The experiences of Care Coordinators using the Mental Capacity Act (2005) in secondary mental health care settings within England

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Contents

Abbreviations

AMHP	Approved Mental Health Practitioner
BIA	Best Interest Assessor
CCO	Care Coordinator
CMHT	Community Mental Health Team
CQC	Care Quality Commission
CR	Critical Realism
DoLs	Deprivation of Liberty Safeguards
HCP	Healthcare Professional
IPA	Interpretive Phenomenological Analysis
MDT	Multi-disciplinary Team
MCA	Mental Capacity Act
MHA	Mental Health Act
NHS	National Health Service
PIS	Participant Information Sheet
SDT	Self determination Theory
SU	Service User
TA	Thematic Analysis

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Abstract

Introduction: The Mental Capacity Act (2005) aims to empower people who may lack the capacity to make their own decisions to be engaged in their own decision-making. Since its inception, existing literature suggests that professional staff have found utilising the act difficult. These difficulties often present as challenges around practical and relational issues alongside systemic and personal difficulties. There is a need to understand the experiences of staff who work in mental health services and are required to navigate the Mental Capacity Act (MCA) as well as the Mental Health Act (MHA) as part of their clinical work in order to support staff to provide the best care to patients. This requirement can be a challenge for some staff.

Research Aim: To understand the experiences of care coordinators using the MCA within secondary mental health care.

Study Method: Within this qualitative study, 10 participants with professional backgrounds in Social Work, Nursing and Occupational Therapy working as Care Coordinators within secondary mental health services from the same NHS trust were recruited. Data was collected through semi-structured interviews and analysed using Thematic Analysis (TA).

Findings: The study found three themes: working in mental health; challenges and risks; learning and doing. All participants reported valuing the MCA as a piece of legislation which empowers service users to be part of their decision-making. Many challenges were reported with using and understanding the MCA with mental health service users, partly due to gaps within their knowledge. They found the nature of mental health difficulties resulted in complications when applying the MCA. Comparative to the MHA, they found the MCA ambiguous and lacking applicable clarity. Staff cited fears and concerns in relation to applying the MCA and located this within personal and emotional risks to themselves and service users on their caseload. Self-determination theory was used to explain staff motivation to engage and work with the MCA. Staff needs of autonomy, relatedness and competence were explored and grounded in their experiences and the links to psychological well-being were discussed.

Conclusion: The study brings implications for clinical practice. It gave recommendations for how to improve staff experiences of using the MCA concerning training, staff support and further partnership building between service users, carers and mental health staff.

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Organisation of the Thesis

The thesis is comprised of seven chapters.

Chapter 1: Introduction. The chapter provides an overview of the MCA as well as the staff position within the NHS, it states the contribution this thesis makes to knowledge. It also states the rationale for exploring this topic, highlighting the researcher's professional experience. Self determination theory is positioned as a lens through which to view the findings.

Chapter 2: Literature Review. This chapter presents an integrative systematic literature review concerning the experiences of health and social care staff in using the MCA in their clinical roles. The review integrated findings from 9 qualitative studies and used thematic synthesis to generate analytical themes. The search strategy, inclusion and exclusion criteria, data extraction and the 4 themes generated from the included papers are presented, culminating in an evidence base relating to the experiences of healthcare staff of using the MCA within their role.

Chapter 3: Methodology. This chapter presents the philosophical orientation of critical realism and the rationale for using a qualitative methodology and Thematic Analysis (TA). It describes the data collection method, sampling, recruitment, and data analysis. The chapter also includes a section on the researcher's reflexivity.

Chapter 4: Methods. The methods chosen for conducting the research are described in this chapter. The sampling method, recruitment, ethical committee approval, and method for interviewing are detailed with their subsequent rationale. The data analysis method of TA, described by Braun and Clark (2013), is also defined with supporting steps on how to maintain the quality of the research.

Chapter 5: Findings. The demographics of the participants are described. The three themes and 10 sub-themes developed from the interviews describe the participants' experiences of using the MCA in their current job roles as Care Co-ordinators (CCO). The three themes are i) MHA v MCA, ii) risks and challenges, iii) learning and doing. The sub-themes are illustrated as a thematic map within the chapter.

Chapter 6: Discussion. This chapter explores the theoretical underpinnings of Self Determination Theory (SDT) in relation to the findings. The theory limitations are considered before an examination of the specific factors affecting mental health professionals working within mental health services.

Chapter 7: Conclusion, Implications for organisations, clinical practice and education are presented followed by suggestions for further research. The strengths and limitations are then examined. The thesis ends with a reflective section by the researcher.

Chapter 1: Introduction

The overall aim of this thesis is to better understand the experiences of mental health staff utilising mental capacity legislation within their clinical practice. Mental health staff working in an NHS community setting are required to negotiate several acts of law, alongside their clinical responsibilities. Legislation such as the Health & Care Act (2022), Human Rights Act (1998), and the Safeguarding Vulnerable Groups Act (2006) exist alongside policies such as *Best practice in managing risk: principles and guidance for best practice in the assessment and management of risk to self and others in mental health services* (2007), *Common Assessment Framework for adults* (2010) and *Personalisation through person-centred planning* (2010) - all require navigation. To date, to the author's knowledge, there has been no published research concerned with the mental health staff's experiences of working with the Mental Capacity Act 2005 (MCA) as part of the legislative framework which underpins their clinical interventions within the UK's National Health Service (NHS).

This chapter sets out the context of this research. This includes the development of the progress to embed the MCA within clinical settings and to explore the mental health positioning in which this study sits. The chapter progresses with a justification of the necessity of this research and the practice implications which arise from it. It concludes with an exploration of the researcher's positionality.

1.1 The Mental Capacity Act

1.1.1 Understanding the MCA: Origin & definitions

The MCA is a piece of legislation which passed royal assent in April 2005 and was fully in legal force in October 2007 within England and Wales. Its primary purpose is to provides a legal framework for making and authorising a wide range of decisions on behalf of adults who lack the capacity to make particular decisions for themselves, as well as for helping people to plan ahead for a time when they may be unable to make decisions, (Department for Constitutional Affairs, 2007). It also provides a framework to enable care staff to facilitate patients to make decisions they are capable of understanding, to “seek capacity” by adapting information. The roots of the MCA lie in the case of *F v West Berkshire HA [1991]* which questioned whether doctors had the legal authority to treat a person whom they regarded as lacking the mental capacity to consent to a particular medical treatment. The legal action provided the medical team with the legal authority to carry out the operation without her consent to the treatment without the risk of litigation from F or any others. The court held that although F was unable to give consent, the operation was lawful as it was in the best interests of F. The defence created by the court formed the basis of Sections 1-6 of the MCA.

A clinically accepted definition for the term ‘mental capacity’ within the field of mental health is “the ability to make one’s own decisions” (Okai et al., 2007, p.292). The MCA applies to all persons aged 16 and over living in England and Wales who lack the mental capacity to make decisions about their lives. The only decisions exempt from the MCA are personal decisions such as marriage/civil partnership, divorce, sexual relationships, adoption, and voting. The MCA is also relevant to those who currently have the capacity to make decisions and who wish to plan for their future. This can be done through the creation of a *lasting power of attorney* for health and care or property and finances. These are created when a person has the capacity to make decisions and allow for the future delegation of decisions should a time come when that person loses their decision-making capacity, such as a result of an advancing neurodegenerative condition, such as dementia. The Office of the Public Guardian estimated in 2021 that there were more than five million registered lasting power of attorneys. Around two million people in England and Wales are thought to lack the mental capacity to make decisions for themselves, supported by around six million members of staff (SCIE, 2022). This means that around eight million people are formally impacted by the MCA. The number of unpaid family or friendship carers is hard to estimate.

An MCA assessment is composed of a two-stage test to determine whether the individual has or lacks the capacity to make a specific decision. The MCA Code of Practice (Department of Constitutional Affairs, 2007) states the assessment must begin with a presumption of capacity, and the onus is on the assessor, whoever that may be, to demonstrate that the person lacks the capacity to make a specific decision. The first stage ascertains whether there is an 'impairment of or disturbance in the functioning of the individual's mind or brain', (Department of Constitutional Affairs, 2007). This could be temporary, for example, due to the effects of substance misuse or delirium caused by an infection. Equally, it may result from a long-term condition, such as a mental health problem, learning disability, stroke or dementia (SCIE, 2022). If such an impairment is present, the assessor may proceed to the second stage of the test which considers whether the individual can: i) understand any information relating to the decision to be made, ii) retain the information relating to the decision, iii) consider, or 'weigh up' the costs and benefits of the information and iv) communicate a decision to the assessor using any means; verbal or non-verbal.

Case law has since offered legal guidance to assessors to restructure the assessment order. In the case of *A Local Authority v JB (Rev1) [2021] UKSC 52*, the Supreme Court was categoric in that the first question is to ask is whether the person is able to make their own decision. The second question is to look at whether there is a causative link between that persons inability to make the decision for himself, and an impairment of, or disturbance in the functioning of the mind or brain. The new Draft MCA Code of Practice (DoH, 2022) reinforces the approach advocated in the case law by providing that the first question to ask is whether the person is able to make their own decision (with support if required), and secondly if not, whether there is an impairment or disturbance in the functioning of the mind or brain. Additionally, the Draft MCA Code of Practice provides that the assessor should determine whether the inability to make the decision is because of the impairment or disturbance.

The MCA is underpinned by 5 key principles which it is useful to consider chronologically: principles 1 to 3 will support the process before or at the point of determining whether someone lacks capacity. Should it be determined that capacity is lacking, principles 4 and 5 support the decision-making process. Principle 1 relates to a presumption of capacity. Every adult has the right to make their own decisions and must be assumed to have capacity to do so unless it is proved otherwise. A HCP should not assume that someone cannot make a decision for themselves just because they have a particular medical condition or disability. Principle 2 directs that people must be supported as much as possible to make their own decisions before anyone concludes that they cannot do so, taking every effort to encourage and support the person to make the decision for themselves. If a lack of capacity is established, it is still important that the person is involved as far as possible in making decisions. Principle 3 is in relation to the idea that people have the right to make what others might regard as unwise or eccentric decisions. Everyone has their own values, beliefs and preferences which may not be the same as those of other people. People cannot be treated as lacking capacity for having an atypical perspective. Principle 4 states that anything done for or on behalf of a person who lacks mental capacity must be done in their best interests. Finally, principle 5 states that anything done for, or on behalf of, people without capacity should be the least restrictive of their basic rights and freedoms. This means that when anything is done to, or for, a person who lacks capacity the option that is in their best interests and which interferes the least with their rights and freedom of action must be chosen.

Professionally qualified staff who work with persons who may lack capacity can be described as Healthcare Professionals (HCPs). This role can be carried out by staff from professions such as nursing, occupational therapy and social work. If an HCP has reason to suspect an individual does not have the mental capacity to make a particular decision, the MCA Code of Practice (Department of Constitutional Affairs, 2007) advocates an assessment should be undertaken. There is no formalised screening process for an assessment, the trigger for an assessment should be that the HCP has doubts about the person's capacity to make a specific decision at issue.

1.1.2 The impact of the MCA

Prior to the inception of the MCA, a range of decisions were made on behalf of Service Users (SU) who lacked the capacity to make them personally; usually by paid staff or family members. These decisions could range from decisions about meal and clothing choices to decisions about daily activities such as attendance at day centres or college, to decisions with significant impact such as health-related decisions. Gillespie (2008) stated that prior to the MCA, these decisions were often made either in a healthcare setting, within which there was the risk of subjectivity, overly oppressive practice or risk-averse paternalism; or in a private setting where there could be abuses of power or safeguarding concerns. It was asserted by Gillespie (2008) that the consequences of this for people with developmental disabilities who lack capacity to make decisions is 'marginalisation' and an absence of their views within care decisions. Given the parallels which can exist between the learning disability sector and the mental health sector; for instance, surrounding care and treatment approaches, it is possible to extend this reality to persons with mental health difficulties who lack capacity to make decisions.

The MCA offers a critical legal framework to promote and safeguard decision-making for individuals lacking capacity who may not otherwise be involved with making choices which impact directly upon them. The MCA places individuals at the heart of the decision-making process and aims to empower them to make decisions for themselves wherever possible. Assuming HCPs are supported to correctly apply the MCA, which requires an understanding of HCP experiences of using this legislation, those individuals who lack capacity have their best interests protected by the legislation. This could be in the form of receiving protection from or being safeguarded against, potentially overly oppressive clinical practice, restrictive care arrangements or people within their circle of care who may seek to influence their behaviour or actions for their own self-interested gains.

The Code of Practice for the MCA, issued by the Department of Constitutional Affairs (2007) draws attention to the decision autonomy that persons who lack capacity experience, such as in respect of health or financial affair-related decisions. Manthorpe and Samsi (2013) assert that this autonomy is sometimes compromised because, if the person is under the care of primary or secondary health services, staff tasked with making the decisions on behalf of the SU are often “unconfident to use and unaccepting of the application of the legislation and often omit to apply it at all” (p.133). This means that there may be occasions where decisions are made for SU without MCA safeguards. Whilst this paper was published over 10 years ago, this issue still pervades across a wide range of clinical areas to date, as evidenced by a range of studies. Aspinwall-Roberts et al (2022) for example found social work participants working with people who self-neglect had a lack of understanding about the MCA and a reluctance to engage in MCA assessments in a Local Authority setting. Looking at a physical health care setting centring around decisions around the place of death for heart failure patients, Beattie et al (2022) concluded there were likely difficulties implementing this legislation in real-life clinical practice. Finally, within a brain injury setting, Cameron et al (2022) also found that the MCA was not yet embedded into clinical practice, suggesting that staff would benefit from bespoke practice guidance designed to help with the application of the MCA with the acquired brain injury/long-term neurological conditions population—particularly where there is a concern about a person’s ability to understand, apply or use information outside of an assessment or supportive conversation.

1.1.3 Progress with embedding the MCA

A post-legislative scrutiny report produced by the House of Lords (2014) concluded that the MCA and its principles are not always directly embedded into the practice of HCPs, suggesting that a lack of awareness and understanding concerning the MCA exists. The consequence of this is that SU may be affected negatively by staffs misunderstanding of the MCA principles, leading to a lack of decision empowerment. Wider literature at the time supported this assertion, stating that the application of the MCA was difficult and complicated (Brown & Marchant, 2013; Phair & Manthorpe, 2012; Regnard & Louw, 2011). Although the legislation came into force in 2007, contemporary research suggests little progress has been made regarding its embodiment in clinical practice (Jayes et al., 2019; Scott et al., 2020, Aspinwall- Roberts et al., 2022).

Walji et al. (2014), noted that any progress to embed the MCA in clinical practice was particularly difficult for professionals who qualified before its enactment. It appears that HCPs are not struggling in isolation. Consultant psychiatrists fall within the definition of an HCP, yet they have a different hierarchical position and tasks of responsibility within the MCA. As a group, they are also finding capacity assessments difficult to resolve, partly as a consequence of clinical pressures and ethical concerns. Owen et al. (2022) cited concerns related to the completion of Section 49 reports. Under section 49 of the MCA, the Court of Protection can order reports from NHS health bodies and local authorities when it is considering any question relating to someone who may lack capacity, and the report must deal with 'such matters as the court may direct.' An order under section 49 of the MCA does place an obligation on the NHS trust to comply and it which must be completed within a tight deadline, often without adequate legal support, and at times impacting their clinical caseloads. Baker-Glen and Price (2024) discuss the difficulties liaison psychiatrists have in implementing the MCA with patients who may wish to end their life; which is not referenced within the MCA or refuse life-sustaining treatment; which is referenced in the MCA. The task requires both clinical skills, to uncover subtle illness which is impairing decision-making and to consider interpersonal dynamics, as well as ethical skills, for example to negotiate the role of values and risks in capacity assessment. There is limited case law in this area to support navigation.

There is also evidence that unpaid carers, such as family members who have a role in the process of the MCA, for instance when their perspectives are sought during the assessment process; also find the MCA difficult to navigate. A study by Wilson (2017) found that relatives of SUs subject to the MCA viewed the legislation itself positively, but had negative experiences with its implementation, and they perceived the potential benefits of the legislation for SUs and carers were not always utilised, that is, the opportunity for carers to be a representative voice in the assessment process was occasionally missed. In addition, Fletcher (2023) reported that informal carers found the MCA to be too sophisticated to understand. It is unclear if carers are able to take advantage of available information-gathering opportunities and resources, in comparison with HCPs who have received formal training and clinical exposure to the MCA in practice.

The evidence base supports the assertion that disempowering, restrictive and oppressive practices are happening within healthcare as a result of the poor implementation of the MCA, (Hinsliff-Smith et al., 2017; Samsi et al., 2012; Wilson, 2017), with an absence of culture change evident in HCP's working within a wide range of clinical areas, such as general nursing, (Marshall & Sprung (2016), learning disability (Ratcliff & Chapman, 2016) and brain injury, (Moore & Wotus, 2019). The outcome of healthcare staff not adhering to or misunderstanding this legislation may be consequential for the individual. First, there is a legal consequence for staff not complying with MCA legislation, as section 44 of the MCA is concerned with 'wilful neglect' for which Bogg (2018) states there were 349 prosecutions in 2015-2016. Section 44 of the MCA makes it a criminal offense to ill-treat or neglect a person who lacks mental capacity, or who the potential offender believes lacks mental capacity. Secondly, a registered HCP could be found in breach of their terms of registration and/ or professional code of conduct should they neglect to adhere to the MCA. As an example, one HCP discipline, nursing, states in its code of conduct at point 19.2 that staff must "take account of current evidence, knowledge and developments…" (NMC, 2018).

Marshall and Sprung (2016a) comment on the impact of professionals with a poor understanding of the MCA endeavouring to applying the MCA suggesting this can result in negative SU outcomes such as a lack of inclusion within decision-making or their voice, values and preferences being absent from their care. Mental health patients' likelihood of experiencing stigma and a reduction in autonomy is greater than the general population or physical health patients (Corrigan & Patrick, 2000). The notion then that mental health patients are perhaps unintentionally being further disempowered and subjugated by the staff designated to care for them, contravenes the guiding principles of the MCA.

1.1.4 MCA Training

One approach which is often proposed to embed the knowledge and skills required for the MCA into clinical practice is a more robust approach to training, (Scott et al., 2020). The training which staff receive on the MCA is not universal across NHS trusts. The NHS Core Skills Training Framework (Skills for Health, 2024) does not identify MCA training as a mandatory or statutory training expectation for all staff. NHS trusts have the discretion to develop a training approach which best suits their workforce and service demands. These approaches can vary considerably which may result in geographical regions experiencing different outcomes for SU concerning the functions of the MCA. For example, Sherwood Forest Hospital NHS Foundation Trust's MCA Policy (2023) allocates staff to levels, based on their professional role and has differing intensities and frequencies for MCA training opportunities. Country Durham and Darlington NHS Trust in comparison appears to require all staff to complete the same one-off E-learning session (CDDFT, 2021). Jenkins et al. (2020) conducted a narrative literature review to identify training strategies and determine how staff change their practice after MCA training. Although the study noted interactive scenarios reflecting practice complexities had the most positive effect on staff confidence and knowledge, they believed that workplace culture could act as a considerable driver to how staff could apply the legislation.

This section has described the progress made in embedding the MCA to date. The experiences of mental health care staff working with the complexities of the MCA alongside the other legislations and expectations of them, which is the focus of this thesis are not yet established within published literature.

1.2 NHS Mental Health Service structure within England & Wales

1.2.1 Progression of Mental Health Services

A review of the history of mental health services (Turner et al., 2015) cements the importance of care provision improvement for SUs who may not be included in care planning or decisions around their care. In 1975, a government paper entitled 'Better Services for the Mentally Ill' proposed the complete abolition of the mental hospital system, formally known as asylums, (Department of Health, 1975). The focus of these provisions was containment and control, with little prospect of recovery or rehabilitation for

SUs. Many experienced staff and older SUs can recall these practices, which Killaspy (2006) suggests may have an oppressive, repressive, and unjust legacy for patients whose care may have been influenced negatively. The move towards 'community care' came about during the 1970s and 1980s as a result of government policies such as 'Better Services for the Mentally Ill' (Department of Health, 1976). The provision of community-based services for people with mental illnesses, such as supported housing, day services and community-based mental health nurses and social workers marked a change from old-style 'asylums' whose purpose was to treat people with mental health conditions that were viewed as 'dangerous'. The advent of community care aimed to integrate people who had been formally cared for in a hospital setting within society, reduce stigma and improve mental health and recovery-related outcomes for SUs, such as a reduction in admission to psychiatric hospitals, improved employment rates and self-reported happiness, (Marks, 1992).

The NHS provides healthcare which is free at the point of delivery for all SUs who come under the geographical responsibility of the MCA (England and Wales), as well as those outside the reach of the MCA (such as Scotland and Northern Ireland). The first point of contact for SUs is typically primary health care e.g. a GP or NHS Talking services, to which SUs can self-refer. This tier of service is concerned with problems which typically, but not always, are managed by one or two professionals. Should an SU's needs require a more specialist approach, their care can be transferred to secondary health services, e.g. a community mental health team. This service is provisioned with a range of professionals who have the knowledge, skills and experience to manage complex or longer-term cases across multiple statutory and non-statutory agencies. The configuration is the same for physical and mental health care.

1.2.2 MCA impact on Service Users

Alongside the changes to statutory services in the 1970s, there were increasing critiques of traditional psychiatry and an interest in involving SUs in their own care and treatment (Millar et al., 2016). The SU movement within mental health championed SUs' rights to be involved in their care and treatment. SU involvement is now an integral part of policy-making and practice implementation. A definition of SU involvement in mental health care comes from Millar et al. (2016, p.213) “An active partnership between SU and mental health professionals in decision making regarding the planning implementation and evaluation of mental health policy services education and training and research”. The SU movement was instrumental in bringing positive changes around inclusion to mainstream mental health care, such as the implementation of the Care Programme Approach (CPA) process (Campbell, 2008). CPA encompassed a package of person centred care that was used for over 30 years within secondary mental health settings promoting decision making, choice, equality, recovery and wellbeing. CPA was introduced by the Department of Health in 1991 and formally reviewed 2008. The elements comprised an assessment of needs, a named care coordinator, a holistic, personalised care plan and a review component.

