some seemed relatively unaffected by it and constituted negative cases in this regard.

3.5. Procedure.

Ethical approval for the study was granted by the local Research Ethics Committee in August 2005 (see Appendix 2). Following this, initial sampling was guided by the overall research area. Potential participants were approached directly by the researcher, the researcher's field supervisor or via a group email to all approved social workers (ASWs) in

the region, providing the researcher's contact details. Most participants then left their contact details in a telephone message or directly with the researcher. Potential participants were sent or given an Information Letter (see Appendix 3). Upon reading the Information Letter, providing the participants retained an interest, a convenient interview date and time were arranged. All interviews took place at the participant's occupational base, within usual working hours.

3.5.1. Participants.

The inclusion criteria for the current study were:

- Current legal authority or informal experience of implementing sections of the MHA.
- Understanding of the study's nature, what their participation would involve and the provision of informed consent.

The exclusion criterion was:

- Employment within a service that was not being studied in the current study (due to practical constraints).

An anonymised list of the participants and their demographic information is presented in Table 1.

Table 1: Demographic information about the research participants.

Participant	Professional title	Gender	Ethnic origin	Age band	Length of involvement in the MHA
P1	SNP ¹	Female	White British	40-50	Information unavailable
P2	ASW ²	Female	White British	30-40	9 months
P3	ASW ²	Male	Afro-Caribbean	40-50	6 years
P4	ASW ²	Male	White British	30-40	1 year 6 months
P5	Psychiatrist	Female	White British	30-40	5 years
P6	SNP ¹	Male	White British	40-50	23 years
P7	ASW ²	Female	White British	50-60	27 years
P8	ASW ²	Male	White British	40-50	19 years
P9	ASW ²	Male	White British	50-60	11 years
P10	ASW ²	Female	White British	40-50	1 year 9 months
P11	Specialist Registrar	Male	White British	30-40	10 months ²⁶

¹ Senior Nurse Practitioner (SNP).

² Approved Social Worker (ASW).

3.5.2. Theoretical sampling.

Theoretical sampling is a key component of the grounded theory method (Strauss & Corbin, 1998). Purposive sampling was initially used to interview participants who would maximise the probability of obtaining meaningful data (Coyne, 1997). These initial interviews were then analysed, thus beginning theory development. To expand the developing theory, participants who may validate, disconfirm, develop or refine the

²⁶ This participant had been a section twelve approved doctor for 10 months, however, he also had some prior experience of using the MHA before gaining his approved status.

emerging theory were then sampled (Pidgeon & Henwood, 1996). This process was continued towards theoretical saturation, whereby further interviews did not reveal any new categories.

Initially, theoretical sampling focused on ASWs and a SNP to generate rich data and expand the analysis. The researcher then sampled a psychiatrist to develop the emergent categories. Further theoretical sampling resulted in interviewing ASWs with a range of experience and seniority, one specialist registrar and one SNP. The researcher was mindful to sample participants from a range of professional backgrounds, given their varying legal and practical responsibilities within the MHA.

3.5.3. The interviews.

At the start of each interview, the researcher reviewed the Information Sheet with the participant and asked them to sign a Consent Form (see Appendix 4). The interviews lasted between 45 and 85 minutes and were recorded using two different dictaphones as a precaution. Written notes recording the participants' non-verbal behaviour and the researcher's general reflections were made immediately after the interviews. Each interview was followed by a de-brief, during which the professionals were thanked for their participation and issues of confidentiality were reiterated²⁷. The researcher transcribed the data as soon as possible following the interviews to aid accuracy²⁸.

²⁷ The researcher also ensured that the participants did not feel distressed following the interview and asked whether they felt they needed further emotional support. None of the participants reported that they were left with residual distress or needed additional support.

²⁸ The longest delay between the interview and finishing the transcription was three days. The original transcripts are bound in a separate volume to this research report.

3.5.4. The Interview Schedule.

The interviews were guided by a general Interview Schedule, developed from the research questions (see Appendix 5). The initial Schedule was brief and broadly focused and the interviews began with general questions to put the participants at ease. The Schedule was used as a flexible guiding framework, rather than rigidly followed, to ensure that participants could explore those issues that were personally meaningful. This avoided the researcher prematurely narrowing down her theoretical or analytical framework. Interesting issues were followed up using probe questions. Most interviews ended by asking participants whether they had anything important to add, as an additional reflective space.

The Interview Schedule was refined as the research developed. Questions were added, which aimed to develop the final theory and test out initial theoretical conceptualisations (Charmaz, 1995; Coyne, 1997). Correspondingly, the questions became more focused towards the end of the study (see Appendix 5 for examples).

3.6. Data analysis.

3.6.1. Open coding.

Coding is the process whereby the data is organised and given meaning²⁹. Although the stages of coding were intended to be used flexibly and interchangeably, open coding³⁰ was the critical first step of the analysis (Henwood & Pidgeon, 1992). The transcripts were

²⁹ Coding was preceded by the researcher reading the transcripts through several times.

³⁰ Also referred to as line by line coding in some texts.

segmented into small chunks of data e.g. short phrases or sentences, each of which was assigned a code. Initially these codes remained close to the participants' own words, ensuring the analysis remained grounded. However, as the analysis developed, these codes became more abstract and conceptual. Initial generated codes were grouped into preliminary categories, depending on their similarities and differences with other codes³¹. These categories were then developed in terms of their properties (characteristics or features) and dimensions (continuum along which properties vary). An example of the open coding can be found in Appendix 6.

3.6.2. The constant comparison method.

Data analysis proceeded in a cyclical process of constant comparison and theoretical sampling, as a hierarchical list of categories was developed. The constant comparison method was used throughout the analysis to facilitate the identification and refinement of categories (Corbin & Strauss, 1990). This method consisted of systematic comparison of incidents, codes, participants and categories, to identify their similarities and differences. This process enabled further characterisation of the categories and clarified the relationships and links between them.

3.6.3. Category integration.

As the analysis progressed and the researcher gained a deeper understanding of the data, the final categories became more abstract and were refined and integrated into a

³¹ This was accomplished through recording preliminary categories in a computer document, which included the working title of the category, the code name, participant identifier and the page and line number of the original transcript data. The categories were then refined and changed as appropriate, as the analysis progressed.

theory. The relationships between the categories and their subcategories were clarified, which increased the theoretical coherence. In the final stage of coding, the core category emerged that represented the central theme or process discovered through the analysis, which unified the theory and tied together the categories (Pidgeon & Henwood, 1996). The interrelationships between the categories, subcategories and the core category were then clarified.

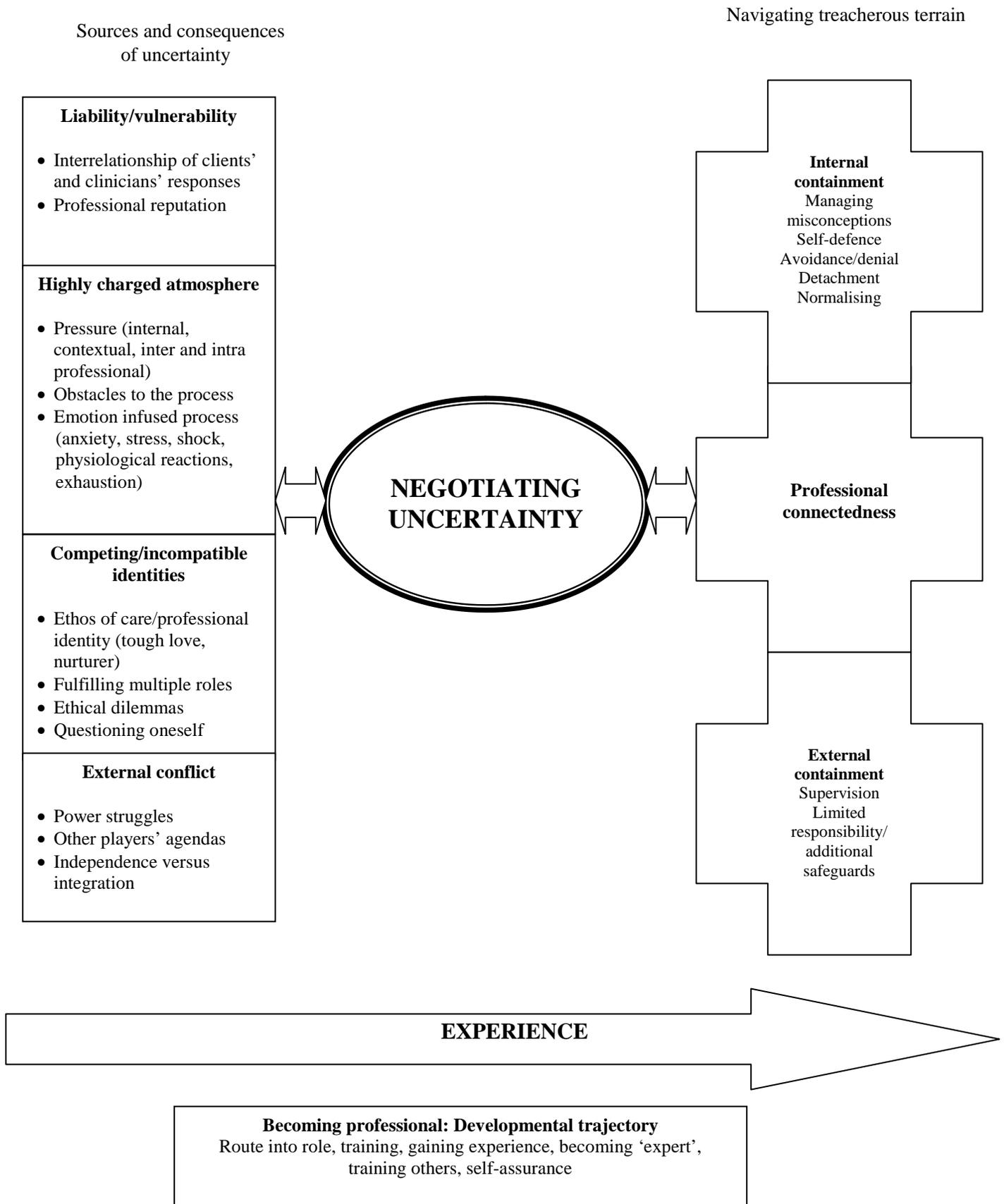
Grounded theory aims to develop the emergent theory as richly and fully as possible. Within the current study, the later research interviews did not reveal any new information, suggesting that the categories, their properties, dimensions, subcategories and the relationships between them were richly developed. This ensured that sufficient data had been collected to provide a comprehensive account of the phenomenon.

