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**An Exploration of How Mental Health Professionals Position
Themselves in Relation to Advance Statements**

And

Clinical Research Portfolio

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BSc (Honours), MSc

Submitted in fulfilment of the requirements of the Degree of Doctorate
in Clinical Psychology

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Chapter 1: Systematic Review and Thematic Synthesis

**A Synthesis of Professionals' Accounts of Involuntarily Admitting Patients to
Adult Psychiatric Hospitals**

Word count (excluding quotes: 575): 6902

Abstract

Background & Aims

Rates of involuntary hospitalisation vary worldwide, though variances are not accounted for by differences in mental health legislation. Factors influencing decisions to hospitalise include diagnosis, risk and lack of treatment adherence though interpretations of legislative criteria vary. This study aimed to synthesise research on the process of deciding to involuntarily admit someone to hospital.

Methods

A systematic search of EMBASE, MEDLINE, PsycINFO and the Cochrane Database of Systematic Reviews was conducted. Results from the studies were synthesised into themes. Transparency of reporting was assessed.

Results

Ten studies were identified. Four themes were identified: Decision-Making, where participants described the need for hospitalisation to treat an illness and restore capacity; Risk, where participants described effective management of risk as influencing decisions to hospitalise alongside concerns about criticism and litigation; Legislation, where the challenges of applying the law were described; and Lack of Alternatives, where participants spoke of feeling there was no other option to hospitalisation.

Conclusion

The perceptions of those deciding to involuntarily hospitalise people are an important factor meriting further research. These may reflect difficulties interpreting legal criteria, as well as concerns about risk and criticism, and more broadly the effects of the broader social and political context and the availability of alternatives to hospitalisation.

Introduction

In 2019 the Scottish Government announced a review of the Scottish Mental Health (Care and Treatment) (Scotland) Act (2003) to ensure that legislation reflects principles of the United Nation Convention on the Rights of Persons with Disabilities (UNCRPD), which classifies a mental disorder as a disability. The UNCRPD assertion that “the existence of a disability shall in no case justify a deprivation of liberty” (UNCRPD, Article 14) presents significant challenges to ratifying countries whose legislation authorises the use of involuntary treatment for people diagnosed with a mental disorder (Stavert, 2015; Szmukler, 2008; Szmukler, Daw & Callard, 2014).

Scottish legislation stipulates that in order to detain a person, a mental disorder must be present alongside diminished decision-making capacity (Scottish Mental Health (Care and Treatment) (Scotland) Act (2003), 36(4)). While this endorses the notion that mental disorder does not equate to incapacity (Boyle, 2008), legislation including mental illness as one of the criterion for detention in hospital is non-compliant with the UNCRPD and therefore discriminatory (Szmukler, 2008; Szmukler et al., 2014).

Legislative criteria for involuntary hospitalisation varies worldwide, though there appears to be no association between these differences and rates of hospitalisation (Cronin, Gouda, McDonald & Hallahan, 2017; Sheridan Rains et al., 2019). Some countries have seen rates of involuntary treatment remain relatively constant while others have seen an increase, like Scotland which in 2018/19 saw the highest rate since the implementation of the 2003 Act (Mental Welfare Commission for Scotland, 2019; Sheridan Rains et al., 2019). Differences may be accounted for by attitudes towards mental illness and a growing societal preoccupation with risk, increasing the pressure on healthcare systems and professionals with the legislative power to ‘do something’, including diagnose and treat mental illness without consent from the individual (Austin, Kagan, Rankel & Bergum, 2008; Bracken & Thomas, 2001; Clark & Bowers, 2000; Hall, 2004; Høyer et al., 2002; Marriott, Audini, Lelliott, Webb & Duffett, 2001; Szmukler, 2008; Szmukler & Appelbaum, 2008).

While lack of social support and sociodemographic variables are associated with the decision to involuntarily hospitalise someone, diagnostic category seems to have the most

influence alongside previous admission, lack of treatment adherence and perceived risk to oneself and/or others (Brooks, 2006; Clark & Bowers, 2000; Myklebust, Sørgaard, Røtvold, & Wynn, 2012; Shao, Xie & Wu, 2012; Silva, Golay & Morandi, 2018; Stastry, 2000; Szmukler, 2008; Vuckovitch, 2010; Walker et al., 2019). Kullgren and colleagues (1997) found that 98% of psychiatrists felt it was ethical to involuntarily hospitalise a person if they believed them to be a danger to themselves or others. Professionals have also expressed being influenced by a desire to avoid criticism from society, particularly in regards to public safety, however a lack of consensus in the conceptualisation of risk leads to variation in decisions about hospitalisation (Brooks, 2006; Clark & Bowers, 2000; Marriott et al., 2001; Walker et al., 2019).

Individuals can be hospitalised if considered as lacking in insight or decision-making ability, which justifies a paternalistic impingement on their liberty under notions of ‘best interest’ (Clark & Bowers, 2000; Cronin et al., 2017; Høyer et al., 2002; O’Brien & Golding, 2003; Marriott et al., 2001; Walker et al., 2019; Welsh & Deahl, 2002). The prioritisation of beneficence over autonomy is problematic because what is best for someone is subjective, and assessments are never conclusive (Austin et al., 2008; Kullgren et al., 1997; Marriott et al., 2001; Vuckovich, 2010). Furthermore, research has shown professionals doubt their interpretation of the law, while others showed interpretations did vary (Dawson & Szmukler, 2006; Marriott et al., 2001; Shao et al., 2011). Vague legislation alongside high levels of uncertainty and complexity seems to contribute to the decision to involuntarily admit someone to hospital (Marriott et al., 2001; Stastry, 2000; Walker et al., 2019). Hospital may seem to be a straightforward solution, particularly in the context of a lack of community alternatives, but it comes at significant cost to the individual who is deprived of their liberty (Lorant, Depuydt, Gillain, Guillet & Dubois, 2007; Marriott et al., 2001; Naumburg, 2018).

Those with the powers to involuntarily hospitalise people are positioned between law and medicine, where they are faced with competing pressures to effectively respond to risk, provide access to required treatment and minimise the use of coercion (Austin et al., 2008; Hannigan & Cutliffe, 2002; Norvoll, Hem & Pedersen, 2017; Stastry, 2000; Welsh & Deahl, 2002). Research highlights factors influencing the decision to detain a person in hospital, but highlight a need to understand more about the decision-making process (Høyer et al., 2002; Szmukler, 2008; Walker et al., 2019). Therefore this systematic

review and meta-synthesis aimed to address the gap in the research by integrating qualitative findings about the process of deciding to involuntarily treat people in hospital in healthcare systems worldwide.

Methods

This meta-synthesis used a hermeneutic approach by grouping together a selection of qualitative studies to interpret findings and integrate them to draw more substantive conclusions (Stern & Harris, 1985; Jensen & Allen, 1996; Walsh & Downe, 2005; Walsh & Downe, 2006).

Data Collection

The following databases were searched in July-August 2019: MEDLINE, PsycINFO, EMBASE and Cochrane Database of Systematic Reviews. A search architecture with four domains was developed: ‘staff’, ‘coercion/involuntary treatment’, ‘hospital’ and ‘qualitative methods’. Keywords for each domain were identified in each database. A boolean search with the word AND was performed to combine the search terms and narrow the results (See Table 1 below).

Inclusion / Exclusion Criteria

The following inclusion criteria were applied: written in English, original studies, qualitative methods exploring experiences and perspectives of mental health staff. Studies which met inclusion criteria were further examined and excluded those investigating staff’s understanding of the law and perspectives of those working in a forensic, care of the elderly, adolescent or learning disability setting. Where studies used mixed-methods designs, only qualitative findings were included in the synthesis. Earlier studies which took an exploratory approach to the topic were included because the data collected were relevant for this synthesis. Research including perspectives from patients and family members was also included, providing that staff responses were presented separately. Reference lists of eligible studies were checked to avoid excluding relevant papers, as well as a forward citation search of each article using Google Scholar.

Table 1. Key words for each domain in each database search.

Database	Domain	Search Terms
PsycINFO	Staff	Health personnel OR mental health personnel OR allied health personnel OR caregivers OR medical personnel OR psychiatric hospital staff OR psychiatric nurses OR psychiatrists
	Coercion / Involuntary Treatment	Informed consent OR involuntary treatment OR resistance OR outpatient commitment OR crisis intervention OR abuse of power OR interpersonal control OR authority OR coercion OR dominance OR oppression OR psychiatric hospitalization OR psychiatric hospital admission OR psychiatric hospital readmission OR hospitalization OR commitment OR hospital admission OR outpatient commitment OR patient seclusion
	Hospital	Crisis intervention services OR psychiatric hospitals OR psychiatric units OR maximum security facilities OR psychiatric clinics
	Qualitative Methods	Interview OR focus group OR grounded theory OR IPA OR interpretative phenomenological analysis OR thematic analysis OR content analysis OR discourse analysis OR qualitative research OR phenomenology OR ethno\$
MEDLINE	Staff	Psychiatric nursing OR Nursing OR Nurse OR nursing staff OR mental health care personnel OR psychiatry OR emergency psychiatry OR psychiatry OR psychiatrist
	Coercion / Involuntary Treatment	Persuasive communication OR involuntary commitment OR psychiatric treatment OR medical ethics OR dominance behavior OR crisis intervention OR hospital admission
	Hospital	Interview OR focus group OR grounded theory OR IPA OR interpretative phenomenological analysis OR thematic analysis OR content analysis OR discourse analysis OR qualitative research OR phenomenology OR ethno\$
	Qualitative Methods	Interview OR focus group OR grounded theory OR IPA OR interpretative phenomenological analysis OR thematic analysis OR content analysis OR discourse analysis OR qualitative research OR phenomenology OR ethno\$
EMBASE	Staff	Mental health care personnel OR psychiatric nursing OR doctor OR medical doctor OR medical practitioner OR physicians OR practitioner OR medical personnel OR nursing staff OR health care personnel
	Coercion / Involuntary Treatment	Persuasive communication OR coercion OR hospital admission OR hospitalization OR social control OR involuntary commitment OR crisis intervention OR psychiatric treatment OR medical ethics OR hospital readmission OR authority
	Hospital	Mental hospital OR psychiatric hospital OR mental institution OR psychiatric clinic OR psychiatric department OR mental ward OR psychiatric ward OR crisis intervention
	Qualitative Methods	Interview OR focus group OR grounded theory OR IPA OR interpretative phenomenological analysis OR thematic analysis OR content analysis OR discourse analysis OR qualitative research OR phenomenology OR ethno\$
Cochrane Database	Staff	Psychiatric nursing, mental health nursing, mental health nursing, psychiatry, psychiatrist
	Coercion/ Involuntary Treatment	Involuntary treatment, coercion, involuntary psychiatric commitment
	Hospital	Hospital psychiatric department, psychiatric hospital, mental hospital, mental institutions

	Qualitative Methods	Interview, focus group, grounded theory, IPA, interpretative phenomenological analysis, thematic analysis, content analysis, discourse analysis, qualitative research, phenomenology, ethno\$
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Data Extraction and Identification of Key Concepts

All data presented as ‘results’ or ‘findings’ were entered into a Microsoft Word document. This included primary data (i.e. quotations) as well as researcher interpretations. Thematic Analysis (Braun & Clarke, 2006) was used to synthesise the data. I spent time familiarising myself with the texts before inductively coding the data line by line to gather underlying concepts. Codes were then grouped together into clusters from which important themes emerged. Once the entire dataset was examined and no further themes could be drawn out, a final synthesis of the themes to an overarching theme was developed, giving rise to a hierarchy of ‘core’ and descriptive themes organised according to their relevance.

Transparency and Reflexivity

A reflexive approach allowed me to acknowledge my personal stance and values with regards to involuntary detention and the impact on this review and synthesis. I considered my role as a trainee clinical psychologist and the influence of the values and philosophy of the profession. I also reflected on my personal perspective which challenges the medical model conceptualisation of distress and therefore the use of involuntary hospitalisation. Keeping a reflective diary helped me use supervision during the analysis stage, which helped me stay close to the research aims and consider my own biases on the results.

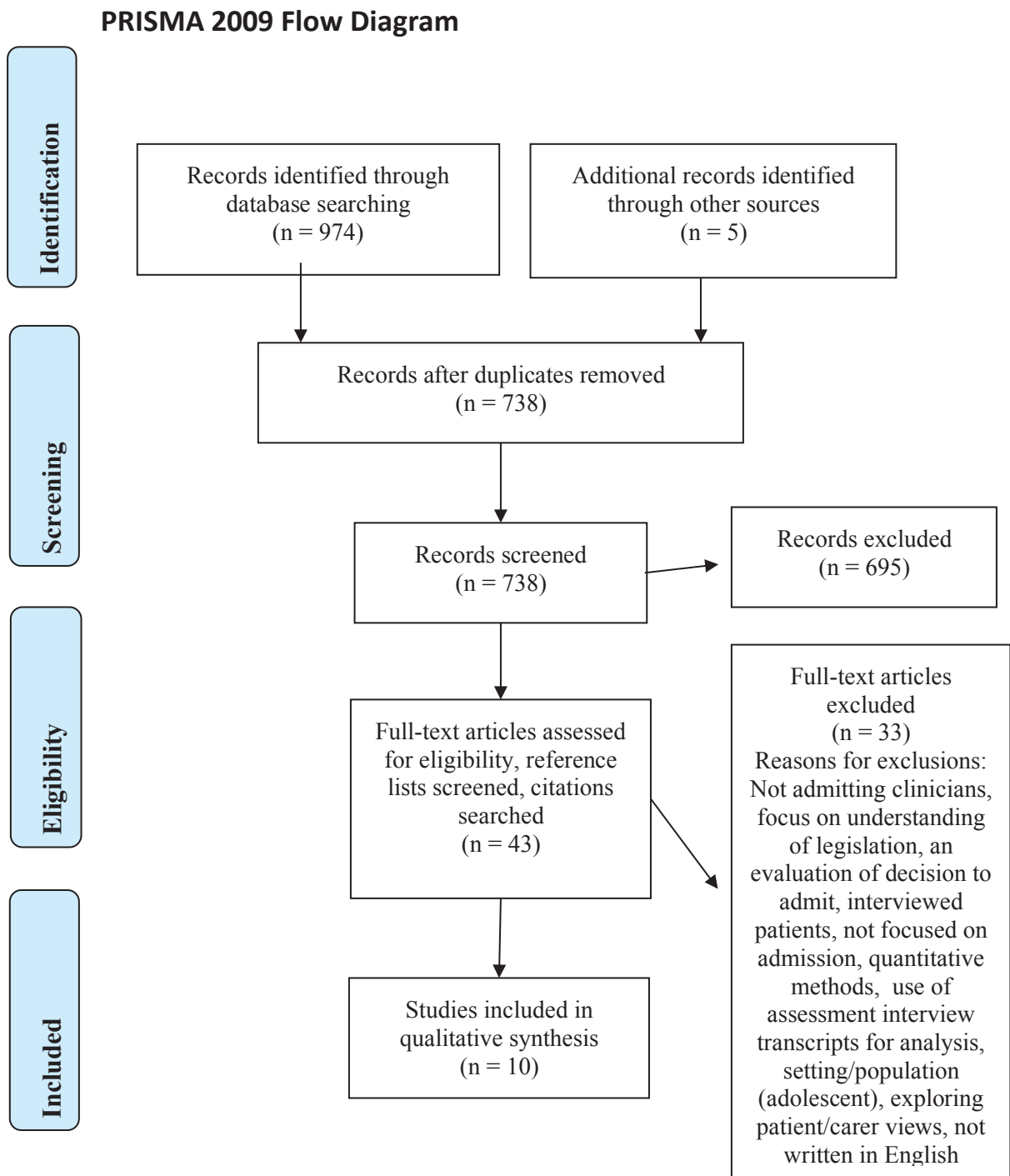
Assessing the Quality of the Selected Studies

Transparency of reporting was assessed using COREQ (Consolidated criteria for Reporting Qualitative Research; Tong, Sainsbury & Craig, 2007; Appendix 1), which comprises a 32-item checklist covering researcher bias, methodology and clarity around the interpretive process.