During the government consultation stage of the MCA in the process of creating green and white papers, the law commission sought to consult with stakeholders in order to receive their perspectives. Several organisations that champion service user rights within mental health, for instance, National Schizophrenia Fellowship and Good Practice in Mental Health were consulted and their viewpoints were incorporated into Appendix C of the Mental Incapacity Report (Law Commission, 1995). This serves to highlight the fundamental prominence of the SU movement within the MCA. The movement has garnered significant strength over the last 30 years and advocates that serious mental health problems should not impede life goals, nor does a person's identity need to be defined by their symptoms, (Woods et al., 2022). This strengths-based movement suggested that recovery in mental health was characterised by low expectations and prognostic pessimism. Supporters of the recovery movement recognise the potential of the MCA in engineering positive change for mental health SUs by positioning the SU at the forefront of any decision making(Winship, 2016; Roberts & Boardman, 2018).

When people have the autonomy to exercise their human rights, they are empowered to shape the decisions that impact their lives (Kim et al. 2022). Mental health SUs have a right to be empowered to be part of their own decision-making and care planning and not overlooked, dismissed or ignored due to their mental health difficulties. Historically, people with mental health problems have been marginalised, institutionalised and stigmatised, since long before the Lunacy Act (1945) (Corrigan & Patrick 2000; Hui et al., 2021). One might hope the scope of the MCA could be a formal contributor to reducing aspects of oppressively controlling practice. The SU movement values the MCA for its potential for inclusion (Manthorpe & Rapaport, 2009), therefore achieving an objective of the MCA, namely empowerment, is imperative. Ensuring HCPs can access the MCA and use it as it was envisaged is of great importance, therefore, this thesis is of value to a broad community.

The impact of the MCA upon SUs can further be appreciated within the work of registered charities which pay regard to this legislation. There are several registered charities which provide advocacy for people with disabilities, (POhWER, VoiceAbility, The Advocacy People) to reduce such issues. One area of support is for people with mental health problems who were not involved in their own healthcare decisions and support. This further highlights the relevance of the powers of MCA within a mental health setting, serving to underline the importance of staff utilising the MCA as it was designed with confidence and competence to fully realise its potential.

1.2.2 The Mental Health Act

Mental health care within England and Wales sits within acts of legislation which give staff a framework for the delivery of care should the SU meet certain criteria determined by the law. One piece of legislation used by secondary mental health care staff is the MHA, which was established in 1956. There have been amendments made to the MHA in 1983 and 1991 with a further one possibly occurring in the next parliamentary term. The MHA confers the legal authority to breach a person's human rights, specifically, the power to detain people against their will and forms the foundation of many acute interventions for mental health staff. Specific sections of the law allow a person to be detained in a hospital for up to six months at a time and treated with medication again, which they may not choose themselves. The MHA has an inherent mechanism of automatic appeals consisting of a tribunal system led by external judges. However, the MCA has no such system of appeal for patients who are assessed under MCA systems.

Fundamentally, the MHA and the MCA are both laws which apply to persons within England and Wales which are concerned with mental health and capacity, but they have different applications and purposes. Mental health staff are required to consider both legislative frameworks within their roles. The MHA applies when someone has a mental health problem, while the MCA applies when someone has a mental health problem and lacks the capacity to make certain decisions. The MCA also applies to physical health interventions. The MHA is mainly concerned with hospital care and medical treatment for mental disorders, while the MCA covers most decision-making. The MHA can be used to detain someone who has the capacity to object to their treatment or detention, because the powers in the MHA are not based on capacity. The MCA mandates that decisions are made in the best interests of people who lack capacity.

1.3 Secondary Mental Health Care

The NHS organises its mental health provision into 50 Mental health trusts in England (NHS England 2023) which are commissioned and funded by Integrated Care Systems. NHS Wales operates at a slightly different strategic level, delivering mental health services through seven local health boards. Operationally, most trusts and boards organise their community mental health provision into multidisciplinary teams (MDT), called community mental health teams (CMHT), each covering a particular geographical area. There are commonly several smaller, specialist teams that cater for SUs with very specific needs, such as early intervention in psychosis or perinatal. The majority of community-dwelling SUs are cared for by a care coordinator (CCO) within a CMHT, in partnership with someone with a medical speciality, usually a consultant psychiatrist.

The role of a CCO is to support the SU and other services outside secondary mental health services to create an individualised care package to address the person's social care, housing, physical health and mental health needs, whilst managing any risks to and from the SU (NICE Quality standard QS188, 2019). A goal of care coordination is to improve the health and function of people with mental health problems and help them towards their individual recovery points (Coffey et al., 2017; Hannigan et al., 2018). Mental health conditions are often cyclical in nature, therefore SU's may be under the care of services for long periods. Research suggests relapse rates for Schizophrenia are hard to quantify, with estimates to be between 52-96% (Mogues et al. 2021). Personality disorders are another group of mental illnesses which CCOs support SUs with and are characterised by patterns of unhelpful behaviours which can put the person experiencing them at extreme risk of self-harm or suicide.

Secondary mental health care professionals working as CCOs may have different professional qualifications and backgrounds, for example, mental health nurse, social worker or occupational therapist. Each CCO working within the CMHT will hold a professional registration which has its own particular governing body and is expected to adhere to that body's code of conduct. The National Association of Social Workers (NASW, 2024) code of ethics, for example, states that the social worker's responsibility is to promote the rights of clients to self-determination. Ideally, each SU is allocated to the CCO whose skill set best meets their needs, however, this is not always the case. CCOs typically have high caseloads and additionally, expectations to meet certain, organisationally determined quality indicators.

As a group, CCOs are particularly vulnerable to burnout and compassion fatigue (Singh et al. 2022), which has implications for SU care and recovery outlook as research states burnout reduces outcomes for SUs due to the possible development of negative attitudes towards SUs (Towey-Swift & Wittington, 2018). Additionally, several studies identified negative associations between burnout in CCOs and recovery for mental health SUs (Nelson et al. 2009; Onyett, 2011; Singh et al. 2020) which would be in opposition to the objective of their involvement with the CMHT. Furthermore, Singh et al. (2022) reported that CCOs experienced a significant impact on the medium of care and their workload as a consequence of the COVID-19 pandemic. This took the form of organisation detachment and professional isolation. These contexts could have implications for the capability and willingness of mental health staff to work with MCA legislation.

The evidence base around the MCA has been operationalised by the Care Quality Commission (CQC), the independent regulator of health and adult social care in England within which secondary mental health care falls. Their website information page on the MCA stresses the importance of the MCA across all sectors (CQC, 2023). The CQC routinely inspect compliance with the MCA within each mental health trust inspection and subsequently produces a rating based on their inspection findings. In 2022, the CQC reported that many organisations were not meeting expected standards regarding the MCA, and consequently called for more work by providers to improve training and strengthen knowledge (Wetherill et al. 2022).

1.4 Self Determination Theory

A framework which offers a possible explanation for staff experiences of using the MCA is Self-determination theory (SDT; Deci and Ryan, 1985). SDT is widely accepted within the published literature as a framework for understanding behaviour relating to motivation and more recently for achieving psychological well-being leaning into the idea of optimal functioning, with links to growth and development. SDT posits that when the three basic needs of relatedness (a sense of belonging or attachment to other people); autonomy (a feeling of being in control of one's own behaviours and goals); and competence (mastery of tasks and skills) are fulfilled, people’s functioning is optimised. Self-determination is when a person can make their own decisions about their life, or aspects within it and how their life is managed. SDT assumes that people strive for growth which drives behaviour and secondly, that internal sources of motivation are essential for psychological well-being to be optimised.

When using the model of SDT to consider staff motivation, SDT implies that the performance and well-being of such staff are affected by the type of motivation they have for their job activities. SDT differentiates between types of motivation and maintains that different types of motivation have functionally different drivers, associations and consequences. For example, intrinsic motivation according to SDT is the most self-determined type of motivation and is characterized by participating in behaviours due to motivations relating to the inherent satisfaction and interest in the behaviour (Deci & Ryan 2000). SDT suggests motivation situated on a continuum from intrinsic to amotivation, a state which is characterized by a total lack of motivation and intention. SDT focuses primarily on internal sources of motivation.

This theory may not offer a complete explanation for the experiences of staff when engaging with the MCA as part of their clinical duties however, thus other factors such as organisational or systemic factors should be considered. Factors such as the lack of recognition of the intensity of the work from the organisation and workload pressures were reported by Boyle et al. (2023) as systemic factors affecting social workers' experiences of implementing the Mental Capacity Act (Northern Ireland) 2016. This legislation is very similar to the England & Wales based MCA, therefore these issues may be seen within this study.

SDT was chosen as a theory partly due to the strong empirical support in relation to well-being present within workplace literature. Manganelli et al. (2018) presented a review of published literature which described the benefits that SDT principles can bring to the workplace. As stated previously, CCOs are particularly vulnerable to burnout and compassion fatigue, (Singh, 2022). One way to guard against this is to increase workplace psychological well-being through meeting staff's psychological needs. It may be that once these needs are met, staff may be able to apply the MCA in the most efficient and effective way. SDT was chosen over other theories of motivation such as Bandura's (1977) self-efficacy theory, which is domain, context and task specific. Self- efficacy theory focuses on a person's belief in their ability to achieve a goal or complete a task. It encompasses a person's confidence in their ability to control their behaviour, influence their environment, and stay motivated. It was felt that concept of motivation to engage with the MCA was a macro idea which would not fit well with a micro level theory.

1.5 Researcher position

As a newly qualified social worker, I began my first role as a CCO working with clients with severe and enduring mental health problems, with very little appreciation for the Mental Capacity Act. Prior to assuming my role as a CCO, I worked as an unqualified support worker in an assertive outreach team that supported SUs with severe and enduring mental health problems who were difficult to engage through traditional approaches. I was sheltered from the Mental Capacity Act, as I took a lead role in SU engagement. Subsequently, I worked in a medium secure forensic hospital for SUs who were detained under criminal sections of the MHA. These SUs had their choices, movements and freedoms particularly restricted. Many of the SU's freedoms were controlled directly by the Secretary of State who needed to authorise any significant changes to their care. As such, the Mental Capacity Act did not frequently enter my clinical world due to the higher-level curtailments authorised by the MHA.

In 2010, I qualified as a social worker. At this point, the MCA had been in legal force for around three years. The professional training I received seemed so obscurely abstract, even with my years of experience in mental health services. As a social worker, I was afforded a vast degree of autonomy and found I was able to cover my misunderstandings or lack of knowledge about the MCA. It was not a piece of legislation I engaged with routinely, preferring to focus on mastering the other job pressures I faced, such as keeping SU safe. I worked for several years with only a scant understanding of the MCA, justifying to myself that, as a social worker, I would be making the best choices for the SU under my care, even without the framework of legislation. I believe I was not alone. Conversations about the MCA were only really referred to in a tokenistic way within team meetings.

Following a life change, I moved organisations and away from frontline clinical practice into the training and education of clinicians. I was asked to consider taking the role of MCA Clinical Lead on the understanding that I would be comprehensively trained and receive support from experienced colleagues working at the local council. My lack of knowledge humbled me but I became aware that I was not alone in possessing inadequate knowledge or skills. My time in the clinical lead role highlighted how much misunderstanding and omission still persist concerning the MCA within the clinical setting in which I was employed. This research stems from my desire to establish a positive change, both for SUs who may be disempowered from inclusion within their care, and for HCPs, who may be less vulnerable to stress and burnout if their psychological needs are met. The application of SDT suggests that such positive change is possible by improving psychological well-being by optimising staff functioning.

The next chapter introduces the systematic literature review which identifies the knowledge gap within which the empirical study sits. Additionally, it positions the systematic literature review amongst existing literature reviews with the identification of key differences.

Chapter 2: Systematic Review of the Literature

This chapter will commence with an outline of the structure of this systematic literature review and then offer a thematic analysis (TA) of the literature, highlighting key themes that emerge from the literature base of health and social care professionals' experiences of working with the MCA.

2.1 Context for the literature review

There are several literature reviews which concern aspects of the MCA to date which serve to provide a context for this literature review. They are described here to situate this systematic literature review within the wider literature base.

The review by Hinsliff-Smith et al. (2017) focussed on the implementation of the MCA within health and social care services with reference to frail older people and everyday acts of care. This review found there were tensions between the MCA implementation and the clinical realities of everyday practice. It found there is a need for improved knowledge and conceptualisation of the MCA by HCPs to embed the act into a routine, clinical consideration. In support of this, Marshall and Sprung (2016b) present a collection of themes lacking in critical analysis which are conceptualised by the idea that the MCA is not embedded into clinical practice and a culture shift is indicated to fully embed the legislation. Both studies receive support by a more recent study by Scott et al. (2020) who found the MCA remains challenging for staff and is still not embedding within practice. It was however liked by practitioners and carers as a means of SU empowerment. This is aligned with Wilson, (2017) who found a sense of positivity with which capacity legislation was viewed by people subject to the MCA.

A systematic literature review by Jeyes et al. (2019) considered how health and social care professionals assess mental capacity and to identify approaches which facilitate and improve assessment. This review suggested modifications to staff training and the introduction of practical resources to help professionals comply with legal standards. Following on from this, Jenkins et al. (2020) aimed to identify training strategies and determine how registered health and social care practitioners change their practice after MCA training. The review suggests that the nature of training that will affect practice change is unknown but states that interactive training produces the most impact and should be scenario based and relevant to trainee's practice. This review does gain support from findings from Rogers and Bright (2020) who focussed on a large sample of Best Interest Assessor (BIA) students and the method they used to successfully consolidate knowledge in a post-qualification setting, namely professional shadowing. Together, these studies suggest that more advanced, experiential training is needed for all staff working with the MCA.

The literature reviews described here go some way to offer the contextual position in which this systematic literature review is situated. None of these, however, offer a picture of the experiences of HCP working in a mental health setting when working with the MCA, therefore this review will fill the gap identified and progress with the goal of offering a picture of enhanced critical clarity and informing the landscape in which this thesis is situated.

2.2 Systematic Literature Review Position

This systematic review forms part of a thesis which is concerned with the experiences of mental health staff and their particular experiences of implementing the MCA within clinical practice. In determining the foundations for this systematic literature review, a scoping search of the literature base found no published empirical studies or literature reviews concerned with the MCA with a focus on community mental health staff. This information led to a revision of the scope of the systematic review to synthesise the body of evidence relating to the experiences of HCPs in all clinical areas working with the MCA. This approach will synthesise the commonalities of all HCPs working with the MCA and allow this thesis to be located within the wider body of current evidence.

At the same time, this review was being conducted, a similar review was published by Scott et al. (2020) which aimed to explore qualitative research on practitioners’ knowledge and experiences of the MCA in health and social care settings. The exclusion and inclusion criteria differed wherein Scott et al., (2020) excluded studies that focussed on specific parts of the MCA, such as the Deprivation of Liberty Safeguards. This was not an exclusion for this review as it forms part of the MCA, and HCPs' experience of this is equally applicable for consideration. The published review uses similar processes however, Scott et al., (2020) searched four databases, (PsychINFO, CINAHL, EMBASE and EMCARE) which resulted in the initial extraction of a smaller number (1272) of studies, concluding in nine studies for inclusion. The review undertaken here uses TA to synthesise nine qualitative papers exploring HCP’s knowledge and experience of the MCA within health and social care settings. There is however an overlap of six studies between the two reviews.

In terms of findings, Scott et al. (2020) seemed to locate the practitioner experiences of the MCA emphasis primarily on the individual assessor and patient interactions and considerations situated within this, for example the emotional impact of the assessment process upon the assessor. The systematic literature review conducted here adds a new perspective wherein it found the experiences of practitioners of using the MCA was primarily located within systemic factors, such as organisational workload pressures and time constraints. This difference is possibly due to the exclusion criteria of Scott et al. (2020) which excluded studies which met the criterion for the systematic literature review detailed here.

2.2.1 Health Care Professionals

The focus of the current review is staff working within the health and social care sector who have health professional qualifications. The rationale for this is that staff with a professional registration have an obligatory requirement to be registered with a professional body. This mandates them to adhere to a set of governing principles and act accordingly as any deviation from professional standards may result in sanctions. Social Workers, for example, may face an investigation around their fitness to practice which may result in their removal from the professional register held by the governing body, Social Work England. Unqualified staff, such as support workers or paid carers in England have no such regulation. HCPs included in this review refer to nurses, social workers, occupational therapists, speech and language therapists and clinical psychologists.

The traditional disease-based model of medicine in which the focus of medical doctors was historically concerned with presenting symptoms, shapes clinical assessments and interactions and additionally forms the basis of the NHS approach to many interventions. Research suggests that it also forms the foundations of the assessment process of the MCA (Owen et al. 2016; Spencer et al. 2017). In contrast, the HCPs of interest typically use the interdisciplinary bio-psycho-social model as a foundation for interactions. Additionally, although many healthcare interventions take place within an MDT, hierarchy is embedded within healthcare culture, which affects how staff with differential status approach the same task, (Essex et al. 2023). HCPs typically occupy the same position within the healthcare hierarchy, regardless of profession. For these reasons, medical doctors were omitted from this literature review.

2.3 Methods

2.3.1 Aim

This literature review aims to systematically review what is known about the experiences of the application of the MCA (2005) by HCPs situated within England & Wales from the date of its implementation in 2007 onwards.

2.3.2 Review Design

This review will examine the experiences of HCPs, using a configurative approach (Booth et al., 2016). This is a review type where the synthesis is predominantly configuring data from studies to answer the review questions. The aim is to broaden the understanding of HCP's lived accounts of using the MCA through integrating findings and perspectives gained from previous empirical research. The type of study that will be included will offer qualitative data from which themes or constructs can be drawn together from individual studies. This form of review is defined as a qualitative systematic review (Booth et al., 2016).

The analysis of the chosen qualitative studies will be done at the level of the findings of the individual studies, using the framework of Thematic Synthesis. This method, developed by Thomas and Harden (2008) combines the methods of both grounded theory and meta-ethnography and preserves an explicit and transparent link between conclusions and the texts of primary studies. It was chosen above Noblit and Hare's (1999) meta-ethnographic method as the goal of this literature review was not theory development.

Methods of synthesis should be supported by an epistemological position that supports the assumptions made about the nature of reality and offers congruence throughout (Levers, 2013). Critical realism is a theoretical approach that supports an ultimate reality and positions perceptions and beliefs to be mediators of the knowledge of reality shaped by culture and language (Fletcher, 2016). This position allows for multiple versions of reality to exist, multiple HCPs can experience the assimilation of MCA in different ways, influenced by their own core beliefs and perceptions of themselves, the environment, their role, and so on. In accepting this explanation of knowledge, this systematic literature review offers internal consistency in the decision to employ thematic synthesis as an approach. Grounded theory and meta-ethnography approaches were not indicated for this systematic literature review as the objective was not validation or generation of a theory.

This review follows the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) reporting standard for systematic review (Moher et al., 2009), as this gives an established framework for a transparent review. Adherence to reporting guidelines is recommended when conducting systematic reviews as inadequate reporting can prevent the accurate interpretation of findings and the corresponding weight carried by the conclusions of the review (Fleming et al., 2014). The review protocol for this review was accepted for inclusion on PROSPERO, the International Prospective Register of Systematic Reviews and is found at ID No: CRD42020158680.

2.4 Search Processes

2.4.1 Scoping Searches

Scoping searches were carried out to determine the viability of the systematic review using guidance taken from Pollock et al., (2016). As this thesis is concerned with the experiences of mental health staff in using the MCA, it was anticipated that a review would focus on the published literature in this area. This however proved to be an area with no current published literature. A scoping of the literature found that published systematic literature reviews that centred on the MCA in this area were primarily concerned with staff outside of the mental health field in other clinical specialities, such as staff who work with older adults (Hinsliff-Smith et al, 2017) or SU experiences (Wilson, 2017). Reviews were mainly concerned with particular parts and processes of the MCA, for instance, the assessment processes staff employ when using the MCA, (Jayes et al., 2019) or the nature of training and post-training practice changes (Jenkins, 2020). The perspective of a librarian was sought to confirm this was correct. Following this, the review question was thus revised to consider HCPs working in all clinical areas. This yielded a much broader literature base from which to execute a literature search.

2.4.2 Database Search Terms

Moving on from the preliminary scoping, Petticrew and Roberts (2006) suggest formalising the search strategy to allow for greater clarity and focus when defining the scope of the research question. PICO was chosen as a framework as it is comparatively more sensitive than SPIDER or PICOS for qualitative research in a health context (Methley et al., 2014). The PICO outcomes are illustrated in Table 1.

Table 1: PICO Search Terms

PICO TERM	DEFINITION WITHIN THIS LITERATURE REVIEW
Population	Healthcare professionals – including nurses, social workers, occupational therapists, clinical psychologists and speech and language therapists.
Intervention	Mental Capacity Act (2005)
Comparison	Partial or non-application of the MCA
Outcome	Experiences of applying MCA legislation to clinical practice

Defining the database search terms required some refinement due to a lack of precision. The search terms chosen for this review (Table 2) were used in combination with Boolean Operators, which are conventionally used to combine keywords within search queries. Adding a third term (mental health OR Psych*) to the search framework was redundant, therefore, to create a balance between precision and sensitivity, only two terms were used. Campbell and Dorgan (2015) advocate the use of a subject specialist librarian during this decision-making process. The specialist subject librarian consulted was able to confirm that using only two search terms was a prudent decision as it was noted that occasionally the movement from search framework to search strategy is not always a direct translation (Methley et al., 2014).

Table 2: Search terms used for database searches

TERM NUMBER	DESCRIPTION INCLUDING BOOLEAN
1	"Mental Capacity Act" OR MCA
2	HCP OR Nurse OR CPN OR "Social Work*" OR AMHP OR "Care Co-ordinator" OR "Health Care Professional" OR staff* OR worker OR clinician OR professional

In a further refinement of the search terms, consideration was given to MeSH (Medical Subject Headings) terms. MeSH terms are a controlled vocabulary used for indexing journal articles in databases, but these terms were not used as the 'Mental Capacity Act' is not a listed term. MeSH terms originate in American-based databases, wherein legislation applying to England and Wales does not have a high profile; but are often used in worldwide databases. Capacity in itself is a listed term; however, as defined by MeSH this relates to a wide range of topics, from lung capacity to bed capacity, and would therefore not be appropriate to use for this systematic literature review.