Previous authors have highlighted that studies employing the grounded theory methodology vary on the level of abstraction they achieve e.g. whilst some authors generate higher-order theories, others aim to elaborate the phenomenon under study by developing a comprehensive conceptual analysis (Henwood & Pidgeon, 1995). In keeping with the time and resources available, the latter aim was adopted for the current study.

4. RESULTS.

A diagram of the final theoretical model can be found in Figure 1. Following a description of the core category and overall model, the major generators of uncertainty during the Mental Health Act (MHA) assessment process will be described. The internal and external coping strategies that the participants used to contain this uncertainty are then further explored. This section only includes shorter key quotes to illustrate the categories, however, references for further supporting quotes are provided for the interested reader. These references are inserted into the text in brackets in the form of the participant number followed by the line number of the quote within the original transcript (e.g. P10/117). The corresponding quotes can be found in Appendix 7.

Figure 1: The final theoretical model of professionals' experiences of the MHA process.



4.1. Overview of the model and the core category: Walking the tightrope and negotiating uncertainty.

All participants described how uncertainty permeated every stage of the MHA assessment process, from the initial referral to the repercussions of being involved (P8/247). MHA assessments often involved the professionals meeting clients for the first time, whilst frequently having very limited information about them. Despite this context, such assessments occurred with the purpose of making significant decisions about the clients' futures and their prospective care. The combination of these factors seemed to generate a significant sense of uncertainty about the appropriate decision to take during the assessments for many of the participants. This sense of feeling unsure or uncertain about which path to take was often exacerbated by the inherent conflicts and ambiguities within the legislation itself and between the purpose of the Act (i.e. to provide assessment/treatment to those in need) and the mechanism of accomplishing this (i.e. against the clients' wishes). The participants' central experience of the process was one of continually negotiating this uncertainty, which was prompted by the need for action (P2/1097).

'I: What were your feelings about the Mental Health Act and, and the principles behind it?

P: Um (pause) dual really um, on the one hand thinking that um, obviously if somebody has a mental health diagnosis and is a danger to themselves or others then, you know, obviously um, if the outcome of the assessment means they need to be in hospital then that, you know, I could, I could go with that, but there's also concerns that, does this person need to be, you know? Thinking, you know, is there any other way? Does this person

need to be in hospital or not? And the worry, worrying about that really, you know, making the right decisions, stuff like that.' (P10/68).

Many factors were unknown when embarking upon and navigating through a MHA assessment. Holding the knowledge that various difficult scenarios *may* arise meant that preparing for every eventuality was an impossibility and feeling unprepared was somewhat inevitable.

'You really don't have much sense of what you might be walking into, so there is a real practical sort of slightly scary bit about it.' (P5/26).

One major category contributing to uncertainty was liability/vulnerability. Some professionals felt their security could be jeopardised during the process, as they could be held legally liable in the context of any adverse outcomes following their decision (P3/534). Having to make ambiguous decisions with the associated responsibility for justifying the choice generated discomfort for many.

'It's the group in the middle that are, that I find difficult, where you kind of um, you're not quite sure how it's gonna go and you're not quite sure how they're gonna, how they're gonna react. You've got the ambulance outside or waiting, you're not sure about the police. I try, we try not to use the police, unless we have to.' (P4/406).

Some participants felt that their professional reputation could also be affected by their actions within the process, which caused some concern (P6/342). More practically,

the participants often faced physical risks from the clients' behaviours during assessments. Many professionals also felt that the therapeutic relationship with a client could become vulnerable during the process, generating additional uncertainty and attempts to protect the existing relationship (P5/407).

The pressured context of MHA assessments was also a major category that exacerbated uncertainty. Pressure generated from many sources, including issues of risk, time restrictions and the practical obstacles encountered (P8/707). There was understood to be a reciprocal feedback loop between uncertainty and pressure, as pressure often resulted from unknown elements, including the variability of external support and how the client would present.

Conflict was a central concept that contributed to uncertainty and arose at many different levels, from the individual professional (micro) to the organisational and cultural (macro) (P3/44). The two major sources of conflict during the process were external conflict generated through interaction with others and internal conflict within the professionals' own minds, both of which often generated from split opinions regarding the appropriateness of sectioning clients (P3/324). The presence of two opposing viewpoints and the possibility of adopting either position introduced ambiguity into the choice. Situations of high ambiguity seemed to amplify the uncertainty that permeated the MHA assessment process, creating contexts where conflict and internal discomfort were increasingly likely to occur.

'You know, you're meeting people for the first time, who've perhaps got no past psychiatric history.

I: Uh huh.

P: Um, and, you know, you don't know much about their past, you don't know much about them, you know, you know some of what's going on, you know bits and pieces um, but you don't kind of know the whole jigsaw. Um, and you've got uncertainty about what the diagnosis might be. Um, and the lady that I went out to see with err, the GP.... it was very unclear what her diagnosis was.... I was uncertain in my own mind as to whether she had um, whether her primary problem was actually a psychiatric oneand I think that's why there was so much debate between myself, the GP and the social worker, about what actually we should be doing. Um, and certainly when it comes to section twos, there's often lots of uncertainty. Um, because it's very difficult to get the whole picture err, you're in someone's house, in the middle of the night um, even if the family are there um, you know, especially if they've got no past psychiatric history, so you can't phone up to get information from records or notes or whatever.' (P11/484).

Uncertainty was also generated by how the professionals' roles in the MHA process fitted in with their overarching professional identity. Some participants felt there was a tension between their role in the MHA and their general ethos of care, which created some uncertainty in their professional identity (P5/52). However, the professionals' duty/ethos of care meant that they had to find some way of tolerating this uncertainty in order to act, as opposed to becoming overwhelmed and immobilised. Internal conflict was seen to be generated by the tension between a) fulfilling a multitude of roles and b) ethical dilemmas raised by the participants' involvement in the MHA process (P9/541).

Power struggles between different professionals or with clients and relatives often exacerbated the tension generated through different parties holding varying opinions of the ideal outcome (P6/299). External conflict also seemed to be generated from a tension between the independence required by the MHA process and the participants' coexisting roles within multidisciplinary teams (P2/393).

The four main categories that contributed to uncertainty also had reciprocal relationships between them. The sense of liability/vulnerability was heightened when the participants were experiencing conflict or when the assessments felt pressured. Conflict during the process and the overarching sense of liability clearly contributed to the pressured context of the assessments. Feelings of professional vulnerability and external conflict often generated internal conflict. Finally, feeling personally liable combined with an awareness of pressure could heighten the tensions with other people involved in the assessment.

There were various core consequences associated with having to negotiate uncertainty, including physiological responses (sleeplessness, gastric disturbance and subsequent exhaustion). Many of the participants described a sense of doubt about some of their decisions during MHA assessments. This could be persistent and was often associated with the tendency to question whether the 'right' decision had been made (P7/78).

'I probably question most of the decisions that I make um, in my own mind. Um, I think I, you know, because of the, the seriousness of the consequences of what I do, when I sign

this tiny, little, pink piece of paper and write my two line scribble on the, on the form. Um, I would say yeah, I mean yes, I, there's not been very many that I haven't questioned. There have been a couple that have been so clear cut that I, I've, there just wasn't anything, any sort of doubt in my mind, but there have been ones that, you know, that you've had to question as well.' (P11/589).

Uncertainty was often associated with a multidimensional emotional response, which included anxiety, stress and anger.

'I mean it's such an anxiety-provoking thing. I mean, you know, I'm a big grown up nurse and I've seen lots of these and it still terrifies me.' (P6/192).

The participants described various strategies used to contain the uncertainty and facilitate action, including seeking additional information and support. However, the relationship between uncertainty and containment was also reciprocal, as the availability of external support was often uncertain (P2/1135). Other containment strategies included using internal psychological processes to make sense of or reduce the uncertainty, such as denial, detachment and normalisation (P1/304). The drive towards containing the uncertainty or having one's decision validated was sometimes extremely strong.

'You end up phoning the wards to see what, what happenedI guess to try and get some affirmation that you have done the right thing.' (P11/630).

The concept of uncertainty was central, as it had relationships with all the other categories and the term uncertainty was used explicitly by some participants. The professionals' ongoing developmental trajectory during their career was also important in enabling or impeding the negotiation of uncertainty. In general, increasingly experienced participants felt more able to tolerate and navigate through the uncertainty (P9/789). The sections below elaborate on the major categories and subcategories within the model.

4.2. Professional liability/vulnerability.

Insecurity about available support and ambiguities within the legislation generated a sense of personal liability, particularly for the ASWs (P7/93). Under situations of vulnerability, such as clients or others raising criticisms or taking legal action, organisational backup was often not guaranteed.

'You actually carry that responsibility as an individual and not as an employee.' (P7/53).

Although many hoped that support would be forthcoming, this uncertainty manifested in cautious practice and other steps to minimise liability (P3/552). Feeling vulnerable also stemmed from a concern about other professionals' perceptions and a desire to protect one's professional reputation (P2/356). Risks to personal safety often engendered feelings of vulnerability and could arise unexpectedly.

'The woman had been quite quiet and.....she got halfway down and she just went completely berserk.' (P6/856).

Some participants believed that feeling liable was a significant disadvantage to holding power, which could be burdensome and associated with self-doubt, feeling overwhelmed, oppressed and exhausted.

'It felt um, you know, that, that power, having that power is, is often, you know, it just really feels enormous.' (P2/1353).

4.2.1. Interrelationship of clients' and clinicians' responses.

Feelings of vulnerability/liability also resulted from the participants' fears about how the client would respond to their decision, particularly when assessing clients on their own caseloads (P3/872). Some clinicians were loathe to jeopardise their relationships, which sometimes led them to avoid assessing clients they knew. Many professionals had observed differential responses to their involvement, including some clients negatively labelling/categorising them and the development of adversarial relationships (P6/565). This could be associated with guilt and anxiety about being disliked (P7/73). However, other clients retrospectively recognised the benefits of being sectioned. Predicting clients' responses was therefore difficult, as there was not a direct relationship between the professionals' responsibilities/power and the impact on the relationship.

'Because, she sees me as the individual that um, contacts the doctor when things are going, you know, she's becoming unwell um, because she sees me as, although I haven't got that much say, but she sees me as bringing the police.' (P1/132).

A pre-existing relationship and feelings of empathy for the client could also be experienced as generating liability, through threatening the participants' objectivity. When this occurred, the professionals felt they needed to draw back to gain a wider perspective (P4/547). Therefore, knowledge that the sectioning process may affect the relationship, combined with uncertainty about the likelihood of this, contributed to feelings of vulnerability and uncertainty.