Results

The search strategy led to the identification of 10 studies to this synthesis illustrated in the PRISMA flow diagram below (Figure 1).

Figure 1. PRISMA Flow Diagram



A summary of each study is presented in table 2.

Table 2. A summary of each study included in the synthesis

Article no., author and title	Year, Country	Aim	Design	Method (selection and method of analysis)
1. Anderson, J., & Eppard, J. Clinical decision making during assessment for involuntary psychiatric admission.	1995, USA	Learn more about the process of clinical decision-making during assessment for involuntary psychiatric admission.	Qualitative. One-to-one interviews with clinicians	Twenty-four clinicians (five psychiatrists, five nurses and 14 counsellors). Van Kaam's phenomenological method.
2. Quirk, A., Lelliott, P., Audini, B., & Buston, K. Non-clinical and extra-legal influences on decisions about compulsory admission to psychiatric hospital	2003, UK	To describe non-clinical and extra-legal influences on professionals' decisions about compulsory admission to psychiatric hospital.	Qualitative. Informal and in-depth interviews with clinicians and observation of their assessment	Seven formal and 'countless informal' participants including community psychiatric nurses, psychiatrists and approved social workers. Grounded Theory.
3. Lundahl, A., Helgesson, G., & Juth, N. Psychiatrists' motives for practising in-patient compulsory care of patients with borderline personality disorder (BPD)	2018, Sweden	To investigate reasons and motives behind decisions to confine BPD patients to compulsory care, and how psychiatrists perceive BPD patients and their experiences of treating them.	Qualitative. Semi-structured interviews with psychiatrists.	Twelve psychiatrists. Qualitative descriptive content analysis to extract sub-categories, categories and themes.
4. Feiring, E., & Ugstad, K., N. Interpretations of legal criteria for involuntary psychiatric admission: a qualitative analysis.	2014, Norway	To investigate which choices clinicians make when asked to decide whether to admit patients that are unwilling to consent to mental health care. Specifically, how they interpret and understand criteria for involuntary admission and variations in interpretation of this criteria.	Qualitative. Semi-structured interviews, based on a theoretical framework, with 10 clinicians	Ten clinicians (psychiatrists and a psychologist). Deductive thematic analysis was used to influence interview questions, and themes were identified and fit into the predetermined analytical frame.
5. Hamilton, B., Manias, E., Maude, P., Marjoribanks, T., & Cook, K. Perspectives of a nurse, a social worker and a psychiatrist regarding patient assessment in acute inpatient psychiatry settings: A case study approach.	2004, Australia	Explore what informs and organises the assessment of patients, as undertaken by a nurse, social worker and psychiatrist.	Qualitative descriptive case study. In-depth interviews.	A nurse, psychiatrist and social worker. Drew upon Foucauldian concepts of discourse analysis to identify themes.
6. Hoge, S., K., Lidz, C., Mulvey, E., Roth, L., Bennett, N., Siminoff, L., ... Monahan, J. Patient, Family and Staff Perceptions of Coercion in Mental Hospital Admission: An Exploratory Study.	1993, USA	Explore methods to refine the conceptualisation and measurement of coercion.	Mixed methods. 1:1 semi-structured interviews and questionnaires. Focus group made up of mixed participant groups.	Clinicians (40), patients (44) and family members (18). ANOVAs. No analysis method for qualitative data – exploration of terminology and descriptions. The research was based on a framework of coercion including whether alternatives to hospitalisation were considered and patient preferences for alternatives.
7. Buckland, R. The Decision by Approved Mental Health Professionals to use Compulsory Powers under the Mental Health Act 1983: A Foucauldian Discourse Analysis	2016, UK	Explore the use of compulsory powers under the Mental Health Act 1983 amongst Mental Health Professionals (AMHPs).	Qualitative. Semi-structured interviews.	Ten AMHPs (social workers). Foucauldian Discourse Analysis.

8. Smyth, S., Casey, D., Cooney, A., Higgins, A., McGuinness, D., Bainbridge, A., ... Murphy, K. Qualitative exploration of stakeholders' perspectives of involuntary admission under the Mental Health Act 2001 in Ireland.	2017, Ireland	Explore the perspective of key stakeholders involved in the involuntary admission and detention of people under the Mental Health Act 2001 in Ireland.	Qualitative. Focus groups.	Sixty-two clinicians participated in 8 focus groups (psychiatrists, GPs, mental health nurses, solicitors, tribunal members, police, patients, relatives). A general inductive approach.
9. Mgutshini, T. Risk factors for psychiatric re-hospitalisation: An exploration.	2010, USA	Explore service user and clinician attributions for frequent hospitalisation to a psychiatric unit over a 24 month period.	Qualitative. Review of case notes, 1:1 semi-structured interviews with clinicians and patients, and focus groups.	Twelve professionals (social workers, occupational therapists and psychiatrists) and 23 patients were interviewed. Focus groups (2 patient groups of 6 and 2 professional groups of 5) were conducted. 59 admission records were reviews. Data from case notes were analysed using content, descriptive and thematic analysis. Thematic analysis and modified Interpretative Phenomenological Analysis was used to review interview and focus group data.
10. Sjöstrand, M., Sandman, L., Karlsson, P., Helgesson, G., Eriksson, S., & Juth, N. Ethical deliberations about involuntary treatment: interviews with Swedish psychiatrists.	2015, Sweden	Investigate ethical issues related to involuntary treatment through interviews with Swedish psychiatrists.	Qualitative. Semi-structured interviews.	Eight psychiatrists. Data analysed using descriptive content analysis

Characteristics of the Selected Studies

This meta-synthesis included data from 126 interviews and 13 focus groups across 10 different studies published between 1993 and 2018. Participants included nurses, psychiatrists and social workers who worked in healthcare systems in the USA (n=3), UK (n=2), Sweden (n=2) and one in Australia, Norway and Ireland.

Synthesis

The studies described various different professionals' accounts of involuntarily admitting patients, and 4 key themes were developed. Table 3 shows how studies were represented across themes. Each theme is described below and includes synthesised results from the individual studies, example quotes from participants and authors, including the page number and profession of participant (if reported).

Table 3. Studies represented in each theme.

Theme	Study Number									
	1	2	3	4	5	6	7	8	9	10
Decision-Making	✓		✓	✓	✓	✓	✓	✓	✓	✓
Risk	✓	✓	✓	✓			✓	✓	✓	✓
Legislation	✓	✓	✓	✓	✓		✓			✓
Lack of Alternatives	✓	✓	✓	✓		✓	✓		✓	✓

Decision-making

Participants described how they came to a decision to admit someone to hospital. Many reported that in doing an assessment, *“the first thing, of course, is to see if they are mentally ill”* (1, Psychiatrist, p. 728) which would determine what happens next: *“You’ve got to arrive at a diagnosis before you can do any sort of rational treatment really”* (5, Psychiatrist, p. 687).

Participants across the studies described *“internal dispositional factors”* (9, p. 262), mainly diagnosis, as influencing the decision to admit a patient to hospital. Many participants seemed to perceive different diagnoses as having different needs as *“with Major Depression you sort of pile in the antidepressants and (pause) of course observe them closely, but the follow up is going to be different. Whereas with Borderline Personality Disorder you don’t want them to be in hospital too long”* (5, psychiatrist, p. 687).

They conceptualised patients’ presentations through a *“curative gaze”* where distress was often described and reframed in the discourse of psychiatric symptoms which could be relieved by medical treatment (5, p. 687). Patients were described as *“very, very ill and you can see there’s just no option but for them to go into hospital”* (7, Approved Mental Health Professional [AMPH], p. 54). The notion that treatment in hospital was the only option was described as a predictable circulatory perspective for those working in a medical model context (6, 7).

Non-adherence to medication was shown to be a risk factor for readmission (9). Participants explained that the most kind way to treat a patient who was hesitant about taking medication was with *“one quick jab”* of an injection to ensure they received required treatment (5, psychiatrist, p. 687). Some reasoned that a reluctance to engage in

treatment was reflective of the patient's illness and not their true preference, thus justifying involuntary admission and treatment (3, 10).

“It could be anything from a patient with psychosis who has a completely different apprehension of the world and does not, at the moment, want medicine. However, I know that when he is better, he will want it, because he wants to be well and get out of this” (10, psychiatrist, p. 5)

Participants in Buckland's (7) study, who had been given Approved Mental Health Professional (AMHP) status meaning they could apply to involuntarily admit patients to hospital, explained that rather than an impingement on rights, involuntary treatment provides a person with their right to treatment. Participants described acting on presumed will and in agreement with peoples' preferences if they had had *“the intellectual and emotional ability to reflect on his situation”* (10). While some described capacity as fluctuating and context dependent (3), some equated the presence of serious mental disorder with an inability to engage in rational decision-making so *“why should I try and convince the patient to voluntarily receive treatment?”* (4, p. 6). Participants explained that the *“solution is then to treat the psychiatric disorder so that they are able to understand what their best interest is. Or to optimise their decision-making capacity”* (10, psychiatrist, p. 5). Others explained that even if the patient has capacity, if they express suicidal intent then involuntary admission was necessary (3) in the process of *“restoring the patient's autonomy”* (10, psychiatrist, p. 5).

In contrast, other participants explained that hospital admission could reduce patient autonomy leading to *“hospitalisation-induced”* (3. Psychiatrist, p. 67) problematic behaviour, particularly in patients with a diagnosis of BPD (10), which was a factor against the use of involuntary treatment. Others presented the potential damage to the therapeutic alliance as a concern in the involuntary treatment of patients, even when legislative criteria was fulfilled (8, 10):

“There are times then when the trust has just gone...in that therapeutic relationship and it's very difficult...where you've been the one to bring them in to hospital” (8, mental health nurse, p. 562)

The development of trust was not understood to be used coercively in the process of admitting someone to hospital, but rather was seen to be supporting patients to get the psychiatric treatment they need (6).

"Your voice can encourage a person. Your physical appearance; if you have a very supportive type of voice. It's more what you're saying too, but even the sound, and your physical appearance, like if you look like a person you can trust." (6, p. 291)

Risk

Risk of suicide, self-harm and risk to others were raised by participants as a motivator to involuntarily admit someone to hospital (3, 4, 9, 10), and in one study (4), whether there was the additional presence of a serious mental health disorder or not. The process of assessment was *"to see if they are mentally ill. Then we see if they are mentally ill and dangerous"* (1, psychiatrist, p.728). The influence of societal concerns and the risk averse culture which study participants worked in was reported to influence decision-making, with participants becoming the *"focal point"* (7, p. 58) for public anxieties (4). Risks, particularly to others, were described as exaggerated and fuelled by the media's reporting of high-profile incidents of things having gone wrong, which positioned participants as accountable, apprehensive and defensive (4, 7). Anxiety in those surrounding the patient (e.g. family) was said to be raised, putting pressure on professionals who were concerned about what might happen if they do not hospitalise the person (3, 9).

Participants described being positioned as taking on the anxiety around a person and feeling responsible for what happened if they send the patient home, including if they self-harmed, as a *"massive ask"* (7, p. 58). Detaining patients functioned to *"safeguard"* (3, p. 66) the clinician who is seeking to avoid personal and professional consequences if something happens.

Participants described feeling unsupported if a serious untoward event happened, even if decisions complied with the law (3). Concerns about litigation and criticism increase the likelihood of admitting someone, particularly those thought to have heightened risk of self-harm and patients diagnosed with BPD as they have increased risk of *"self-*

destructiveness and consequently suicide risk” (3, p. 66, 9). In deciding not to admit someone, participants described the value in a team approach in increasing confidence in their decision (1, 2). Support from the team also helped ease practical issues of the admission process allowing people to access timely treatment (8).

Legislation

Mental health legislation was described as “*open to interpretation*” (10, p. 7) by participants who reported criteria for involuntary hospitalisation as broad, where the judgement of a presence of a mental disorder was subjective and dependant on who was assessing (7). Variation in participants’ understanding of ‘serious mental disorder’ was evident as participants in study 4 (p. 5) described “*psychosis*”, “*severe personality disorders*” and “*a description of a person’s functioning*” while in study 7, it was interpreted as how distressed a person is. This vagueness left professionals able to choose how they portrayed patients’ symptoms in applications for involuntary treatment (10) which could lead to “*dubious or wrong*” (3, psychiatrist, p. 66) use of legislation.

Participants discussed the challenges of applying mental health legislation and that if they decide to intervene, “*then you will have to use the law the way you can*” (10, AMHP, p. 7). Participants spoke of broadening their interpretation of legislation to use compulsory powers, especially in treating people diagnosed with BPD because legislation does not adequately apply to these individuals (3).

“the Mental Health Act is designed better to be applied to people with psychotic disease, who evidently lack decision competence for a period of time, and then they receive a medication that totally changes the situation and then they’re decision-competent. It’s not designed to be applied to people who feel totally fine, but then five seconds later have a strong anxiety reaction and become super suicidal and harm themselves” (3, p. 66).

The studies showed that lack of clarity in mental health legislation allows space for professionals to make their own judgements and decisions (10). In deliberating whether to involuntarily admit someone participants used their own values systems above the mental health act despite acknowledging that this was not appropriate (7). Participants

described using their “*sixth sense*” (1, p. 728), “*gut*” (1, p.728; 5, nurse, p. 686; 7, AMHP, p. 56) alongside “*hunches*” and *being aware of “red flags”* (1, p. 728) to make intuitive decisions about whether a patient needs to be admitted to hospital. One AMHP explained: “*the law does inform my decision-making, erm, but fundamentally I would have to say, bizarrely perhaps, it’s my heart, whatever that is*” (7, p. 56).

It was noted that participants’ accounts evidenced societal gender norms in their descriptions of MHA assessments, evidencing a lack of universality in social values (7). As a result, professionals can make different judgements and decisions about the same patient, as participants explained that if they have worked to keep a person out of hospital and take time off work, they “*come back and find they’ve been sectioned by somebody else*” (2, CPN, p. 125).