2.4.3 Database Searches

As each journal has its own ontological and epistemological leanings, a range of databases that index them was searched to minimise publication bias. Qualitative studies and mixed method studies where HCPs are the subject remain the focus of the systematic review and so, the following databases were chosen with support from a specialist librarian as they offer coverage of health research:

- Medline/Pubmed Complete
- PsycInfo
- CINAHL Complete
- Web of Science
- Scopus
- SocINDEX with Full Text

In addition to published literature, grey literature is defined as material that has not been published through conventional routes, for example, conference papers, government papers or press releases, and may be difficult to access, (Kiteley & Stogdon, 2014). It was decided after an initial scoping that relevant grey literature would be used. The focus of the MCA means that there are large numbers of charities, voluntary organisations and public sector bodies interested in the application of the law (Marshall & Sprung, 2016b). These organisations may self-publish their findings, rather than submit them to a peer-reviewed journal.

A database called Open Grey which holds European grey literature revealed 10 results, all of which were theses, of which the content of eight was relevant for consideration within the review. Social Care Online (SCIE) is a further database that was searched as this holds legislation, government documents, practice and guidance, systematic reviews, research briefings, UK grey literature (informally published), reports, and journal articles. SCIE is updated daily and contains over 160,000 records from the 1980s onwards (SCIE, 2021). As a complement to Open Grey, a published thesis which contained unique empirical studies, but had not yet been published in a peer-reviewed journal was considered for inclusion. EThOS online, a UK thesis repository was searched using the term “Mental Capacity Act”, generating 71 results for inclusion within this review. Finally, it has been suggested by Littlewood et al., (2019) that electronic database indexing is not always complete. In an attempt to increase the sensitivity of the search, the reference lists of the relevant, contemporary theses and journal articles were scrutinised. This hand search located four otherwise uncollected articles.

The searches were carried out in January 2020 and reviewed in August 2022 for completeness.

2.5 Selection Criteria

To strive toward this protocol being rigorous, systematic and reducing subjective researcher bias, a set of criteria for selecting studies was determined. The inclusion and exclusion criteria provide information about the scope and relevance of the review that is not detailed within the review question (Aveyard, 2010). Table 3 details the inclusion and exclusion criteria with an accompanying note on the rationale for decision-making.

Table 3: Inclusion and Exclusion criteria

	INCLUDE	EXCLUDE	RATIONALE
STUDY LOCATION	England & Wales	Other countries	The MCA (2005) only has legal jurisdiction in England and Wales. Other countries such as Scotland and India may have similar legislation, but this is outside the scope of this review
RESEARCH DATE	2007 - Present	Pre 2007	Legislation was enacted in 2007.
POPULATION STUDIED	HCPs with a professional registration – nurses, social workers, occupational therapists, physiotherapists, speech and language therapists and clinical psychologists	1) Medical Doctors 2) Healthcare Support worker 3) Volunteers 4) Carers	The focus of the research is on staff delivering clinical interventions within health care. The excluded populations do not meet the definition of HCP as defined at 2.1
SAMPLE	Staff	SUs and carers	The focus of the research is not the SU and carer experiences of the MCA.
METHODOLOGY	Qualitative	Quantitative Mixed methods studies with limited qualitative data	Quantitative results may not deliver the type of data suitable to The focus is on qualitative data, therefore this should be the majority focus.
PROCESSES	Staff experiences of the MCA generally	Focus only on Deprivation of Liberty Safeguards (DoLS) or procedure	DoLs legislation cases are too specific and the procedure does not capture staff experiences.

2.6 Results

Of 1385 results which were identified from searching and exported to a Mendeley reference management database, nine were included in the synthesis of the literature. Figure 1 details the PRISMA flow diagram of study selection. Detailed records within an Excel spreadsheet, were kept of every decision to exclude or include a study from the review, including the rationale for the decision to aid transparency.

2.6.1 Quality Assessment

Following a process of refinement, the selected articles were critically assessed to determine their quality. There is a debate in the literature as to what 'quality' is in terms of rigour, especially regarding qualitative studies. For this review, a critical appraisal is a systematic process used to identify the strengths and weaknesses of a research article (Young & Solomon, 2009). The idea behind critiquing papers is concerned with methodological rigour (Thomas & Harden, 2008; Zeng et al., 2015), yet critical appraisal of qualitative papers remains contentious, despite multiple critical appraisal tools in current use (Toye et al., 2014).

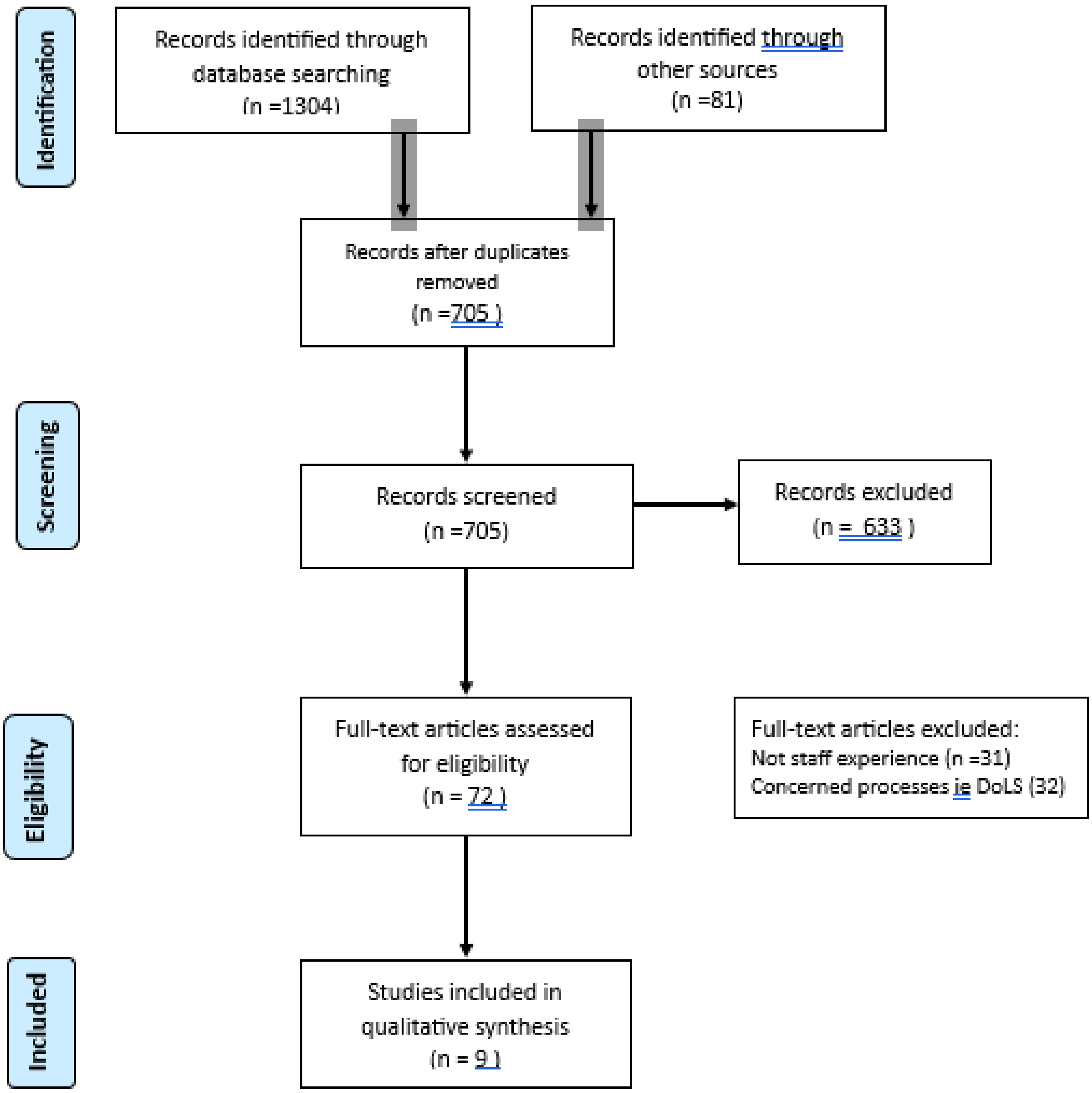

Figure 1. PRISMA (2009) Flow Diagram

Critical appraisal tools for qualitative studies have been reviewed within the published literature, (Crowe & Sheppard, 2011; Katrak et al., 2004; Young & Solomon, 2009) leading to varying accounts of tool validity and integrity. The quality of the studies was determined using a CASP checklist (Critical Appraisal Skills Programme, 2018). This is a tool used within qualitative research to appraise the quality of research. This CASP tool is one of 8 offered by the Critical Appraisal Skills programme and is research-specific. Although not specifically developed for use within evidence-based practice, unlike the JBI checklists (Jordan, 2019), it is the most commonly used criteria-based tool for quality appraisal in health and social care-related qualitative evidence synthesis (Long et al., 2020). The tool is concerned with taking a pragmatic approach to evaluating rigour, reliability bias and application.

The tool does not recommend a scoring system, therefore, guidance was taken from Buccheri and Sharifi (2017) concerning completing the tool and scoring. The approach chosen here aligned with their recommendations is as follows: Question answered completely – 2 points, question partially answered - 1 point, question not answered – 0 points, with a possible score of 20. The scores awarded to each paper included in the systematic review are located in Table 6, with all of the papers located at the higher end of the quality spectrum. No papers were disregarded based on quality as felt this would narrow the opportunity to review other study insights. The impact of study quality was reviewed during the analysis stage, however, it was not impactful as similar themes were noted across the breadth of quality scores. The CASP scores are summarised in Table 4, with the complete version of the table presented in Appendix I.

Table 4. CASP Scores

Literature Review Paper	**CASP score** (/20)
Murrell & McCalla (2015)	19
Samsi Manthorpe, Nagendran & Heath, (2012)	16
Manthorpe, Samsi & Rapaport (2014)	16
Marshall & Sprung (2016)	17
Ratcliff & Chapman (2016)	18
Cliff & McGraw (2016)	18
Walji, Fletcher & Weatherhead (2014)	19
Moore, Wotus, Norman, Holloway & Dean (2019)	17
McVey (2013)	19

2.6.2 Data Extraction and Analysis

Data extraction requires a pre-specification of the data that will be collected, thus identifying all the relevant details of the study (Munn et al., 2014). An academic peer performed the data extraction for two articles using the same form. This was reviewed by the primary researcher and issues were discussed, following which a consensus was reached. Details of the study aim, methods, key findings and limitations derived from the data extraction are summarised in Table 5.

As the extracted data is qualitative, once synthesised, it is anticipated that the data will represent a set of statements that explain and represent the phenomenon under investigation (Munn et al., 2014). Given that the data comprises themes around staff experiences and perspectives, the thematic synthesis will be used to bring together and integrate the findings of multiple studies (Thomas & Harden, 2008). The review intends to preserve the link between the primary data and the conclusions that will be drawn, which Thomas and Harden (2008) believe can be transparently achieved using analytical themes within thematic synthesis. Thematic synthesis has a long history of use within reviews that address questions about experiences and perspectives and has been used here to identify factors significant for understanding how HCPs experience working with the MCA.

The analysis was undertaken in three stages. Initially, free line-by-line codes derived from the findings of the primary studies were generated (stage one). These were organised into related areas to create descriptive themes (stage two) which were then finally analysed to result in the creation of third-stage analytical themes. The analysis was completed by the primary researcher, following discussions with the supervisory team.

Table 5. Characteristics of included studies

Author (Year)	**Method /Analysis**	**Population Studied**	**Clinical Speciality**	**Study Aim**	**Key Findings**	**Limitations of study**
Murrell & McCalla (2015)	Interviews – Thematic Analysis	Social Workers (n=6)	Working Age Adult - Physical	To explore how social care practitioners interpret the MCA and assess capacity using thematic analysis	Interpretations of the MCA vary among staff. Assessment is complicated and subjective and situated amongst competing demands. The role of risk is discussed and practice recommendations clear.	5/6 participants from the same team – potential culture implications
Samsi Manthorpe, Nagendran & Heath, (2012)	Interviews – Thematic analysis	Admiral Nurses (n=12)	Dementia	To explore the experiences of specialist community nurses providing information about the Mental Capacity Act and supporting people with dementia and carers	Predominantly positive experiences concerning using the MCA with SUs with dementia. However, limited confidence particularly concerning experiences in the community, knowledge acquisition and training are still of concern.	Timing – done shortly after the act implementation – not much time to fully embed
Manthorpe, Samsi & Rapaport (2014)	Interviews – Longitudinal follow-up. Thematic Analysis	Community Dementia Nurses (n=15)	Dementia Community	Exploring changes over time in nurses' practice experience of the implementation of the MCA and their reflections on change in nursing practice.	Awareness and confidence increased, and greater involvement for SUs. Concerns about lack of understanding amongst other professionals and felt more carer awareness was needed. Recommendations for mentor and supervisory roles within practice.	Only 2 years between interviews. 10 of 15 were interviewed at the second time point.
Marshall & Sprung (2016)	Focus group and paired interview – Content analysis	Adult Community Nurses (n=9)	District Nurse	Community nurses' experiences of using the MCA within their clinical practice	Practitioners lacked knowledge confidence, training, and awareness of MCA. Working together with the wider MDT was cited as problematic. Findings suggested clear examples of self-appraised confidence yet there was scope for development within clinical practice.	Declared researcher bias due to the researcher's position of power. Participants were reluctant & uncomfortable. Brief description of data analysis methods
Ratcliff & Chapman (2016)	Semi-structured interview –	3 Learning Disability Nurses, 1 Physio	Learning Disability - Community	Challenges and barriers to undertaking MCA assessments and the way	A wide range of organisational, systemic, and person-specific factors affected the quality of and confidence within capacity assessments.	All participants were from the same small team and attended

	thematic network analysis	1 Occupational Therapist 1 Speech & language therapist 2 Social Workers (n=8)		practitioners and services could address these.	These factors created a range of tensions for staff in which staff struggled to reconcile theory with practice. This was noted when staff found it difficult to make decisions about SU capacity.	the same training. Not representative
Cliff & McGraw (2016)	Semi-structured interviews – Thematic Analysis	5 Nurses: 3 Occupational therapists 6- Physio-Therapists (n=14)	Community Nurse / Hospital Avoidance team	Identify the facilitators and inhibitors to the capacity assessment process as perceived and experienced by non-medical health professionals conducting assessments in community settings	Influences such as SU diagnosis, family intervention and physical distance from co-workers make the process complex. Findings suggested the SU-practitioner relationship affects the conduct and process of the assessment.	Sampling was not representative Only band 6+ interviewed. Some professions omitted
Walji, Fletcher & Weatherhead (2014)	Interviews – Thematic Analysis	Clinical Psychologists (n=7)	Learning disability/ Neurology/ Acquired brain injury	Clinical Psychologist's experiences in implementing the MCA	Clinical psychologists are uniquely placed due to their values and training to uphold MCA principles and maintain a person-centred approach. Training needs identified alongside a need to strengthen MDT relationships and a requirement for strong effective supervision with reflexivity.	No mental health psychologists were interviewed.
Moore, Wotus, Norman, Holloway & Dean (2019)	Semi-structured telephone interview – Mixed thematic approach	Brain Injury Case Managers (Nurses) (n=12)	Acquired Brain Injury	To highlight potential conflicts or tensions that the application of the MCA might pose and identify approaches to mitigate the problems of the MCA and capacity assessments	MCA training should be diagnosis-specific. The staff were concerned about the lack of safeguarding for SUs. Disagreements with other professionals were a concern of staff, particularly concerning the very specific needs of SUs with brain injury.	Very narrow subject recruitment. Results very specific to acquired brain injury situations
McVey (2013)	Interviews-grounded theory	9 Nurses 1 Speech and language therapist 1 Clinical Psychologist (n=11)	LD - Community	How learning disability staff make sense of and use the MCA What factors influence staff's use of the MCA in clinical practice	Professional risk and emotional risk drive decision-making. Both result in strategies to mediate the risks. Findings report a great deal of uncertainty using the act, which was primarily located in the subjective nature of the evidence gathering. Peer support was championed for staff.	Participants from only one service. Difficulty sampling inexperienced staff who did not self-select. PhD Thesis – not currently published.

Total number of participants N=94

2.7 Findings

This review described nine qualitative studies, in which a total of 94 participants' views and perspectives were collected from eight studies employing semi-structured interviews and a further study which collected data from a focus group. All studies were published between 2012 and 2019, in peer-reviewed journals, aside from one thesis retrieved from OpenGrey (McVey, 2013). The studies which met the inclusion criterion had small sample sizes (8-15) and collected data from within small geographic or organisational boundaries, with the majority coming from single teams. Participants in the studies were from a wide range of professional backgrounds (Table 6) working with SUs with a broad spectrum of presenting needs, such as dementia, learning disabilities, brain injury and physical illness. Mental health staff were not represented within the literature.

Table 6: Profile of participant characteristics within the selected studies

Professional Background	FREQUENCY
Social Worker	8
Nurse	65
Clinical Psychologist	8
Physiotherapist	7
Occupational Therapist	4
Speech & Language Therapist	2

Thematic synthesis was chosen as the method of analysis and aimed to integrate the findings of the included papers. This resulted in the development of four overarching analytical themes and 15 sub-themes: subjective uncertainty; MCA as a tool of empowerment; risks & threats to application; and staff confidence & impact. A summary of subthemes that sit under the themes is presented in Figure 2.

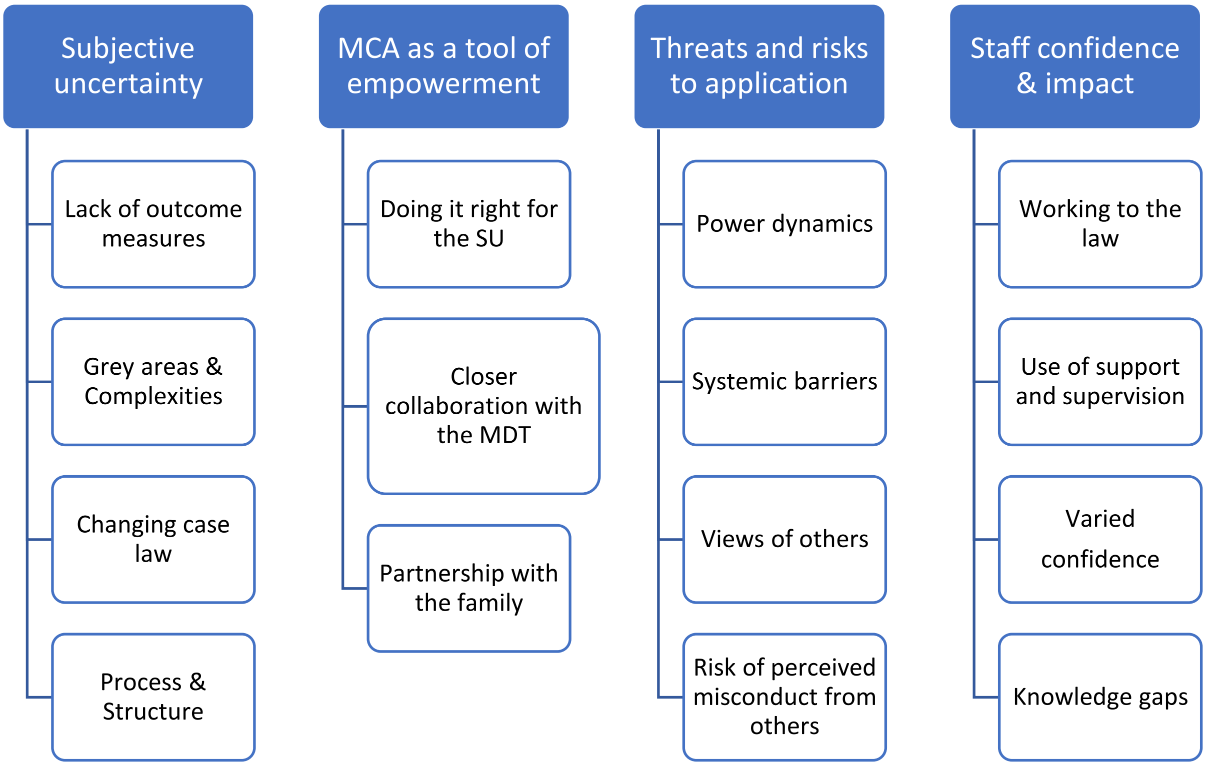

Figure 2. Themes and Subthemes

This literature review aimed to determine what is known about professional staff's experiences of applying the MCA within their clinical speciality within the published literature. Across all studies, that is across all professional groups and within different settings, researchers commented on the difficulties staff experience when implementing the MCA alongside their other clinical expectations.

2.7.1 Theme 1: Subjective Uncertainty

This theme brings forward the idea of subjectivity and fluidity. The MCA is not received as a fixed, static piece of legislation with a clear pathway of use. There are almost unlimited variables which staff must negotiate, whether this is in relation to the SU; their diagnoses and circumstances or the construction of the legislation itself which can be informed by case law and local IT systems.

Lack of outcome measures: Further located within this theme was the idea that clinicians have a degree of insecurity around the conclusion of an assessment. It was commented that sometimes assessments are 'redone' for the answer that was desired – which was suggested to be the answer the organisation or the family wanted, and decisions were made to appease the bigger system. In relation to resource demands, Murrell and McCalla (2016, p69) suggest that "Given that staff have no outcome measures for performance/competence in routine practice, their work remains unchecked unless a serious challenge occurs".

Grey areas & complexities: This sub-theme reflects the findings around the reported struggle with uncertainty, resulting from staff members using the MCA within their clinical practice. The idea of 'grey areas' was raised in eight papers: Murrell and McCalla (2015); Samsi et al., (2012); Manthorpe et al., (2014); Marshall and Sprung (2016); Ratcliff and Chapman (2016); Cliff and McGraw (2016); Walji et al., (2014); and McVey (2013). These are the ambiguous situations in which neither policy nor established practice offers a clear path forward. In relation to the MCA, this was sometimes noted as a lack of a standardised form but also noted concerning SUs having a fluctuating capacity to make decisions. In terms of capacity assessment, the idea of an unwise decision (Principle 3) was most problematic for staff. Principle 3 states that a person cannot be considered to lack capacity to make a decision solely because others think it is unwise. This principle is based on the idea that everyone has different values, beliefs, and preferences, and that these decisions should be respected. This appears in part due to the idea of an unwise decision which is grounded in cultural, professional, and personal norms (Jenkins et al., 2020). Interestingly, this seems more prevalent in more recent articles from 2016 onwards as the local cultural norms are ingrained and national case law is established.