4.3. Highly charged atmosphere.

There were often multiple pressures bearing on the professionals during the MHA process, which was often highly charged in terms of expressed emotion and crisis. Pressure varied from being overt, such as the client brandishing a weapon, to covert, including subtle hints of desired outcomes from senior professionals (P7/364). The urgency of scenarios meant that participants were usually unable to prepare as well as they wished, practically or emotionally (P9/915). The consequences of working within highly charged situations sometimes extended beyond the assessment's end into the individual's personal life.

'I said, just let me walk round and I was walking round the house sort of, so, you know, just trying to de-stress, because I couldn't go to bed.' (P10/552).

Aspects of the unknown resulted in anxiety, disquiet and fantasies about worst-case scenarios at several points, particularly whilst preparing for assessments, given the uncertainty of what they would find upon meeting the client (P2/1111). This often related

to possessing limited information and all of the participants tried to gather sufficient information from a variety of sources in order to reduce this uncertainty (P11/113).

4.3.1. Obstacles to the process.

Numerous obstacles exacerbated the pressured nature of the assessments, including ensuring that necessary services or professionals were present, transportation issues and the timing of the assessments.

'It was a Friday night, about nine o'clock by that stage and I just thought, I've gotta ring the out of hours team, I can't do this anymore. I can't, I can't, I couldn't, I hadn't got another decision left in me.' (P7/259).

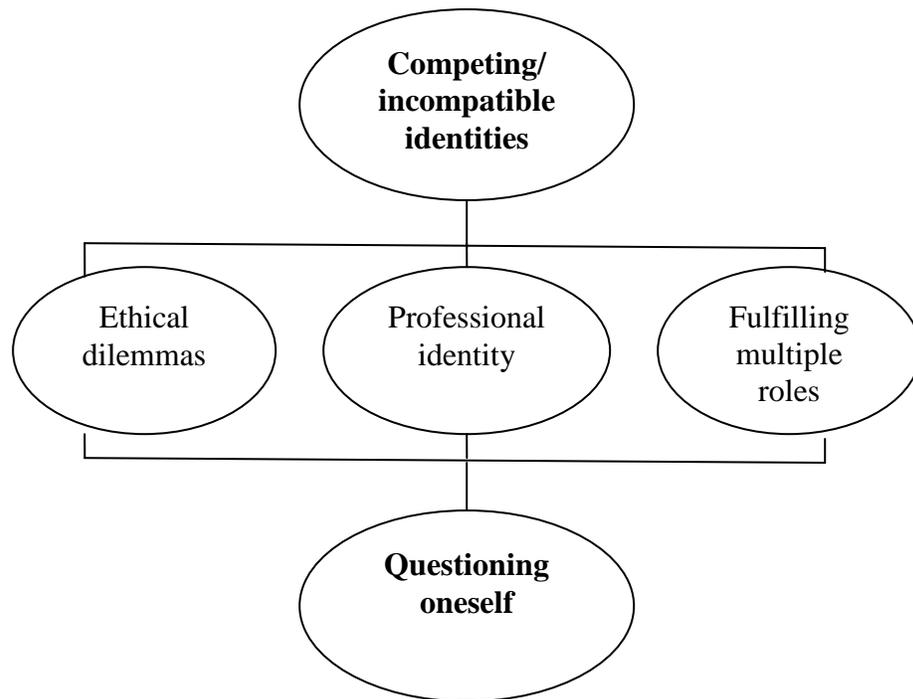
Although the participants generally found the tightly prescribed aspects of the legislation containing, parts of the law are open to interpretation (P2/1097). This ambiguity enabled the construction of an argument for and against sectioning, which left participants feeling more ownership and responsibility for the decision.

'Most of the big decisions aren't completely clear-cut, most times you can argue it one way or the other.' (P7/281).

4.4. Competing/incompatible identities.

Many participants described internal conflict generating from several sources, including feeling torn between legislative duties and obligations towards others and tension between their legal role and ethos of care (P5/812). For some, this was associated with dissonance, guilt, frustration and feeling restricted. These tensions are represented in the diagram below.

Figure 2: Competing/incompatible identities within the professionals' role.



4.4.1. Wrestling with ethical dilemmas.

Most participants described discomfort with various ethical issues during the process.

'It's never um, never been um, an easy experience or a comfortable experience.'

(P10/379).

Participants' awareness of the potential short- and long-term consequences of sectioning, including stigmatisation, limited safeguards and knowledge about the problems with available services, generated discomfort (P11/569). Others mentioned points where they felt that the process may conflict with human rights issues.

'It's a huge invasion of privacy and personal liberty.' (P5/694).

Many participants described agonising over or wrestling with these dilemmas, often weighing up both sides to try to reach a conclusion (P5/345).

4.4.2. Professional identity.

Participants' conceptualisation of sectioning as parental was protective for some, as it was congruent with their professional identity. However, others viewed the process as predominantly controlling, which conflicted with their identity as collaborator, healer or helper.

'The fact that I end up doing something to them, when I want to work with them.' (P5/818).

The clients' reactions were intractably interlinked with the professionals' emotional responses, as more extreme resistance by clients amplified the professionals' mindfulness

of the tension between their roles (P6/641). For some participants, trying to establish a rapport with clients whilst knowing they may have to section them, generated feelings of misleading or betraying the clients (P5/65).

4.4.3. Being all things to all people: Fulfilling multiple roles.

Throughout the process, participants held a multitude of personal and professional responsibilities towards themselves, the client and their family, other professionals, the organisation and the wider community (P10/602). This often generated confusion, pressure and feelings of being overwhelmed.

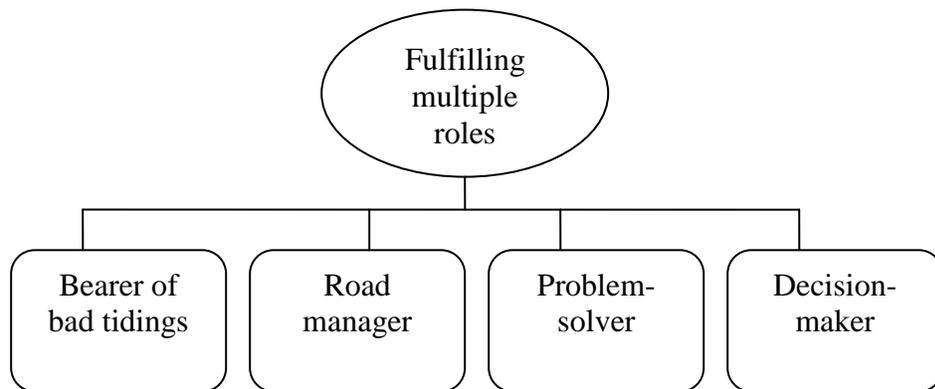
'I just wanted to weep on the ambulance staff's shoulder at that point thinking, what am I supposed to do in this?' (P7/381).

Often, these responsibilities conflicted, particularly obligations towards considering the clients' wishes and the legislative requirements.

'I do recognise that there is a role, a conflict of role between needing to um, engage with the person and making a decision to detain, of course that's central, central to it.'
(P8/405).

The different roles are presented in Figure 3.

Figure 3: Professionals' multiple roles within the MHA assessment process.



4.4.3.1. Bearer of bad tidings.

Some participants held the responsibility of imparting the decision to the client, their family or others. They described anxiety and uncertainty associated with their fantasies of how the client may react, including possible aggression (P4/380). The uncertainty was exacerbated by knowing that they may have to stay with the client while they processed the news³² (P3/1084).

4.4.3.2. Road manager: Creating order from chaos.

Many participants felt either an explicit or internally driven responsibility to control the process, through organising people's attendance, arranging transportation and ensuring police presence, if needed.

³² This was usually dependant on other services arriving e.g. the ambulance or police.

'I've ended up almost like a sort of road manager.' (P6/206).

This was generally driven by a desire to appear professional or to manage risk³³. The organisational process was often anxiety-provoking and stressful, as other professionals' behaviours could be obstacles e.g. not turning up on time (P3/160).

4.4.3.3. *Problem-solver.*

Problem-solving was a central skill required in order to plot one's way through the process. A delicate balancing act was required, whereby risk, severity of illness and perceived consequences of either decision were balanced against others' views, the professional's self-doubt and ethical dilemmas (P3/758). Creativity was often key, as professionals struggled to find solutions to near impossible scenarios (P2/1062). Problem-solving served numerous functions, including making the process more manageable and averting sections when possible, through informal admissions or enabling the client to be cared for at home. Many felt this was the ideal scenario.

'When you've actually been able to talk through stuff and, and everything and persuade them to go in informally I, you know, that, that feels obviously far better than, than having to detain somebody.' (P10/748).

Problem-solving took various forms aside from persuasion, including negotiation, monopolising on flexibility, compromising and even bribing on occasions (P2/1034).

³³ Either risk of the client wandering off during the assessment or of the client becoming aggressive.

4.4.3.4. *Decision-maker.*

Decision-making was key throughout the process. Many decisions were not clear-cut and participants were aware of their negative implications (P3/484). This was associated with a weighing up process, which could be difficult and anxiety-provoking (P10/495). Many participants described discomfort and distress upon making the final decision to apply for a section.

'After a lot of angst and talking it through together, we both sort of thought, I think we are gonna have to bite the bullet, we're gonna have to do it. The fact that I use the expression bite the bullet gives you a sense of, it's not something we're comfortable about doing.' (P5/236).

It was important to practitioners to feel that they were using their power cautiously and benevolently, to ensure that clients' best interests were pursued (P7/437).

4.4.3.5. *Questioning oneself.*

The multiple sources of uncertainty, feelings of internal conflict and tension between roles, resulted in most participants reflecting on their decisions regarding sectioning someone (P5/489). Although some decisions seemed 'clear-cut', the ambiguity surrounding many assessments resulted in participants analysing their practice and reliving the process, searching for alternatives.

'You go home, you get into bed and....you're going through it all, should I have done that?' (P10/368).

4.5. External conflict.

4.5.1. Power struggles.

The locus of responsibility, control and accountability between professionals also generated some conflict (P9/826). The traditional authority and power of the medical profession was reduced during the process, as the ASWs had the final say³⁴. Some participants welcomed their limited responsibilities, whilst others felt that power differentials prevented them from challenging others or feeling they had a niche (P6/484). At times, participants felt that others used power to influence or coerce them. Others felt that their role was often unacknowledged, undervalued or underestimated, resulting in frustration and obstacles to following prescribed process.