Others referred to the challenge in negotiating governmental priorities which “*want the use of force to be reduced, but at the same time they want to make sure that no one takes his own life*” (4, p. 6). Participants in the same study described receiving strong messages from government bodies to make certain decisions which less experienced professionals were thought to attend to more than those with more experience.

Lack of alternatives

Though legislation for least restrictive interventions “*pressure the clinician to search for alternatives*” (1, p. 728), participants described a lack of suitable alternatives to hospitalisation as influencing their decisions (2, 4, 6, 7, 9). Participants reported hospital admission being used because they have no other option.

“*So if there’d been another way of making her safe and a bit more time to think it through and I don’t mean a bit of community support I mean a proper respite, cuddle cottage type thing, you know...and erm, not necessarily had to go down the route of right, you’re mentally disordered, here’s your label, erm, and into the medical profession*” (7, AMHP, p. 55)

Participants explained if “*apartments and services are provided, then I would imagine the use of compulsory admissions to be reduced*” (4, p. 7). Though hospital is not the

option to best meet the person's needs, a lack of alternatives means risk from not admitting is heightened (2). Participants reported there were differing opinions on the appropriateness of admission, but it can often be used "*not entirely for the sake of the patient – because I might find it negative for the patient – but for sake of the police, the relatives' sake, our sake*" (3, psychiatrist, p. 66; 2)

Geographical location was also highlighted as having an impact on decision-making, as rural areas were described as having reasonable alternatives to hospital resulting in staff feeling more comfortable not admitting someone (2). Some participants also highlighted situational influences on whether to admit someone to hospital, though less so than factors such as diagnosis. A person lacking in social support, employment and bereavement were also more likely to be admitted to hospital (9, 10).

Quality Appraisal

Studies reported between 10 and 22 of the 32 CORE-Q (Tong et al., 2007) checklist items. Table 4 provides full details of the appraisal. There was variability in the quality of reporting with areas of strength across the studies, including thorough reporting on methodology and theoretical standpoint, sampling strategy, sample size and descriptions of how researchers derived the results presented. Reporting was less clear in different areas across the studies, most prominently for participant knowledge of the interviewer, data saturation, use of field notes and clarity around any minor themes.

Table 4. Summary of the Results of the COREQ Appraisal (Tong et al., 2007)

COREQ Criterion	Study Number									
	1	2	3	4	5	6	7	8	9	10
Interviewer/facilitator identified	Red	Green	Green	Green	Green	Red	Green	Green	Red	Red
Researcher Credentials	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green
Occupation	Green	Green	Green	Green	Red	Red	Green	Green	Red	Green
Gender	Green	Green	Green	Green	Red	Green	Green	Green	Red	Green
Experience/training	Red	Red	Red	Green	Red	Red	Red	Red	Red	Green
Relationship established	Red	Green	Red	Red	Green	Red	Green	Green	Red	Green
Participant knowledge of interviewer	Red	Red	Green	Red	Red	Red	Red	Red	Red	Green
Interviewer characteristics (bias)	Red	Green	Green	Red	Green	Red	Red	Red	Red	Red
Methodology & Theory	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green
Sampling strategy	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green
Method of invitation	Green	Green	Green	Red	Green	Red	Green	Green	Red	Green
Sample size	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green
Non-participation	Green	Red	Green	Red	Red	Red	Red	Red	Red	Green
Setting of data collection	Red	Green	Red	Red	Red	Red	Green	Green	Red	Red
Presence of non-participants	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red
Sample characteristics	Green	Green	Green	Green	Red	Green	Green	Green	Red	Green
Interview guide	Red	Red	Green	Green	Red	Red	Red	Red	Red	Green
Repeat interviews	Red	Red	Red	Red	Red	Red	Red	Red	Red	Green
Audio/visual recording	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green
Field notes	Red	Red	Red	Red	Green	Red	Red	Red	Red	Red
Duration	Red	Green	Green	Green	Red	Red	Green	Red	Red	Green
Data saturation	Red	Red	Green	Green	Red	Red	Red	Red	Red	Green
Transcripts returned	Red	Red	Red	Green	Red	Red	Red	Red	Red	Red
No. of coders	Red	Green	Red	Green	Green	Green	Green	Green	Red	Red
Description of coding tree	Red	Red	Green	Red	Red	Red	Red	Green	Green	Green
Derivation of themes	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green
Software	Red	Red	Red	Red	Red	Red	Red	Red	Red	Red
Participant checking	Green	Green	Red	Red	Red	Red	Red	Red	Red	Red
Quotations presented	Green	Green	Green	Green	Green	Green	Green	Green	Red	Green
Data and finding consistent	Green	Green	Green	Green	Green	Green	Green	Green	Red	Green
Clarity of major themes	Green	Green	Green	Green	Red	Green	Green	Green	Green	Green
Clarity of minor themes	Red	Red	Green	Red	Red	Red	Red	Red	Red	Red
Total no. of COREQ items	15	19	22	19	17	11	15	21	10	21

Discussion

This systematic review and thematic meta-synthesis explored mental health professionals’ decision to involuntarily admit people to adult psychiatric hospitals. Concerns about risk and the difficulty in applying mental health legislation revealed that professionals used heuristics in their decisions to admit people to hospital. The highly complex and uncertain situations arising in psychiatry means intuitive heuristics (such as a ‘gut feeling’ or ‘sixth sense’) are more likely to be used as a shortcut to reduce the time and cognitive load required to make a decision (Tversky & Kahneman, 1974; Crumlish & Kelly, 2009; Naumburg, 2018). This synthesis highlighted that professionals’ concerns about criticism influenced their decisions to involuntarily admit people to hospital, thus engaging in secondary risk management to cope with intolerable levels of anxiety (Undrill, 2007). Concerns about blame as a result of unfavourable outcomes exacerbate the anxiety already created by the process of doing a risk assessment (Undrill, 2007). This

can be problematic as it can lead to ‘affective errors’ (failed heuristic) in decision-making (Croskerry, 2002). Although useful in pressured contexts like the NHS where time is lacking, decisions based on heuristics are susceptible to bias and assumptions (such as ‘confirmation bias’) which, if unchecked, may lead to repeated mistakes in judgement (Crumlish & Kelly, 2009; Croskerry, 2002; Naumburg, 2018; Tversky & Kahneman, 1974;).

This synthesis highlighted that professionals’ decision-making was often based upon assessments of dangerousness, which can be unreliable and function to compromise the notions of beneficence (Welsh & Deahl, 2002). Moreover, using involuntary treatment to manage risk may not be ethically sound, since most treatments are designed to treat a mental illness, not reduce risk (Undrill, 2007).

In addition to keeping people safe, involuntary treatment was described as reinstating peoples’ autonomy and capacity which was thought to be diminished as a result of their mental illness. This notion seems to contradict findings in a recent systematic review which found that admission to hospital increases the risk of further hospitalisation (Walker et al., 2019). This may be related to the fluctuating nature of distress, though it is important to note that a recent meta-synthesis found people experienced involuntary treatment as frightening and distressing so avoid seeking help until they reach crisis point and admission is necessary (Akther et al., 2019; Walker et al., 2019).

Judgements about decision-making capacity and autonomy in people with severe mental health problems influence the decision to admit someone to hospital, with professionals acting on people’s presumed will. Professionals have been shown to link refusal of treatment with incapacity or symptoms of their illness rather than a reasoned and rational decision to reject treatment felt to be unacceptable or unwanted, and treatment agreement with capacity (Bowers, Wright & Stewart, 2014; Okai et al., 2007). However, research has shown that people can express treatment preferences and refusals with justifications, such as that they felt worse for taking them or experienced side effects, which when considered, mediates negative impacts of coercion (Akther et al., 2019; Read & Williams, 2019; Srebnik et al., 2005).

Professionals also felt that hospitalisation could be unhelpful, particularly in relation to trust and the therapeutic alliance. This is important considering people using mental health services want a trusting relationship with staff treating them (Akther et al., 2019). While the trusting relationship was described as useful in coercing people into receiving required treatment, people subject to coercive methods have expressed that staff who are kind, caring and interested in their wellbeing further soften any negative consequences (Akther et al., 2019; Gilbert, Rose & Slade, 2008).

A lack of suitable alternatives was a factor influencing the decision to involuntarily admit someone to hospital. The effect of political austerity on society and services which are being forced to do more with less has resulted in mental health services finding themselves in “the eye of the storm” (Knapp, 2012, p. 55).

Strengths and Limitations

The exclusion criteria means relevant literature may have been missed in this review, such as literature published in other languages. Further, the researcher’s own perceptions may have influenced the interpretation and development of themes. Lack of explicit reporting in important areas reduced the transparency and trustworthiness of the findings and interpretations made by researchers in the studies.

The results of this synthesis compliments quantitative investigations around the use of involuntary hospitalisation by providing insights into professionals’ decision-making process.

Clinical, Policy and Research Implications

It is unclear how UNCRPD principles will be applied in circumstances where people have fluctuating capacity as a result of mental health difficulties (Szmukler et al., 2014), and this should be key a key concern for the review of Scottish legislation. Further research is required to increase our understanding of the factors influencing clinicians’ decision-making, including contextual factors that may bias decision-making including stress and emotional wellbeing.

Conclusion

This synthesis sought to understand the process of deciding to involuntarily admit someone to an adult psychiatric hospital. The wider context in which professionals work is highlighted in this synthesis, as they are expected to effectively manage service users with reduced community resources in a society increasingly preoccupied with risk. The perceptions of those deciding to involuntarily hospitalise people is an important area meriting further research, and may reflect difficulties in interpreting and applying legislation alongside concerns about risk and criticism from others.

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Chapter 2: Major Research Project

**An Exploration of How Mental Health Professionals Position Themselves in
Relation to Advance Statements**

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Plain English Summary

A qualitative exploration of health professionals' perspectives on Advance Statements ***Background***

Many countries now have legislative provisions for Advance Statements (AS) in accordance with United Nations' Convention on the Rights of Persons with Disabilities (UNCRPD) principles concerning rights of people with disabilities. Despite developments in policies moving towards patient empowerment, the uptake of AS is low.

Aims

This study aimed to explore health professionals' perspectives on AS to help understand the low uptake.

Methods

A sample of 13 mental health professionals were recruited (4 Mental health nurses (MHNs), 6 community psychiatric nurses (CPNs) and 3 psychiatrists) into the study. These professionals were chosen because of their involvement in making treatment decisions and administering treatments. They took part in a semi-structured interview which was audio-recorded and transcribed for analysis. The data were analysed using a qualitative method called Discourse Analysis to explore how they positioned themselves in relation to AS.

Results

Five main positions emerged from the data: Taking Account of Peoples' Wishes where participants described their understanding of AS; Enabling People to Have Their Say (to a Point) where participants spoke about AS enabling service users to be involved in treatment decisions, but only when professionals judged it to be appropriate; We Know What's Best, where participants spoke about knowing what is best for people; Firefighting with Risk which involved participants describing how risk management and crises dominated their work; and Leverage and Liability, where participants spoke of the different levels of accountability which influence their work.

Conclusions

Interventions to improve the uptake of AS must consider the complexity of the NHS system, how decisions are made and address the low value of knowledge from lived experience. It is crucial that all stakeholders are involved in these endeavours.

Abstract

Background & Aims

Despite progressive legislative provisions for Advance Statements (AS), the uptake remains low. This suggests aims of empowering people with human rights on an equal basis with others are not being realised in practice. This study aimed to interview mental health professionals about AS to increase our understanding of low rates of implementation.

Methods

Thirteen participants (4 Mental health nurses, 6 community psychiatric nurses and 3 psychiatrists) were recruited. They were purposively sampled because of their involvement in making treatment decisions. They participated in a semi-structured interview which was audio-recorded and transcribed. The data were analysed using Discourse Analysis to explore how participants used language to position themselves in relation to AS.

Results

Five positions emerged from the data: Taking Account of Peoples' Wishes where participants described their understanding of AS; Enabling People to Have Their Say (to a Point), where participants explained that they enable people to become involved in treatment decisions, but only when professionals judged it to be appropriate; We Know What's Best, where participants used medical discourse when explaining what is best for people, limiting the credibility of AS; Firefighting with Risk where participants described the need to prioritise risk and crisis management over AS; and Leverage and Liability, where participants spoke of the different influences in their work.

Conclusions

Legislation is not enough to improve implementation of AS and improving knowledge is unlikely to lead to change. Interventions designed to address the low uptake must consider the complexity of the system which it hopes to change while addressing the disparity in how knowledge derived from lived experience is valued. It is crucial that all stakeholders are involved in these endeavours.

Introduction

Advance directives (AD) for physical illness were introduced as a ‘living will’ to allow people to plan future treatment should illness mean they lack capacity (Jankovic, Richards, & Priebe, 2010; Robertson, 1995). Szasz (1982) first proposed the concept of a ‘psychiatric will’, enabling people with fluctuating capacity as a result of severe mental health difficulties to engage in anticipatory care planning in relation to involuntary treatment. This has developed to take the form of Advance Statements (AS), a term encompassing AD and Joint Crisis Care Plans (JCCPs). Under The Mental Health (Care and Treatment (Scotland) Act (2003), an AS specifies:

“(a) the ways the person making it wishes to be treated for mental disorder; (b) the ways the person wishes not to be so treated, in the event of the person’s becoming mentally disordered and the person’s ability to make decisions about the matters referred to in paragraphs (a) and (b) above being, because of that, significantly impaired” (275(1).

An AS complies with the law if the person makes it at a time where they have capacity and it is witnessed, and mental health professionals must pay regard to it in treatment decisions (Scottish Executive, 2005; Hobbs, 2007). Should it be deemed necessary to override an AS, Scottish Health Boards have a statutory requirement to inform the Mental Welfare Commission for Scotland (MWCS; Scottish Executive, 2005). AS differ from a personal statement which includes preferences apart from treatment and does not have the same standing in law (Scottish Executive, 2005).

Many countries now have legislative provisions for AS, seen by the Committee for the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) as an important step in meeting the convention’s aims of ensuring people with disabilities exercise their human rights (Scholten, Gieselmann, Gather & Vollmann, 2019). States which have ratified the CRPD are required to *“take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity”* (UNCRPD, Article 12(3)), which AS are proposed to do (Gooding, 2015; Stavert, 2015).

Successful implementation of AS requires participation by key stakeholders (Zelle, Kemp & Bonnie, 2015). Studies exploring professionals' views have shown that they are supportive of the principle of AS, describing them as a way to encourage autonomy, increase agreement in treatment decisions, improve therapeutic relationships and promote continuity of care (De Souza & Wheeldon, 2013; Elbogen et al., 2006; Gieselmann, Simon, Vollmann, & Schone-Seifert, 2018; Maylea, Jorgensen, Matta, Ogilvie & Wallin, 2018; Ruchlewska, Kamperman, Wierdsma, van der Gaag & Mulder, 2016; Srebnik et al., 2005; Swanson et al., 2003; Van Dorn, Swanson, Swartz, Elbogen, & Ferron, 2008). Similarly, service users reported that they felt JCCPs increased feelings of empowerment, respect, trust and improved therapeutic relationships (Farrelly et al., 2015a; Farrelly et al., 2015b; Van Dorn et al., 2008). People with experience of compulsory treatment have stressed the importance of relationships which value their preferences and choices and highlighted the potential for AS in ensuring their preferences are heard (MWCS, 2018).