Changing case law: The MCA legislation is routinely superseded by case law. This means that in practice, practitioners might believe they understand the word of the law, subsequently, a judge delivers a ruling which supersedes this and modifies the practical application. Some studies reported that clinicians struggled to maintain contemporary knowledge of the MCA and the staff found they were not equipped to integrate changes within their practice. Moore et al., (2019) and Walji et al., (2014) suggested that this was the responsibility of the organisation, rather than the personal responsibility of the clinician. Walji, (2014, p.117) cited there should be “significant awareness of the need to keep up to date with changing case law supported by a process for disseminating this information in an accessible way” with an emphasis on the externally located process. This fluidity of the case law knowledge base enhanced the anxiety that staff reported about conducting an assessment or making a capacity-related decision (Walji et al., 2014).

Process & Structure: Some participants within the dementia care group (Samsi et al., 2011; Manthorpe & Samsi 2014) found the layout and structure of the legislation worked well for their SU group. However, due to the subjective nature of evidence gathering, staff working with SUs with brain injury found the process to require highly specialised assessors to conduct the assessments (Moore, 2019). McVey (2013) suggested learning disability staff struggled to apply the process to highly complex scenarios, a fact which was supported by the other paper situated in a learning disability care setting. Ratcliff and Chapman (2016, p.33) state “Assessors often have to take into account a significant range of complex factors when looking at decision-making capacity, and this complexity in practice may not be fully reflected in statutory provision and guidance, or in training”.

2.7.2 Theme 2: MCA as a tool of empowerment

This theme held largely positive content. HCPs reflected on the change in the position of the SU to be situated at the centre of the decision-making process and compared this to pre-MCA practice. This was predominantly marked in staff who worked with SUs with a diagnosis of learning disability who valued the change to legitimise positive risk-taking, (McVey, 2013; Ratcliff & Chapman, 2016).

Doing it right for the SU: Staff found the MCA process engendered a feeling of closeness to the SU as the subject of the assessment process, due to the time invested into the assessment to achieve a positive outcome for the SU. Unfortunately, staff working in the field of learning disability believed the process could be distressing for the SUs which the staff found challenging to process (Ratcliff & Chapman, 2016). Conversely, it was noted by Cliff and McGraw, (2016, p.575) that having a long-standing professional relationship with SUs was a threat to MCA assessment objectivity, and staff were "…aware of personal biases and mindful not to let factors such as their own values, beliefs and preferences or the quality of any pre-existing relationship with the patient hinder objectivity during the assessment".

Staff working with SUs with dementia spoke positively about the diagnosis no longer being a label of exclusion as the MCA employs a functional test of capacity and is not merely concerned with diagnosis.

Closer Collaboration with the MDT: Some studies found the MCA brought collaborators closer when working through the process of assessing SUs and shared decision-making in a team environment. Murrell and McCalla (2016, p.77) provided a representative summation of MDT working, "This 'safety in numbers' diffuses the burden of responsibility and is important for providing reassurance to staff that the sense they make of a situation is right – and furthermore that they are doing a good job". Staff valued the opportunity to work inter-professionally, with social workers perceived as being better equipped to assess SUs due to their professional training. Some found the experience less positive and reported tensions, particularly when practitioners in the same team disagreed about clinical decisions relating to the MCA. The disagreements were resolved either through further discussion followed by consensus of agreement, or one party acquiescing to another.

Partnership with the family: All nine studies discussed how using the MCA affected the staff who participated and their experience of working with families and carers. The experiences were mixed for the staff. Families were regarded as an asset to the process, helping to engage with SUs. Ratcliffe and Chapman (2016, p.66) state, "The presence of a strong legal framework in the form of the MCA was seen as helping professionals to bring families 'on-board' with the process and to help families recognise that this is a duty rather than the subjective position from a particular practitioner". Other studies suggested staff found families had limited understanding of the MCA or were in opposition to their loved ones taking risks that they perceived as detrimental to their well-being. This caused tension, which requires tact and skill to navigate, as the motivations for disagreement were reported as on occasion self-interest, but often uninformed yet well-meaning. The need to explain "why" to the carers improved the transparency of the assessment process as it required a rationale for decision-making to be justified by professionals. In contrast, Cliff and McGraw (2016, p.573) suggested that in relation to family members "their input was seen as a threat to the conduct of an objective assessment" and "they deemed interruptions to be intentional and used to deny the person being assessed the opportunity to demonstrate capacity". The clinical group at the focus of this study were generalist community nurses working with patients in their own homes. It appears the dynamic which was observed in other settings may manifest differently with this staff group who offer a more generalised service than the other staff involved in this systematic review.

2.7.3 Theme 3: Risks and threats to the application

This theme illustrates the worry and anxiety that some studies reported that staff felt around using the MCA; the sub-themes below drill down into the origins of this anxiety.

Power dynamics: Power dynamics were pertinent in most participants' experiences, and often involved power imbalances between HCPs and SUs such as when capacity and agreement with professionals became synonymous. Power dynamics were also inherent within professional systems, especially in hospital settings (Walji et al., 2014), where the views of consultant psychiatrists could be considered more important than the views of other professionals. Manthorpe et al., (2011) and McVey, (2013) mentioned a nursing perception that medical doctors were best placed to conduct the assessment, which contrasts with the MCA code of conduct, which suggests this is not routinely indicated. Within healthcare settings, there are inherent power imbalances which were captured as staff acquiesced to either senior team members or staff of another discipline, such as medicine, when there was disagreement over a capacity decision. Staff, on occasion, were intimidated by colleague knowledge and confidence, this appeared to affect their judgement of their skills. This was demonstrated by staff opting not to challenge colleagues or engage in assessments which many have been reviewed by their colleagues within a team setting. However, Walji (2014) cited a difference in unspoken authority between medical doctors and psychologists, who described instances where medical staff ceded expertise to psychologists. However, this falls outside of the scope of this literature review.

Risk of perceived misconduct: Risks, in the specific guise of legal action, were noted in studies by Moore (2019), Walji et al. (2014) and Manthorpe and Samsi (2014). As professionals, there is the possibility of a legal challenge by SUs and their carers against either staff or their organisation. The studies commented on this in an abstract sense, however, rather than from personal experience, participants were mindful of legal consequences of their MCA-related decision-making or actions that may account in some way for their proclivity for embodying the MCA within their practice. Whilst getting the MCA 'wrong' was discussed in every study, this idea of the error being perceived as misconduct was only present in 3 articles (McVey, 2013; Walji et al., 2014; Ratcliff & Chapman 2016). The organisational culture may account for this as some organisational systems have a supportive culture about reporting mistakes or near misses.

Views of others: Some staff commented on how the views of their peers towards themselves impacted the assessment process. Within specialist brain injury nurses, Moore (2019) found staff from different clinical areas working alongside the brain injury nurses were intimidated by the brain injury nurses' knowledge base and the staff from different clinical areas were reticent as well as reluctant to engage with the MCA process for fear of being exposed as having very little understanding of the process. It is worth noting, however, that Wilson et al. (2010) believe undertaking a capacity assessment with a patient with a brain injury is most successful when the assessor is familiar with the executive impairment and lack of insight often present with such patients. Seniority within the organisation appeared to affect engagement with the MCA, with less clinically experienced staff feeling intimidated around their more experienced peers. This is however likely to be a situation which occurs commonly in clinical settings, outside of the application MCA, therefore this cannot be accepted as an absolute conclusion.

Systemic Barriers: There were significant systemic barriers reported to the implementation of the MCA experienced by staff. Ratcliff and Chapman (2016, p.331) cited “work-related pressure caused by volume of work and limited time to complete assessments” as an obstacle. The dual issues of a scarcity of time and financial resources for interventions were seen as impediments to a good assessment. A further barrier concerned the idea that organisations would prefer assessments to have a particular outcome, thus placing staff in a difficult predicament. The expectation by services that risk would be reduced conflicts with the positive risk-taking ethos of the MCA. It was noted that organisational pressures are often sufficient to deter staff from adhering to the MCA. The MCA is designed to empower SUs and for HCPs to conduct an assessment with integrity, the time spent with SUs increased for some staff which increased pressure on workloads. It is recognised however that many areas of the NHS have increased financial pressures, therefore the overarching impact of resource deficits specifically on MCA is difficult to quantify.

2.7.4 Theme 4: Staff Confidence & Impact

This theme is concerned with the personal impact staff may feel from working with and negotiating the MCA as part of their clinical duties. It is also concerned with staff confidence to work with the MCA.

Varied Confidence: Clinicians' confidence in using the MCA was remarked upon universally. It was reported to be varied within every study with no trends identified across time or professional groups. Some studies linked staff self-reported levels of confidence to their practical experience of using the MCA; for example, Marshall and Spring (2016) identified staff confidence appeared to increase after undertaking MCA assessments with a SU.

Confidence around the MCA goes far beyond knowing the content of the MCA, yet several studies failed to take into account personality type and the impact this has on confidence within a workplace setting. It would also be prudent to reflect on the skew that may occur from the participant's choice to volunteer to engage with a study on the MCA and the representation of underconfident staff. Walji et al. (2014) suggested that staff who had MCA decisions questioned or challenged experienced a change in their confidence levels around decision-making. The lack of standardisation also affected staff confidence as the complexity of the legislation made it difficult to work out whether they were employing the legislation correctly. The relationship between knowledge and confidence appeared unclear with McVey (2013) suggesting a strong link between MCA training and confidence, however, Marshall and Sprung (2016a) suggested that clinical experience was the primary mechanism affecting confidence.

Use of Supervision and Support: Studies reported staff found clinical supervision to be a crucial factor in developing confidence in engaging with the MCA in clinical practice, however, it was not perceived as a replacement for robust training (McVey, 2013). Appropriate use of supervision aided clinical reflexivity in relation to the process and outcomes of cases. Staff gained assurance from shadowing senior colleagues as well as carrying out assessments jointly (Murrell & McCalla (2016). Staff found a positive support network engendered confidence when making professional judgements concerning high levels of risk.

Personal & Emotional Impact: This sub-theme raised issues of emotional impacts for staff who were concerned about the impact of their decisions on SUs within their care. Staff reflected upon this and were on the whole able to articulate their paternalistic feelings of care and responsibility (Walji et al 2014). The burden of the decision-making created an emotional response for staff. There was a sense of staff ‘needing’ to do the right thing, as an alternative would impact their self-esteem (McVey, 2013). Staff working in healthcare are bound by a ‘duty of care’; yet the MCA allows for persons with mental capacity to undertake unwise decisions. This experience can create an unpleasant dichotomy for staff when working with the MCA; for example, they encourage the SU to make decisions which may have a negative outcome, yet feel protective of the SU due to the relationship that has been established (Ratcliff & Chapman, 2016).

The metaphorical weight of responsibility on staff was felt concerning the magnitude of the decisions and perception of consequential loss to either themselves or the SUs whom they were caring for. Decisions such as accommodation were mentioned due to the global impact it had on both the SUs and their support systems.

Knowledge Gaps: Another area which was located universally across studies was the idea that staff had more to learn or gaps within their knowledge of the MCA. Staff reported limited and varied formal training experiences, with many learning 'on the job' having only had a basic introduction to the subject area. Whilst reactive learning experiences were seen as valued for staff, understanding the legal framework under which the MCA sits is essential and seemed to be occasionally missing. Self-study was not identified universally as a personal obligation. Murrell and McCalla (2016) linked the knowledge gaps with staff integrity to assess SUs, and thus their confidence to move from theoretical concepts of the MCA to the actual clinical application was lacking. This may suggest the knowledge standard for organisational MCA training is in some way not optimal.

2.8 Discussion

This review identified an evidence base relating to the experiences of healthcare staff in using the MCA in their clinical practice. The review includes nine studies which sought the perspectives of healthcare staff with professional qualifications who use the MCA as part of their role. The review identified four overarching themes relating to these staff experiences. These were 1) subjective uncertainty; 2) the MCA as a tool of empowerment; 3) the risks and threats to application and 4) staff confidence and impact, which were considered through the lens of critical realism.

The studies tended to conclude that staff continue to find the MCA challenging to translate into clinical practice. There were wide inconsistencies within training experience and knowledge within and between staff. Evidence suggests that staff continue to struggle with the subjective nature of the MCA which can affect their confidence to carry out assessments. Staff are vulnerable to the emotional impact of MCA-related decision making and this was mitigated by the support systems they engage with.

This literature review evidences a wide range of issues that staff experience when using the MCA. What is unclear from this review however is the degree to which mental health staff would experience these issues. This thesis aims to understand mental health staff experiences of using the MCA. Due to the needs of their SU group, these staff are required to navigate both the MCA and the MHA. The data collected and subsequent analysis will serve to expand the empirical knowledge base in this area.

2.8.1 Review Strengths & Limitations

This review successfully answers the review question set out at part 2.3.1. The review was conducted with sufficient rigour, a transparent methodology and robust processes to stand as a review of this subject area. Rigour was attained by providing a clear review protocol describing each element of the review. The process of decision-making within the review was transparently documented earlier in this chapter. Another review was published around the time this review was being finalised (Scott et al., 2020). The authors noted as a limitation that they “may have missed additional insights from grey literature”, which this review includes. In addition, Scott et al. (2020) searched a smaller selection of databases thus affecting the pool from which articles were retrieved. The review builds on similar reviews in the area and the results are similarly positioned. Hinsliff-Smith et al., (2017) and Scott et al., (2020) found that although the MCA was embedded within clinical practice, staff found implementing it challenging and hoped for more training, findings which were aligned with the conclusions drawn here.

Given that, to date there has been limited research undertaken in this area, the conclusions that can be drawn from this review are limited. The studies appeared to show a geographical underrepresentation of HCPs from the devolved Wales where this legislation applies; although some studies did not disclose their location. There was also very little information relating to the diversity of the participants or the country in which they were trained. Evidence demonstrates there are many NHS trusts which have over 10% of staff who were trained overseas (Nuffield Trust for Research and Policy Studies in Health Services, 2022). This review contained studies that were heavily skewed towards participants with a nursing background, as indicated in Table 4 which, originating from a system in which paternalism is endemic, may have affected the cultural position of the nurses. This insight will be used to inform my own research.

2.9 Why is further research needed?

As evidenced in this literature review, there has been no specific exploration of mental health staff's experiences of using the MHA alongside the MCA. It is unclear how staff are aligning the two pieces of legislation alongside their clinical interventions. Substantial research implies the MCA has not been completely embedded within clinical practice, yet it appears the MHA was never subject to these issues as referenced by Gilburt, (2021) and Barcham, (2008). This could be in part due to the method of application of the MHA. Applications are made by a mental health worker with specific advanced training - an Approved Mental Health Practitioner (AMHP) – rather than the person who knows the SU best and who often has very generic training as is the case with the MCA. This difference in the process may affect the application of the MCA in clinical practice.

A further consideration that has not yet been investigated by the current literature base is a theoretical underpinning offering an explanation of staff motivation to engage with the MCA. SDT (Deci & Ryan, 1986) offers insights into how work contexts influence basic needs which optimise worker motivation. Implementing and embedding changes to clinical practice within healthcare require adjustments to be made by staff and SDT may go some way to explaining the difficulties which have been presented within current literature for staff using the MCA in clinical practice.

2.10 Summary

This systematic review which included 94 health and social care staff experiences of the MCA located within nine papers was underpinned by four overarching themes, giving insight into the challenges and rewards associated with delivering clinical care alongside a piece of legislation that may not have existed when the staff member undertook their training. In essence, the Mental Capacity Act was seen as valuable, both for the staff and the SUs, but the efforts required to move the staff member from aware to competent were huge, with some staff never gaining self-perceived confidence. The challenges were reported from every professional background and each clinical area represented within this systematic review.

The results of this review illustrate how staff continue to require support with their clinical practice around both understanding and working with the MCA. NHS trusts appear to have widely delivered a roll-out programme of familiarisation, yet the movement from classroom understanding to competent practitioner appears to be occurring for every HCP. It is anticipated that the findings from this review can be used to inform senior decision-makers about the need for further investment of resources within this area. Equally, the discussion around MCA needs to continue, both at the practitioner level as well as commissioners to keep the importance and value of the MCA at the forefront of all associated decision-making. The knowledge gaps identified as a result of this review will inform the research aims of this thesis. Mental health staff were not recruited or considered in any paper contained within this review. These gaps in published research pave the way for this thesis.

Chapter 3: Methodology

3.1 Introduction

Within this chapter, I will discuss my philosophical assumptions alongside the epistemological and ontological positions in which the research is situated. The rationale for adopting a qualitative methodology will be discussed and the chapter will end with a positionality statement.

3.2 Research Aim

This research aims to understand the processes that influence the experiences of Mental Health Care co-ordinators implementing the MCA in Clinical Practice within secondary mental health care. Achieving my research aim will provide the answer to my research question: “How are staff working with SUs with severe mental illness negotiating the use of the MCA as part of routine clinical practice?”.

3.2.1 Objectives

- Establish how staff reconcile the remits of the MCA and the MHA within their clinical practice
- Understanding the impact of any personal, organisational or systemic obstacles to using the MCA in practice.
- Determine how staff operationalise any formal and informal learning opportunities and the impact this has on their clinical practice.

3.3 Philosophical Assumptions

In justifying each of the philosophical decisions made during the research process, I will defend the ontological position taken to achieve the previously stated research aim. In seeking to understand the experience of mental health staff, there should be congruence between the theoretical framework, methodology and the research question (Creswell, 2013). A researcher's philosophical position should make explicit the theoretical assumptions which frame their research, as such clarity will be offered as to the perspective in which the research is situated and the nature of my own perception of the reality in which the research was conducted (Waring, 2012). My ontological position undoubtedly provides a foundation for and determines the thrust of any conclusions surmised from the research data due to the mode of data analysis (Darlaston-Jones, 2007). The philosophical framework underpinning this research is critical realism (CR). There will follow a discussion of alternative positions considered followed by an overview of the strengths and weaknesses of CR in relation to this study.

This research aimed to understand aspects of human behaviour which exist in the observable world. As such, a deductive approach in which fixed effects are observed was rejected as a foundation for this study as it accepts that truth is found within a closed system, such as a laboratory. In practice, the world outside of such a closed system is open to change at the level of observable events. With this in mind, positivism was excluded as incompatible with understanding human experiences within a healthcare setting as it neglects to take account of the complexity of human interactions. McMillan (2015) suggests positivism usually tests a hypothesis, which provides laws and mechanics that govern the workings of that reality. This research does not align with such a method of ascertaining a HCP's reality.

The first consideration of a philosophical framework within which to situate this research was that of social constructionism (Weinberg, 2014). This philosophical system focuses on the development of knowledge that is established through the process of social interaction;

as such, it was initially considered a fit for this research. Social constructionism holds that all knowledge is relative to one's location within a set of social norms. Cruickshank, (2012) however, suggests social constructionists foster a negative attitude towards knowledge claims, especially toward the assertions made by those considered experts, such as health professionals due to their roles being imbued with power. Interview data under this philosophy would be viewed as a story, rather than a transcript, as stories allow for a unity that does not rely on a group submissively accepting the truth exposed by the researcher, but rather a commonality of feelings and experiences (Merttens, 1998). This approach allows for persons to engage with a story which can be interpreted in different ways. Rather than the research asserting what may be accepted, the audience may select which aspects of the text they will allow to alter their own narrative. A social constructionist approach does not align with a supporter of critical realism, who may argue that this approach renders research difficult to justify as any truths associated with reality could never be uncovered.

CR is ideally positioned to investigate health and social sciences and provides an alternative to the problems and limits presented by social constructivism. It combines positivist and subjectivist approaches into one distinct philosophy which accepts the presence of an external world, as well as a socially constructed one. Originating from the work of Bhaskar (1998), CR defines an objective reality as one that exists independently of individual perception, yet it also accepts the role that individual subjective interpretation plays in defining reality (Fletcher, 2017). A key feature of CR is it stresses a stratified ontology of social reality, with empirical (sensory experience), actual (action in events) and real (causal powers separate but not always evident in empirical and actual) manifestations (Smith & Elger, 2012). CR treats the world as theory-laden, but not theory-determined. CR does not deny that there is a real social world we can attempt to understand or access through philosophy and social science rather than other knowledge. CR does, however, have its critics. Zhang (2023) argued that it provides researchers with an approach where they can 'sit on the fence' when interpreting research data to maintain the illusion of objective reality. This position offered by Zhang (2023) fails to acknowledge that in any research study, the world and knowledge they are investigating exist independently of the study, however, the researcher cannot assess all the external knowledge of the phenomena, that is every CCO experience of using the MCA on every occasion it is operationalised or considered.

With this in mind, this research will sit within the framework of CR in that the data that will be collected will conceive an understanding of the individual's real world through an analysis of individual staff experiences of MCA constructed through what is observable (Lawani, 2021). CR accepts that unobservable structures can cause observable events and the social world can only be understood if people understand the structures that generate events (Gorski, 2013). This contrasts with a social constructivist world perspective in which the world is known by any way that people see it. The participants may not be fully aware of the factors and influences affecting and maintaining their practices and behaviours. Staff knowledge and experiences are 'real' to them and CR accepts this as authentic knowledge within a socially influenced world.

Interestingly, among the professionally registered staff working in mental health represented by the participants within this study, there are several different professional disciplines each with their own perspectives coming together to provide mental health care to the SUs on their caseload. For instance, the positivist psychiatrist trained in the medical model would look to prescribed medication as their solution promoting what has been regarded as an 'illness ideology' (Joseph et al. 2009); whereas a social worker, who may be concerned with reducing marginalisation and oppression and empowering SU to take an active role in their care could be seen to have more of a pragmatist alignment. Evidence-based practice is recognised as the gold standard for the delivery of safe and effective patient-based care within nursing (Dalrymple & di Napoli, 2022). Practitioners must use a critical lens to determine which knowledge they accept as evidence from their philosophical perspective. This may have an impact on their application of the MCA and could be seen within the findings as variances between professional groups, however, the determination of this is not an aim of this study.

3.4 Research decisions linked to methodology

The next consideration affecting this research was the adoption of a methodological framework. This research situates its acceptance of knowledge through the lens of critical realism, the methodology should support the underpinning principles of the position. The research question for this study was concerned with the experiences of mental health staff working as CCOs; as such, a quantitative methodology employing a hypothesis would not align with the critical realism philosophical viewpoint due to the manner it views knowledge and this straightforward relationship between the world and our perception of it.

The study seeks to uncover multiple layers of staff reality and journey without detaching them from their position within their social structures whilst being mindful that the opportunities to improve interactions and outcomes for SU are an overarching driver of the research. This is an outcome that can only be achieved through qualitative study and the collection of rich data and its subsequent analysis. Rich data is data which will reach below surface-level reports and gain a deep understanding of staff experiences. It is influenced by an interviewer who asks critical, probing questions within an interview as well as participants who reflect thoughtfully on the questions being asked. Hence, the rich data I wish to capture (that is, staff experiences and perceptions) is not aligned with a quantitative data collection method as this would not allow for an understanding of the version of reality in which the knowledge sought is located.