'They couldn't, couldn't grasp that I had more..... legal power.' (P7/657).

Power struggles also took place between the client or their relatives and professionals, particularly when clients resisted the process or when the usual power distribution was unbalanced (P11/369).

³⁴ However, some ASWs felt that their medical colleagues still used informal persuasion or coercion to try to influence their decisions.

4.5.2. Others' agendas.

Other peoples' agendas and actions, including the family and other professionals, also generated uncertainty and sometimes conflicted with the participants' views (P3/1032). The participants' concern with these agendas was reflected in analysing and questioning others' motives and goals. This manifested in perceiving incoming information with caution.

'I think the important thing is to... try and make yourself aware of all the agendas of all of the people who are involved in the patient's care um, and then come to your own conclusions.' (P11/836).

4.5.3. Independence versus integration.

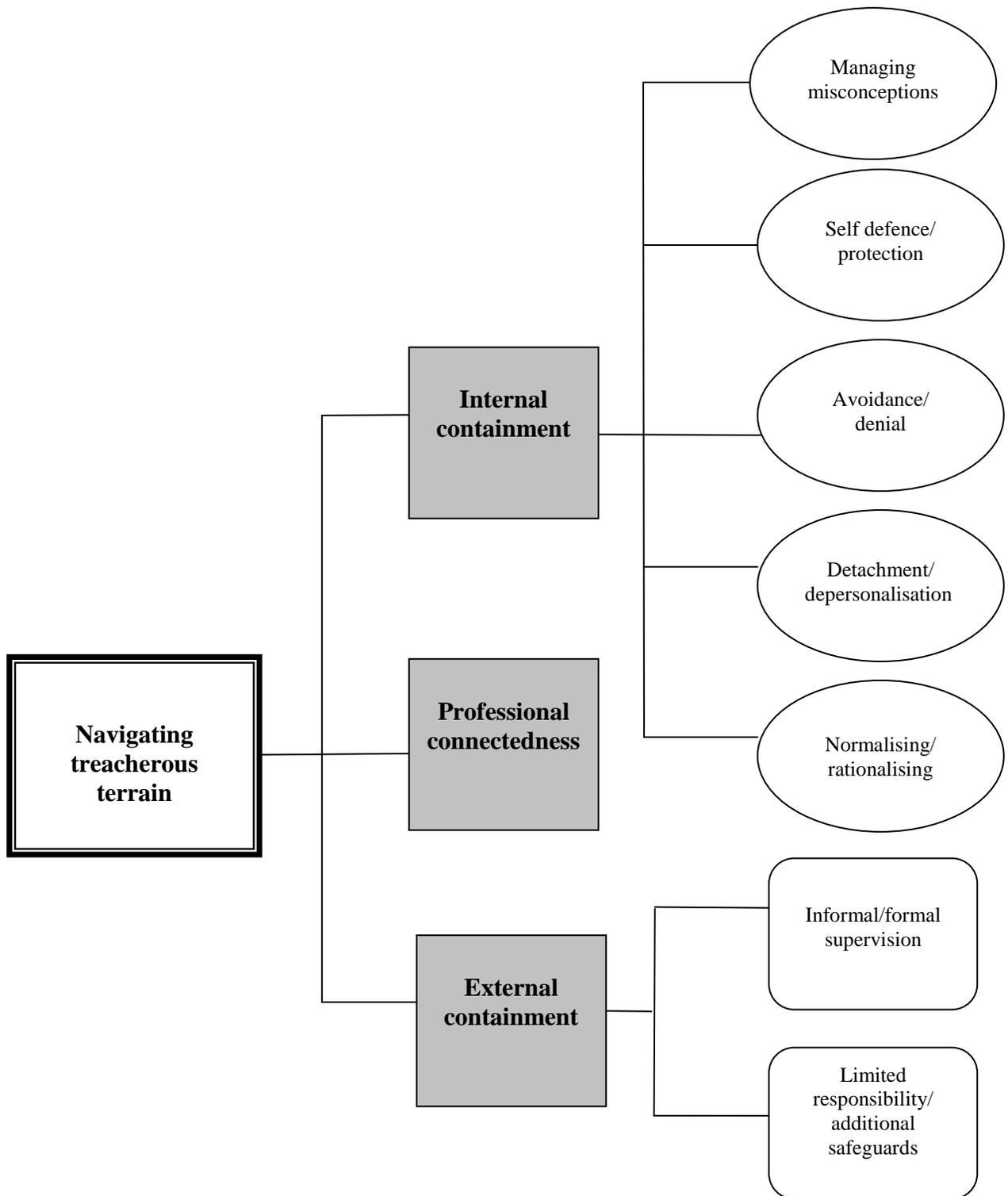
Many participants felt that the independence and responsiveness required by the MHA conflicted with their other roles, particularly multidisciplinary team working and obligations towards other clients (P8/133). This was associated with anxieties about how other team members may perceive them and concerns about the potential effects of being unable to offer guarantees to other clients (P2/356). Holding dual roles necessitated switching between these models of working.

'I see them as, I wouldn't say separate, I see them as distinct roles, you, you put the right hat on when you go out.' (P3/1020).

4.6. Navigating treacherous terrain.

Given the inherent uncertainty within the process and the need to generate a final decision, many strategies were used to make the process feel more acceptable and reduce any dissonance or negative effects. However, emotional reactions could seep out, particularly when these factors broke down (P8/857). The multitude of strategies used for adapting to, tolerating and mastering uncertainty are shown in Figure 4 below.

Figure 4: Strategies used by the professionals to contain and manage uncertainty.



4.6.1. Internal containment.

4.6.1.1. Managing misconceptions.

The participants often needed to manage misconceptions, both their own and others. Experiencing the process sometimes resulted in shattered expectations of what the ideal assessment would be like, which prompted a cognitive reconstruction of one's beliefs about the process (P9/80). Many participants felt that the client, their relatives or other professionals held misassumptions about their role, resulting from stereotypes or misinformation. This was frustrating for some.

'I think the most frustrating thing..... is when as I said, assumptions are made. So, there's an assumption that you're not considering all the issues, that you haven't thought about the implications of ruining somebody's liberty.' (P5/548).

The professionals felt obligated to correct these misperceptions, either to make the process smoother, to re-establish their authority or to encourage others to perceive their role more positively (P7/613).

4.6.1.2. Self-defence/protection.

The participants described an awareness of the role's challenges, either before entering it or shortly after taking it on, which prompted the instinct to protect oneself from any long-term negative effects of involvement.

'I was very, you know, gonna be very protective of, of my own needs, my own health needs.' (P3/96).

The participants described both psychological and practical strategies of self-preservation, including constructing sound arguments for their decision to minimise liability and protect their reputation (P11/113). Allowing oneself to be fallible and accepting that ambiguous decisions were inevitable were also protective (P7/303). For others, reassuring or reminding oneself about the benevolent motivations of the MHA and one's role buffered against negative emotional reactions or dissonance.

'I think one of the things that we realise is important is that we're following, is that we're following a legally based process and we're upholding the person's rights.' (P8/266).

4.6.1.3. *Avoidance/denial.*

Participants described both self-denial and denial to others (P8/351). Some professionals felt that even if negative emotional reactions were inevitable, denying these to others enabled the maintenance of a professional façade/front.

'You go into um, a mode of working whereby, you know, you can't get all stressed up openly, you know, you, you've gotta keep your cool for everybody else around you.' (P10/532).

In other cases, participants wanted to protect themselves against acknowledging or experiencing negative feelings (P2/638). Avoidance was also useful at times, particularly

after delivering the decision to clients. This could be accomplished by enlisting others to wait for transportation with the client, to avoid tolerating any personal discomfort associated with remaining in the situation (P3/1106). Others preferred to avoid the whole situation to prevent them from becoming associated with the sectioning process, particularly when their own clients were being assessed.

4.6.1.4. *Detachment/depersonalisation.*

Detachment or ‘switching off’ was a central strategy that enabled the participants to continue in the process in the short and longer term (P6/498). Detachment occurred at several levels. Internally, participants described trying to detach themselves from their negative emotions.

‘You have to let those feelings go, those emotional bits go really and detach yourself from them.’ (P4/547).

This was accomplished through trying to create home/work boundaries or emotionally distancing themselves from the client, the client’s family or other professionals (P5/66). This enabled them to cope with their negative affect, whilst maintaining the objectivity and independence necessary for the role. Detachment sometimes involved a depersonalisation process, whereby the professionals fragmented the client into a set of symptoms, rather than seeing them as a person with whom they had a human connection.

'Sometimes I just have to write down the symptoms, write down what's happening and make the decision from that, so I don't even think about who they are, they almost become an anonymous person.' (P4/491).

4.6.1.5. *Normalising/rationalising.*

Some participants did not perceive the MHA process as divorced from other aspects of their role (P9/320). This normalisation process served a protective function. The knowledge that they were following an official process intellectualised the role and made it more detached (P2/327). The rationalisation process also involved the participants feeling that the legislation was often necessary to protect or care for clients.

'I think broadly speaking the, the process of getting somebody into hospital is usually a necessary one.' (P6/275).

4.6.2. Professional connectedness.

Support and collaboration with other professionals was helpful in various ways before, during and after the sectioning process. Many participants spoke of the bond or sense of community amongst colleagues from their own profession (P11/856). This solidarity grew from sharing similar experiences, training and knowledge bases. The common framework for understanding within professional groups linked the professionals together.

'We use each other quite a lot and there's a good, there's quite a good um, bond between the ASWs.' (P7/544).

The sense of integration that could develop in certain teams, who were carrying out specific MHA assessments had similar effects and also generated a sense of diffused responsibility, flexibility, lower anxiety and mutual support.

'That was like, you know, a real life example of cooperation..... it can be quite a lonely job and just things like that make it, oh, I can't tell you how much easier they make it.' (P7/356).

However, some combinations of professionals maintained independence and distance from one another, resulting in a sense of isolation and lack of collaboration (P6/106).

4.6.3. External containment.

4.6.3.1. Informal/formal supervision.

Most participants mentioned other professionals as a valuable source of emotional, practical and technical support (P2/1203). However, formal supervision was not mentioned as frequently as peer support.

'The ASWs within this geographical area, we just meet once a month, just to um, and we try and just keep that for saying, this happened to me, do you think, what would you have done?' (P7/557).

Some participants were not provided with the option of formal supervision. For others, the frequency of supervision was variable (P2/1135). The professionals generally voiced a preference for support from others who could understand or empathise, through having personal experience of the process and preferably the participant's specific role.