Research shows the low uptake of AS means positive outcomes are not being realised in practice (McManus, 2009; Ridley & Hunter, 2013). Indeed, while there was over 6,000 new orders for compulsory treatment in Scotland during 2018/19, only 271 AS were received by the MWCS (MWCS, 2019). Some professionals report a lack of knowledge or training about AS as a key issue (De Souza & Wheeldon, 2013; Julia-Sanchis et al., 2019; McManus, 2009; Van Dorn et al., 2006) while others have expressed knowledge and awareness of AS but a lack of experience working with them (Amering, Denk, Griengl, Sibitz & Stastny, 1999; Gieselmann et al., 2018; Swanson et al., 2003). Operational issues such as lack of time, lack of clarity in how to implement them and uncertainty in how they would know/access it if a person has one have been raised as barriers (De Souza & Wheeldon, 2013; Gieselmann et al., 2018; Julia-Sanchis et al., 2019; Srebnik & Brodoff, 2003; Van Dorn et al., 2006). Additionally, clinical concerns around risk, duty of care and concerns about litigation and the legal parameters for following an AS has led professionals to place limits on how far they support their use (Elbogen et al., 2006; Gooding, 2015; Hobbs, 2007; Sellars et al., 2017; Srebnik & Brodoff, 2003).

Concerns about the use of AS to refuse all treatments is unsupported by research (Backlar, McFarland, Swanson & Mahler, 2001; Elbogen et al., 2007; Reilly & Atkinson, 2010; Srebnik et al., 2005; Srebnik & Brodoff, 2003). Furthermore, the majority of AS preferences fit with standard clinical care, showing AS have high clinical utility, scope

for promoting agreement about treatment decisions and can help professionals deliver treatment (Elbogen et al., 2007; Farrelly et al., 2014; Farrelly et al., 2015b; Henderson et al., 2004; Julia-Sanchis et al., 2019; Srebnik et al., 2005; Swanson et al., 2008).

While some studies have found AS reduce the use of coercion (Henderson et al., 2004; Swanson et al., 2008), others are less encouraging. In a large-scale trial of 569 participants, Thornicroft et al. (2013) compared JCCPs with usual care and saw no significant impact on reducing coercion into hospital, with clinicians returning to team norms and practice instead of referring to JCCPs. Similarly, Patient Advocate Facilitated Crisis Plans and Clinician Facilitated Crisis Plans offered no benefit in relation to reducing hospital admission (Ruchlewska et al., 2016). Notably, clinicians expressed a lack of faith in AS, describing them as an optional, unimportant paperwork task (De Souza & Wheeldon, 2013; Thornicroft et al., 2013). Therefore, implementation of AS are an example of a ‘wicked problem’¹ requiring the development of a detailed understanding of how mental health professionals understand their value in the context of a broader service system.

Therefore, Stryker’s symbolic interactionism (Stryker, 2008) provides a theoretical basis to understand issues raised by professionals. It endeavours to describe the impact of systems using role and identity theories where people take on positions such as nurse or doctor. Risk management has been shown to be the most important aspect of their professional identity, which perhaps reflects societal expectations of their role, highlighting an interdependence between individual professionals and the broader systems in which they work (Farrelly et al., 2015a; Grad & Rojo, 2008).

Aims

Therefore, this study aimed to explore mental health professionals’ discourses to understand how they construct their roles in relation to AS to help understand the complexities and implementation barriers relating to their low uptake.

¹ “A wicked problem is a problem that is difficult or impossible to solve because of incomplete, contradictory, and changing requirements that are often difficult to recognize. It refers to an idea or problem that cannot be fixed, where there is no single solution to the problem.”

https://en.wikipedia.org/wiki/Wicked_problem

Methods

Epistemological Position

This study adopted a social constructionist approach emphasising the importance of language in the construction of ‘knowledges’ giving rise to diverse ways of understanding a topic (Willig, 2013).

Discourse Analysis

A discourse analysis (DA) approach was used in this study, which is concerned with the use of language in constructing social realities and what is achieved by these constructions, therefore is well aligned to social constructionism (Potter & Wetherell, 1987; Willig, 2013; Gergen, 2009). Foucauldian DA (FDA) is concerned with how discourse makes available ways of being in the world and is concerned with exploring how language is used to negotiate roles and identities (Farrelly et al., 2015; Parker, 1994; Starks & Brown-Trinidad, 2007; Willig, 2008; Willig, 2013). FDA is also concerned with legitimation and power and pays attention to how discourses are validated and reinforced by institutional structures and how these institutional structures are supported and legitimised by individual discourse (Willig, 2013), making it particularly suitable to the aims of this study. Stryker’s structural symbolic interactionism (Stryker, 2008) understands society as organised systems of interactions and role relationships where people take on positions, and was used to guide the analysis.

While Willig’s (2013) 6-stage approach to FDA does not constitute a complete analysis of text, the strength is in its structure which facilitates analytic thinking in a manageable way. It focuses on *discursive constructions* and how people talked about topics, including differences and similarities. *Action orientation* is concerned with indicators of what constructions can achieve. *Positioning* identifies the range of positions that participants take up through their discursive constructions, while *practice* gives attention to the relationship between discourse and practice, paying consideration to how positions help or hinder action. Finally, *subjectivity* is concerned with what is felt, thought and experienced from the different subject positions.

Transparency and Reflexivity

A reflexive approach let me acknowledge my own biases and reflect on the impact of my perspectives on this study, particularly in relation to AS. I considered my values which challenge the balance of power in mental health services and support service user empowerment and rights. I also reflected on my role as a trainee clinical psychologist and influence of the philosophy of the profession. Keeping field notes helped me use supervision to reflect on my bias and stay close to the research aims.

Ethical Approval

Ethical approval was granted from the University of Glasgow School of Medical, Veterinary and Life Sciences Ethics Committee (Appendix 2; 200180162). NHS ethical approval was not necessary for interviewing NHS staff, as they are not regarded vulnerable participants. Research and Development (R&D) approval was granted from NHS Greater Glasgow and Clyde (NHS GGC; Appendix 3 & 4; GN18MH141). The information sheet is included in Appendix 5 and the consent form in Appendix 6.

Recruitment

A purposive sampling approach was used. Mental health nurses (MHNs), community psychiatric nurses (CPNs) and psychiatrists with knowledge and/or experience of making or using AS were sought. These participants were thought to be most suited as they frequently administer treatments and make treatment decisions. They had to be working in NHS hospital wards or in Community Mental Health Teams (CMHT) and be able to converse in English. There were no other inclusion criteria. As part of the recruitment process, the health board's mental health legislation sub-committee was consulted, who gave their support for the project.

CMHT and ward team leads were approached via email with an invitation letter (Appendix 7) and the information sheet. Staff were also approached in person where I verbally provided brief information about the study.

Sample

Discursive methods require a smaller sample size than quantitative approaches, as the focus is on the depth of understanding and meaning rather than making broad generalisations (Potter & Wetherell, 1987; Dworkin, 2012). Rather than aim for data

saturation, information power in the data was felt to be appropriate in determining sample size to allow a sufficient depth of understanding (Malterud, Siersma, & Guassora, 2016).

A sample of 13 was recruited (3 psychiatrists, 4 MHNs and 6 CPNs). One MHN was known to the researcher through clinical placement. Demographic information was not collected as because this study was focused on the ways in which discourse constructs reality, and from a DA perspective, such information is a way of constructing reality (Willig, 2013).

Materials

Recording and Transcription Equipment

The interviews were recorded in a SONY IC digital voice recorder and transferred to a university laptop. The interviews were then transcribed using Express Scribe Transcription software.

Interview Schedule

A copy of the interview schedule is in Appendix 8, and was designed with open ended questions to cover relevant topic areas including participants' understanding of AS, thoughts on the low uptake and strengths and weaknesses of AS.

Interview

All interviews were conducted by the researcher and took place in a private office in participants' places of work. Participants were reminded of my role and the purpose of my research was to obtain an educational qualification. Participants each signed a copy of the consent form and were reminded that they could withdraw from the study at any time without reason and consequence. Interviews were carried out from September – November 2019 and ranged from approximately 20 minutes to 50 minutes. They were offered the opportunity to receive a copy of the final study.

Transcription and Analysis

Transcription

I transcribed all audio recordings of the interviews into separate Microsoft Word Documents which allowed me to engage with the data and reflect on its contents. All

transcripts were allocated a participant number and identifying information was omitted to ensure anonymity.

Reading and Re-Reading

During the reading and re-reading stage, I made notes in the margins of each transcript where there were points of interest in terms of what was said or how it was said.

Coding and Initial Analysis

As I coded and explored the data using this framework, I paid attention to how participants constructed their subject positions and how these constructions varied throughout the text. I assumed that their position in relation to AS was not only explicitly talked about, but also constructed through their discourse. I reflected on my own biases throughout the analysis.

Results

Participants began by describing their understanding of AS in different ways, and there was some variation in how they reported their understanding. Participants stayed faithful to their descriptions, or not, in different ways and although AS were described as an important method to empower people, different dilemmas, inconsistencies and complexities were revealed which showed how participants appeared to endorse AS to varying degrees. Participants highlighted the complex and unpredictable nature of their work, which was navigated using medical discourse and notions of accountability.

Taking Account of Peoples' Wishes

Much of the sample described learning about AS as part of their training for their role, whether they were a nurse or psychiatrist, while others who had more years of experience had learned about them as mental health legislation had changed and developed. Participants explained that they must have a sound knowledge and understanding of mental health legislation to be able to provide patients with information concerning their rights, including their right to an AS. Participants explained that AS were made at a time when a person is well which outlines what treatment they prefer in future, particularly in relation to medication. Participants used the term 'unwell' when they explained the

circumstances which someone's AS would be used, and that being unwell can impact on a person's ability to make decisions.

Though all participants described being aware of AS, their descriptions highlighted variation in the depth of their knowledge. For instance, participant 3 (CPN) said "*It didn't to me really kinda highlight anything from a kinda, a clinical perspective, of what they wanted*" (p. 5, lines 225-228) as they described a personal statement belonging to a person he had worked with, rather than an AS. Participant 13 (MHN) explained they felt they had a greater level of understanding than their colleagues through their training: "*I done it in my essay so I had to go research it and look intae it more. Whereas somebody who didn't put it in their essay, wouldn't know about it*" (p. 5, lines 206-208). Furthermore, AS were referred to as both a wish list and a legal document highlighting a lack of understanding among the sample. There was discourse of doubt and uncertainty around whether they are a "*legal requirement or, em, it's just kinda, a- a numbers*" (Participant 8, CPN; p. 6, lines 224-225).

Participants described having little experience of making or implementing AS: "*We've only really come across three and I've been nursing for 35 years*" (Participant 5, MHN; p. 9, lines 322-323). Of those who had made AS, they only did so a maximum of three times and because the person they were working with approached them to make one. Participants felt they should be encouraging people to make an AS, with many stating this was part of their role as they were the one with the knowledge to help them do so.

AS were described as generally helpful for all people receiving treatment, though discourse around detention brought to light limited knowledge and understanding of the applicability of AS as they were described as relevant for people who are in hospital.

Participants spoke about their role in both inpatient and community settings and saw listening to patients' views and preferences on treatment as a key part of their role, fitting with the principles of AS and enabling people to be involved in treatment decisions.

Enabling People to Have Their Say (to a Point)

Participants described their understanding of the function of AS to encourage people to reflect on their mental health and what treatment has been helpful or unhelpful. AS were constructed as facilitating people becoming more involved in decisions about their care

and treatment. Anticipatory care planning was described as offering people “*peace of mind*” (Participant 1, CPN; p. 3, line 72) that if they were unable to express their preferences when they are unwell or in crisis, their AS would provide them with “*a voice when they’ve- they don’t have a voice themselves*” (Participant 5, MHN; p. 1, lines 36-37). This was described as helpful for professionals, allowing them to understand the person’s perspective and take it into account in their decision-making, enabling a “*more person centred*” (Participant 9, Psychiatrist; p. 6, line 233) approach. This helped to avoid treating people in a way they don’t want or repeating any negative experiences while encouraging professionals to stop and consider all available treatment options.

Rather than simply a means to express their wishes, AS were constructed as allowing people to become an active participant in decision-making about their treatment, providing them with “*more power*” (Participant 7, CPN; p. 13, line 526) and control, which participants were supportive of, but only to an extent. If a person was judged too unwell, the AS “*doesn’t actually count*” (Participant 6, CPN; p. 2, lines 43-44) highlighting the fact that AS can be overridden, and that a judgement is made by the professional about when an expression of preference is valid.

We Know What’s Best

Discourse around knowing what is best for the patient helped participants navigate the reconciliation of professional knowledge and patient choice, and although the control over decision-making was constructed as sitting with the doctor all participants used medical discourse reflecting the medical model context in which they worked, placing them as knowledgeable experts about treatment required to make a person well.

“There’s a medical model an’ that is the process to recovery like if you’ve had your appendix out you’re gonnae give that operation it’s gonnae be stitched and it’s gonnae take so long” (Participant 2, CPN; p. 16, lines 746-748)

Medical discourse allowed professionals to take sole power and control over treatment decisions, as this equipped them with the specialist professional knowledge about treatment. Discourse around the notion of being too unwell and the importance of accessing correct treatment legitimised treating people against their will and overriding their AS, as did AS judged to be unrealistic or unreasonable, such as coming off

medication. These AS were constructed as pointless and "*another reflection of how unwell they are*" (participant 12, Psychiatrist; p. 5, lines 205-206), limiting the credibility of the person and their AS, while positioning professionals as knowledgeable about when the person has capacity to make one. Timing was described as important in making an AS to ensure it reflected the person's true preferences and not driven by psychosis, mania or grudges.

Expert discourse around doing what is best for the person or having no other option was offered as a justification for the decision to override an AS, though the decision was placed on the psychiatrist, "*the villain, most of the time*" (Participant 10, Psychiatrist; p.2, lines 69-70) but also whose "*job is to save lives*" (Participant 10, Psychiatrist; p. 8, line 325). Role discourses illuminated that decisions took place in the context of an acknowledgement of the importance of hierarchies in decision-making, where psychiatrists hold responsibility and nurses hold less autonomy and power, and patients even less so. Participants' accounts conveyed discomfort in decisions to treat a person against their will:

"as a nurse feel, a bit of both, you're feeling really bad about doin' it but good that you're doin' somethin' that's going to get them well. So you can be a bit confused in your own mind, but you have to keep tellin' yourself that this is the best for them" (Participant 11, MHN; p. 3, lines 122-126)

Role discourse highlighted the difficulty in navigating the perceived need to treat and respecting individual wishes. Discourse around risk cast light on how participants navigated the decision-making process and the risk-management part of their role:

"As a treating person, do I then treat or do I not treat? That's the question. Because if I don't treat, what if the person goes and does something to themselves or does something to somebody else? Eh, at the same time, em, eh, if I treat is it going to be 'battery' as in is it- am I treating the person, outwith his advance statement?" (Participant 10, Psychiatrist; p. 8, lines 317-322)

Firefighting with Risk

Participants spoke of their experience of firefighting in their work, though this was described in different ways depending on the context of their role. Those working in an inpatient setting described the fast-paced environment in which they worked, where people are admitted in crisis, and their job is to support patients being discharged back to the community. They highlighted the reduction in inpatient beds as exerting an added pressure to get people out of hospital quickly adding to the short-term nature of their work with patients who are acutely unwell. As such, the responsibility of making an AS was described as more suited to community staff who were thought to have more time to work with the person who would likely be more well and able to engage in the process.