It is a good practice within healthcare to position the SU experience at the heart of service development and delivery. NICE guidelines research recommendations (NICE CG136, 2011) suggest that improving SU experiences lies partly in educating and understanding staff decision-making. This study focuses on mental health staff who are contributing to SU experiences of care within mental health services.

3.4.1 Data analysis

It is accepted within published literature (Lawani, 2021; Fletcher, 2017) that CR supports data collection and analysis by diverse methods. As a consequence, there were a small number of analytical approaches which were considered to coherently analyse the data derived from this study with a view to producing quality research. Willig (2013) suggests an alignment should be sought not just across theoretical assumptions, but also research questions and methods to ensure overall coherence in the entire research design. Following consideration of several pattern-based analytical approaches, some were discounted. For instance, due to the research aim's concern with understanding staff experiences, content analysis was disregarded as a data analysis method due to the primary focus residing on the content of the communication, such as the words and phrases. The approaches considered in detail will be contrasted with a rationale given for the choice made to adopt TA.

Interpretative Phenomenological Analysis (IPA) was made popular in the 1990s by Smith and colleagues. IPA is concerned with exploring people's lived experiences and the meanings people attach to these experiences (Smith, 1996), which appears to offer congruence with the research aims. The interpretive component of IPA lies in the researcher making sense of the participant's world using their own interpretive processes. Despite the clear and precise procedures necessary to undertake IPA, it has been criticised for lacking standardisation, as well as being mostly descriptive and not sufficiently interpretive (Tuffour, 2017). Its main critique lies within its dual focus on individual cases as, IPA incorporates both a thematic and an idiographic approach to its analytic focus, which can lack the substance of a TA approach. The IPA approach is more aligned with research questions that focus on understanding individual experiences and the complexities of individual cases, which is not the goal of this research.

TA, also known as reflexive TA (Braun & Clarke, 2006) is one of the most popular methods of data analysis within social sciences, and a well-used method within health and social care research offering flexibility without prescribing data collection methods, theoretical positions, epistemological or ontological frameworks (Cresswell, 2013). It identifies themes developed from codes resulting in overarching patterns of meaning across a dataset. Unlike IPA, TA allows the extraction of themes that can be generalised to broader contexts and populations. It also allows for the development of new theories based on patterns within the data. TA is not without its critics, with Bryman (2016) suggesting it lacks substance and has limited interpretive power. This perspective does not discount from the vast array of published literature which uses TA as the method for data analysis.

In comparison to TA, the focus of IPA on the unique features of individual cases felt unsuited to this research which aims to uncover the experiences of care coordinators, and not the care coordinator's individual experiences. Sandelowski and Leeman (2012) suggest that IPA should not be used if there is a need for the research to have actionable outcomes with clear implications for practice. This is due to the requirement to organise the analysis into thematic statements – shared meaning-based themes. It is anticipated this research will be of consequence to the staff and SUs within the host organisation as well as the wider NHS, both strategically and at policy level. In view of all that has been mentioned so far, TA was chosen as the method for data analysis for this research.

3.5 Researcher position

As a researcher, I am naturally present within the research situation more so because I work within the trust in which I am conducting my research, although not in a CCO role. It has been suggested that if the interviewer is acknowledged as a fellow clinician, the interview data is "broader in scope and provided richer and more personal accounts of attitudes and behaviour in Clinical Practice" (Chew-Graham et al., 2002, p 286), a view supported by Coffey et al. (2017). I disclosed my professional background as a social worker to potential participants but highlighted that I had no frontline clinical practice within this NHS trust. This served as an aid to transparency (Mason & Dale, 2012), and it was hoped, to establish a rapport; a situated sense of connectedness which would increase participants' motivation to participate, disclose or provide accurate information, (Garbarski, 2016). It is noted however there could be a perception of power imbalance as there was a small possibility that I could have taught the participant at a training event. Roiha and Likkanen (2022) discuss prior relationships between a researcher and the participants they include in their studies. Their perception, which I share, is that what is termed *acquaintance interviews* can positively influence data collection as the rapport is already established due to existing common ground. Garton and Copland (2010) additionally discuss how prior relationships can affect interview data, due to common experiences and shared practices and guide researchers to be mindful of their framing within the interview setting.. On reflection, there was one participant whom I had a contemporary connection with via a training course. This connection was discussed prior to the interview, as McDermid et al. (2014) stress the importance of transparency, self-disclosure and confidentiality when conducting interviews within a dual role.

A great deal of regard was given to my own position of 'power' within the study which resulted in a reflection on whether this research constitutes participatory health research (Wright & Kongats, 2018). While there are no strict rules as to what constitutes participatory research, Bourke (2009) suggests the overarching idea of participatory research is the active participation of stakeholders in the research process. Whilst this research was initiated by myself, the identification of the issue emerged from my own experiences of holding the role of a CCO and from working with CCOs raising their own practice issues in my time as an MCA clinical lead. Participation from a CCO from another trust was achieved during the interview schedule design and pilot (section 4.6.1) in which amendments were made following their input and feedback. The findings will be shared with the staff population who were sampled within the study and the recommendations will be disseminated and hopefully incorporated with their and others working practice. The research therefore can be considered to be participatory health research (International Collaboration for Participatory Health Research, 2013), thus offering an opportunity for transformative change within the health field.

The following Methods chapter will outline the method used to answer the research question. Further, the sampling strategy, inclusion and exclusion criterion, geographical positioning, recruitment, data collection and ethical considerations will be discussed.

Chapter 4 Methods

In this chapter, the rationale for the choices made regarding data collection and analysis are described. The reason for situating the study within one NHS trust in northern England is explained and justified. The sample, inclusion and exclusion criteria, sampling, ethical considerations and recruitment are described, and the associated decisions are explained. There is a statement relating to COVID-19 prior to a description of the data collection approach and the associated decisions relating to the analytic process.

4.1 Justification of study situation

This study was conducted with staff from one NHS trust in northern England which has over 3000 staff, two acute care hospitals, numerous specialist services and community provisions. The trust chosen is a large organisation serving a vast geographical area, ranging from deprived inner-city areas to rural farming communities. These differences in geography often result in significantly different clinical presentations of SU which it is expected will lead to diverse applications of the MCA and varying approaches to clinical practice and resource allocation. As a consequence of this position, the data that could be elicited is likely to be sufficiently broad in nature.

Consideration was given to a multisite method, which in this case would mean recruiting from multiple NHS trusts. It was identified however that the training the participants may have been exposed to may represent a problem in collecting a homogeneous sample of participants. Using a multi-site approach would have ensured that staff experiences were not institutionally exclusive and were reflective of a wider picture of MCA experiences. Ultimately, due to the timing of the data collection, the COVID-19 pandemic made it extremely unlikely that sufficient data could be realistically collected from other organisations. In addition, due to the small scale of this blended learning PhD as stated earlier, and the limited resources available to the researcher, the result was a focus in depth on one organisation which only served to concentrate the richness of the data collected.

Education and training for mental health staff in relation to the MCA are not universally mandated by NHS England, at the time of data collection, each trust is responsible for the curriculum it delivers. It would be hard to draw comparisons with other NHS trusts and not conclude that these were solely due to training exposure. A further concern with recruiting participants from other trusts was located in the workplace culture of differing trusts. This may have resulted in different clinical experiences due to the different organisational level priorities which would have directly affected CCO's implementation of the MCA. As with the concern relating to training, it would have been hard not to conclude that experiences were solely organisation related. The choice to use only one trust was a pragmatic decision. At the time of application to the ethics committee, I was familiar with the structure of the organisation and could access gatekeepers to the participants without undue obstacles. As this is a small-scale PhD project, this decision felt prudent. The limitations associated with only recruiting from one trust will be discussed in the discussion chapter in section 7.6.

4.2 Sample

CCOs are members of staff who work for the NHS in secondary mental health care. They are responsible for a caseload of SUs who have severe and enduring mental illness and are typically based in a community setting. The role can only be held by a social worker, mental health nurse or occupational therapist, thus requiring the member of staff to have a professional qualification, which is achieved by degree-level study. The job requires staff to be knowledgeable about several pieces of legislation, for instance, the MHA as well as the MCA; both give staff the power to detain SUs against their will should certain conditions be met.

I am mindful that staff who volunteered for this study are likely to have felt comfortable talking about the MCA to consider engaging in an interview that could last up to an hour. With that in mind, the data is unlikely to come from members of staff who have little or no knowledge about the MCA as they would be unlikely to feel comfortable talking about a topic which they were not comfortable with for up to an hour. As this study is concerned with the experiences of using the MCA, it may be unlikely to capture staff who either knowingly or unknowingly abstain from using the MCA. This self-selection bias and its effect on the data will be discussed further in the concluding chapter.

4.3 Sampling

In order to produce coherent research data, the study sampling choices were informed by the research question. An understanding of mental health staff experiences of using the MCA was captured by interviewing CCOs working in the community with mental health service users. Following the decision to employ a single-site approach, the next consideration was to determine which sampling strategy would elicit rich data whilst remaining rigorous and justifiable. The sample was stratified to ensure that the proportional balance of professions which are employed as CCOs within the care trust mirrored the sample. This method allowed data, in the form of experiences, to be collected from different types of participants who may have different perspectives related to the research question. A Freedom of Information request made to the organisation determined the number of CCOs, and the ratios of nurses, social workers and occupational therapists working within community mental health services. This ratio required to match the proportions within the staff population was 5 nurses: 4 social workers: 1 occupational therapist.

A further decision that required consideration was that of the estimated sample size. The sample size is contextual and somewhat dependent upon the paradigm under which the research is located. CR requires an “intensive study with a limited number of cases where a researcher systematically analyses the interplay between the ontological layers”, (Stutchbury, 2022, p.128). Qualitative research does not involve making statistical inferences; therefore, large numbers are not expected (Boddy, 2016). The estimation of sample size for a study using TA should be determined as a consequence of data saturation. This can loosely be defined as information redundancy (Lincoln & Guba, 1985). Several researchers have sought to operationalise data saturation and offer concrete guidance on the number of interviews which are required to capture data saturation in TA research, with conflicting results (Guest et al., 2006; Constantinou et al., 2017). Braun and Clarke (2022 p.201) critique these perspectives, stating that the decision to stop data collection is "inescapably situated and subjective and cannot be determined (wholly) in advance of analysis". Studies using a similar methodology typically recruit between 7-12 participants (Scott et al., 2020; Walji et al., 2014; Moore et al. 2019) therefore it is envisaged that the sample size for this study will be within these parameters.

4.3.1 Inclusion criteria & exclusion criteria

There were constraints placed upon the potential pool of subjects in order to successfully answer the research question. In order to be considered for the study, participants needed to meet the following criteria:

- staff with a professional qualification working in the role of a CCO within a community mental health team (CMHT).
- staff working with adults (age 18+).

In order to recruit a homogeneous sample which would be exposed to similar clinical situations and experiences, some trust staff were excluded from the study. This was due to the differences within the clinical population, job role and professional background being located too far from the role of CCO, which the research question is concerned with. The trust staff were excluded if the subsequent criteria were met:

- staff without a professional qualification
- staff working in a specialist team such as perinatal, crisis or first response.
- acute, forensic or low secure ward staff
- medical staff
- staff working in the learning disability sector
- staff not currently holding a caseload – such as with management-only responsibilities

Two individuals were unfortunately excluded from the study after meeting the inclusion criteria due to work absence, despite appearing to have valuable insights into the research question. One staff member was on long-term sick leave, and another was on maternity leave. Both had been absent from the workplace for over 5 months and as a result, they would not have been aware of any recent organisational changes which could have affected their perception and application of the MCA.

The staff's spoken language was not explicitly mentioned as an inclusion or exclusion characteristic. This is because staff qualifying in an English-speaking country must be proficient in English at degree-level standards in order to pass their placement and qualifications. International staff hoping to work for the NHS are expected to pass an English language test. The Nursing and Midwifery Council (NMC) for example accepts two language tests as evidence that applicants can communicate effectively in English – the International English language test system and the occupational English test (NHS Professionals, 2024). As such, it felt unnecessary to add a language criterion.

Some staff within scope may choose to pursue further qualifications aligned to the MCA or the MHA once qualified. An Approved Mental Health Practitioner or 'AMHP' for example, has the legal authority to detain persons who are a risk to themselves or others using the MHA. A Best Interest Assessor or 'BIA' has the legal authority to authorise a deprivation of liberty using MCA legislation. Staff with these qualifications will be identified at 6.1.

4.4 Recruitment procedure

Participants were recruited between February 2020 and May 2023. Within the trust, there is a population of around 300 CCOs who are arranged into teams covering different geographical areas. Each location has its designated base location which CCOs visit at least daily.

The first step of recruitment was to visit each base and place a flyer on the staff notice board (Appendix A). The notice board was chosen within each base as it was felt it was somewhere in which the staff may linger, and the poster would therefore attract their attention. A week after the poster was put up, an email was sent to each team leader (Appendix B). These members of staff are the direct line managers for the CCO and may hold a very small case load, but their role is primarily managerial. The team leaders were asked to disseminate the email to their staff and/or raise the study as an item on their team meeting agenda. It is not known how many team leaders forwarded the email or raised the study within a team meeting environment. As a result, potential participants may have missed the opportunity to engage with the study. Team leaders who found the study interesting and enthusiastically shared it with their team or members of staff who frequently use the area adjacent to the noticeboard may have been overrepresented within the study.

The participant information sheet (PIS) located in Appendix C was attached to the team leader's email and detailed a Lancaster University email address rather than an NHS trust email. This was to give a degree of separation between the researcher's work persona and the research persona. Participants were asked to email expressions of interest, after which they were sent a PIS indicating that questions were welcomed. A team leader did express an interest in the study however at the point the recruitment was taking place they were not carrying a caseload and working purely in a managerial capacity therefore there are excluded from the study.

After two months had passed without successful recruitment and insufficient data to progress with analysis, a memo was placed on the staff intranet electronic notice board. A screenshot of this is detailed in Appendix D. The aim of this strategy was to refresh the memory of the staff who may have seen the original email but had not acted upon it. Bryman (2016) suggests that the use of a second medium for recruitment is often advantageous. Other strategies employed to recruit staff utilised the flyer (Appendix A) printed at A3 size and displayed in the canteen and library of the acute mental health hospitals which CCOs would visit.

Once participants had expressed an interest and indicated they were happy with what the study entailed, a time for the online interview was negotiated via email, which was usually within two weeks of the initial contact. Participants were asked to read and sign a consent sheet before the interview (Appendix E). Some participants emailed a signed copy of the consent sheet whilst some printed the sheet and signed it during the interview and emailed a scan of the document. At the start of each interview, the likely topic areas were outlined, this was followed by a recheck of consent with each participant. All participants were assured that they were able to withdraw from the study within the following 14 days, should they feel the need. If this were to happen, their data and all associated documentation would have been erased and/or shredded. This situation did not arise within this study.

4.4.1 Beneficence

Turning now to the concept of informed consent, which Saunders (2023) suggests is a complex issue within qualitative research. Semi-structured interviewing is open-ended and iterative; therefore the analysis of the data can often lead to unexpected conclusions. It is important to note that both interviews and analysis may result in unanticipated situations, which make seeking consent possible only for the broad research question. Beneficence, which Bream and Gordon (2021, p.109) define as "acting in such a way to benefit others while promoting their welfare and safety" is asserted as the results of the study may positively affect the clinical practice of the participants through an awareness of and reflection upon their practice decisions. When the findings of this study are disseminated within the trust, the SUs whom the staff work with may find themselves increasingly empowered to be part of the decision-making process.

4.4.2 Staff benefits

There were no tangible benefits for any of the members of staff from volunteering their time to participate in the study. There may, however, have been an indirect benefit to the members of staff who volunteered their time through an opportunity for self-reflection regarding their clinical practice. All interviews were undertaken within normal working hours which may have represented a workload cost to members of staff as they may potentially need to make up any missing hours in order to manage their caseloads appropriately.

4.4.3 Safeguarding Participants

Whilst planning the research, a concern was that participants may experience distress either during or after the interviews as a consequence of talking about particularly difficult cases in which there could have been negative outcomes for either the SU or the participant. As part of their role, CCOs receive monthly supervision in which they discuss and reflect upon their clinical practice. It is expected within supervision that professionals are open to discussing cases with a critical eye and mind. Unfortunately, when working within the mental health services some SUs do sadly choose to end their lives, which can be traumatic for the member of staff involved. Staff are accustomed to seeking out and receiving support when and if it is required. It was agreed with a member of staff from the trust's therapy team that any concerns that the researcher had from the interviews about staff well-being would be raised anonymously initially and jointly with the interviewee if indicated. Thankfully, this provision was not accessed. In addition to this well-being safeguard, the current MCA clinical lead for the trust agreed that any concerns arising from clinical practice could be discussed with them. An anonymised concern was discussed concerning a respondent's knowledge base. No further action was required.

4.4.4 COVID-19

The data collection period coincided with the COVID-19 pandemic. Staff working with SUs in a community setting were asked to work from home, using video or telephone calls where possible unless there was a clinical need for a face-to-face visit. The effect of this change in working practice for the staff on the research was twofold. Firstly, there was little opportunity for spontaneous conversation about this research, that is, discussion by word of mouth, for instance in the office setting was less likely to happen.

The second consequence of the working-from-home directive was that no interviews were carried out face-to-face. This had been the goal initially due to the possibility of missing non-verbal cues which could happen when an interview does not take place in person (Bryman, 2016). A decision was made to offer the participants the choice of conducting the interview as an audio-only mode of data collection via telephone or using technology such as Microsoft Teams, Zoom or Skype with the audio-only recorded. If they chose the latter, they were offered the option of video on or off. There has been research conducted on the disadvantages of virtual interviews. Irani (2019) presents both the strengths and drawbacks of online video conferencing interviews and argues they are the closest alternative to the qualitative interview done in person. Audio-only interviews were chosen by three participants. One participant stated she just wanted "a break from teams and to relax into the interview" which she didn't feel she could do with the video-enabled, even though she knew it was not being recorded. This is supported by Seitz (2016) who argued the loss of intimacy and lack of natural body language became an obstacle when videos were enabled. Further evidence shows people are more relaxed when they feel they have a power balance. The idea of my own position and its links with power were discussed previously in section 3.5.

4.5 Confidentiality, Anonymity & Researcher prior knowledge

4.5.1 Confidentiality

To provide the participants with a safe non-judgemental space, the interview and the data collected were confidential. There could potentially be situations where confidentiality would need to be broken, such as participants disclosing cases or scenarios in which unlawful or bad practices were occurring. This could be SUs being deprived of their liberty unlawfully or oppressive practices being conducted. These disclosures could be done by the participant with knowledge of their actions or with a lack of awareness of their actions. Additionally, participants may disclose breaking or breaching their own professional conduct guidelines or a lack of adherence to the NHS trust policies and procedures or CQC Guidelines. Participants were made aware through the PIS that the advice of a Senior NHS Clinician will be sought in all cases should there be a concern that there is a risk to the participant or others. This is in line with the local supervision policy. Should there be any suspected harm regarding the participant's implementation of the MCA, a Senior Clinician from the trust who holds a lead role in the Mental Capacity Act agreed to be a point of contact for any legislative or practice concerns. The limits of confidentiality were written on the PIS (Appendix C) as well as verbally discussed with each participant prior to the interview. Participants were asked to read and initial several statements relating to confidentiality before signing the consent forms.

4.5.2 Anonymity

One duty of a researcher is to protect the privacy of participants. This goes beyond the requirements of the GDPR legal obligations which are discussed in section 4.6. It is recognised that the processes of anonymisation should consider identifiability in its broadest sense; it should not simply focus on removing obvious information that clearly relates to someone. The direct identifiers of identity for staff and their SUs were substituted with an appropriate alternative identifier on a like-for-like basis. This meant that the participant's names, place of work and any other identifiable information would be removed at the point of transcription but would remain in place on the data recordings. Indirect identifiers are information which when combined could lead to the identification of a SU or staff member, such as SU case presentations and family dynamics presented a greater challenge due to the need to maintain the essence of the SU case information (Øye et al. 2019). As a researcher who was formally a CCO with applied experience working in this geographical and cultural setting, I was able to find a balance between the risk of identification and the needs of the research, meaning I was able to use my clinical knowledge and experience to ascertain how indirect identifiers could be sensitively substituted to maintain the integrity of the data, for example, modifying elements of a clinical presentation. The Information Commissioner's Office (2021) recognises the challenges for qualitative researchers of effective anonymisation without impeding the utility of the research data. It offers guidance, which was followed on anonymisation and pseudonymisation, suggesting strategies to maintain the integrity of the dataset and maintain the anonymity of participants.

4.5.3 Researcher Prior knowledge

As stated in Chapter 3 (Methodology), prior to the research, I was employed by the trust in a role in which I was responsible for delivering face-to-face mandatory training to CCOs. Therefore, there was a chance I had met and discussed clinical practice with participants. In the event, only one participant approached me after such a training session and queried if I was the same person undertaking this PhD research study, which I confirmed I was. As discussed in section 3.5, I disclosed my background and position within the trust to participants at the expression of interest stage. I refrained from offering any of my own clinical experiences during the interviews, nor did I raise during the interviews information which I had been made aware of within my paid role as it may have affected the power dynamic established and the nature of the data.

4.6 Data Collection Choices

This was a single-phase study in which participants were interviewed once with no repeat interviews or interviews which required a second appointment to gain completion. There was consideration given to alternative approaches to collect data which could answer the research question and achieve the research objectives. Focus groups have been successfully employed by other researchers to explore staff experiences of the MCA (Jayes, 2017; Marshall & Sprung, 2016; Wilson & Seymour, 2010). Some researchers believe focus groups can facilitate naturalistic disclosure around sensitive topics, for example, Jordan et al. (2007) urged authors to consider focus groups for illuminating locally sanctioned ways of talking about sensitive issues. Whilst healthcare staff commonly share traumatic experiences within judgement-free group supervision settings, connoting an existing norm for staff, there was a possibility that staff may advertently or otherwise disclose practices which may result in external scrutiny (Broyles et al. 2011). Due to the nature of this research project and the lone researcher position, there was a practical consideration around the decision not to use focus groups to collect data. Pragmatically, the logistics of coordinating a focus group with members of staff who are exceptionally busy and geographically dispersed was considered unrealistic. Further, the COVID-19 pandemic would have made these face-to-face focus groups impractical. An online focus group could overcome geographical obstacles, yet this approach would still encounter the same logistical difficulties. Practically, however, moderating an online focus group requires a skilled moderator. Stewart and Shamdasani (2016) argue more skills would be required for an online group than a face-to-face focus group. As I did not possess this skill, nor was it possible to acquire this skill for this small-scale PhD, this data collection method was not a reasonable consideration.