'And just talking to somebody who um, and it, it can't be somebody that's not an ASW, I don't feel, I feel it needs to be somebody that knows exactly what you've been through.' (P10/581).

4.6.3.2. Limited responsibility/additional safeguards.

Many participants described the limits to their responsibilities/power and the safeguards built into the process as protective against some of the negative effects of participating, including liability, questioning oneself, negative emotional reactions and burden (P11/728).

'But, I'm happy for them to take the ultimate decision. I think actually, their job is a horrible job and I wouldn't want it, because they're left holding the baby.' (P5/599).

4.7. The professional trajectory.

The participants described numerous significant changes, which took place throughout their career and involvement in the MHA process. They depicted a developmental trajectory, through gaining increasing experience and familiarity with the legislation and the role (P5/495). Endpoints of the trajectory were becoming or feeling like an expert and increasing comfort with the legislation.

'There's a sort of a familiarity about it.' (P9/339).

Becoming 'professional' enabled a clearer demarcation between personal life and professionalism and reduced the intensity of the participants' emotional reactions, as they developed ways of conceptualising the process and managing their responses (P1/861). Experience also contributed to feeling more self-assured.

'That responsibility...has sat a bit more lightly as the years have gone by, as I've felt more experienced and more confident.' (P9/241).

4.8. Summary.

In conclusion, the core experience of involvement in the MHA assessment process was one of continually negotiating uncertainty. This uncertainty was inescapable, as it generated from multiple, interacting sources. The main categories which fed into uncertainty were liability during the process, the pressured context of the assessments, the

tension between competing roles and external conflicts that sometimes arose. The professionals' duty of care necessitated the ability to tolerate and contain this uncertainty in order to act in accordance with the law and their prescribed roles. The participants used a range of containment strategies, including external resources, internal psychological processes and their links with other professionals. This negotiation process could also be facilitated by accumulating experience of the role, which enabled increasing assimilation of the process into one's professional identity.

5. DISCUSSION.

The current qualitative research study aimed to explore how mental health professionals experienced the Mental Health Act (MHA) assessment process. The results suggested that an interwoven tapestry of factors contributed to a profound sense of uncertainty during this process. The final theoretical model (see Figure 1) is discussed in relation to previous research and relevant theoretical frameworks, including the clinical implications of the findings. The final section ends by considering the methodological issues in the study and how future research could build upon the current results.

5.1. The core category: Negotiating uncertainty.

The intense uncertainty experienced by the participants during the MHA process was influenced by macro, legal, organisational and individual factors. Previous studies have found that uncertainty is central within health/social care professionals' occupational experiences (Manktelow *et al.*, 2002). The extent of the uncertainty surrounding the decision of whether to apply the MHA was somewhat surprising in the current findings, given the prescriptive nature of the Act and the Code of Practice. However, it seems that applying this legislation can be complex and ambiguous and that clinical judgement plays a significant role. Previous research into decision-making under situations of uncertainty has found that individuals employ various cognitive coping strategies in such situations, including: reducing uncertainty by obtaining further information; using assumption-based reasoning; delaying the decision; and balancing the advantages and disadvantages of the

alternatives (Lipshitz & Strauss, 1997³⁵; Tiedens & Linton, 2001). The current participants used all of these strategies at different times during their decision-making.

The inherent uncertainty within the MHA process has major implications in terms of training and preparing professionals for their roles under the Act. Many of the current participants expressed reservations about the comprehensiveness of their training in the experiential and emotional aspects of the role³⁶. Other researchers have highlighted that training may not adequately equip professionals for the realities of their roles (Roberts, 1997). Professional training courses must explicitly acknowledge and encourage discussion about the intricacies, ambiguities and uncertainty within the decision-making process under the MHA, the likely emotional and practical implications of this and how they can be negotiated within highly pressured situations. This is likely to be invaluable in helping professionals to feel more prepared to face these significant challenges.

5.2. The pressured context of MHA assessments.

The participants described numerous obstacles encountered during the MHA process, mirroring the findings of previous studies (Huxley *et al.*, 2005). Many participants described feeling exhausted, stressed or anxious during the assessments, i.e. emotional exhaustion (Maslach *et al.*, 2001). Involvement in MHA assessments exposes professionals to witnessing the client's and their relatives' intense suffering/distress and prolonged or

³⁵ These authors found that assumption-based reasoning was most often employed when inadequate information was the source of uncertainty, reducing uncertainty was most often used under situations of inadequate understanding and weighing the pros and cons of the options was most frequently used to cope with equally attractive/unattractive options (Lipshitz & Strauss, 1997).

³⁶ Although some felt that academic and competency-based issues were more adequately covered.

repeated exposure to such emotional crises is likely to have detrimental psychological effects on these professionals.

Theoretical models of stress (e.g. Duquette *et al.*, 1994; Kilfedder *et al.*, 2001) propose that the relationship between stressors and negative outcomes, including burnout and poor mental health, is moderated by the individual's coping resources (hardiness and high self-esteem), social support and protective occupational factors (e.g. support from managers/colleagues). Karasek's model (1979) links the combination of low control over one's role ('decision latitude') and high demands as causal to stress. The MHA assessment process is characterised by such conditions, as working within a prescribed legislative framework allows limited decision latitude and the crisis context of many assessments results in high pressure.

Given the intensely charged nature of MHA assessments and the numerous inescapable stressors encountered, professionals are likely to need a high level of support to tolerate these pressures. Some participants reported negative personal outcomes from the process, including anxiety, guilt and ethical conflict. However, others seemed less affected, as they possessed more sufficient/efficient coping strategies, including peer support and a psychological conceptualisation of the process that reduced their role conflict/dissonance. Those professionals who possess fewer psychological buffers may find the MHA process more difficult to tolerate and may subsequently leave the profession. Given the recruitment and retention problems within psychiatry and social work (Royal College of Psychiatrists, 2004), employers must give more consideration to the stressful nature of the MHA process and how clinicians can best be supported. Strategies which may reduce occupational stress

include: training in stress-management skills (Fothergill *et al.*, 2004); increased occupational flexibility and control (Kilfedder *et al.*, 2001); ring-fenced time for emergency duties (Kennedy & Griffiths, 2002); and paid/unpaid breaks (Tillett, 2003). A confidential, accessible therapy service for those who are struggling to cope with their role demands may also be helpful (Pajak *et al.*, 2003).

5.3. Professional vulnerability/liability.

The reported sense of liability/vulnerability by the current participants reflects previous researchers' findings (Fothergill *et al.*, 2004). Authors have highlighted that there are often contradictions between different procedures pertaining to professional accountability e.g. professional codes of ethics, civil law/tort law and the MHA (Dowling *et al.*, 1996). Given the saliency and influence³⁷ of perceived accountability/vulnerability for the current professionals, training in issues of legal liability and access to legal advice may be helpful in clarifying these issues, particularly for newly qualified professionals. Reducing the blame culture may also decrease this burden (Roberts, 1997). This may be facilitated through developing an ethos of shared responsibility within organisations and using the media to foster increased empathy and realistic expectations of health/social care professionals within the public domain.

5.4. Internal conflict.

The current participants reported that the role conflict and ethical dilemmas they experienced during the MHA process could be distressing, which supports previous

³⁷ In terms of increasing uncertainty and pressure during the process and in prompting defensive practice at times, as sectioning was often perceived as the less risky option.

research findings (Olofsson *et al.*, 1999). Decisions under the MHA can be conceptualised as genuine ethical dilemmas, as there were negative consequences of deciding to section the client (stigma and effects on future opportunities) and deciding not to section (potential risks to the client's safety and legal ramifications for the professional). Therefore, a complex decision-making process was often necessary.

In the current study, some participants struggled more intensely with ethical dilemmas within the process, which may have reflected their varied socialisation experiences, including the values of their family, those learnt during training and the culture of their employer organisation/professional team. Holland and Kilpatrick (1991) suggested that socialisation factors may influence whether professionals prioritise either the means³⁸ versus the ends³⁹ in ethical dilemmas, self-determination versus community safety and internal values versus external criteria, such as policies and laws. These variations were evident in the current study, as some participants were more willing to section to potentially improve the clients' lives, whereas others were more reluctant to restrict clients' autonomy. Similarly, some participants were reluctant to deviate from external loci of authority, which may have reflected a concern with justifying their decisions in the litigious climate, whereas others focused on conforming to their own ideals.

There were surprisingly few differences between the ethical issues described by the different professional groups who participated in the current study, given the differences in their training and theoretical models of human distress. The discomfort generated by

³⁸ Deontological approach of following ethical principles.

³⁹ Utilitarian approach of focusing on desired outcomes.

compulsory treatment was universally experienced, but in varying degrees and the factors contributing to the discomfort varied somewhat between the professions. Although all of the participants stressed their concerns about the potential impact on the therapeutic relationship, this was particularly salient for the senior nurse practitioners (SNPs) who relied on a strong relationship and frequent contact with clients to fulfil their occupational roles. Legal liability was more of an issue for the approved social workers (ASWs) than the SNPs or psychiatrists, given their individual accountability. Within professional groups, different individuals also held varying conceptualisations of the ethics of the MHA. Therefore, the interaction between individual, organisational and cultural issues shaped how the professionals experienced the process.

The internal conflict that many participants described can be related to cognitive dissonance theory (Festinger, 1957). This theory suggests that holding two contradictory beliefs/attitudes produces unpleasant psychological dissonance, which people will be motivated to reduce through avoidance or compromising/adapting aspects of the roles (Jones, 1993). Some of the current participants described a conflict between using the legislation to coerce clients and the wish to work collaboratively, which generated discomfort and dissonance. The coping strategies described by the participants may have been used to reduce such dissonance through re-evaluating beliefs about the legislation or their ethos of care.

Jones (1993) found that some professionals resolved the conflict between their therapeutic and legal roles through developing beliefs in the 'therapeutic use of authority', enabling successful reconciliation of these roles. Similarly, many of the current

participants stressed the paternalistic aspects of the MHA and felt that many clients wanted them to take control of their lives. Such cognitive constructions/reconstructions of their legal roles were not unproblematic, however. These opinions seemed at odds with the current Government health care agenda towards increasing service user empowerment, autonomy and choice (Department of Health, 1999). The discordance between the MHA process and the general cultural climate within health services emphasises that mental health professionals must simultaneously hold conflicting models of care when combining their generic and legal roles. Some professionals resolved this conflict through increased prioritisation of paternalism over self-determination, which may diverge from the conceptual frameworks of other professionals who are not involved in the MHA and may therefore generate conflict within multidisciplinary teams.