However, participants working in the community described their role as dominated by crisis management. They described high caseloads of patients who are unpredictable and presenting with high levels of risk, which lead them to focus on the here and now management of difficulties. Working in a chaotic, high-pressure context with competing demands, participants explained *“it’s more important to keep people safe isn’t it, than to do their advance statement”* (Participant 7, CPN; p. 6, lines 251-252). Discourse around risk highlighted that AS were felt to be peripheral to participants’ role demands and not prioritised:

“I definitely don’t ask people about advance statement, I don’t because, ah, that’s not- like I said that’s not the first thing that comes to my head when I’m seeing somebody” (Participant 10, Psychiatrist; p. 5, lines 180-183).

Participants felt that they faced scrutiny from society which dictated how they approached their work, and a discourse around blame and criticism showed the embattlement participants faced, while risk and safety serve to legitimise decisions to involuntarily treat people:

“society, the pressures from the general public ehhm because, they’re quite quick to be very critical if something goes wrong an, we’re the firs- we’re the first point-port ah call really ones that get the blame” (Participant 1, CPN; p. 4, lines 121-125).

Leverage and Liability

Participants described different levels of accountability and at the broadest level, expectations from society that professionals, the NHS system and governments will effectively manage risk and safeguard the public were presented as having the widest influence on how the system and individuals approached their work. Participants described prioritising the tasks for which they were accountable, explaining the Code of Conduct which all healthcare staff follow and highlighted the nursing professional body (Nursing and Midwifery Council) which holds them to account through their registration to practice. This legitimised their accounts for not being able to make AS as if “*you’re no gonnae get hauled over the NMC for no having it done then the chances are you might no get round to doing it*” (Participant 2, CPN; lines 708-710).

As part of the completion of essential nursing tasks they paid “*lip service*” (Participant 2, CPN; p. 12, lines 575-576) to AS: “*your risk assessments, you’ve got your care plans, you’re identifying appropriate coping strategies, you’re identifying appropriate sort of psychoeducational materials, em, and therefore there within the midst of it you’re also aware of advance statements*” (Participant 3, CPN; p. 7, lines 298-302). They described being held to account by team managers who don’t ask about AS, highlighting that the priorities of their seniors have influence over their work rather than directly through legislation. Psychiatrists however described their work as being led by mental health legislation which directly informed their work, for example when they detain people and treat them under the Act.

Participants described recurrent ‘pushes’ for the completion of AS but while this came and went, the push for risk management persisted and participants’ ‘duty of care’ left little scope for AS. Participants correctly identified that the making of an AS is no single person’s responsibility. While some were clear “*it is something we do talk about when we’re care planning with patients so, I guess, you know, it is somethin’ we probably should do a bit more*” (Participant 6, CPN; p. 5, lines 186-188), others described professionals external to the treatment team, such as Mental Health Officers or Advocacy Workers, as key in taking the responsibility for the making of an AS, explaining “*I wouldn’t want to exert kind of undue influence over, over the person’s wishes*” (Participant 9, Psychiatrist; p. 3, lines 96-97).

Others explained that staff avoided taking on the extra responsibility because they did not have to. Some highlighted that “*professional fear around “am I doing this right?”*” (Participant 4, MHN; p. 9, line 379) led them to avoid making AS. There were concerns about “*being pulled up by kinda seniors for doin’ the wrong thing if you think li- you’re not sure what you’re doin’ you’re like that “mm, ah, I might get into trouble for this”*” (Participant 8, CPN; p. 7, lines 241-243). One participant explained that the tasks for which they were accountable for should already do the job of an AS:

“*So, lots of people will tell you, and I agree with them, that there’s a very robust treatment plan, so what’s the point in an advance statement? Surely the treatment plan has acknowledged their wishes*” (Participant 12, Psychiatrist; p. 12, lines 525-529).

Discussion

This study aimed to explore how mental health professionals position themselves in relation to AS to understand their low uptake. FDA was used to understand how participants used linguistics to construct their roles and explore how their individual discourses legitimised and supported the institutional structure in which they work, and how this structure reinforced and validated their discourse.

Discourse at an individual level revealed complexity and contradictions in how participants talked about their understanding of AS. They were described as a way for people to express preferences and have a say in decisions about treatment. Quite quickly though, there were limits imposed as their narratives departed from supporting people having choice and control in their treatment, to concerns about risk, notions of correct treatment and accountability. Their accounts reflect that the dilemmas within mental health policy and law regarding respecting individual autonomy and the social responsibility of ensuring the delivery of appropriate treatment arise in the implementation of AS (Swanson, Tepper, Backlar & Swartz, 2000; Swanson, Van McCrary, Swartz, Van Dorn & Elbogen, 2007).

Similar to previous findings, participants’ accounts showed that decision-making was influenced by broader contextual factors (Allen et al., 2020), including high caseloads,

perceived expectations from society and accountability to managers with effective management of risk a key concern. Concerns about blame were raised, in accordance with previous research (Henderson, Jackson, Slade, Young & Strauss, 2010). As such, crisis management was emphasised as a key part of their role, rather than spending time reflecting on experiences of treatment and anticipatory care planning. Participants' appraisal of and response to risk was closely connected to their own professional role while 'duty of care', necessary treatment and effective risk management served to help participants navigate the competing demands of their work, including in decisions to treat people against their will (Allan et al., 2020; Swanson et al., 2007).

Participants considered involuntary treatment as a necessary aspect of their work, though the power to make the decision sat with psychiatrists. This reflected hierarchies of decision-making in the NHS system, where patients' preferences are least credible and least valued. Medical discourse reflected the power of the NHS institution while legitimising professionals' identities and reasons for not making AS, overriding them and treating people against their will (Harper, 1995; Hui & Stickley, 2007).

Participants' accounts reflected a lack of knowledge, clarity and confidence around AS, explaining that they are relevant when people become unwell rather than lack capacity as stipulated in the Act, and there are times it doesn't count. Lack of knowledge has been identified in previous research, which perhaps unsurprisingly has led to a recommendation for staff to be trained around AS (Srebnik & Brodoff, 2003). However, based on the data in this study educational interventions aimed at improving knowledge will have a limited impact and strongly suggests it will not improve the uptake of AS.

Implications for Policy and Services

This study suggests that progressive principles influencing the development of legislation and policy in accordance with UNCRPD priorities are not being realised in practice, with the power remaining in the hands of professionals (Ridley & Hunter, 2013; Stavert & McGregor, 2017). The challenge is in how to legitimise service user knowledge and experience while creating systems where it is given equal regard in decision-making. Designing services with the involvement of people with lived experiences alongside involving them in the training of mental health professionals may begin to address this issue. Additionally, how the organisation more broadly responds to and manages risk

must be critically explored. Clearly, risk and safety are prioritised in the here and now, though could also be met by prioritising AS, thereby prioritising legislative expectations and standards. To create change the involvement of all stakeholders is of paramount importance, including service users, health professionals, health service management, policy makers and researchers.

Strengths and Limitations

Mental Health Officers were not included in the sample, and they may have offered additional relevant insights. Further, the sample was recruited from one geographical area therefore are not generalisable to wider mental health professions. While the results from this small purposive sample are not necessarily generalisable, the power in the data is that it provides detailed and in-depth insights (Malterud et al., 2016) using discourse to unpack some of the complexities around why it is difficult to implement AS in the NHS system.

A critique of the use of interviews to collect data is that it may lead to participants self-monitoring their talk more than they would in more naturally occurring situations (Nikander, 2012). However, no qualitative data are entirely detached from researcher involvement because participants must still be told about and provide consent to participate in the research (Hammersley, 2014; Nikander, 2012). FDA is concerned with how language reflects individuals' roles and positions, and how individuals' discourse reflects institutions and power. The interview schedule was designed to use topic areas as a guide, which allowed for sufficient flexibility while minimising the influence of the researcher's own position and language in the interview.

In dealing with a large amount of complex data, compromises had to be made when considering what was to be included in the results. A decision had to be made about how to convey the results in an integrated way and balance this with the inclusion of quotations. In order to provide a narrative account of how participants' discourses came together to form a whole, a decision was taken to reduce the number of quotes used. To compensate for this the researcher was strategic and purposeful about what quotes to include, and endeavoured to ensure the results represented each participant.

A strength of this study is in the analysis, which critically questions the status quo and gives important insights for policy development and interventions designed to improve

the uptake of AS. The sample spanned across disciplines of nursing and psychiatry and inpatient and outpatient settings, providing an in-depth understanding from these different perspectives. Further, during the development of this study I consulted with the Scottish Government's Mental Health Directorate and the Health Board's mental health legislation sub-committee who both provided support for the study.

Conclusions

This study highlights the complexity of implementing AS in the NHS. A review of Scottish legislation was announced in 2019, which pledged to further strengthen the rights of people subject to mental health treatment and bring domestic law in line with broader human rights principles and the UNCRPD. AS are key here. This study provides an understanding of how things are 'on the ground' which is essential to translate progressive legislation into practice. We are in an urgent crisis as we continue to see an increase in the use of coercion by involuntary treatment, with the potential benefits of AS not being realised by service users, staff or the NHS. Interventions to increase the uptake must consider the complexity of the system as solely focusing on increasing knowledge will not lead to any change. Until there is a shift in how different types of knowledge is valued in the NHS it is unlikely that the uptake of AS will be improved.

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Appendix 1: Consolidated Criteria for Reporting Qualitative Research Checklist

COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
<i>Personal characteristics</i>			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	
Occupation	3	What was their occupation at the time of the study?	
Gender	4	Was the researcher male or female?	
Experience and training	5	What experience or training did the researcher have?	
<i>Relationship with participants</i>			
Relationship established	6	Was a relationship established prior to study commencement?	
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	
Interviewer characteristics	8	What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	
Domain 2: Study design			
<i>Theoretical framework</i>			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	
<i>Participant selection</i>			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	
Sample size	12	How many participants were in the study?	
Non-participation	13	How many people refused to participate or dropped out? Reasons?	
<i>Setting</i>			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	
<i>Data collection</i>			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	
Repeat interviews	18	Were repeat interviews carried out? If yes, how many?	
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	
Field notes	20	Were field notes made during and/or after the interview or focus group?	
Duration	21	What was the duration of the interviews or focus group?	
Data saturation	22	Was data saturation discussed?	
Transcripts returned	23	Were transcripts returned to participants for comment and/or	

Topic	Item No.	Guide Questions/Description	Reported on Page No.
		correction?	
Domain 3: analysis and findings			
<i>Data analysis</i>			
Number of data coders	24	How many data coders coded the data?	
Description of the coding tree	25	Did authors provide a description of the coding tree?	
Derivation of themes	26	Were themes identified in advance or derived from the data?	
Software	27	What software, if applicable, was used to manage the data?	
Participant checking	28	Did participants provide feedback on the findings?	
<i>Reporting</i>			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	
Data and findings consistent	30	Was there consistency between the data presented and the findings?	
Clarity of major themes	31	Were major themes clearly presented in the findings?	
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

Appendix 2: College of Medical, Veterinary and Life Sciences Ethical Approval



19th June 2019

MVLS College Ethics Committee

Project Title: An Exploration of How Mental Health Professionals Position Themselves in Relation to Advance Statements: A Discourse Analysis

Project No: 200180162

Dear Prof Gumley,

The College Ethics Committee has reviewed your application and has agreed that there is no objection on ethical grounds to the proposed study. It is happy therefore to approve the project.

- Please accept the tracked changes in the documents so that printouts will look tidy.
- Please align the title of the project in the application form with the title on the PIS.
- I note that the applicants state that this project underwent NHS R&D review (PIS, item 10). For our records the relevant correspondence should be forwarded
- Consider inclusion of people with a physical disability.
- Project end date: End February 2020
- The data should be held securely for a period of ten years after the completion of the research project, or for longer if specified by the research funder or sponsor, in accordance with the University's Code of Good Practice in Research:
(http://www.gla.ac.uk/media/media_227599_en.pdf)
- The research should be carried out only on the sites, and/or with the groups defined in the application.
- Any proposed changes in the protocol should be submitted for reassessment, except when it is necessary to change the protocol to eliminate hazard to the subjects or where the change involves only the administrative aspects of the project. The Ethics Committee should be informed of any such changes.
- You should submit a short end of study report to the Ethics Committee within 3 months of completion.

Yours sincerely,

◀

Jesse Dawson
MD, BSc (Hons), FRCP, FESO
Professor of Stroke Medicine
Consultant Physician
Clinical Lead Scottish Stroke Research Network / NRS Stroke Research Champion
Chair MVLS Research Ethics Committee

Institute of Cardiovascular and Medical Sciences
College of Medical, Veterinary & Life Sciences
University of Glasgow
Room M0.05
Office Block
Queen Elizabeth University Hospital
Glasgow
G51 4TF

jesse.dawson@glasgow.ac.uk

Appendix 3: R&D Approval



Senior Research Administrator: Kayleigh McKenna
Telephone Number: 0141 232 1826
E-Mail: kayleigh.mckenna@ggc.scot.nhs.uk
Website: www.nhsqgc.org.uk/r&d

Clinical Research & Development
West Glasgow ACH
Dalnair Street
Glasgow G3 8SJ
Scotland, UK

21/05/2019

Miss Angela Glasgow
NHS Greater Glasgow and Clyde
Institute of Health and Wellbeing
First Floor, Admin Building
Gartnavel Royal Hospital
Glasgow
G12 0XH

NHS GG&C Board Approval

Dear Miss A Glasgow,

Study Title:	An Exploration of How Mental Health Professionals Position Themselves in Relation to Advance Statements
Principal Investigator:	Miss Angela Glasgow
GG&C HB site	Community Mental Health
Sponsor	NHS Greater Glasgow and Clyde
R&D reference:	GN19MH141
REC reference:	n/a
Protocol no: (including version and date)	Version 1.0 dated 13.05.19

I am pleased to confirm that Greater Glasgow & Clyde Health Board is now able to grant **Approval** for the above study.

Conditions of Approval

1. **For Clinical Trials** as defined by the Medicines for Human Use Clinical Trial Regulations, 2004
 - a. During the life span of the study GGHB requires the following information relating to this site
 - i. Notification of any potential serious breaches.
 - ii. Notification of any regulatory inspections.