Interviews are the most common method of qualitative data collection within social research. Semi-structured interviews were chosen as the mode of data collection due to their suitability for exploring understanding, perceptions, and constructions of topics in which participants have first-hand experience. DeJonckeere and Vaughn (2019) advocate for the researcher to arrange a flexible interview schedule which can be supplemented by clarity-seeking questions, probes, and reflections.

When reflecting upon the epistemological position within which this research is situated, the semi-structured interview could be seen as a professional conversation within a socially based interaction (Kvale, 2007), not dissimilar to a member of clinical staff assessing a patient. Society is constructed and behaves around certain norms and values as does an interview (Brinkmann, 2021). The participants in this study assess SU's clinical risks and mental wellness routinely in what is in essence a semi-structured interview. From a critical realism perspective, therefore, Smith and Elger (2012) suggest they understand the role of the participant, in the process of accessing the interviewees' interpretations of their own reality. In support of this statement, Brinkmann (2021, p.32) claims that interviewees are “almost too familiar with their role in a conversation in a world already saturated with conversation”.

Whilst the interview process is critically influenced by the research agenda, Smith and Elger (2012) discuss the idea of the interviewer and the interviewee engaging in a fluid interactive process which represents different facets of a complex and multilayered social reality. There must, however, be a critical analysis of the accounts informed by an analytical framework. Merely possessing narrative accounts does not yield insights and knowledge. The data collected will be used to appreciate the interpretations of the participants. A position as an active researcher was chosen, and techniques to generate rich data were employed for example, holding a position and keeping a focus on specific events, rather than generalities, probing for details and implications and encouraging participants to look across their caseloads.

Finally, the requirements of the General Data Protection Regulations (GDPR, 2018) were considered. The data collection choices made within this study follow researcher good practice. As this research will be carried out as a task in the public interest, it has a lawful basis for being undertaken including collecting and recording personal information from NHS staff. The interviews were recorded on a digital voice recorder. Once satisfied that the quality was acceptable, the audio files were encrypted and saved on a secure server with password protection. The audio files were deleted once transcription was completed. The anonymised transcripts were also encrypted and stored on a secure server as well as a password-protected laptop which was accessible only to the researcher. The anonymised transcripts on the secure server will be stored following the GDPR (2018) guidance timescales of 10 years and in accordance with Lancaster University’s regulations. The transcripts on the laptop have been deleted in line with data protection principles of data minimisation. Following ethical approval stipulations (see section 4.7), the data was accessible to the researcher and their supervisory team only. The transcription of the data was completed solely by myself.

4.6.1 Interview schedule

In order to give a sense of structure to the interviews, the interview guide (Appendix F) was designed following a review of similar studies in different clinical settings (McVey, 2013; Jeyes, 2019) and studies which had a similar research question but focused on the MHA rather than the MCA (Buckland, 2014) in order to establish a sense of what worked well and generated rich data. Opening and closing questions were included to ease the participant into the interview and to bring the interview to a close. Once the questions were constructed and sequenced in draft form, a CCO from another trust was consulted to informally pilot the interview and offer feedback. At that point, it was clear the questions about the MCA and MHA were unhelpfully linked, meaning the pilot interview data appeared more comparative in nature than reflective of the CCO's experiences. The guide and its prompts were reworked as a result of this feedback.

Whilst considering questions, social desirability response bias was a concern. The participants were asked to discuss aspects of their practice in which they may be aware of deficits or may have been aware of cases in which their practice was potentially oppressive or lacking in integrity. Rather than a specific question on the interview schedule which it was felt would be too confrontational, this information was elicited through using opportunities within the interview in which the potential for this topic arose. Research by Bergen and Labonte (2019) around the detection and limitation of social desirability bias within qualitative research suggests that 1:1 interviews which use humour, self-disclosure and respect can limit social desirability bias. Specific strategies which were included within the research here included providing assurances, probing for complete information and asking for illustrative examples.

4.7 Ethics approval

Ethical research involves being clear with participants about the nature of the research that they are consenting to take part in. As a PhD student at Lancaster University, ethics approval came from the Faculty of Health and Medicine Research Ethics Committee (FHMREC). This was granted in December 2019 which can be seen in Appendix I (Reference Number FHMREC19030). Following this approval, the research and development team for the trust in which data collection was planned were approached. An application to the Integrated Research Application System (IRAS) found that as the project is concerned with members of staff who work for the NHS, rather than SUs, approval was not required. The trust's organisational procedure for research data collection and project registration, including NHS-specific researcher training was followed. Authorisation was granted from the organisation to begin data collection in February 2020. In line with approval conditions, there has been occasional liaison with the host NHS organisation's research and development team who have monitored the progress of the research.

4.8 Data Analysis

The transcripts were coded line by line using TA, a method for identifying and analysing patterns in qualitative data pioneered by Braun and Clark (2006). The variety of TA chosen was experiential TA as this focuses on the participant's standpoint and how they make sense of their world.

The analysis was conducted according to the following phases:

1. Transcription - The data was transcribed soon after each interview took place in a verbatim style which focussed on transcribing spoken words and accompanying sounds with style guidance from Hoey (2013). Time was given to transcribe each interview with breaks for reflective note-taking during the process.
2. Reading and familiarisation of the transcripts - This involved immersion by repeated reading in an active manner with notes made on ideas for coding. The researcher kept detailed notes at this stage with thoughts and feelings captured for later reflection.
3. The production of an initial coding list - This was produced systematically working through each transcript as it was produced. Each data item was considered individually and within the piece of data within which it was situated. Many items were coded multiple times to ensure ideas or patterns were not lost.

4. Probing for themes – Once all the data was fully coded, the different codes were sorted into individual themes using physical pieces of paper to move the codes between themes.
5. Reviewing themes – at this stage, the themes were refined into a thematic map. This involved reviewing the themes at the level of the coded extracts. This resulted in collapsing four smaller themes into three coherent themes as there was not enough data to support four themes.
6. Defining and naming themes – This involved identifying the story that accompanied each theme.
7. Final analysis – The consideration of data extracts to demonstrate the content within the themes.

This Chapter presented and justified decisions related to the method of the research. The following chapter will present the findings of the 10 semi-structured interviews which were analysed using TA.

Chapter 5: Findings

This chapter details the findings derived from the 10 interviews with CCOs working in secondary mental health care concerning their experiences of working with the MCA as a part of their clinical responsibilities. The chapter describes the three themes which originated from qualitative analysis of the interviews using a TA approach. Participant demographics and interview characteristics are described, followed by an exploration of the themes and sub-themes. Participant quotations will provide a context for the thematic grouping.

5.1 Participant and interview characteristics

Table 7 presents the participant characteristics. All 10 participants were employed in the role of a CCO at the same NHS mental health trust at the time of the interview. The participants came from three professional backgrounds, with an average length of post-qualification practice of 13 years. Half of the 10 participants worked solely with SUs in what is termed an adult team. The SUs cared for by the adult teams are typically of 'working age', which is indicatively adults under 65 years old, however, if the SU diagnosis has not changed, staff remain working with SU who are older until their needs change significantly or they develop a condition which is best managed by a member of staff with specialist knowledge of conditions more frequently seen in older age, such as dementia. Table 7 details that four of the 10 participants held higher qualifications of AMHP and BIA.

Table 7. Characteristics of the participants included in the study

PSEUDONYM	PROFESSION	YEARS QUALIFIED	CURRENT SPECIALTY	ADDITIONAL TRAINING
HELEN	Occupational Therapist	18	Adults	BIA
STEVE	Social Worker	10	Adults	AMHP
PETER	Nurse	25	Adults	-
LEN	Nurse	12	Older Persons	-
SOPHIE	Social Worker	2	Adults	-
OLUMIDE	Nurse	4	Adults	-
ANNE	Nurse	4	Older Persons	-
LOUISE	Social Worker	22	Older Persons	BIA
NATHAN	Nurse	8	Mixed	-
RACHEL	Nurse	26	Mixed	BIA

All interviews were carried out over the video conferencing software Microsoft Teams. The participants were recruited by stratified opportunity sampling and were not financially compensated for the time they contributed to the study. The interviews ranged in time from 32 to 69 minutes in length with an average interview length of 50.7 minutes. Pseudonyms were given to the participants for anonymity and confidentiality purposes. The names used as pseudonyms were chosen with consideration of the participant's cultural heritage.

5.2 Thematic exploration

Braun and Clarke, (2022) suggest a theme captures something important about the data in relation to the research question. The three themes identified from the analysis process all link to the overarching theme of ‘Experiences’. The process of undertaking TA with interview transcripts was explored in detail in section 4.8. Following this phased process of working systematically through the entire data set, 262 codes were identified as relevant to the research question during the complete coding of the data set comprising 10 interviews. At the end of phase five of the analysis in which themes were searched for and then reviewed, three themes and 11 sub-themes were derived which are displayed in Figure 3.

5.2.1 Theme 1: Working in Mental Health

The role of a CCO within secondary mental health care obliges all participants to work with both the MHA and the MCA. The first theme emerged as the consequence of the expectation of CCOs to consider and employ both pieces of legislation, in addition to the issues emerging from working with this particular client group in navigating the MCA in clinical practice.

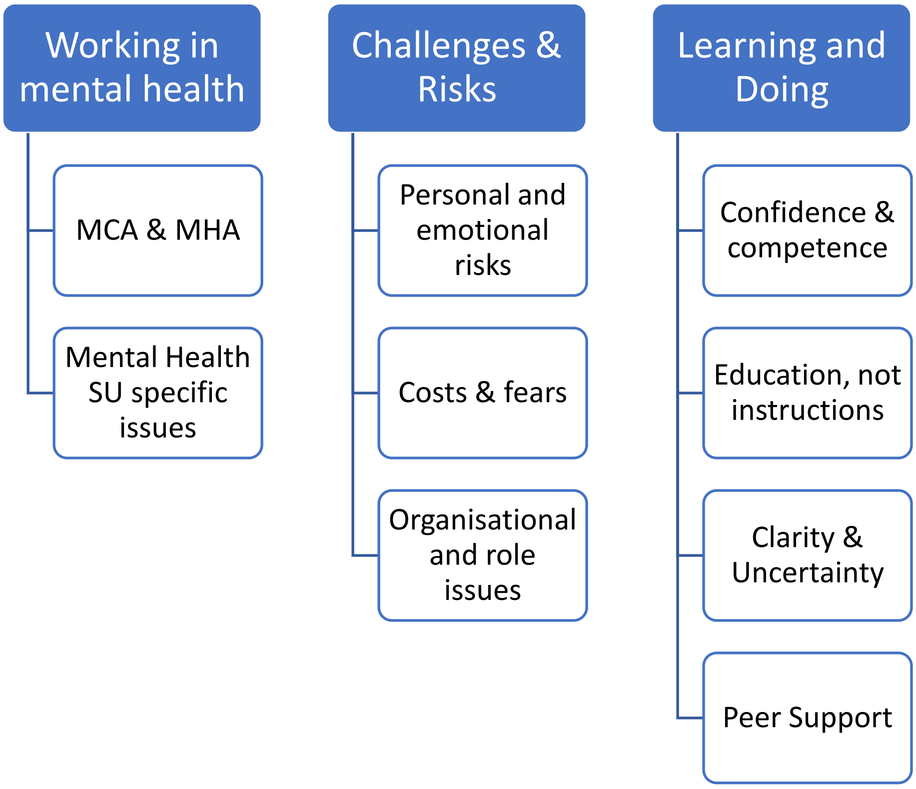

Figure 3. Themes and Subthemes of the study

Subtheme 1: MHA & MCA: The old and the new

> *"It still feels new, but it's over 15 years old" Len*

The participants in the study reported a deep and broad understanding of the application and processes of the MHA, which is partly due to its location at the foundation of their professional practice. Regardless of their professional discipline, participants who trained in England were tutored extensively about the MHA during their undergraduate courses. In addition, participants gained practical exposure to the MHA on clinical placements within mental health hospitals or community settings, in which the MHA is at the forefront of clinical interventions. In contrast, familiarity with the MCA was less established for the CCOs. The four staff who qualified before the inception of the MCA, and one staff member who did not train in England had no training on the MCA during their professional clinical training. These four participants were all somewhat reliant on workplace efforts to introduce and embed the new legislation as well as their own private efforts to understand the MCA, such as through independent learning.

> "*Oh there was an intro, well they said it was an intro but it's the only training I've ever had with the trust. I've had to look into it myself. There is a really good E-learning I've watched online and I've seen some webinars from the …… BASW social work place and also SCIE" Sophie*

All participants currently have SUs on their caseloads who are subject to the MHA's legal powers to detain someone, against their will for up to six months at a time. In contrast, the majority of participants had not encountered the MCA's provision to refer cases to the Court of Protection within their own clinical practice. Staff with further qualifications, i.e. BIAs or AMHPs were familiar with this provision due to detailed coverage of this provision within a postgraduate environment, but as with the majority of participants, not from direct clinical experience.

> *"I've never had a case that went to the Court of Protection, never even had a disputed best interests meeting actually, I've never heard of a court of protection in my team anyway. I doubt [colleague] even knows what it is. I know it from my BIA training" Rachel*

Staff favoured the MHA due to its rigidity, documentation and explicit processes. The MCA has "*no teeth*" was a statement explicitly voiced by four of the 10 participants, reflecting their lack of assurance in the legislation. This descriptive term appears to be used as common vernacular amongst HCPs. The meaning behind this term for HCPs is likely to have different definitions depending on the clinical situation in which it is used. One staff member used it in relation to the documentation, another in relation to repeating MCA assessments and a further used it concerning the lack of cases reaching the Court of Protection.

Comparatively, the MHA and MCA legislation appeared to be perceived to have a hierarchy of power with references made to the authority of the MHA to enforce the physical detention of persons, thus, the MHA was perceived as the '*stronger*' legislation.

> *"…more often than not, the MHA trumps it in a lot of situations" Peter*

Interestingly, but perhaps due to their higher level training, the only participant qualified as an AMHP with powers to detain under the MHA had an alternative perspective:

> *"MCA is stronger, where it's indicated. It could be most of the time, really, if you're looking at people making decisions which are considered unwise" Steve*

The MCA and the MHA have very different functions, which some participants seemed to misconstrue. Sophie for instance wasn't aware that patient detention on an acute mental health ward using the DoLS section of the MCA was a possibility for her patients. When comparing the legislative acts, some staff tended to focus on the incarceration aspect of the MHA, whilst seemingly overlooking the potential strength of the MCA's possibilities. If certain criteria are met, for example, the MCA carries the authority to sell someone's home or restrict social contacts. Peter, (and others) held the belief that the MHA carries more force due to the provision to compel SU to remain in a psychiatric hospital for up to six months at a time and receive medical treatments against their will.

Staff conceptualised a difference between the partnership aspect of employing the MHA and the MCA. SUs were viewed as the "*passive recipients*" of the MHA since the MHA gave legal authorisation to breach that person's universal human rights and allowed for SUs to be detained against their will. The power of the MHA is situated with professionals, who are acting in the interests of the SU or others to maintain safety and reduce danger, either to the SU themselves or to members of the public and staff. Conversely, the MCA was viewed by many as a piece of partnership legislation, wherein the SUs' views, rights and preferences are central to the decision-making process.

> *"With the capacity act, they're not subservient, more like a partnership, not you know, in our awe, more like colleagues with different skills" Helen*

Social workers appeared to find the empowering nature of the MCA aligned well with their professional code of conduct which aligns with a biopsychosocial approach to working with SU with a mental health problem. This idea was not raised spontaneously by the other professionals during the interviews.

> *"My mentor said mental health social work is the last true bastion of social work. The MCA feels like real social work, true to the very essence of the job. It sees the person at the centre and fights for their voice in a noisy world." Sophie*

Aside from the one participant who, as an AMHP, had a legal warrant to detain people under the MHA, the remaining participants were not, on the whole, major decision-makers of an MHA assessment. This means that staff apply the consequence of another professional's decision, rather than making the decision themselves. Conversely, all participants identified they were able to assess and make decisions within the MCA framework, should the need arise. It was a position that many nurses seemed uneasy about, this is exemplified by Olumide, who stated "*I don't really do that law",* citing he had the skills to make decisions within the framework, he just avoided it if possible. All nurses within this study had worked on an inpatient ward, wherein legal decisions were regularly made and discussed collaboratively with the ward staff on shift.

Staff were familiar and comfortable with the binary nature of the MHA assessment procedure, whereby an AMHP and two Psychiatrists with additional training would make a Yes/ No decision to detain a person very quickly in an emergency situation. The MCA in contrast was described by participants using adjectives such as *"fluffy", "woolly",* and *"vague"*, with participants stating that assessments can take *"weeks*" to complete. Typically, MHA assessments are completed once, unless the SU's presentation significantly changes. Staff recounted MCA assessments taking place repeatedly with no change in presentation noted, which was described predominantly by the nurses qualified for over 10 years as improper or wrong. This is, however, advocated by the MCA Code of Practice.

When considering the whole organisational approaches to the different legislations, staff cited mechanisms within the trust that some perceived as demonstrating the organisational priority of the MHA. The corporate reporting structure to the trust's executive leadership team was perceived to be heavily dominated by the MHA, with staff referencing a discrete team which supports the MHA. Participants referred to this team's duty to scrutinise every MHA assessment document generated. The organisational support provision for the MCA in contrast to the MHA is a single staff member in a named Clinical Lead role, which Anne believed was evidence of under-investment in the MCA.

> *"The MHA has an actual team to support it, and paperwork, real paperwork. In this world that must mean it's more important. The MCA is just a form on the IT system that no one bothers with. That must mean the trust see it as more important. I suppose there might be a financial consequence to the MHA though". Anne*

Subtheme 2: Mental Health SU-specific issues

All participants work with SUs with severe and enduring mental health conditions within their role. Mental health diagnoses, and the people diagnosed with them are complex and multifaceted. The experience of assessing the capacity of someone who has Schizophrenia for instance was found to be problematic for staff due to staff struggling to identify evidence of the SU demonstrating one of the mandatory components of the assessment process - 'weighing up' information related to the decision in question - within the clinical presentation of Schizophrenia. The experience of both the positive and negative symptoms of schizophrenia was perceived to compromise mental capacity, resulting in difficulties for staff when wishing to use the provisions of the MCA to empower unwell SUs to be part of their decision-making.

"If they don't have insight, then how can they have capacity…or can they? " Anne

Insight is a concept widely recognised as part of some mental health conditions which refers to the SU's ability to recognise they have a mental health problem and that the experiences they are having are abnormal. Insight can vary over time within and between SUs. The MCA legislation contains no explicit reference to SU insight. The term is relevant to, but not determinative of the question of whether SU's have the capacity to make the decision in question. Many participants found uncoupling insight and capacity very complicated, with Nathan citing it was "bewildering". Staff with further training were more able to reflect on higher concepts of MCA assessment such as the specific domain the person lacks insight about, how the impaired insight is manifested, and how it impacts the person's ability to understand the decision in question, weigh up the options, retain pertinent information and communicate this to the assessor.

There exists a concept within the MCA of fluctuating capacity which was particularly tricky for the staff to understand which refers to situations where a person's decision-making ability varies. There are many different conditions where fluctuating incapacity may occur for example as a result of mental illness, dementia or an acquired brain injury. There was a sense for some that it was aligned with relapse or insight. Whilst the misunderstanding was clear, the reasons for the misunderstanding were mixed. Staff reported these cases as stressful and often led to disagreements within and between teams.

Understandably, due to the role they have, the overriding primary concern of staff, that is, the lens of assessment through which staff view their SUs was perceived primarily to focus on initial risk assessment and consequently signs and indicators of wellness. Not all staff were able to align primary indicators of relapse with mental capacity. Sophie for example, discussed a SU with a diagnosis of bipolar disorder. This is a condition characterised by periods of highly elated mood, during which her SUs would engage in high-consequence spending on unnecessary items. Sophie reflected that assessing her SU's mental capacity to make an unwise decision to spend her rent money on luxury skincare was not her immediate concern. Ensuring the SU's tenancy remained intact whilst coordinating a crisis intervention was her primary focus.

> *"With X, I struggle you know, we all go out and have a big spend sometimes, and it's consequential, but we won't lose our house. She might. Working out then if she's making an unwise decision and she's happy, or if it's a relapse triggered or a jumble of the two…. I just need to keep her in the flat." Sophie*

Other participants echoed this notion, believing that monitoring relapse indicators was "more worthy" than assessing capacity as the trajectory of a relapse which could require detention under the MHA was of greater consequence to the SU, their family and society as a whole. This value priority was specifically in relation to a SU during a phase of relapse, rather than generally.

Within their client groups, staff reported working with a number of SUs with addiction problems, namely, drug or alcohol misuse. SUs with alcohol-related brain damage issues were reported as extremely difficult to assess under the MCA, due to their frontal lobe impairment which affects suggestibility. Participants found this interplay especially complex when considering a person's capacity to engage in such risky behaviours due to the higher threshold of risk which the SU is prepared to tolerate, compared to clinical staff who have a clinical duty to safeguard SU's, thus resulting in a lower threshold tolerance.

> *"How on earth does it work with SUs who are always under the influence of something or other? Can you even assess them? Probably... I'd say they just lacked capacity by default and not even try to assess them to keep them safe" Len*

SUs with a diagnosis often seen in older age, for example, dementia, were described by staff who work with such SUs as challenging to assess due to the potential to confuse psychiatric symptoms for instance a lack of retention or recall, with those of intoxication or substance use impairment. MCA assessments with older people are further compounded by the complex and often adverse reactions between the use of prescribed medications in older people which CCOs must review and manage as part of their role.

> *"With my elderly patients making decisions, I don't know sometimes if it's too much codeine, the antipsychotic dose is too high, or both; or it's a straightforward lack of capacity" Anne*

Mental health SUs are routinely the subject of many assessments during their time with mental health services. Staff working with SUs for whom this was the case reported feeling 'guilt' about what they described as unnecessary assessments, with the concern that it would jeopardise the professional rapport they had with them.