5.5. Power struggles.

Issues of power struggles emerged strongly in the current study and those professionals who were emotionally invested, yet without power, reported frustration, feelings of being undervalued and a desire for more influence. The tensions between professional groups in terms of power differentials and varying professional philosophies have been discussed previously (Mizrahi & Abramson, 1985). Mental health services in the UK have been moving towards multidisciplinary team working in recent years, following recent Government initiatives (Department of Health, 2000). Such changes are likely to have created some occupational insecurity/instability and a corresponding desire within professional groups to defend or protect their roles within services (Brown, Crawford & Darongkamas, 2000). The current findings suggest that at this stage of its

implementation, the multidisciplinary team coordination agenda is a rhetoric that has not yet deeply permeated the traditional boundaries between professional groups. It seemed that one SNP and some of the ASWs continued to feel undervalued or powerless in relation to their medical colleagues, although there were signs of a shift, as some participants felt that the nursing and social work professions were gaining increasing respect. These dynamics may continue to alter as the multidisciplinary agenda becomes more embedded within the spirit of mental health services and there is improved inter-professional communication and cooperation⁴⁰.

5.6. Navigating through uncertainty.

Previous studies have found that professionals use various strategies for coping with their roles, including: religion; withdrawal; denial/minimisation; humour; relaxation; splitting; using professionalism to mask their emotions⁴¹; and ‘acting out’ through destructive behaviours (Burnard *et al.*, 2000; Pines & Maslach, 1978). Lazarus and Folkman (1984) described two types of coping strategies for managing stress: emotion-focused and problem-focused. The participants in the current study used emotion-focused strategies, such as detachment and normalisation and problem-focused strategies, such as seeking assistance and using supervision to contain their uncertainty. Concepts from the psychodynamic literature can be drawn upon in understanding these coping strategies. Psychodynamic theorists propose that individuals use defence mechanisms, such as denial, projection, repression and splitting, to shield themselves from consciously experiencing

⁴⁰ For a discussion of how this may be accomplished please refer to *Working in teams* (British Psychological Society, 2001), *The National Service Framework for Mental Health* (Department of Health, 1999) and *Guidance on new ways of working for psychiatrists in a multi-disciplinary and multi-agency context* (Royal College of Psychiatrists, 2004).

⁴¹ This has been termed ‘terror induced pseudo calm’ by some authors (Hodgkinson & Stewart, 1991).

distressing emotions (Bowins, 2004). These theories suggest that as negative emotions come closer to conscious awareness, individuals experience anxiety that triggers the use of defences to ensure that distressing feelings are kept from awareness (Jacobs, 2004).

The current participants' coping strategies mirrored these psychological defences, as they used denial and avoidance to shield themselves and others from their emotional responses and detachment to keep uncomfortable material from their conscious experience (Jacobs, 2004). The participants' use of rationalisation/normalisation closely resembled intellectualisation, whereby an event is overly cognitively processed to reduce its emotional saliency (Bowins, 2004). These defence mechanisms served several functions, including anxiety-reduction and protecting the professionals from fully experiencing the dissonance generated by simultaneously caring for and deciding to section somebody. Taking part in MHA assessments exposed the professionals to intense human suffering, which may have increased their awareness of their own vulnerability, generating anxiety (La Cour, 2002; Philpin, 2002). The development of defence mechanisms thus enabled the participants to tolerate the negative emotions that their role evoked and to carry on in their roles. Although defences can be adaptive in protecting individuals from being overwhelmed by negative feelings, Menzies (1960) highlighted that avoidance-related strategies can paradoxically sustain anxiety, as they prevent the resolution of the issues that are generating negative feelings.

The current professionals found that formal/informal supervision was helpful in coping with their responses to the MHA process. Previous researchers have discussed the multifaceted functions of supervision for health/social care professionals, including

holding/containment and facilitating the working through of negative emotional reactions generated during clinical work (Rafferty, 2000). The idiosyncratic nature of the MHA process has major implications for the type of supervision that is likely to benefit the professionals involved. The current participants found the MHA process complex, demanding and draining at times and for as long as this legislation exists in its current form, professionals will have to make difficult decisions under highly pressured circumstances. The professionals' use of psychological defences must be understood within this context and the advantages and disadvantages of both the use of and relinquishment of such strategies must be considered. These defences undoubtedly shield the professionals from fully experiencing their own and the client's distress. However, the long-term use of such defences, without accompanied awareness or understanding by the individual, is likely to have detrimental consequences, including: increased detachment from clients; reduced self-awareness; and deeply buried distress that may later resurface in less innocuous guises. However, if clinical supervision confronts and challenges any such use of these defences, the professionals may be left exposed to repeatedly experiencing significant personal distress.

Therefore, a delicate balancing act is required during supervision in the context of the MHA process, whereby professionals could be assisted to gradually increase their awareness of their defences and the reasons behind them, whilst respecting the professionals' continued use of such strategies wherever necessary. This is a complex task and providing regular training for supervisors may usefully assist them to provide high quality, sensitively gauged support.

As in previous studies (e.g. Campbell *et al.*, 2001), some participants found that formal supervision could be difficult to find or access, which may have influenced their extensive use of internal psychological coping and prevented them from working through their feelings in a containing environment. Given the demanding nature of the MHA process, employer organisations must raise the profile and availability of supervision/peer support. Supervision arrangements should be built into initial job descriptions and professionals' Continued Professional Development (CPD) plans and managers should make every effort to ensure that clinicians can choose their preferred supervisor, as the current participants felt that support from colleagues in similar roles was most helpful. Ensuring that supervision is regularly provided is likely to have considerable resource implications that need to be considered when developing organisational budgets and financial plans⁴². Setting up regular peer support or reflective practice groups is also likely to be a cost-effective method of increasing professionals' support networks.

The current participants found that professional connectedness with clinicians in their own profession or those involved in the MHA assessments was supportive. Other researchers have discussed the advantages of group membership in terms of social identity, mutual support and achievement of goals that cannot be accomplished independently (Hogg & Vaughan, 1995). However, the participants felt that the professionals in some MHA assessments largely operated independently. Researchers have suggested that group cohesiveness is variable and can be influenced by the individual members sharing mutual goals, valuing group membership and effectively communicating (Festinger, 1950). Given that the professionals involved in MHA assessments come from different professions, the

⁴² Using resources available for CPD may by one method of securing the necessary funding.

amount of interaction between them may be limited, inhibiting group cohesiveness. In addition, some participants felt that independence was crucial in effectively fulfilling their legislative roles, which will have decreased their desire for group membership. Therefore, weak group cohesion had both disadvantages, in limiting professional support and advantages, in terms of fulfilling the MHA process.

5.7. Which professionals should be involved in the MHA process?

Three different professional groups participated in the current study and the final theoretical model was applicable to all of these groups, despite their varying roles within the process⁴³. The subcategory ‘interrelationship between clients’ and clinicians’ responses’ encapsulated the potential effects of the MHA assessment process on the therapeutic relationship. Some clients reacted to the professional’s involvement in their assessment by negatively categorising them or ending the relationship. The participants found that there were advantages to assessing clients who were unknown to them as this did not jeopardise the therapeutic relationship and protected the professionals from fully experiencing the tension between their generic and legal roles. These issues will have significant implications if the Mental Health Bill is passed, as clinical psychologists may acquire new legislative roles. It could be argued that psychologists would be well placed to fulfil roles within the MHA, given that they emphasise the development of therapeutic relationships and often know a lot of information about clients’ lives and their problems. However, given the centrality of the therapeutic relationship for successful outcomes in many psychological approaches, acquiring roles that may detrimentally affect the

⁴³ However, as mentioned above, some categories were more salient for certain professions.

relationship has fundamental implications for the way the clinical psychology profession can operate.

Clinical psychologists are often encouraged to become aware of and reflect upon their use of defence mechanisms in their clinical work, during supervision or self-reflection in order to improve their interventions and therapeutic relationships with clients. Acquiring legislative roles and the associated legal liability and pressure is likely to increase clinical psychologists' use of psychological defences. This will complicate psychologists' abilities to differentiate between the defences they are using in their therapeutic work, from those that protect them within their legal roles. Reconciling their therapeutic roles with the role of compulsorily imposing assessment/treatment on clients is also likely to be particularly difficult for psychologists, given that direct therapeutic interventions are a significant part of their professional identity and are often major motivators for choosing this career. Therefore, internal/role conflicts are likely to become a major issue for existing clinical psychologists and may deter others from pursuing this career. It seems that professions whose success does not depend as significantly on the therapeutic relationship may be better placed to fulfil these legislative duties⁴⁴. If Clinical psychologists do acquire these roles, ensuring that they are not responsible for assessing clients on their own caseload under the MHA may afford some protection. Ensuring high quality, reflective clinical supervision is available and giving psychologists the choice of whether they wish to take on these roles would also be essential safeguards.

⁴⁴ Such as members of the legal profession who receive specific training in mental health issues or health care professionals who do not have an ongoing therapeutic relationship with the client e.g. approved social workers working in emergency duty teams.

5.8. Methodological critique.

The current study was carried out during a major re-organisation of mental health services in the region where the study took place and a period of limbo for the professionals, in terms of whether or not the Mental Health Bill would be passed in Parliament. Some of the anxiety, stress and uncertainty described may have reflected participants' feelings about wider organisational issues, in addition to the MHA.

The researcher's role must also be considered in terms of any potential influence on the analysis. It is now generally accepted that the qualitative researcher cannot be a blank slate, which necessitates ownership of any attitudes and views that may have influenced the analysis. Although the current researcher did hold strong views about the MHA, she remained aware of these issues and used the research diary to reflect on how this may have been influencing the research. Steps taken to increase the study's validity included the coding of sections of the transcripts by the researcher's supervisors and peers, the constant comparison method and theoretical sampling and these will have minimised any influence of the researcher's biases when analysing the interview data.

Time constraints during the current research inevitably limited the number of participants studied. Although the researcher felt that the theoretical model was richly developed and integrated, sampling a few final participants may have provided further validation of the model. In terms of the final model, the line between description, conceptual analysis and substantive or formal theory is somewhat subjective. It could be

argued that the final model did not represent a formal or substantive theory, but a rich conceptual description.

In terms of generalising or transferring the findings, the multidisciplinary professional participants were drawn from one geographical region, where idiosyncratic service reconfiguration was taking place. However, different professional groups were sampled and it is likely that the participants' experiences of the MHA process would not have differed greatly from other regions, given the prescriptive nature of the legislation. Therefore, the findings are likely to have relevance in terms of similar professional groups in regions of England. However, given legislation differences in other countries, professionals in other areas may have different experiences.