It is your responsibility to ensure that all staff involved in the study at this site have the appropriate GCP training according to the GGHB GCP policy (www.nhsqgc.org.uk/content/default.asp?page=s1411), evidence of such training to be filed in the site file.

2. **For all studies** the following information is required during their lifespan.
 - a. Recruitment Numbers on a quarterly basis
 - b. Any change of staff named on the original SSI form

Page 1 of 2	R&D Management Approval Letter	GN19MH141
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- c. Any amendments – Substantial or Non Substantial
- d. Notification of Trial/study end including final recruitment figures
- e. Final Report & Copies of Publications/Abstracts

Please add this approval to your study file as this letter may be subject to audit and monitoring.

Your personal information will be held on a secure national web-based NHS database.

I wish you every success with this research study

Yours sincerely,

Kayleigh McKenna
Senior Research Administrator

CC: Prof. A. Gumley (CI)

Appendix 4: Non-substantial Amendment

Dear Miss Glasgow,

R&D Ref: GN19MH141 **Ethics Ref:** n/a

Investigator and site(s): Miss Angela Glasgow (Community Mental Health)

Project Title: An Exploration of How Mental Health Professionals Position Themselves in Relation to Advance Statements: A Discourse Analysis

Protocol Number: V1.0; 13/05/19

Amendment: Non-substantial Amendment 1 (30/07/19)

Sponsor: NHS Greater Glasgow and Clyde

I am pleased to inform you that R&D have reviewed the above study's Amendment and can confirm that Management Approval is still valid for this study.

Non-substantial amendment documents reviewed:	Version	Dated
Notice of minor amendment form	AM01	05/08/19
Participant information sheet	1.2	29/07/19
Participant flyer	1.1	29/07/19
Consent form	1.1	29/07/19

I wish you every success with this research project.

Kind regards

NHS GG&C R&D

Ward 11 Dykebar Hospital
Grahamston Road
Paisley PA2 7DE

Tel: +44 (0)141 314 (4)4001

Generic email for PR team: RandD.PRTeam@ggc.scot.nhs.uk

Web: www.nhsggc.org.uk/r&d

Appendix 5: Participant Information Sheet



University of Glasgow | College of Medical,
Veterinary & Life Sciences



PARTICIPANT INFORMATION SHEET

Health Professionals' Views of the Uptake and Implementation of Advance Statements

You are being invited to take part in a research study because you currently work in an NHS Community Mental Health Team or Mental Health Ward in NHS Greater Glasgow and Clyde. Before you decide whether you would like to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and ask me if there is anything that is not clear or if you would like more information. If you decide you want to take part in the research project, you will be asked to sign the consent section. By signing it you are telling us that you:

- Understand what you have read
- Consent to take part in the research project
- Consent to the use of your personal information as described.

You will be given a copy of this Participant Information Sheet and the signed consent form to keep.

1. What is the purpose of this study?

The purpose of this study is to explore the experiences of mental health professionals in developing and implementing Advance Statements.

This information will be collected using a 1:1 interview which is expected to take no more than 1 hour of your time. The information collected will be used to understand how mental health professionals experience developing and implementing Advance Statements. The information collected would help to understand facilitators and barriers to the development and implementation of Advance Statements. This research is undertaken as part of the Psychosis Research Group in the University of Glasgow and will contribute directly to developing approaches to increase the uptake of Advance Statements in psychiatric care.

This study will contribute towards the educational qualification award of Doctorate in Clinical Psychology.

2. What does participation in this research involve?

This project will be conducted in NHS Greater Glasgow and Clyde premises and Gartnavel Royal Hospital. You will be invited to take part in an 1:1 interview which should last no longer than 1 hour. The interview will be audio-recorded. Once the interview is complete your participation in the project will come to an end and it is not anticipated you will be invited to take part in a second interview.

3. Do I have to take part in this research project?

No, participation in any research project is voluntary. If you do not wish to take part you do not have to. If you decide to take part and later change your mind that is also OK. You have the right to withdraw from the project at any stage without giving a reason. This will not affect your employment in any way.

4. What are the possible benefits of taking part?

You will receive no direct benefit from taking part in the project.

5. What are the possible risks and disadvantages of taking part?

We do not anticipate any significant risks associated with participation in this project. A potential disadvantage is the time burden, which may be up to an hour out of your busy working day.

6. What if I withdraw from this research project?

You can withdraw from the project at any time. You do not have to provide a reason and if you withdraw your employment will not be affected. If you do withdraw from the project, any personally identifiable information about you will be destroyed and the interview recording will be destroyed.

Part 2 How is the research project being conducted?

7. What will happen to information about me?

By signing the consent form you consent to the relevant research staff collecting and using information about you for the research project. Any information obtained for the purpose of the research project which can identify you will be treated as confidential and securely stored in a locked filing cabinet in Gartnavel Royal Hospital and a password protected University of Glasgow laptop. It will only be disclosed as required by law.

Your interview and personal information (e.g. age, gender, duration of employment in NHS Greater Glasgow and Clyde) will be collected. The interview will be audio-recorded. The recording will be stored on a password-protected computer at the University of Glasgow. Any paper files will also be stored securely in a locked filing cabinet in a locked office at Gartnavel Royal Hospital. The audio recordings will only be accessible by select researchers for the purpose of coding the specific responses of participants. After completion of the project personal data will be destroyed, while research data will be stored for 10 years.

The investigators listed on this Participant Information Sheet/Consent form will have access to the de-identified project data (i.e. demographic information, interview codings). Representatives of the study sponsor, NHS Greater Glasgow and Clyde, may also have access to your personal information for audit purposes.

Your information will only be used for the purpose of this research project, and it will only be disclosed with your permission, except as required by law. Your information will be collected, stored and processed in accordance with the General Data Protection Regulation (2018).

8. What will happen to the results of the research study?

It is anticipated that the results of the research project will be published and/or presented in a variety of forums. In any publication/presentation, information will be provided in a way that you cannot be identified. Information that is published from this project will only include summary information that describes the whole group of participants in this project and not to any individual participant. We will use quotations taken directly from interviews, however you will not be identifiable based on these quotations.

9. Who is organising and funding the research?

The University of Glasgow is funding this research project. The Chief Investigator for the project is Professor Andrew Gumley at the University of Glasgow.

10. Who has reviewed the study?

The project has been reviewed by the College of Medical, Veterinary and Life Sciences Ethics Committee and the NHS Greater Glasgow and Clyde Research and Development Service.

11. Contact for further information

If you have any further questions about this research project you may contact Professor Andrew Gumley at Mental Health and Wellbeing, Gartnavel Royal Hospital, 1st Floor, Admin Building, University of Glasgow, Glasgow G12 0XH.

12. What if I have a complaint about the study?

If you have a complaint about the study you should contact Miss Angela Glasgow in the first instance. If your complaint is unresolved you are entitled to contact NHS Complaints at complaints@ggc.scot.nhs.uk.

13. Can I speak to someone who is not involved in the project?

You may contact Professor Hamish McLeod at Mental Health and Wellbeing, Gartnavel Royal Hospital, 1st Floor, Admin Building, University of Glasgow, Glasgow G12 0XH, 0141 211 3922

Thank you for reading this Participant Information Sheet.

Appendix 6: Participant Consent Form



University of Glasgow | College of Medical,
Veterinary & Life Sciences



Centre Number:

Project Number:

Participant Identification Number for
this trial:

Title of Project: Health Professionals' Views of the Uptake and Implementation
of Advance Statements

Name of Researcher(s): Angela Glasgow, Trainee Clinical Psychologist
Professor Andrew Gumley

CONSENT FORM

Please
initial
box

I confirm that I have read and understood the Participant
Information Sheet version 1.2 dated 29/7/19

I have had the opportunity to think about the information and
ask questions, and understand the answers I have been given.

I understand that my participation is voluntary and that I am free
to withdraw at any time, without giving any reason, without my
legal rights being affected.

I confirm that I agree to the way my data will be collected and
processed and that data will be stored until the project is
complete, in University archiving facilities in accordance with
relevant Data Protection policies and regulations.

I understand that all data and information I provide will be kept
confidential and will be seen only by study researchers and
regulators whose job it is to check the work of researchers.

I agree that my name, contact details and data described in the
information sheet will be kept for the purposes of this research
project.

I understand that the recorded interview will be transcribed word by word and the transcription stored for up to 10 years in University archiving facilities in accordance with Data Protection policies and regulations.

I understand that my information and things that I say in an interview may be quoted in reports and articles that are published about the study, but my name or anything else that could tell people who I am will not be revealed.

I would like to know the results of this study, and would like you to email these to me.

I agree to take part in the study.

I understand that if I withdraw from the study, my data collected up to that point will be destroyed.

I agree to my interview being audio-recorded

Name of participant

Date

Signature

Researcher

Date

Signature

Participant email address:

(1 copy for participant; 1 copy for researcher)

Appendix 7: Invitation Email

Invitation to participate in research project

Dear (mental health professional),

I am a Trainee Clinical Psychologist working in NHS Greater Glasgow and Clyde. As part of my training, I am conducting a research project focusing on the development and use of Psychiatric Advance Statements.

I am emailing you because I understand that you may have experience developing Advance Statements in your capacity as a mental health professional and therefore may be able to take part in my research. If you were able to, your experience and perspectives would be so valuable.

Participation involves an interview which should last around one hour, and we can meet on NHS premises that are convenient for you. Your responses will be confidential. Participation may count as one hour of education or reflective practice, which may help should you require revalidation as part of your role.

If you'd like to take part or have any questions, please reply to this email (angela.glasgow@ggc.scot.nhs.uk).

Many thanks,

Angela Glasgow
(Trainee Clinical Psychologist)

Appendix 8: Interview Schedule

Advance Statements Interview Schedule V 1.0 (15th May 2019)

Prior to interview the following procedures should be undertaken.

1. Check that the potential participant has read and understood the PIS attached to initial email. If necessary provide with another copy of PIS.
2. Check if the participant has any questions regarding study participation. Remind the person that participation is voluntary, that they can change their mind or withdraw at any time and that this will in no way affect their employment.
3. Explain Digital Recording device, privacy and purpose of recording and transcription..
4. Ensure that all appropriate aspects of the Consent Form are initialized.

Topic Area	Possible Probes
<p>Initial phase</p> <ul style="list-style-type: none"> • Tell me about your role <p>Interview</p> <ul style="list-style-type: none"> • Can you tell me about your understanding of what an Advance Statement is? • What have been your experiences of Advance Statements in the team you work in? • What has been your experience of Advance Statements in relation to the patients you have worked with? • How do you understand your role in relation to Advance Statements? • In Scotland, there has been a general lack of uptake of Advance Statements – what are your thoughts on this? • Do you have any thoughts on how the uptake of Advance Statements might be improved? • What do you see as the strengths and limitations of Advance Statements? <p>Ending</p>	<ul style="list-style-type: none"> • Setting, team, colleagues, size and complexity of caseload • Personal statement vs advance statement • How did you come to know what an advance statement is? • Have you developed/used one? • What was the context (Admission, discharge, inpatient, outpatient) • What did you see, what happened? Developed, implemented, discussed by team/patient? • Did you find it helpful? Engagement? • How did you find the process of developing/using one, what does it look like? • Validity? Ability to deliver? • Who's role is it to develop one? • How multidisciplinary is it? • Are there things you routinely do which could be used in the development of an Advance Statement? • What do you see as the barriers? (Individual/system?) • What does the barrier mean? • Are there things individual staff members/NHS/Advocacy workers could do? • Should they be developed more organically? • Recommendations to improve development and implementation? • What are the strengths/weaknesses of developing/implementing Advance Statements for staff/patients? • Mention Mental Welfare Commission website for documents on Advance Statements, and guidance on capacity.

<ul style="list-style-type: none">• Is there anything I haven't asked you about? Is there anything you would like to add?	
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Appendix 9: Proposal



Institute of Health
& Wellbeing

Doctorate in Clinical Psychology
Major Research Project Proposal Version 2

An Exploration of How Mental Health Professionals Position
Themselves in Relation to Advance Statements

University Supervisor – Professor Andrew Gumley

Field Supervisor – Dr Callum Jackson

17/12/2018

Word count 3536

Introduction

The legislative change driving the development of community based mental health treatment, perhaps most importantly the Mental Health (Care and Treatment (Scotland) Act (2003; 2015), includes guidance on Advance Statements. The update to The Act in 2015 introduces a requirement for NHS Healthboards to keep a copy of any Advance Statement developed with the service user's records and to provide information about the existence and location of it to the Mental Welfare Commission. An Advance Statement is a term used to describe a range of written preferences for future treatments and treatment refusals if the person loses capacity to make decisions, which must be taken into account in decisions about their treatment (Scottish Executive, 2005; Jankovic, Richards & Priebe, 2010). Types of Advance Statements also include Joint Crisis Plans (JCPs), which are mutually agreed between the individual and the mental health team involved in their treatment and Crisis Cards, very basic information, which people can carry around with them.

Advance Statements may be considered from an ethical perspective as providing service users with access to basic human rights of self-determination as well as increasing collaboration between service users and mental health professionals, reducing coercive approaches to treatment and empowering service users (Jankovic et al., 2010). More broadly, the use of Advance Statements is in accordance with the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD; United Nations General Assembly, 2006) which requires states to provide people with disabilities the support they may need in exercising their legal capacity. Increasing collaboration between service users and mental health professionals through an anticipatory care and shared decision making (SDM) approach to treatment is a priority in UK government policy, which proposes that mental health care and treatment can be transformed through SDM (Department of Health, 2010). SDM has been defined as

“a process in which clinicians and patients work together to select tests, treatments, management or support packages, based on clinical evidence and the patient's informed preferences; it involves the provision of evidence-based information about options, outcomes and uncertainties, together with decision support counselling and a system for recording and implementing patients' informed preferences” (Coulter & Collins, 2011, p. iv).

Crucially, service users must be adequately informed about their treatment options so that they are able to develop their own preferences and describe them to the relevant mental health professional (Hamann, Leucht & Kissling, 2003). This political, societal and legislative emphasis on service user empowerment and self-determination

has provided challenges for professionals working in mental health teams (Laugharne et al., 2011). Perceived barriers in relation to the development and implementation of Advance Statements include concerns about the duplication of work, whether service user preferences were in accordance with staff members' notions of clinical value, lack of resources impacting on the ability to meet preferences and the feasibility of service users' preferences (Farrelly et al., 2015). However, Srebnik and colleagues (Srebnik et al., 2005) found that in 95% of Advance Statements, service user preferences were largely feasible and consistent with current standards of treatment. Service users stated their preferred medication in 81% of Advance Statements, 64% listed medications they would refuse and 68% stated alternatives to hospitalisation (Srebnik et al., 2005). Although individual needs may differ, the most commonly recognised preferences for treatment were individualised care, greater provision of information and treatment choice and SDM (Byrne & Morrison, 2014).