> *“It's just another thing that will make them not trust us. They’re already overly suspicious and asking more questions about…you know them weighing up their choices and decisions about their new relationship – that they might think is fine, but I think could be a safeguarding issue is tough to manage.” Len*

This was not universal. Others viewed it as an extension of their general and ongoing mental health assessments that were a routine part of every interaction with SUs which are designed to promote wellness and safely manage risk. It was aligned with a position of privilege to ask for information on personal life choices.

> *“It's what we do innit? SUs are used to our nosy parker ways and they get it” Louise*

5.2.2 Theme 2: Challenges & Risks

This theme is comprised of three subthemes which centre around the perception of the MCA use presenting a degree of cost to the clinician. The core element of risk was experienced by all participants. The nature and degree of the risk, comprising personal risks and emotional risks to the staff alongside costs from external sources were experienced differently across the participants.

Subtheme 1: Personal & Emotional Risks

Paternalistic feelings towards their SUs seemed to be common amongst the participants. They appear to sincerely care about their SUs and the experiences and difficulties they are facing.

> *“We do this job because we care about people, it’s all a bit pointless otherwise” Len*

As such, from a reported paternalistic standpoint, limiting SU’s rights or freedoms in order to keep them safe was aligned with good practice for some. This would be seen as clinical practice that was culturally accepted to produce subjectively positive outcomes, such as removing a SUs opportunity to purchase items to safely express distress through self-harming behaviours. This means allowing a SU to purchase clean razors, dressings and bandages, rather than unsafely reusing dirty blades and using toilet roll to stem bleeding. Nathan makes a specific reference to this in the following quote

.

> *"We kind of think about the consequences, don't we? We have a duty of care for SUs, and we're obliged to put autonomy first but it kind of feels like we're colluding with a risk of harm occurring….so sometimes we override SUs and we can if we justify it, because, it's… well… it will lead to a better outcome" Nathan*

Following on from this, nurses in particular explicitly cited the legal obligation of a *duty of care* towards their SUs as a reason to overlook the MCA. For some, not intervening when making what participants considered to be unwise decisions, even with the authorisation of the MCA felt too uncomfortable and the weight of the emotional burden reported by participants was affecting them outside work. Some staff were concerned about their own well-being as a consequence of engaging with the MCA, with Anne describing that her sleep had been disturbed by intrusive thoughts concerning her use of the MCA.

> *"I wake up in the night you know, wondering if I should have stopped her somehow. It's too much you know, on top of everything else to be making this sort of decision. Anne*

Ethical integrity was raised as a risk for staff. Integrity amongst participants was expressed by Rachel, who described it as "*being true to myself*". Sophie described integrity along the lines of lacking courage, honesty and sincerity in the quote below.

> *"….and then in the team meetings, people just say 'well has he got capacity'? and I'm like well I don't know but I feel too silly to have a full discussion about it in the team environment when everyone is looking at me and I know they're all supportive and I know they were all inexperienced once though I feel like I should know and it makes me feel like a bad person." Sophie*

Participants expressing ideas of the MCA application threatening their integrity described the impact on themselves as threatening their sense of self and consequently feeling guilt or upset with themselves, and seeing the MCA as the cause. Self-reflection upon their emotional responses was common, as would be expected from this participant population. The participants seemed divided upon the case of their feelings. Some, such as Sophie, located the reason for their negative feelings as failings within themselves internally. Some located the reason for their emotional reactions externally, and viewed the shortcomings of MCA legislation as at fault.

Subtheme 2: Costs and fears

This subtheme explored the costs and fears that the participants felt as a result of engaging with the MCA. The relationship and rapport that staff have with the SU on their caseload was identified as important to staff members due to the effect it has on positive outcomes for the SU. Some participants felt that using the MCA could negatively compromise this relationship, as an MCA assessment requires questioning any unwise decisions in which the SUs were engaging, thus potentially eroding trust which had been built up during earlier stages of their clinical relationship. In contrast, a number of participants were of the opinion that it could enhance transparency and contribute to an open and honest relationship. Staff who had a good working relationship with carers were also concerned that engaging with the MCA could result in themselves and carers losing their positive relationship with each having differing opinions about what was 'best' for the SU involved. Rachel voiced her opinions about her colleagues' suggestions that the MCA was affecting their rapport with their patients.

> *It’s a perfectly functional piece of legislation, it’s just people are terrified of using it” Rachel*

Participants commented on the criticality of the involvement and contributions of carers as part of the team. The impact of family members within the assessment process was noted. Whilst Sophie suggested that “some carers use [the MCA] as a weapon to meet their own ends and misrepresent things”, suggesting that there were occasionally situations where loggerhead occurred due to a carer self-prioritising, this was uncommon. The majority of comments around positive carer involvement were around hopes of maintaining positive relationships.

Older person’s MCA assessments were marked by family members acting as navigators or interpreting behaviour for the assessor, for instance offering their interpretation of unclear speech or reframing verbal replies. At times this threatened assessor objectivity, however, it was remarked that on the whole, the intention of the family member was to aid the process. This is captured by a statement expressed by Helen which was expressed within a conversation about her exasperation with a carer who was not allowing Helen to form her own opinions about her SU who experienced dysarthria, a condition that manifested as slurred speech.

> *“The problem with capacity assessments is they’re completely subjective and can lean into the influences of the carers, who can be biased themselves when they’re trying and being too helpful”. Helen*

Staff reported their concerns about ‘getting it wrong’ for the SU, resulting in a negative outcome for the SUs. Sophie cited a SU she was struggling to support who was hoping to share accommodation with his partner. Sophie viewed it as an unstable relationship which would negatively impact her SU's stable mental state. She considered using the MCA to restrict this SU from moving, which would keep him safe, but he would not experience what she perceived as a rite of passage – available to any other teenager. Not moving into the same accommodation as his partner however could equally be perceived as damaging for the SU as it could prevent him from pursuing the depth of relationship the SU was aiming for, alongside conflicting with his human rights to a private life.

There was a perception that the MCA might result in a safeguarding risk to SUs, for example, if it was decided that a SU did have the capacity to engage in risky behaviours, such as promiscuous sexualised behaviours, non-prescribed drug use or a willingness to offer accommodation in return for alcohol, they may as a consequence become a target for unscrupulous or dishonest members of the community. This consequence could take the form of financial, physical or emotional abuse. Len cited a case wherein a male had received a substantial inheritance. The man's son encouraged the SU to invest the money in the son's own business, citing the man could make his own choices. Len was reluctant to assess the man using the framework of the MCA as he was concerned the outcome may be detrimental to the man's financial status. This gave a sense that the MCA could give the legal authority for negative acts to take place.

Aside from the costs to their SUs, staff were concerned with the costs and fears relating to themselves and their jobs. Sophie passionately described her dilemma in this quote.

> *Fear drives a lot of what we do, which isn't right isn't it coz the whole point of it is to empower people to be part of their decision making but I do have that battle you know about autonomy and freedoms and human rights and crapping myself that I'll be sued" Sophie*

Should a MCA assessment fail to be resolved by the Best Interests meeting, or if there is a dispute between professionals, the case should be referred to the Court of Protection. Staff spoke about this possibility with anxiety, asserting they would 'fear' a case proceeding to the Court of Protection due to resource commitment needed in the form of clinical time which they understand such a court case requires. It is unclear how their fear influenced their engagement with the MCA process. Len for example suggested he might allow an inauthentic conclusion which was in contrast to his true beliefs to a Best Interest meeting to avoid a court appearance.

> *"Well, you know I might just go along with it, even if I don't agree. The idea of then having to deal with whatever happens at that Court if I don't is too much for me really. I don't think I'm cut out for having my clinical work challenged in a court!" Len*

Interestingly, no participant had the experience of a case being heard at the Court of Protection, nor did they know anyone personally who had. The staff aligned the Court of Protection with the experience of a Coroner's Court appearance, which staff who have an unexpected SU death on their caseload must attend. These experiences can be very difficult for staff and often involve thorough questioning of their clinical practice.

Within mental health services, each member of staff is responsible for assessing the risks presented by, to and from their SUs and assessing and documenting this on the clinical IT system. This is a skill which should form one of the foundations of good clinical practice. Documenting MCA assessments however was met with apprehension, with some choosing not to record the MCA assessments on the clinical system to avoid scrutiny, and anticipated criticism from colleagues. Staff newer in the post found the MCA documentation more anxiety-provoking than their more established colleagues. The idea of a professional challenge to their documentation of the MCA was cited as a reason not to document the assessment. Olumide believed his documentation would allow his colleagues to discover his lack of knowledge. It may however be indicative of his engagement with counterproductive work behaviours.

> *"..if I don't do the assessment, they won't be able to scrutinise it". Olumide*

A further participant admitted to locating her completed MCA assessment in a part of the IT system that she knew was incorrect to reduce the potential it to be commented on by other members of the MDT.

Subtheme 3: Organisational and role issues

All participants referenced the pressure from the organisation to achieve certain task expectations and objectives which were made of them as part of their overall clinical role. Staff reported struggling to complete mandatory expectations around documentation and contacts with SUs as well as the expected activities of supervision, training and meetings. Personal well-being activities such as lunch breaks were often foregone to manage their workloads. It followed then for some participants that undertaking robust, meaningful MCA assessments was viewed as a lesser priority in comparison with, for instance removing a victim of domestic violence from a dangerous situation. Meeting all clinical obligations was not achievable for some staff, therefore staff set their own priority of tasks based on keeping SUs as safe as possible. This is clearly demonstrated by the following quotations:

> *"I think the [workload] priority isn't the MCA but risk because we all work with some very, very risky people in the community and [management] tell us to do the fluffy capacity act where we're supporting people to make decisions and it is very nice in an ideal world, but when we're talking about risk and we're talking about real risky SUs, I do get why it might not be a priority." Rachel*

> *"We all want to work with integrity but sometimes just to reduce the pressure on our workloads and maintain our own sanity we cut corners and we actively make a choice over which corners we're going to cut, well whether we actively do that or not, I don't know but we all make judgments about what is priority one" Olumide*

Alongside an increase in caseload size, participants within secondary mental health services found their caseloads were increasing in severity and complexity alongside each SU's biological, psychological and social needs which have increased over time, with a noticeable exponential change following COVID-19 within adult services. Staff reported that the threshold for clinical intervention from secondary services had raised over time due to bed pressures within acute psychiatric wards resulting in acutely unwell patients being cared for in the community. Nathan discussed the recruitment difficulties and vacant posts within the sector

> *"…If you don't take an extra case on that somebody with a family are just left floundering in the community, possibly getting more poorly"* Nathan

Additionally, the diversity of the geographic area which the trust serves was commented upon in relation to difficulties with the role, as well as the sensitivity which is given to allocating a staff member to a SU who will increase the potential of a positive recovery.

> *" I don't speak Punjabi or Urdu so there's some cases that I'm not the best person to hold. But sometimes you've just gotta make do like some cases really should do with a male over female and it's just trying to match everyone up isn't it everyone's got a different skill set and a different attitude some of the newer social workers do better with some clients some of the older traditional nurses do better with other clients. Nathan*

Participants were divided about the organisation requirements of the procedure for documenting MCA assessments. The IT system itself was met with divided opinions, with some staff stating a preference for the previous IT system as it felt more 'user friendly' and offered a time economy to the user. The MCA assessment electronic form within the IT system was considered by half of the participants to require improvement, with the suggestion made of prompts or explanations within the document. It appeared the template assessment available to staff was comprised of an itemised proforma listing assessment components, rather than a document providing specific assessment strategies.

> *"……but one of the other barriers is the actual form itself…the IT system, it's rubbish. It's absolutely tiny, so it doesn't support you to make or evidence your decision-making in any way, shape or form so it's just, 'Has somebody met the criteria?' Yes or no?" Helen*

Louise stated she did not use the approved process for documenting an MCA assessment, preferring to write the assessment up in a style which suited her approach to documentation and locating this within the general notes section. She believed this allowed for the assessment to have a higher visibility for other professionals yet acknowledged this was not the organisational procedure.

At the onset of the MCA, those staff in practice reported a 'push' to embed the MCA in line with government recommendations at the time. In the years since, staff had the opinion that they believed the MCA has been perceived as less valued within the organisation, as participants cited that the training refresher was not mandated at a high frequency or time intensity. Staff with over eight years of experience tended to report not noticing a 'presence' of the MCA within the trust for a long time, with two unaware there was a Clinical Lead for MCA. The MCA was not always discussed in management or clinical supervision, which could be due to supervisor choices, however, it is not a mandated topic within clinical supervision.

> *I think there's multiple factors [why the MCA is not embedded] and I think it's really difficult to pinpoint. I think it probably starts with the trust. The trust still probably don't value it as much as they should." Rachel*

Within the organisation, the executive team seek board-level assurance about compliance with training. This was viewed as “just numbers” by Len with some participants doubting the integrity of using the quantitative measure of merely counting staff who had completed the E-learning. One participant asserted the organisation tolerated superficial levels of knowledge across a range of clinical areas, MCA being the primary concern. Rachel believed the senior leaders were driven by concerns of inspections by the CQC, therefore ensuring a wide range of knowledge and online training compliance was perceived as more important than a deep understanding with applicability to clinical practice of subjects such as safeguarding, eating disorders and the MCA. Interestingly, the idea that very senior staff are too far removed from frontline work was commented upon by Peter, Helen and Nathan with suggestions made on how to engage very senior staff within MCA assessments. Nathan suggested the senior leadership team spend a day shadowing a CMHT worker which would offer them the opportunity to experience the stresses and pressures that CCOs encounter in trying to juggle clinical and non-clinical work.

5.2.3 Theme 3: Learning and doing

This theme captures the staff’s acquisition of knowledge about the MCA through training, both formal and informal and their experiences in implementing this knowledge and its application within clinical practice. Finally, the support that participants feel they benefit from in relation to the MCA is presented.

Subtheme 1: Competence & Confidence

There was a strong link between staff of their level of competence using the MCA and their confidence about using it within clinical practice. Using a degree of circular reasoning, less confident staff tended to describe themselves and their practice in negative terms.

> *"Yeah, it's a tough one, isn't it? Because you get, how do you get confident unless you're experienced? And how do you get the experience unless you're confident to do it?" Peter*

There was a perception that newly qualified staff may lack competence, due to their lack of practical exposure to assessments. Abstract classroom learning about the MCA isolated from clinical exposure was not viewed as likely to equip staff with the capability needed to manage complex MCA assessments in clinical practice. Staff with higher qualifications viewed themselves as both confident and confident in using the MCA, such as Louise who is qualified as a BIA.

> *"I do feel confident because I understand the principles I'm also professionally confident to make professional decisions and not one who assesses capacity and then wobbles around as to whether they do all the don't because I'm worried about what other professionals might say." Louise*

When exploring their confidence, personality type and style were an influential factor for some staff. Anne who described herself as "not really sure of myself with the MCA" felt she wouldn't go out of her way to challenge MCA-related decisions of other staff without concrete grounds and reasoning as she felt it would not be received well from strong personalities within the team. Working jointly as part of an MDT increased the staff's confidence to apply the MCA. As each professional within the team comes with their own unique experience history, shared experiences build confidence in a way that working in isolation didn't seem to achieve. The process of articulating their thoughts and exposing themselves to supportive questioning bolstered confidence.

> *"When it's done as part in the MDT, I feel on it and certain cos we all just bounce off each other. We're stronger as a team" Anne*

Finally, following the guidance written in the code of practice, as well as seeking help when indicated were contributors to self-rated confidence, even though she believed the guidance was beset with difficulties in comprehension, Sophie said it gave her "an anchor" to base her assessments on.

Subtheme 2: Education, not instructions

The participants were critical of the training they had experienced on the subject of MCA. Staff found it too basic and not relatable to complex clinical practice. Some suggested it may be more suited to unqualified workers, rather than qualified staff, as an introduction to the MCA. It was noted that all professionals who qualified in the last 17 years should have received training prior to qualification.

> *"The people who have had trust mental capacity training, they haven't, they've just had a bit of education" Helen*

The investment by the organisation into the training was appraised negatively, with comparisons to other mandatory training sessions which were longer, such as the MHA and more rigorous, such as those requiring a 'test to pass'. The training content was cited as a barrier to the application of the MCA as it gave little guidance on the practical application of the MCA, for instance, completing documentation or inputting information on the IT system. Many felt the training material around Best Interests meetings gave inadequate preparation for managing the event in a real clinical situation.

There was a perception by nurses that the staff who attended the Local Authority training, namely social workers were 'more qualified' than staff who had only accessed NHS staff training. This view was verbalised by two of the social work participants, who believed their training was 'not as basic' and 'the next level' which was corroborated by Anne.

> *"…… not the training we get at the trust anyway, the social workers seem to get much more like dynamic training. Well, this annoys me actually coz they hear about stuff and the emails that are supposed to be for everybody, but they never seem to get cascaded to us. The LA team puts on training apparently, so, the LA staff get to come on our training but I've never been on LA training I don't know if I can or not." Anne*

On the whole, staff working in an older persons or mixed setting viewed the training more positively. They found the examples discussed more clinically relevant, for instance, the delivery of information shared about Lasting Powers of Attorney was situated within a geriatric scenario. An accepted complexity of the MCA is when a client has a fluctuating capacity, such as in the event that a person with a severe and enduring mental health diagnosis has a relapse or when the SU's drug or alcohol use places the assessor in a difficult situation. Staff working with SUs with this need found the training did not sufficiently prepare them for the ambiguities which are inherent within the MCA. Staff who had higher training were thankful for their opportunities, recognising that the up to 6 days they were afforded to learn had a strong link with their willingness to engage with the MCA process. Staff with this insight were more critical of the in-house training.

> *"Knowing what I know, I do feel a bit sorry for the others [CCOs] who only have the trust e-learning. No wonder they struggle, it's leaving them wide open" Rachel*

Some staff mentioned self-directed training they had chosen to access through non-NHS sources, such as YouTube to deepen their understanding as they believed their knowledge base was incomplete. Others, (for example Sophie and Anne) found the MCA Code of Practice, both paper and online versions a useful companion to their learning. There appeared however to be a lack of external resources published which were specific to mental health clients. Resources reported by participants were located around the specific decision in question, for instance, a change of accommodation, but these typically involved SUs with a learning disability or degenerative condition related to old age, such as Alzheimer's disease.

Improvements to the training were suggested by every participant, with recommendations made to radically overhaul the current training offering.

> *"Just bin that e-learning and get some proper people in" Olumide*

Participants aspired for training that met their needs, that is, working with SUs with a severe and enduring mental health presentation. Training that focussed solely on this client group was identified as crucial. Other proposals ranged from encouraging every CCO to undertake either BIA or AMHP training, to face-to-face day-long training sessions and a wide 'curriculum' of courses based on different aspects of the MCA. The positive impact on SU outcomes and the desire to use the act with the intention it was designed for were cited as reasons to increase participant skills and knowledge.

Subtheme 3: Clarity & Uncertainty

Staff found the complexity of MCA difficult to apply to people with a mental illness, however, the process seemed more achievable for cases wherein a simple decision was being considered, such as decisions about outings or low amounts of spending, which had only limited impact on the person's global well-being.

The concept of case law presented much confusion for participants. Case law refers to the collection of legal decisions made by judges in court, which interpret statutes, regulations and previous case decisions. These decisions create a body of law known as a precedent that future cases must follow. Some staff were unaware of the idea of caselaw precedents set following the implementation of the MCA and became confused when this was suggested during their interview. Staff with higher training were both aware of and comfortable with the concept and implications of case law.

> *"You mean it changes? Or how we use it changes? Is it the same as the MHA?" Anne*

Staff were also unassured by the language used within the MCA legislation, which was viewed as vague and ambiguous, thus hard to apply to their clinical settings. Staff found the language used within the legislation was not fully explained or given to any great level of clarity within the Code of Practice, which led to uncertainty about the essence of the legislation for some participants.

Social workers appeared more at ease with the terms used within the MCA, both through their verbal delivery as well as their language choices during the interviews. Sophie, Louise and Steve for example spoke with accurate precision about the functional and diagnostic components of the MCA, unlike many of the nurses who often used "errrrr", "is it the….." and " that…." to preface stating technical facets of the MCA. Collectively, staff judged that it was too far removed from everyday terms for it to be used by unqualified professionals, SUs and their carers.

> *"Well, if its tough for us, the carers will definitely struggle. Its too out there isn't it? Especially if you're not culturally British" Len*

Staff found the lack of checking or feedback on their clinical assessments uncomfortable, which gave the assessor no assurance of the standard of their assessment. Other reports completed by practitioners are the subject of scrutiny, both by the team around the SU as well as other teams working with the SU. Risk assessments, for example, are regularly reviewed and updated in a multi-professional setting. The MCA assessment, as a single-time assessment, is not subject to this review process, which gave little opportunity to learn and develop their written assessments.

> *"I think it's far easier to be held accountable under the Mental Health Act with all the scrutiny.....I think the MCA objectively, doesn't really hold you to account" Steve*

Further ambiguity came from work with other agencies. Joint work with the police and ambulance service gave some evidence that other agencies were appearing to apply the MCA with mindfulness to suit their own outcomes. Steve gave an example of a case where an SU had committed an offence and had the mental capacity to make the decision. The police, however, assessed that the person lacked capacity and therefore should be managed by mental health services, which Steve suspected was a decision to preserve their own resources.

Subtheme 4: Peer Support

The final sub-theme within the findings is concerned with exploring mechanisms staff use to feel safe, enhance their knowledge, and build confidence. There was a strong value placed on the support received from peers around clinical issues relating to the MCA assessment process as well as documentation issues, such as IT difficulties. MCA support for participants at all points of interaction with the MCA was sought during the assessment process as well as fact-checking points of procedure. This support from peers came from ad-hoc interactions and emails as well as online chats. At times, the support consisted of encouraging statements rather than points of practice clarity. All were welcomed by participants, both newly qualified and with more substantial clinical experience. Peer supervision takes several modes for the participants. Forms such as physical chats in a shared area, back-and-forth emails or personal WhatsApp messages were cited as appreciated methods of support interaction. All forms were valued as a mechanism to reduce stress and gain support from staff facing similar challenges, which Nathan and Peter remark upon.

> *“You know, over coffee. Ohh, I've got this case and I just don't know what to do with it. Yeah, that that does come up like that, or in the lift, those little chats are such a boost!” Peter*

> *“I used to shadow someone who knows what they’re doing, like XXXXX, she’s a BIA. I get her to check my work actually. Thinking about it, she has taught me loads of stuff over the last few years. She’s nice to me, you know, dead sound, doesn’t judge me. I think she made me feel confident. I should probably listen to her more!” Nathan*

Within teams, many found there was a colleague whom they perceived as the most knowledgeable about the MCA. Some participants found themselves to be the point of contact. This was on occasion a role they fell into unintentionally but spoke positively of the experience of helping others with the MCA.