5.9. Future research.

The current study was one of few to explore how professionals are affected by the MHA process. The findings suggested that involvement may be burdensome, stressful and anxiety-provoking. Further research in other geographical regions would helpfully clarify whether these experiences are widespread. The specific stressors, moderators and coping strategies identified in the current study could be used to develop a questionnaire of professionals' experiences of the MHA, to facilitate regional comparisons and validate the current study's findings. Further research exploring how professionals' fear of litigation, organisational culture and individual factors affect their experiences of this process would also be helpful. Observing professional decision-making under the MHA in different regions may further our understanding of how these issues affect practice. Future research

could explore the differential effects of implementing the interventions suggested above, such as different models of supervision and stress-management initiatives. Prospective, longitudinal designs could be used to compare the effects of such interventions on the long-term retention rates, stress levels and mental health of clinicians who receive them and those who do not. This would provide valuable information on the most efficacious and cost-effective methods of managing occupational stress in these professional groups.

5.10. Conclusions.

The current qualitative research study explored mental health professionals' experiences of the MHA assessment process. The final theoretical model that was generated indicated that the combination of liability, fulfilling incompatible/competing roles, conflict with others and working within highly charged circumstances often resulted in intense uncertainty throughout the assessment process and beyond it. The professionals tried to contain this uncertainty by using psychological defences and external resources, including informal/formal supervision. The findings have major implications in terms of professional training and occupational support needs. Employers must give greater consideration to the demands of this process and how the professionals involved could best be supported in executing these roles.

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PART THREE

CRITICAL APPRAISAL

CRITICAL APPRAISAL.

An enriching journey through uncertainty to personal growth; this appraisal is focused on what I learnt through completing a qualitative study of professionals' experiences of the Mental Health Act (MHA) (Department of Health, 1983).

1. Developing the research proposal.

It was whilst employed as an assistant psychologist within a medium secure forensic unit that I developed an interest in the MHA. This role exposed me to the intricacies of the MHA and the emotions that it seemed to generate within clients and the multidisciplinary team. Observing clinical meetings, where the team agonised over decisions under the MHA⁴⁴ and the frustration that emerged when their decisions were not supported by the local Mental Health Review Tribunal, generated questions in my mind about how the MHA functioned in clinical practice. The importance of the MHA in the clients' lives was overwhelming and I observed clients reacting with intense sadness, anger, frustration and hopelessness at times, as others made key decisions about their lives. I was left with many questions about this legislation, including how clinicians coped with observing clients' reactions. This also led to an interest in the MHA assessment process and how the initial decision to use the legislation affected the people involved. When formulating possible questions for the current study, these issues immediately returned to mind.

⁴⁴ Such as whether clients should be allowed leave or supervised discharge or whether their section should be extended.

Initially when planning the current research, I felt that it would be interesting to explore clients' reactions to this process. However, during an initial literature search, I realised that whilst studies of clients' experiences were increasing, professionals' experiences seemed largely unexplored. Given that there were only a few research studies in this area, I felt that using qualitative methods would provide meaningful information about this process. In addition, I had a long-standing interest in qualitative research, although not coupled with experience. The possibility of carrying out a study that captured the complexity of professionals' experiences of the MHA process was very appealing to me from the beginning.

The choice of using the grounded theory method was largely influenced by pragmatic reasons, including having some basic knowledge about the approach and the expertise of the course staff and my preferred field supervisor in this method. However, I was also attracted to the grounded theory method as it is well established and has gained increasing recognition within the academic field. It also provided a clear set of strategies that seemed containing for a novice researcher. Choosing an epistemological position for the study was more difficult, as this was a new area of debate for me. However, I believed that the participants' narratives about the process would faithfully portray their experiences, although I also felt that what would be said may be shaped by the context of the research and the rapport that developed between the interviewee and myself. I felt that the participants' accounts would enable me to gain insight into how they experienced the MHA process and that there would be a thread of shared experience and understanding amongst the participants. Therefore, the critical realist position seemed most in tune with my conceptualisation of the qualitative research process.

2. Parallel processes.

During the current research, I became aware of various parallel processes, whereby the research process seemed to mirror aspects of the participants' experiences.

2.1. Power struggles.

In the planning phases of the research, I assumed that interviewing mental health/social care professionals would be relatively unproblematic, although I was aware that I was potentially asking professionals in authoritative positions to disclose feelings of vulnerability or distress and that their desire to present themselves as competent/professional may have affected their disclosure. However, during certain interviews I found it more difficult to ask the participants my pre-planned questions or to interrupt and redirect them when they were discussing tangential issues. Initially, I put this down to my mindfulness to carefully frame the questions so as not to lead the participants.

However, after further reflection I realised that power differentials were an issue. As a trainee clinical psychologist interviewing qualified and sometimes highly experienced professionals, I became aware of my own concern about how the participants would perceive me and my professionalism during the interviews. This bore some similarities to the participants' concerns about their professional reputation during the MHA process. I had thoughts about wasting the professionals' valued time, which seem heightened when the participants felt that the MHA process did not affect them greatly. Sometimes my initial reluctance to ask certain questions also generated from my wish to protect the

participants from re-experiencing any distressing memories. The location of the interviews may also have contributed to the power differentials, as most of the interviews took place in the participants' place of work. Although this was intended to ensure that they felt at ease and were not inconvenienced, meeting them in buildings that were unfamiliar to me may have increased my own sense of trepidation. My concerns about approaching and interviewing psychiatrists were also influenced by some of the stereotypes in the mental health services, such as that they are notoriously busy and overstretched. However, I overcame these preconceptions and was surprised when the psychiatrists I did approach were interested in taking part and provided rich data during their accounts. This altered my assumptions and made me feel less aware of the power differentials between the participants and myself.

Many of the professionals made positive comments about participating in the interviews, as they felt that the research question was an important issue that was often neglected in their daily work. Many of the interviews continued for over an hour and some participants sacrificed other tasks to continue talking to me. Knowing that the interviews were proving valuable to the professionals was encouraging and I felt that it was a worthwhile use of both their time and mine. In retrospect, the power differentials in the study may also have enriched the quality of the data that was provided by the clinicians. Initially, I had some concerns that professionals may be reluctant to discuss difficult experiences, as they may have wanted to present a professional image. I was also aware that reflection and open acknowledgement of the effects of clinical work are not encouraged within some professions to the same extent that they are in clinical psychology, which may have made this more difficult or unusual for some participants.

However, I was very pleasantly surprised by the openness of many of the participants' accounts and their willingness to acknowledge feelings of vulnerability and fragility. The richness and quality of data within many of the interviews was more than I could have hoped for. On reflection, the participants' awareness of my trainee and student status may have helped them to feel relaxed and uninhibited within the interviews. I also felt that my interviewing style may have facilitated the participants' open disclosure. My experience in psychodynamic techniques and my preference for an exploratory, non-directive therapeutic style invariably influenced the way that I conducted the interviews. I was eager to learn about the professionals' experiences and largely let them guide the direction of the interview. I believe this enriched the participants' accounts.

Whilst many of the participants described profound effects emanating from their involvement in the MHA process, some participants found it more difficult to reflect upon the process in a personal way or felt that it did not affect them significantly. I found this surprising, as my preconceptions were that the MHA process must have an impact given its powerful nature. I made sense of this within the analytic process in terms of the strategies that clinicians used to protect themselves, such as denial or detachment and the effects of experience. In retrospect, it may have been useful to provide the participants with the option of producing an anonymous written narrative/diary about their experience of the MHA, as this may have felt less personally revealing and enabled the professionals to have more time to think about the impact of the process. However, this approach would have prevented me from further pursuing interesting issues that were raised by the participants in the same way that the interviews enabled me to.

2.2. Negotiating uncertainty.

The participants' core experience of the MHA was one of negotiating uncertainty. I experienced a similar process during some stages of the research process, largely because of my unfamiliarity with the grounded theory method. The times when uncertainty seemed to be prominent were:

- During initial open coding, when I felt torn between not wanting to misrepresent participants' words and needing to abstract from the data.
- Whilst developing the Interview Schedule, as theoretical sampling required that the questions became more focused as the research progressed (Strauss & Corbin, 1998). This did not fit with my preconceptions about qualitative research as allowing the participant to direct the interview.
- Selecting a core category, as I felt attached to many of the generated categories due to immersing myself in the participants' accounts and feeling a familiarity and empathy with their experiences. Many processes seemed so important, as illustrated by an excerpt from the research diary:

'Balancing act still seems a possible core category, as this is what it is- trying to search for a solution and process, which fulfils everyone elses' needs, often at the cost of fulfilling your own, all the time with the overarching possibility and awareness of the implications of getting it wrong. This is a lot of pressure to take! Perhaps pressure would more adequately capture the process as the core category, given that burden seems such a central theme. However, I cannot seem to find a way

to relate all the categories to feeling pressured. Surely it cannot be right to still feel confused about this!' (19th February 2006).

- In practical terms, a number of interviews had to be rearranged because the participants were unable to attend, usually due to emergency situations. This made planning the process more difficult.

My sense of uncertainty during these stages was influenced by my conviction that there must be a 'right way' of doing things. I drew upon a number of resources in order to help me to negotiate my uncertainty. I enjoyed the early interviews where the participants were largely directing the interviews, as this seemed to fit my preconceptions about qualitative research. I found it somewhat difficult to alter the style of my interviewing to become more directive in later interviews, as I felt that asking too many questions may have been restricting for the participants. Rereading the literature about the grounded theory method and the rationale behind asking more focused questions helped to reduce the tension between not wanting to restrict the interviews, whilst wanting to adhere to the method and I was more comfortable with an increasingly directive style by the final interview.

Attending a qualitative research group with my peers, who were also learning about the grounded theory method, was invaluable throughout the process. Through sharing experiences and realising that all members of the group were facing similar challenges, the sense of feeling uncertain became normalised. The group discussions helped me to accept that there was no 'right way' to analyse the data and that using oneself and trusting one's

conceptualisation of the transcripts was crucial in creating the final model. Analytic coding was a learning process and after coding the first few transcripts, I felt sufficiently freed up to begin to play with the data.

Discussions with my research supervisors were also helpful in terms of letting go of this preoccupation with correctness. I was encouraged to try not to concentrate so intensely on doing things perfectly in order to free up creativity. I felt that focusing on the professionals' experiences, rather than issues such as the wording of questions was far preferable and stimulated richer material, as I was able to reflect upon and immerse myself in their stories. Changing my style within the interviews and assuming a more relaxed position thus renewed my energy and enthusiasm for the project. My acceptance of the idea that my conceptualisation of the data would represent the participants' experiences faithfully was incredibly liberating and facilitated the emergence of the core category. This occurred by going away from the written material and reflecting on the entirety of what the participants had described. Similarly to the participants' experiences, it seemed that following protocol and procedure could be restricting at times and prevented moving forward. It was only through letting intuition play a role that this was overcome.