Research by Hamann et al. (2006) compared a SDM approach and routine care in state hospitals in Germany, and reported that the integration of a shared decision approach was feasible and possible for service users with psychosis in that setting. Service users reported that their knowledge of their difficulties increased, their attitudes towards treatment improved and the hospital saw a change in the pattern of peoples' treatment, with an increase in participation in psychoeducational and sociotherapeutic interventions.

Research investigating the views of psychiatrists working in the UK indicates that psychiatrists feel they face a dilemma in exercising a SDM approach during consultations with service users about treatment. They describe a conviction that medications are the core treatment for many mental health problems, but expressed concern that providing full knowledge of the side effects of medications may impact on service users' willingness to engage with treatments (Seale, Chaplin, Lelliott & Quirk, 2006). Psychiatrists also reported that service user competence (capacity to make rational choices) is an obstacle to a SDM approach to treatment decisions.

Despite the perception from psychiatrists and mental health nurses that insight and competence in terms of making decisions is impaired by the severity of symptoms (Vuckovich & Artinian 2005; Seale et al., 2006), service users have shown to have the capacity to express their needs during an episode of psychosis (such as support to manage anxiety) as well as future needs (Byrne & Morrison, 2014). This provides further support for the argument that service users express reasonable preferences for treatment.

Research shows that service users express a motivation to be involved in decisions regarding their treatment, but feel that care planning is often developed about

them rather than with them (Laugharne et al., 2011; Andreasson & Skärsäter 2012; Ridley & Hunter 2013). A review by Byrne, Davies and Morrison (2010) found that there is a persistent reliance on the judgement of professionals surrounding service users' treatment needs, which are less idiosyncratic and are often informed from a biomedical understanding of the service users' difficulties. A stark finding surrounding of the lack of individuality in service users' Advance Statements is demonstrated in Farrelly et al.'s (2013) study where 85% of JCPs did not contain any individual preferences.

It appears that traditional views of service users being perceived as unable to make decisions about their treatment on their own, as highlighted in Davis (2002) and O'Brien and Golding's (2003) research, is pervasive over time. Mental health professionals in Farrelly et al.'s (2015) study reported mental health system's need for risk management as an obstacle to collaborative discussions around treatment. This issue can be understood when considering mental health professionals have different roles and identities included in their sense of who they are in their job, with the role which could meet the needs of the service (i.e. risk management) taking priority (Stryker, 2008; Farrelly et al., 2015).

Aims

The aim of this research is to observe how mental health professionals use discourse to shape and construct their roles and identities in relation to Advance Statements. More specifically, it is hoped this research will increase understanding around how mental health staff position themselves in relation to Advance Statements.

Plan of Investigation

Participants

Recruitment will be guided by a purposive sampling approach, where participants will be selected according to criteria relevant to the research question, which helps ensure homogeneity in that participants will have a shared experience they will be asked to describe (Willig, 2008).

Participants will be mental health professionals working in Community Mental Health Teams in NHS Greater Glasgow & Clyde, including Community Psychiatric Nurses and Psychiatrists, but may also be Social Workers and Mental Health Nurses working on mental health wards. There are no age/gender/time in post criteria. Participants will be recruited via NHS Community Mental Health Teams and via the Mental Health Network. Nurse team leaders will be approached to request permission to approach nurses via email to ascertain those with an interest in participating in the study. Additionally, clinical leads of the geographical area of Glasgow will be approached to request permission to

contact psychiatrists via email. Andrew Strachan (Mental Health Legislation Nurse Advisor) will also be approached to help identify participants from the Greater Glasgow and Clyde Legislative Team.

The email sent to potential participants will include a simple flyer with a brief description of the study and what participation will involve. Those who are interested in participating will be asked to reply via email to my (Angela Glasgow) NHS Greater Glasgow and Clyde email address. Those who express an interest in taking part will be provided with the Participant Information Sheet.

Consent will be obtained through a written signature subsequent to the participant being provided with another copy of the Participant Information Sheet and given the opportunity to ask questions. Participants will then take part in a semi-structured interview lasting approximately one hour. Interviews will be audio recorded on an encrypted recorder meeting appropriate NHS standards in relation to confidentiality. Research data will be access by Angela Glasgow and Professor Andrew Gumley. Recordings will be stored on a password protected University of Glasgow laptop then transcribed, fully anonymised by allocation of a participant identification number and the omission of all identifiable information.

Saturation

Saturation, the point at which no further insights are provided by the data (Dworkin, 2012), has traditionally been seen as the ideal when determining an adequate sample size for research, originating in the sampling process in Grounded Theory methodology (Nelson, 2017). However, O'Reilly and Parker (2013) suggest the undisputed acceptance of such a concept perpetuates unconstructive myths about adequate sampling while undermining research not meeting such expectations. They suggest methodological integrity may be preserved while assessing on alternative measures of quality. Theoretical sufficiency (Dey, 1999), where a sufficient depth of understanding is obtained rather than a stage where it is not possible to reach new insights, as well as safeguards to protect and improve the quality of analysis, reflexivity and the identification of the researcher's own assumptions would ensure quality, transparency and openness.

Sample size

Assuming that interviews will last around one hour, the data generated from the transcription of these interviews alongside the notes from the transcription process will result in a large amount of data which is highly likely to produce an insight into discourse

around the implementation of Advance Statements. Studies using the same methodology have recruited between 8 and 16 mental health professionals from NHS settings (Benson et al., 2003; Stevens & Harper, 2007) and will guide the sample size of this project. It is predicted that 10 – 12 participants would be feasible for this project.

Inclusion and exclusion criteria

Participants included in this research will be mental health service staff who are currently employed with NHS Greater Glasgow and Clyde. Participants work in a Community Mental Health Team or on an inpatient ward and have experience developing or implementing Advance Directives.

Methodology

A social constructionist position proposes that all human experience is mediated by factors such as language (Willig, 2008). Linguistics allows individuals to describe the same phenomenon in various ways, giving rise to a variety of legitimate interpretations and perceptions; as such, social constructionism proposes that language is especially important in relation to socially constructed knowledge (Willig, 2008). As such, the proposed research is concerned with examining the variety of ways reality and meaning is constructed using discourse analysis (Willig, 2008), specifically how mental health professionals use discourse to position themselves with regard to Advance Statements. This discourse will be explored in relation to wider policy and legislation, such as the Mental Health Act (Scotland) (2003; 2015) and the Universal Declaration of Human Rights (United Nations General Assembly, 1948).

Analysis

Advance Statements are implemented by mental health professionals taking up professional roles and identities working within the NHS system. This project aims to understand the low uptake of Advance Statements from a systemic perspective with the data provided coming from roles and identities of participants. Foucauldian Discourse Analysis allows an investigation into systemic issues by understanding the discourse around Advance Statements.

Foucauldian Discourse Analysis is influenced by the work of Michael Foucault, and is concerned with the use of language in social and psychological life (Willig, 2008). Stryker's structural symbolic interactionism (Stryker, 2008) will be used to guide the analysis. Structural symbolic interactionism understands society as organised systems of interactions and role relationships (Stryker, 2008). It endeavors to describe the impact of structure through the use of group, role and identity theories where people take on

positions as familiar social categories, such as nurse or doctor. A role entails a set of expectations ascribed to those positions, expectations resulting from experience and assumptions made by society, and Discourse Analysis allows an exploration of how roles, meanings and identities are negotiated through the use of language (Starks & Trinidad, 2007; Farrelly et al., 2015). Expectations of mental health staff may include having power, control, being there to help and the level of knowledge and expertise. Further, the internalisation of these positions and roles constitutes the individual's identity, which can change depending on interactional context and the importance or commitment to the role (Farrelly et al., 2015). As Willig (2008) states, the positions taken have consequences with regard to subjectivity and experience.

Other qualitative analysis methods were considered in the development of this project. This project does not seek to develop an explanatory theory about the low uptake of Advance Statements, therefore Grounded Theory was not considered an appropriate approach to analysis. Additionally, an Interpretative Phenomenological Analysis (IPA) approach would investigate the experience of participants with an aim of identifying meaning and commonalities in these experiences to develop themes which represent the experiences shared by all participants which would not allow for an investigation into language used by participants when talking about Advance Statements.

Project Timeline

Subsequent to submission of the research proposal, an application to the University of Glasgow School of Medical and Veterinary Sciences ethics panel will be submitted. It is anticipated ethical approval will be granted by late February 2019. The researcher can then proceed to NHS Research and Development Approval (R&D). It is anticipated R&D approval for the project will be granted by the end of March 2019.

Data collection will commence April 2019, as soon as R&D approval is granted. It is anticipated data collection will be complete in June 2019 (over 14 study days).

Analysis will commence alongside the transcription of interviews. It is anticipated that an interview lasting around one hour will produce 20 pages of transcription, with transcription taking around 10 hours (i.e. 1 day). This allows time for note making alongside the initial transcription. The researcher aims to begin transcription and data analysis by July 2019, to be completed in October 2019 (over 28 study days).

The final write up of the project is expected to begin in November 2019, to be completed by the end of December 2019. Time to review and make changes will be from January to February 2020, with the final submission of the project in February 2020.

Ethical Issues

Ethical approval will be sought from the University of Glasgow alongside Research and Development (R&D) approval from NHS Greater Glasgow and Clyde. Participants will take part voluntarily, confidentially and will be fully informed of uses of the research, what involvement entails and possible risks. It is possible that interviewing staff members about their experiences working with service users, the wider multidisciplinary team and within the NHS, may evoke strong emotions and disclosures of concern to the researcher. Upon consulting the NHS Greater Glasgow and Clyde Policy on Stress in the Workplace, any participants who disclose work-related stress will be encouraged to contact their line manager to resolve any work-related issues. If appropriate, the in-house counselling service may be suggested.

The primary aim of the research is to examine discourse around Advance Statements. It is recognised that mental health professionals use language to communicate from the perspective of their role within the NHS as a wider system, the multidisciplinary team they work in and the therapeutic relationships with service users, taking account of the expectations inherent within that role. Interviews conducted for discourse analysis are not typically used to gain information about participants' experiences. Rather, it is hoped a sample of the discourse will be obtained in order to understand not only the content of the interviews, but how things are said, the nature of the discursive practices used and how they function (Hammersley, 2014). As a result, it is possible there will be a discrepancy between participants' expectations and what is done with the data the participants provide (Hammersley, 2014). To a degree, participants' expectations will be shaped by what they are told by the researcher (Hammersley, 2014), therefore, the researcher will ensure participants' expectations of taking part in the research and what will happen to the data will be addressed using informed consent.

Transparency and Reflexivity

The research process is shaped by the researcher, both personally and epistemologically (Willig, 2008). A reflexive approach to research acknowledges biases of the researcher, while encouraging the researcher to reflect upon how they may be implicated in the research (Willig, 2008). The researcher's background and work experience as a trainee clinical psychologist may introduce bias and assumptions about participants and their experiences in relation to Advance Statements. Supervision and ongoing documentation of the analysis of the data will be used to ensure transparency, encourage reflexive practice and help identify the researcher's assumptions and a critical perspective on the researcher's own use of language.

Financial Issues

Financial considerations will develop as the project does. Please see Appendix B for a breakdown of the financial costs of the project.

Health and Safety Issues

The emotional strain by disclosures of stress on the researcher is acknowledged. The researcher receives supervision and has resources for support through the University of Glasgow, as well as NHS Greater Glasgow and Clyde.

The location of the interviews will be considered to ensure participants are comfortable and able to speak freely. The location and contact details of each place interviews are being conducted will be communicated to a colleague/the researcher's supervisor to ensure the safety of the researcher.

Please see Appendix C for the Health and Safety form.

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Appendix A

Interview Schedule Version 1

28/09/2018

Pre-Interview

Provide participant with information sheet

Check dictaphone

Ask if they have any questions about taking part

Obtain informed consent to take part

Initial phase

Tell me about your role generally?

Probes – place of work, colleagues, size and complexity of caseload

Interview

Can you tell me about your understanding of Advance Statements?

What has been your experience of advance statements generally, in the team you work/have worked in?

What has been your experience of advance statements in relation to patients you have worked with?

How do you understand your role in relation to Advance Statements?

What do you see as the barriers to implementing advance statements?

- How do you think these barriers may be addressed?

What do you see as the strengths and limitations of advance statements?

Ending

There have been concerns regarding the lack of uptake of Advance Statements, what would be your recommendations to develop and improve implementation?

Is there anything you expected to be asked today, that wasn't asked? Or is there anything else you'd like to add?

Thank them for taking part

Appendix B

RESEARCH EQUIPMENT, CONSUMABLES AND EXPENSES Trainee

2018 Year of Course 2nd Intake Year2017

Version 1

Item	Details and Amount Required	Cost or Specify if to Request to Borrow from Department
Stationary		Subtotal:
Postage		Subtotal:
Photocopying and Laser Printing		Subtotal:

Equipment and Software	Foot pedal for transcription Dictaphone (Olympus DS500)	Subtotal: £120
Measures		Subtotal:
Miscellaneous		Subtotal:
Total		£120

For any request over £200 please provide further justification for all items that contribute to a high total cost estimate. Please also provide justification if costing for an honorarium:

Trainee Signature

Date 28/09/18

Supervisor's Signature Date 28/09/18

Appendix C

HEALTH AND SAFETY FORM

28/09/2018

Version1

1. Title of Project	An Exploration of How Mental Health Professionals Position Themselves in Relation to Advance Statements
2. Trainee	Angela Glasgow

3. University Supervisor	Professor Andrew Gumley
4. Other Supervisor(s)	
5. Local Lead Clinician	Dr Calum Jackson
6. Participants: (age, group or sub-group, pre- or post-treatment, etc)	Participants included in this research will be mental health service staff who are currently employed with NHS Greater Glasgow and Clyde. Participants work in a Community Mental Health Team or on an inpatient ward and have experience developing or implementing Advance Directives.
7. Procedures to be applied (eg, questionnaire, interview, etc)	A semi structured interview will be used to gather data.
8. Setting (where will procedures be carried out?) i) General	On NHS premises (e.g. where the staff member is based)
ii) Are home visits involved	No
8. Potential Risk Factors Identified see chart	It is possible that interviewing staff members about their experiences working with service users, the wider multidisciplinary team and within the NHS, may evoke strong emotions and disclosures of concern to the researcher.
10.Actions to minimise risk (refer to 9)	Upon consulting the NHS Greater Glasgow and Clyde Policy on Stress in the Workplace, any participants who disclose work-related stress will be encouraged to contact their line manager to resolve any work-related issues. If appropriate, the in-house counselling service may be suggested.

Trainee signature:

Date: 28/9/18

University supervisor signature:

Date: 28/9/18

Appendix 10: Manuscript Submission Guidelines: Psychology, Public Policy and Law



Psychology, Public Policy, and Law[®]

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Michael E. Lamb
Department of Psychology
University of Cambridge
Free School Lane
Cambridge CB2 3RQ
United Kingdom

General correspondence should be directed to the [Editor](#).

The journal encourages authors to write comprehensive pieces, rather than submitting smaller pieces to multiple journals.

Psychology, Public Policy, and Law encourages the submission by scholars of empirical studies, as well as theoretical, conceptual, and critical reviews dealing with psychology and with relevant information derived from related disciplines, law, and policy studies.

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This journal has adopted a policy of masked review for all submissions.

Each copy of the manuscript must include a separate title page with the authors' names and affiliations, and these should not appear anywhere else in the manuscript. Footnotes that identify the authors must be typed on a separate page.

Authors must make every effort to see that the manuscript itself contains no clues to their identities.

Please ensure that the final version for production includes a byline and full author note for typesetting.

Manuscript Preparation

Until May 31st 2020, prepare manuscripts according to the [*Publication Manual of the American Psychological Association using the 6th or 7th edition. Starting June 1st 2020, all manuscripts should be submitted in the 7th edition. Manuscripts may be copyedited for bias-free language \(see Chapter 3 of the 6th edition or Chapter 5 of the 7th edition\).*](#)

Review APA's [Journal Manuscript Preparation Guidelines](#) before submitting your article.

There is no page restriction and all copies should be double-spaced. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the Manual. Additional guidance on APA Style is available on the [APA Style website](#).

Below are additional instructions regarding the preparation of display equations, computer code, and tables.

Display Equations

We strongly encourage you to use MathType (third-party software) or Equation Editor 3.0 (built into pre-2007 versions of Word) to construct your equations, rather than the equation support that is built into Word 2007 and Word 2010. Equations composed with the built-in Word 2007/Word 2010 equation support are converted to low-resolution graphics when they enter the production process and must be rekeyed by the typesetter, which may introduce errors.

To construct your equations with MathType or Equation Editor 3.0:

- Go to the Text section of the Insert tab and select Object.
- Select MathType or Equation Editor 3.0 in the drop-down menu.

If you have an equation that has already been produced using Microsoft Word 2007 or 2010 and you have access to the full version of MathType 6.5 or later, you can convert this equation to MathType by clicking on MathType Insert Equation. Copy the equation from Microsoft Word and paste it into the MathType box. Verify that your equation is correct, click File, and then click Update. Your equation has now been inserted into your Word file as a MathType Equation.

Use Equation Editor 3.0 or MathType only for equations or for formulas that cannot be produced as Word text using the Times or Symbol font.

Computer Code

Because altering computer code in any way (e.g., indents, line spacing, line breaks, page breaks) during the typesetting process could alter its meaning, we treat computer code differently from the rest of your article in our production process. To that end, we request separate files for computer code.

In Online Supplemental Material

We request that runnable source code be included as supplemental material to the article. For more information, visit [Supplementing Your Article With Online Material](#).

In the Text of the Article

If you would like to include code in the text of your published manuscript, please submit a separate file with your code exactly as you want it to appear, using Courier New font with a type size of 8 points. We will make an image of each segment of code in your article that exceeds 40 characters in length. (Shorter snippets of code that appear in text will be typeset in Courier New and run in with the rest of the text.) If an appendix contains a mix of code and explanatory text, please submit a file that contains the entire appendix, with the code keyed in 8-point Courier New.

Tables

Use Word's Insert Table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.

Data and Stimulus Materials

Psychology, Public Policy, and Law encourages authors to make their data and stimulus materials (if relevant) publicly available, if possible, by providing a link in the author note of the manuscript submitted.

Making the data and materials publicly available can increase the impact of the research, enabling other researchers to incorporate the original author's work in model testing, replication projects, and meta-analyses, in addition to increasing the transparency of the research process.

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APA can place supplemental materials online, available via the published article in the PsycARTICLES® database. Please see [Supplementing Your Article With Online Material for more details](#).

Abstract and Keywords

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the References section.

Examples of basic reference formats:

- **Journal Article:**

Hughes, G., Desantis, A., & Waszak, F. (2013). Mechanisms of intentional binding and sensory attenuation: The role of temporal prediction, temporal control, identity prediction, and motor prediction. *Psychological Bulletin*, *139*, 133–151. <http://dx.doi.org/10.1037/a0028566>

- **Authored Book:**

Rogers, T. T., & McClelland, J. L. (2004). *Semantic cognition: A parallel distributed processing approach*. Cambridge, MA: MIT Press.

- **Chapter in an Edited Book:**

Gill, M. J., & Sypher, B. D. (2009). Workplace incivility and organizational trust. In P. Lutgen-Sandvik & B. D. Sypher (Eds.), *Destructive organizational communication: Processes, consequences, and constructive ways of organizing* (pp. 53–73). New York, NY: Taylor & Francis.

Figures

Graphics files are welcome if supplied as Tiff or EPS files. Multipanel figures (i.e., figures with parts labeled a, b, c, d, etc.) should be assembled into one file.

The minimum line weight for line art is 0.5 point for optimal printing.

For more information about acceptable resolutions, fonts, sizing, and other figure issues, [please see the general guidelines](#).

When possible, please place symbol legends below the figure instead of to the side.

APA offers authors the option to publish their figures online in color without the costs associated with print publication of color figures.

The same caption will appear on both the online (color) and print (black and white) versions. To ensure that the figure can be understood in both formats, authors should add alternative wording (e.g., "the red (dark gray) bars represent") as needed.

For authors who prefer their figures to be published in color both in print and online, original color figures can be printed in color at the editor's and publisher's discretion provided the author agrees to pay:

- \$900 for one figure
- An additional \$600 for the second figure
- An additional \$450 for each subsequent figure

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Authors are required to state in writing that they have complied with APA ethical standards in the treatment of their sample, human or animal, or to describe the details of treatment.

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The APA Ethics Office provides the full [Ethical Principles of Psychologists and Code of Conduct](#) electronically on its website in HTML, PDF, and Word format. You may also request a copy by [emailing](#) or [calling](#) the APA Ethics Office (202-336-5930). You may also read "Ethical Principles," December 1992, *American Psychologist*, Vol. 47, pp. 1597–1611.

Appendix 11: Discourse Analysis Example

Can you tell me about what your understanding of an advance statement is?

It's something that's done for the patient, *em*, a lot of patients that spend a lot of time goin' in and out of hospital have them, *em*, and it's for them to document their preferences for maybe they become unwell and they're no able to tell you what they prefer. *Em*, we don't use them, to be honest, very often and I think it's probably because we don't have to use them. *Em*, I think they're good and I think they're helpful, especially *wi'* how unwell people become, *em*, in my experience here it's been people who've used them specifically if they don't want a medicine or if they've got a kinda specific diet or religious reasons, that's my kinda experience, but in general we don't use them.

Okay, can you tell me a bit about your thoughts on maybe why they're not used so much?

Because it's another time we've not got time for (*right*) we've got huge caseloads so it takes all your time to *dae* the kinda. legal paperwork I suppose. *Em*, and that takes priority. And I think advance statements are kinda on the backburner, and it's no promoted like, you know we don't kinda have anybody *pushin'* it. So I think, if we have somebody maybe *pushin'* it cos I think it's helpful for patients, and a lot of patients don't go into hospital now. A lot of patients are kept at home. So I don't know if that's maybe part of it. Because if somebody was going into hospital, it seems to be a bit more relevant I think (*okay*) which probably isn't true actually.

What makes you say it's maybe more relevant for hospital?

Because they've got less control over their choices (*right*) whereas we see them, one hour, every three weeks (*okay*) whereas in a ward there'd be nurses round about them constantly. *Em*, and nurses are more *sorta* in charge of medicines, mealtimes, all the things people s- tend to talk about when you talk about an advance statement with them. I think mealtimes and medicines the biggest kinda things that come up.

Okay. And you said there's something about them possibly being more relevant for people going into hospital than in the community?

Mhmm, but we should probably do the advance statements cos then they're in place for them going into hospital. Because when they go into hospital they're normally very unwell, *em*, I think nursing's changed. I think *em*, and it used to be when people

Angela Glasgow... AS constructed as more common ↓

Angela Glasgow... AS constructed as a way for patients to ↓

Angela Glasgow... Team they work in does not use AS ↓

Angela Glasgow... Don't use AS because don't have to. ↓

Angela Glasgow... AS constructed as good and helpful ↓

Angela Glasgow... AS are for patients who don't want a ↓

Angela Glasgow... Generally AS are not used ↓

Angela Glasgow... AS another thing staff don't have time ↓

Angela Glasgow... AS on the backburner, not a priority ↓

Angela Glasgow... AS are not pushed within the team, ↓

Angela Glasgow... Having someone else to push it – lack of ↓

Angela Glasgow... Lack of coherence in narrative – AS ↓

Angela Glasgow... Initially construct AS are mainly relevant ↓

Angela Glasgow... Laughter ↓

Angela Glasgow... Patients in a ward environment have ↓

Angela Glasgow... AS should be completed in community ↓

Angela Glasgow... Constructs the nursing profession as ↓

became a wee bit unwell they went into hospital so they could maybe still do the advance statement, but now they're managed in the community, em, but it isn't first time it isn't somethin' we consider. And I think that's habit, probably. Probably a bad habit to be honest, cos I think we should do them. But people don't go into hospital anymore, people don't go in and out the way they used to. Em, cos we used to have planned admissions and things, and I think if you were in a planned admission you'd do an advance statement. But we don't do that, we don't have beds to do that now.

Right.

So I think that's maybe somethin' to do with it.

Okay. And somethin' about if there was a planned admission then an advance statement would probably be used then? (Maybe) Can you tell me your thoughts on why that would be?

Because if they're goin' into hospital the chances of them becoming more unwell is obviously the reason they're going into hospital, so therefore they wouldn't be able to tell you their choice - or they might not be able to tell you their choices. So, if they can't tell you their choices, the advance statement would be there to promote their choices on their behalf. Em, but, my view of it is, it's most beneficial for somebody going into hospital, and I think that's probably wrong and I know that's probably wrong but (why do you say that?) well why not do them for everybody? D'you know we should, good practice would be doing them for everybody. Em, but it's definitely no somethin' we do, an' I think for the last two years, aye the last two years our team has been overwhelmed w' referrals and patients coming onto caseloads, it's definitely a lack of time (lack of time) definitely a lack of time, yeah, mmhmm. Aye cos if you've done aw your other paperwork you would kinda move on to it, I'd like to think. But you don't ever complete your paperwork that needs done, so I think that's why we don't do them. And even if somebody comes out of hospital we don't do them now (right) but normally because they're at crisis when they're goin' into hospital, so that wouldnae be the best time for the patient to do it.

Okay, when do you think might be a good time, do you have any sense of that?

I think if somebody had just come out of hospital would be a good time to do it, cos if they've just go out of hospital they'd be well. Em, an' I think maybe for your patients who didn't go in and out of hospital, it would be helpful to do them maybe when you

were daein' the stayin' well plan. Because that's about lookin' at their recovery and stuff, so the stayin' well plan, it would be appropriate to do that then.

Okay. And I'm wondering if you have any thoughts around how you see your role in relation to advance statements and developing them?

I think we should be daein' them. I dae hink we should be daein' them and I hink it's no somethin' we prioritise and I think we should. An' we don't because nobody's on our case aboot it. (ah okay) whereas everythin' else there's somebody on your- your d'you know your team leads like "risk assessment, care plan, stayin' well plan, crisis management plan" an' advance statement doesny come intae it. So we kinda, we don't do it. But I think we should.

And why are those other things prioritised, and you said on your case about them, why are they things prioritised?

Cos they're about keeping people safe. So I think that's, aye.

Angela Glasgow (student)

AS are not what nurses consider in their work as managing patients in the community - "bad habit"

Angela Glasgow (student)

Nurses should be doing AS

Angela Glasgow (student)

Goes back to context that patients no longer go in and out of hospital, and have planned admissions, so AS would be more likely to do an AS

Angela Glasgow (student)

Planned admission was in response to patients with a chance of becoming more unwell - these patients may not be able to express choices so more likely to complete an AS to promote their choices

Angela Glasgow (student)

AS constructed as promoting patient choice when they may be unable to express their choices

Angela Glasgow (student)

Incoherence in narrative - most beneficial for patients going into hospital, but know that's wrong

Angela Glasgow (student)

Question - everybody could have an AS

Angela Glasgow (student)

Constructs good practice as developing AS for all patients, though the team does not. Team does not work according to good practice?

Angela Glasgow (student)

Team overwhelmed with patients

Angela Glasgow (student)

Time constructed as barrier to completing AS - priority is completing legal paperwork which doesn't get finished, so less prioritised tasks do not get completed

Angela Glasgow (student)

Position AS as the likely next task to complete, if all other priorities were finished.

Angela Glasgow (student)

Not completing the jobs which are a priority

Angela Glasgow (student)

When a patient is going into hospital they are in crisis so this is not a good time. Timing important for completion of AS

Angela Glasgow (student)

Patients are well when come out of hospital, so a good time to do an AS

Angela Glasgow (student)

Staying well plan focused on recovery - AS done with Staying well plan. AS constructed as focusing on recovery

Angela Glasgow (student)

AS are not prioritised - team/NHS system? Position is that AS should be prioritised

Angela Glasgow (student)

Lack of autonomy over work, prioritise what managers prioritise

Angela Glasgow (student)

Management do not ask about AS - they are not prioritised in the team/system

Angela Glasgow (student)

Keeping people safe is the priority for staff so paperwork doing this is prioritised. Wider system/expectations about the role of nurses/NHS?

Appendix 12: COREQ Checklist for This Research

COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
<i>Personal characteristics</i>			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	42
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	33
Occupation	3	What was their occupation at the time of the study?	40
Gender	4	Was the researcher male or female?	
Experience and training	5	What experience or training did the researcher have?	
<i>Relationship with participants</i>			
Relationship established	6	Was a relationship established prior to study commencement?	41
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	42
Interviewer characteristics	8	What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	40
Domain 2: Study design			
<i>Theoretical framework</i>			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	40
<i>Participant selection</i>			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	41
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	41
Sample size	12	How many participants were in the study?	41
Non-participation	13	How many people refused to participate or dropped out? Reasons?	
<i>Setting</i>			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	42
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	
<i>Data collection</i>			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	42
Repeat interviews	18	Were repeat interviews carried out? If yes, how many?	42
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	42
Field notes	20	Were field notes made during and/or after the interview or focus group?	41
Duration	21	What was the duration of the interviews or focus group?	42
Data saturation	22	Was data saturation discussed?	41
Transcripts returned	23	Were transcripts returned to participants for comment and/or	

Topic	Item No.	Guide Questions/Description	Reported on Page No.
		correction?	
Domain 3: analysis and findings			
<i>Data analysis</i>			
Number of data coders	24	How many data coders coded the data?	43
Description of the coding tree	25	Did authors provide a description of the coding tree?	
Derivation of themes	26	Were themes identified in advance or derived from the data?	43
Software	27	What software, if applicable, was used to manage the data?	42
Participant checking	28	Did participants provide feedback on the findings?	
<i>Reporting</i>			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	43-49
Data and findings consistent	30	Was there consistency between the data presented and the findings?	49-51
Clarity of major themes	31	Were major themes clearly presented in the findings?	49-51
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	49-51

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

Once you have completed this checklist, please save a copy and upload it as part of your submission. DO NOT include this checklist as part of the main manuscript document. It must be uploaded as a separate file.