My research supervisors also read many successive drafts of sections of the final thesis. Their positive comments and constructive feedback was invaluable and often reassured me that I was producing something that others found interesting and worthwhile. My clinical supervisor during the project was relatively unfamiliar with the literature on the MHA and offered to read the final thesis. This was encouraging, as she reflected that

the research was accessible to others and helped her to feel more informed about the MHA process.

Being aware of some of the challenges and advantages of doing qualitative research in advance of the study, through discussions with other psychologists who had been through the process was also useful. This enabled me to think through these issues before committing to the project and made me feel more prepared. The psychologists I had spoken to warned me that, although some stages of the process felt overwhelming or difficult, the model came together eventually. They also described enjoying and growing through their research. Reminding myself of these issues was often helpful and encouraged me to trust in the process.

3. Reflexivity.

I was mindful of the need to be aware of and analyse how my own attitudes and ideas were influencing the research project from the outset of the study. This seemed especially important, as I held strong views about the MHA developed through my previous experiences. I had only observed the effects of being sectioned on clients, as I had never attended a MHA assessment. As a result of my inexperience of having to make this decision, I was aware that, initially, most of my empathy lay with the client's position, resulting in some negative perceptions of the process. There were some points during the early stages of the research, where I felt that my beliefs were potentially affecting the analysis. An example of this occurred when I showed some of my early open coding to one of my supervisors. She highlighted two codes, where it seemed that I was abstracting too

far from the participant's words and may have made assumptions, which were influenced by my own attitudes. This was invaluable in highlighting this as a potential issue, which increased my internal monitoring of this.

Another issue concerning the potential impact of my position during the study was my clinical placement within the community mental health team, where three of the participants were also based. I did not know any of the participants personally or professionally before they took part in the study, as I was only just beginning my placement. However, these participants may have seen me working in the same building. Their knowledge that they may have future contact with me while I was on placement may have increased their own monitoring of what they were disclosing. However, my sense was that this was not a significant issue, as these participants seemed as willing to discuss their difficult experiences as the other participants, who did not work in this team.

The participants were aware that the study was being carried out as part of a doctoral course and many of them knew that I was also employed by the National Health Service. As a result, they may not have wanted to disclose the full extent of their distress or experiences. Some professionals explicitly raised concerns about whether they would be identifiable in the study and asked that their anonymity was assured. It seemed that some participants might have been nervous about any potential implications of their words on their employment or others' perceptions of them, which may have constrained their expression. Although issues of confidentiality were outlined in the Information Sheet for the study, in carrying out future research with professional participants, I would place more emphasis on confidentiality issues during the recruitment stage to ensure that any concerns

were addressed early on. One participant usefully highlighted that he may be identifiable from his occupational title, as there were few professionals employed in similar roles in the area. I had not considered this issue previously and responded by using a more generic title for his role.

An unexpected outcome of the research process was the extent that my own conceptualisation of the MHA process altered. Initially, I perceived the legislation negatively and felt empathic towards the clients whose liberty was deprived under the Act. However, hearing the clinicians' experiences increased my awareness of the compassionate reasons that the MHA was often used and how difficult many of the participants found it to make the decision to section a client. Immersing myself in their experiences of agonising over these decisions, carrying the burden of the decision and questioning oneself, engendered feelings of empathy for the professionals. I also began to feel personal frustration that their struggle so often went unnoticed by others and that they received so little support in terms of coping with the effects of their roles. The powerful impact of the research process on my own views was surprising and has increased my enthusiasm and commitment for carrying out qualitative research in the future.

4. Managing the research process.

A constant theme throughout the current study was how to negotiate the multitude of tasks within the available timeframe. Initially this felt overwhelming and I became aware that I needed to contain the research process by providing some boundaries for myself. I therefore made a research timetable, proportioning prescribed amounts of time to

each aspect of the process. This worked extremely well. However, as the timetable was based on estimations of how long each task would take, I set aside less time than would have been ideal to complete the interviews. Although I transcribed and open coded each interview before the next⁴⁵, leaving additional time between interviews to reflect more fully on what had emerged may have been useful. A significant advantage of the timetable I worked to was that it enabled a large amount of time for the final stages of the data analysis. I was able to gain an intimate familiarity with the data and could explore different ways of coding (e.g. by hand, on flashcards and on the computer). This enabled me to find the method that worked best for me. However, if I were to undertake qualitative research in the future, I would leave more time between each interview to enable even more analytic processing as the interviews progressed.

5. Ongoing adaptation.

I initially intended to use the method outlined in Strauss and Corbin's (1998) book. I made this decision as I felt that as a novice qualitative researcher, using a method with prescribed techniques would be containing and reassuring. However, after reaching the point of going beyond open coding, the number of the techniques to be used and the rigidity of the method in terms of needing to use all of these strategies felt constricting. Some of the strategies did not seem to fit with my personal style, as I felt they were too technical and limited creativity. Other authors have also criticised Strauss and Corbin's variation of grounded theory for being highly prescriptive and restricting researchers' creativity (Coyne, 1997). Therefore, I decided to follow the techniques outlined by

⁴⁵ Aside from one that took place on the same day as the preceding interview.

Pidgeon and Henwood (1996) that were more congruent with my own style, as they balanced technical guidance with affording creativity⁴⁶.

Being a well-organised and methodological person by nature, I needed to find a way of reconciling these aspects of my personality with the creative and unstructured elements of qualitative research. I accomplished this by carefully recording analytic decisions within my research diary, along with the justification for the decision. On finalising the theoretical model, I returned to my original transcripts to check that the model accommodated all of the original data and I created a table of quotes that supported the final categories. This process was extremely enjoyable and reassuring, as during much of the analysis I was using the open codes, rather than the original data. Returning to check that my model had remained faithful to the participants' accounts was invaluable in confirming the fit of the theory.

The process of writing-up the final thesis proved to be a difficult time that required compromise. My original model was highly complex and I felt that simplifying the model was necessary to make it more manageable and understandable for others. However, I did not want to discard important categories, as I wanted to capture the meaning of the process for the participants. Taking time and space away from the written material to make sense of how the model could be condensed was extremely useful and enabled me to clarify my thoughts about the analysis.

⁴⁶ This was possible as the process described by both pairs of authors was similar up to the stage of open coding.

Throughout the research process, I struggled with adhering to the word limit as I had read widely around the research topic and felt there was so much to say in terms of setting the research context and capturing the participants' experiences. However, cutting down the initial drafts prompted me to think about what was relevant and potentially interesting to the reader, which served to clarify my thinking. This process was also useful in terms of writing the thesis in a form that was more appropriate for potential publication.

6. The process as an end in itself.

There has been a longstanding debate within the research literature of how to judge the standard of qualitative research. Some researchers contend that the criteria used to judge quantitative research, such as validity, reliability and objectivity should be directly transferred to evaluate qualitative studies (Cavanagh, 1997). Others argue this is inappropriate and that the criteria used to judge qualitative research should be adapted to fit the particular epistemological and methodological stance of each study (Barbour, 2001). Standards such as 'trustworthiness', 'relevance', 'significance' and 'internal coherence' of the theory have often been invoked as suitable alternatives to traditional quality criteria (Glaser, 2004; Smith, 1996).

In the current study, many of the participants seemed surprised by my interest in their experiences of the MHA. They also expressed gratitude and pleasure that someone was acknowledging the difficulty and complexity of this issue, as they felt it had not been acknowledged before. This assured me that the study was meaningful and relevant to those professionals who are affected by the legislation. The interviews seemed to provide some

participants with a sense of validation that their struggle had been recognised and that another party had shown an interest. Many participants stated that they had not consciously thought about how the process affected them before being asked to participate. Others were surprised at how difficult it felt to think purposefully about these issues, as if this was novel. It seemed for some participants, that the interviews were useful on their own. Many of the participants expressed to me and to others that they found it useful to reflect on the process and that the interviews had stimulated their thinking.

In terms of my own development, I felt increasingly comfortable with the interviews as the research went on and I began to enjoy the creativity they afforded. The participants varied in what they brought to the interviews and how in touch they were with their personal responses to the MHA process. This variation made the research process exciting, as it was unknown what each interview would bring. Being trusted enough by the participants for them to disclose distressing experiences felt rewarding and reassured me that the study was meaningful and relevant to others.

Personally, I feel I have gained a great deal during the process of carrying out the study. Learning about the participants' experiences of the MHA process has helped me to understand the pressures that these professionals face. This is likely to have implications for my future work in multidisciplinary teams, as I feel my empathy for the members of these professional groups has increased. It has also raised my awareness of how clinical psychologists may be affected if we acquire roles in this process in the future. The participants' accounts of how their relationships with clients could be affected by their involvement was particularly unnerving, as this is likely to have major repercussions for

the clinical psychology profession and our ability to develop collaborative working relationships with clients.

The development of the analysis and linking this with psychological theory often had connections with my clinical work. I was using psychodynamic ideas on my clinical placement during the study. This theory was useful in helping me to make sense of the participants' use of defence strategies to protect themselves against the effects of participating in the MHA process. This consolidated my understanding of this theoretical model and its wider application in non-clinical situations.

Going through the process of doing qualitative research was an invaluable personal experience that enabled me to gain insight into the challenges and rewards that this brings. The research process resulted in learning to retain hope and faith in my own skills during times of confusion. The main lesson I have learnt about qualitative research is that perfectionist traits can be disadvantageous during some stages of the analysis and that relinquishing ideas about the analysis being right or wrong, whilst simultaneously maintaining scientific rigour, is essential. Having reappraised this to aim for an interpretation that would be good enough and meaningful, the process became infinitely more enjoyable and fulfilling and has reinforced my interest and skills in terms of carrying out further qualitative research in the future.

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LIST OF APPENDICES.

- Appendix 1:** A copy of the Notes for Contributors from the International Journal of Law and Psychiatry.
- Appendix 2:** Copies of the letters of ethical approval for the study.
- Appendix 3:** A copy of the Information Sheet for the study.
- Appendix 4:** A copy of the Consent Form for the study.
- Appendix 5:** The Interview Schedule used in the study and changes made as a result of theoretical sampling.
- Appendix 6:** An example of open coding.
- Appendix 7:** Additional verbatim quotes from the participants that illustrate the final theoretical model.