> *“Yes, they come to me. I seem to be the MCA bod in the team. It's good. They learn, I’m kept on my toes. Hopefully one day they won’t need me though. You can see the penny of clarity drop for them when it clicks how simple it can be” Louise*

The majority of the participants reported dependable, helpful relationships with colleagues, although, this contrasts with an increased sense of loneliness and isolation following the move to agile/remote working since COVID-19.

> *"I I think peer support is one of the most valuable things we have in these jobs and working in the community makes it harder especially now we're all agile" Sophie*

Clinical supervision, which is a forum wherein the participant can engage in a judgement-free 1:1 conversation with a peer or senior member of staff, gave participants a highly valued opportunity to reflect on problematic MCA cases. Many participants sought out reassurance from their supervisors in an environment where feedback would be formally supportive and encouraging, rather than critical. Mutual availability as well as caseload pressures were seen as an obstacle to receiving supervision, with one participant stating they had no current clinical supervisor. Several participants suggested regular group supervision might be well received by clinicians with a different MCA topic each session, however, reflected that it was unlikely to be of value to those with an immediate problem.

Peer support was also conceptualised as a formal mechanism of MCA support the organisation offers to staff, outside of the supervision process. The organisation offers office hours support from a senior clinician to support all aspects of the MCA process. Whilst the overwhelming majority knew about this role within the trust, two did not. Less confident staff admitted they would not contact the clinical lead as they felt silly or intimidated by formalising their concerns.

5.3 Summary

As the more longstanding legislation, staff remain more familiar with the MHA than the MCA. They find applying the MHA to SUs a very binary experience, yet the successful application of the MCA to mental health SUs is for some staff fraught with complications. The very nature and subjectivity of mental health diagnosis afford a degree of confusion for the assessor. Staff found SU's insight into their illness a further obstacle when using the MCA. Staff found the application of the law was beset with difficulties resulting from the organisational setting such as time, resource provision and caseload dynamics. Training experiences were mixed for staff, with some staff remaining confused about the MCA and fearful about applying it to their clinical practice. Staff who have benefited from advanced training however do not seem to share these beliefs. Universally, all staff found support helpful, but staff expressed preferences for various modes of support.

In the subsequent chapter, a theoretical framework will be explored from which to view the findings and the implications of the research for clinical practice will be demonstrated.

Chapter 6: Discussion

6.1 Introduction

This chapter discusses the findings drawn from this study concerning the experiences of CCOs working within secondary mental health services and their use of the MCA as part of their clinical duties in relation to the existing literature and SDT. Research on this particular staff group and their use of the MCA within clinical practice remains, to date, limited. This study is pertinent in understanding the complex interplay of the responsibility this staff group faces whilst working in a specialist role with a high degree of stress and burnout (Towey-Swift & Whittington, 2021).

This study identified three themes; *working in mental health, challenges & risks* and *learning & doing*. It establishes that although staff see the merit in utilising the MCA as a piece of legislation to empower mental health SUs, the MCA remains not fully embedded within clinical practice in a secondary mental health setting, especially in comparison to the MHA. The experiences of CCOs within this study suggest that the legislation is often not operationalised as the lawmakers intended, and staff perceive costs with its use in the form of risks and fears such as compromises to personal value bases. Staff report incomplete knowledge bases using an act they find lacks clarity, which contributes to their degree of confidence and competence. An explanation for why staff struggle to engage with the MCA may be linked to their motivation to engage with the legislation (Cliff & McGraw 2016).

Self Determination Theory (SDT) is a framework for understanding motivation. It identifies three basic needs that should be met for people to be self-determined: relatedness (a sense of belonging or attachment to other people); autonomy (a feeling of being in control of one's own behaviours and goals); and competence (mastery of tasks and skills). The results of this study will be discussed within the framework of SDT following a discussion of the position of the findings within existing literature.

6.2 Location of the findings within the existing literature

The findings from this study concerned with mental health staff echo many of the findings of the systematic literature review presented in Chapter 2 of this thesis, within which practitioners from many different clinical areas and professional groups were examined. Offering further support for the current findings is a recently published large-scale quantitative study by Ariyo et al. (2021) of 611 healthcare professionals. They concur that most staff do have a degree of confidence to assess capacity, yet they noted the significant challenges around practical and relational issues. The study was not included in the systematic review due to its quantitative method. The relationship between Ariyo et al (2021) to this empirical study is one of parallel support given the differing approaches to methodology. Both studies conclude that staff are confident to undertake MCA assessments of uncomplicated cases, however, assessments with multiple complex domains were challenging for staff. Whilst both studies captured perspectives of SU being negatively influenced during the assessment process, this was a considerably stronger within the Ariyo et al (2021) study, which could be a result of the quantitative questionnaire specific focus on this area.

The knowledge gaps identified by the participants for new and established practitioners is an area which unfortunately remains problematic for the overwhelming majority of practitioners, despite the substantial time that has now passed since the MCA came into legal force. Both the current study and the literature review findings identified knowledge gaps appearing to result from educational provision across and within the organisations in which the staff were employed (McVey 2013; Ratcliffe & Chapman, 2016). Interestingly, both the study and the literature review identified instances where staff claimed to have knowledge gaps, yet were able to confidently answer questions and give detailed case examples (Moore et al, 2019, Murrell & McCalla 2015). This could be an example of staff moving through the stages of Burch’s (1970) conscious competence learning model wherein staff are moving from the conscious incompetence phase, where they know they don’t have the knowledge about the MCA; to the conscious competence phase, where they know that they have the knowledge about the MCA.

In the current study, participants recognised clear deficits in their knowledge, for instance around the process for application to the Court of Protection. The findings corroborate the evidence base that staff struggle to apply the knowledge they have assimilated into clinical practice. What is interesting is that within this study, staff routinely, and seemingly successfully, translate the MHA from an educational setting into a clinical setting. The difficulty therefore seems located either inherently within the MCA or possibly the different approach to training for the MCA. This appears to be a topic warranting further exploration. Fluctuating capacity, which is not referenced specifically within MCA is a topic further frequently perceived as a knowledge gap. Given the difficulties associated with this area, perhaps surprisingly there is little case law that deals specifically with this subject. This is an area in which there is also an absence of published literature.

Consistent with the systematic review findings, many practitioners found it challenging to apply the MCA in practice and reported difficulties moving from the abstract to the concrete. There were worries about using the MCA alongside protecting people’s human rights as well as getting things ‘right’ for the people they were working with. Consistently, the desire to “help” has been cited as a reason to choose a career in health or social care. Studies with nurses (Genders & Brown, 2014); social workers (Couturier et al., 2022) and doctors (Tehrani et al., 2018) confirm that helping others is the primary motive for choosing their current profession. It then follows that healthcare staff would find balancing a desire to help with a degree of dissonance which they would wish to ameliorate as a result of their unsuccessful application of the MCA.

The current study builds upon the evidence base of the findings of the systematic review in relation to the higher-level concept of risk, which featured more prominently within the findings of this study than within the systematic review. Risk for mental health staff when using the MCA seemed situated as a comparison to the risks when using the MHA. It was manifested through the lens of care for this patient population, in which risk is a central concept. The consideration of risk seemed to result for some staff in self-reflection on the personal and emotional consequences and fears around MCA application with mental health SUs. This is an area which would benefit from further, in-depth exploration.

6.3 Application of Self Determination Theory (SDT)

In order to move beyond the findings to a position where the wider significance and applicability of these phenomena can be appreciated, the application of SDT will be presented. This theoretical framework underpins the findings of this study and provides a context for understanding the staff experience as viewed from a critical realism standpoint. As discussed briefly within the Introduction in section 1.4, SDT (Deci & Ryan, 1985) as depicted in Figure 4, is underpinned by the assumption that personal growth is needed for people to develop a sense of satisfaction, psychological fulfilment, and a perception of self. Secondly, it assumes that people possess the capability to achieve intrinsic motivation, which is the inner motivation that does not rely on external rewards, punishments or coercion. To achieve intrinsic motivation, three basic needs must be met: namely relatedness, autonomy and competence.

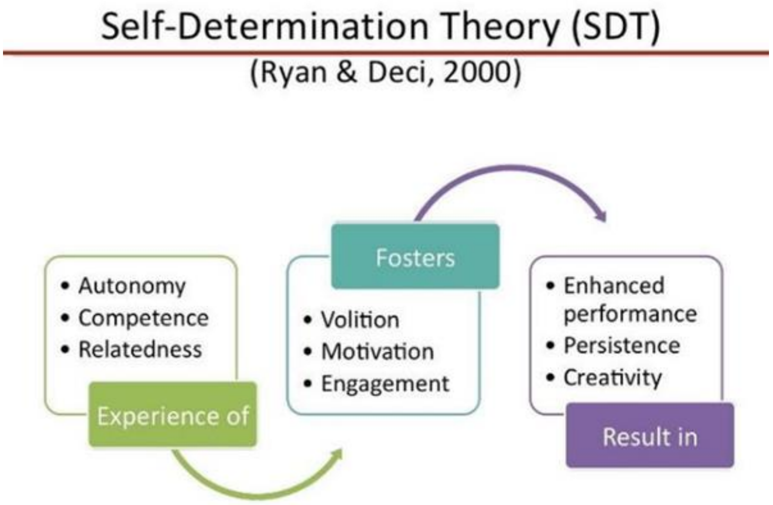

Figure 4. Pictorial representation of SDT

According to Deci and Ryan (1986), motivation can be extrinsic or intrinsic. For NHS staff, extrinsic motivation, that is, the drive to behave in certain ways based on external sources and external rewards is likely to take the form of employee awards or managerial scrutiny. Focusing on external motivation is unlikely to be a sustainable or effective approach to driving culture change (Zeng, 2022) for example, to increase staff motivation to engage with the MCA. Intrinsic motivation is sustainable and is likely to be seen in a worker who is internally driven to behave in ways that align with their own core values and personal sense of morality. Figure 4 demonstrates the potential consequences of staff of increasing their motivation to engage with the MCA. Use and application of the MCA may be improved and they may be more persistent in their attempts to apply the legislation, for instance seeing support from the MCA Clinical lead. Additionally, they may seek and apply more dynamic ways of applying the legislation. All such benefits are then realised by the service users at the heart of the legislation.

The findings here offer a perspective situated within critical realism to gain an understanding of the reasons why staff may lack motivation to apply the MCA.

6.3.1 Relatedness

The concept of relatedness is generally considered a basic psychological need which manifests in a need to experience meaningful connections with other people (Deci & Ryan, 1985). Within this study, this was recognised by staff seeking out a variety of formal and informal opportunities to engage with other staff to discuss the MCA, reflect on assessments and seek advice on cases in which they required support. A positive experience for staff which meets the need for relatedness whilst utilising the MCA was their feeling of connectedness to other members of staff who were able to support their use of the MCA. Although not explicitly used by many, the knowledge of the organisation's provision of a clinical lead – a highly trained professional within the organisation - gave the staff reassurance and appeared to be valued as a meaningful connection. Sharma (2021) supports this idea by suggesting that knowing the resource exists appears to contribute to a sense of connectedness within the organisation.

Both receiving and giving peer support around issues and difficulties with the MCA was seen as extremely valuable for participants which may be in part due to the desire to have meaningful relationships with others, but also may be linked to seeking to increase their competence. The change in working practices as a result of the COVID-19 pandemic was seen within this study as a change in the sense of relatedness. There was a general sadness which was felt concerning the ad-hoc conversations which were significantly reduced since the move to agile working to aid safer working practices. This appears to have affected staff practice universally, not specifically in relation to the MCA. Gagné et al. (2022) commented that different technology types can both increase and decrease feelings of connectedness depending on the extent to which they promote meaningful interactions. Staff typically use work-owned devices to facilitate productivity. Lisitsa et al. (2020) found that systems such as Microsoft Teams can be a buffer against loneliness for remote workers and enable stronger connections for agile workers. Data collected from the participants within this research found that CCOs were more likely to use instant messaging applications to communicate with each other due to the impracticability of using laptops for video calls in their cars in an agile environment. Such use could result in staff being vulnerable to car theft within the community by persons who see and wish to steal their equipment . Using text or voice messages in this manner could serve to connect isolated workers struggling with MCA assessments and promote relatedness.

The role of introjected motivation was unclear. This is a type of extrinsic motivation, located within this domain of relatedness. Chaman et al. (2021) suggest that introjectedly motivated staff engage in work activities because they feel obliged, not because they fully internalise the activity itself. This was seen as some staff ‘going through the motions’ of their role. They argue that staff with introjected motivation engage in knowledge sharing to improve their self-worth and feel good about themselves. Offering support to colleagues was seen as valuable and this offers a fit within the need for relatedness. This suggestion may explain why staff under considerable time pressure and vulnerable to stress would choose to engage in such altruistic, knowledge-sharing behaviours.

In relation to relatedness, rising from the theme concerned with costs and fears is the idea that CCOs may feel that engaging with the MCA could affect their relationship with the SUs on their caseload. This concern about a potential threat to their relationship may be a reason why some staff fail to engage with the MCA in clinical practice. It is reasonable to speculate that this desire to conserve and protect relationships may extend to carers and possibly other members of staff. This has far-reaching implications for the use of MCA and any innovations to move forward with embedding the MCA into clinical practice should ensure that the basic need of relatedness is promoted by mitigating the threat of a risk to relationships.

6.3.2 Autonomy

SDT defines the need for autonomy as the individual's need to act with a sense of ownership of their behaviour and act in accordance with one's own values (Ryan & Deci, 2000). This need emphasises the desire to act with a sense of choice and volition – even if acting in this manner involves obeying the requests of others, for instance, line management requests for information. CCOs are expected to work with a degree of professional autonomy; this might be making reasoned decisions about clinical priorities and the ability to manage their own work diary being mindful of management directions to complete or prioritise specific tasks. The application of the MCA may therefore present a challenge to CCO autonomy through organisational expectations. Experienced staff working before the advent of the MCA may experience a threat to their autonomy as it presents a threat to established ways of working in line with their values which have been established over time.

A literature review by Lluch (2011) concluded that barriers within IT systems hamper healthcare-related outputs and compromise staff autonomy, resulting in staff dissatisfaction. An example of an organisational effect which prevents CCOs completing their job in line with their own preferences for working is a requirement for staff to input their MCA assessments correctly into a system which is not universally understood or valued. This could affect autonomy within the definition of SDT. Job crafting is a term that can be defined as staff actively redesigning their jobs in a bottom-up process, where individuals change the boundaries of their jobs to fit their own skill sets with the aim of creating the best fit between their own individual desires, resources, and job demands (Jutengren et al. 2020). There is an element of job crafting occurring with the participants of this study, for example, the use of the IT system and output prioritisation to align with their own values as they potentially strive towards a greater degree of autonomy. Research suggests bottom-up job crafting has been successfully implemented in healthcare, (Gordon et al., 2018) and may have a role to play with motivation to engage with the MCA in CCOs.

Workload pressures were found to be a universal experience for participants and such pressures may result in MCA processes not being prioritised as senior leaders direct staff to value other quantitively reportable outputs with the secondary consequence of reducing staff autonomy. This occurs due to the organisation creating an environment where CCOs cannot be completely autonomous which may result in a decrease in motivation. It is recognised that organisations value comparative output measures which enable benchmarking (Pantall, 2001). The challenge for healthcare organizations is ensuring the voice and experience of the SU are not lost within this data capture. The Bamford report (Donnelly et al. 2011) puts forward several ways of measuring mental health recovery, for example, admission lengths, referral length, and detention length. Strategic leaders should ensure that capturing the value of the MCA is also noticed and perceived by the staff undertaking the assessments. Additionally, processes to ensure that HCP's autonomy to complete the 'soft' assessments remains a priority by organisations and is not compromised at the cost of target-based faceless outputs. If this need is unmet, staff motivation to complete assessments with integrity and value and to engage in tricky clinical cases could decrease further.

What is interesting to reflect on here is the alliance of the MCA with the individual staff values. The core values inherent within the act's architecture for example, maximising SU individuality and autonomy, supporting SU capacitous decision-making, and ensuring SU engagement do not stray far from HCP professional values, (NASW, 2024) yet it would be hard to state with certainty that these professional values align in all respects with individual staff values. The point here is how these dovetails with autonomy. Staff may be feeling compelled to behave in opposition to their own personal values, for example, preventing an SU from engaging in risky activities in order to keep them safe. Conversely, staff whose personal and professional values align with the ethos of the MCA may find it increases their sense of autonomy and therefore working with the MCA as part of their clinical duties contributes to their motivation to engage with their role and increases their job satisfaction. Alternatively, the situation may be that the embedded and ingrained MHA does not align with the MCA. From the findings presented within this study, it is reasonable to suggest the role of personal value systems upon staff embodiment of the MCA is of importance when considering the integration of the MCA into clinical culture.

6.3.4 Competence

Competence, as defined by SDT, is represented as workers' needs to feel effective, successful and good at their job, (Deci & Ryan, 1987). Within the wider literature around the organisational application of SDT, competence has been found to be key to workplace well-being. Gomez-Baya et al. (2018) argue that higher self-perceived competence is related to higher job satisfaction which is associated with higher psychological well-being. Within this study, the notion of competence was seen universally as well as specifically. The findings that workers perceived themselves as either competent to engage with the MCA or incompetent pervaded across many domains of the MCA; for example, an application for a DoLS, an MCA assessment, a CoP referral or general documentation. Within healthcare, competence can be defined as the capability or ability of an individual to effectively perform a specific set of tasks or activities within a given context, which is often influenced by a combination of knowledge, skills, attitudes, and behaviours (Andersson et al. 2017). It encompasses not only the possession of requisite knowledge and skills but also the capacity to apply them appropriately in real-world situations. In this case, this would be the application of the MCA in a live clinical setting from acquiring the knowledge in a classroom setting. A member of staff who has a mastery of the MCA and its wide-ranging applications with a diverse clinical population may feel more competent than a member of staff without this skill set. The findings of the study did suggest a link between higher trained staff and confidence, which could be partly due to the role that Rogers and Bright (2020) identified of professional shadowing which is mandatory component of the BIA and AMHP role qualification. The expectation of NHS Commissioners is that all trusts will offer assurance that their staff have induction and refresher training alongside policies for staff development (NHS England, 2014), yet further directions to increase competence are not mandated by commissioners.

Competence is a dynamic concept that is likely to evolve as staff acquire new clinical experiences and adapt to changing environments, such as organisational culture change or a change of role. For professionals, however, it is not as simple as compelling staff to undertake further MCA training and expecting an impact upon confidence; there are more sophisticated mechanisms at play within the framework of SDT which would lead the staff to progress along the confidence continuum.   Competence is influenced by factors such as motivation, self-regulation, and social context (Bandura, 2008). Competence can also be domain-specific, with different areas of expertise requiring distinct sets of competencies (Eraut, 2002), for example, a mental state examination would require different skills to an MCA assessment, yet both required components of a CCO role.

The participants within this study expressed varying levels of competence when using the MCA alongside other legislations as part of their clinical duties. Some were satisfied with their level of competence, and some were frustrated. What was interesting was the differing responses to their competence. These can be considered through the lens of SDT (Deci & Ryan, 1985), as, if staff are responsible for successful outcomes, they should feel more competent and intrinsic motivation to engage with the MCA should increase. However, if staff feel less competent, they may be exposed to workplace extrinsic motivation which may be perceived as a punishment such as an increase in the frequency of management supervision. This can lead to a reduction in perceived autonomy resulting in a lessened intrinsic motivation to engage with the MCA.

In what can be seen as a positive, staff with higher level training were noted as being more confident to undertake MCA assessments as well as more competent when making MCA-related decisions. The finding could be situated in the idea of legal literacy. Braye and Preston-Shoot (2017) write that connecting relevant legal rules with professional priorities and the objectives of ethical practice constitutes legal literacy. Research has demonstrated that teaching law to non-law students is associated with low confidence and high anxiety about knowledge and skills for practice (Preston-Shoot & McKimm, 2013). Higher-level training, such as BIA and AMHP involves postgraduate training with a heavy slant on the corresponding law from a clinical perspective. Increasing clinician legal literacy seems to have a firm correlation with increased competence and subsequent competence with the MCA, which is likely to have a positive effect on employee performance, motivation and well-being.

Remaining with legislation, the idea of personal risk can be quantified in the consequences of the law, as that has just been explained, or as the concept of emotional risk affects staff experiences of the MCA in practice. Emotional risk for staff about utilising the MCA can be conceptualised as the emotional burden from engaging with the MCA for example making decisions which affect a person's long-term accommodations or relationships. The findings locate this within the theme of ‘Challenges and Risks’, however, it touches on each theme. Personal and emotional risk therefore could be considered as an extension to the model of SDT. Some aspects of the concept of risk map onto autonomy – for instance the idea that risk is a threat to personal integrity. It does not however take into consideration the processes involved in decision-making that contribute to personal and emotional risk. Slovic et al. (2005) suggest that emotional reactions to assessing risk, such as feelings, often drive behaviour and affect decision-making. During times of self-questioning, staff may be experiencing risk as a feeling which may affect the MCA assessment process. This may speak to the concept of professional intuition, which is an established concept within mental health care (Welsh & Lyons, 2001). Future research pathways to determine the reach of SDT with the extension of risk should consider other situations in which staff are exposed to situations of personal or emotional risk. This could be located within healthcare for instance frontline HCPs assessing clinical risk within a mental health setting. Other approaches may consider other systems in which staff experience burnout such as education, (Fiorilli, et al. 2017).

Whilst the application of SDT offers a lens through which to view findings as a whole, it should be considered alongside the specific issues relating to CCOs working with SUs with a severe and enduring mental health diagnosis in a community setting. The acknowledgement of issues specific to this SU group and the influence they have on relatedness, autonomy and competence is essential. The role of insight within a capacity assessment for example is unlikely to be an issue often seen with other clinical groups, adding to the complexity of implementing an act with most HCPs from other settings have struggled to implement (Scott et al. 2020). Secondly, staff are at all times vigilant to relapse indicators that SU may be exhibiting due to the consequence of a SU potentially requiring hospital treatment should a crisis occur. Staff may be required to judge whether to prioritise a capacity assessment or to attend to crisis warning signs in an effort to maintain stability for the SU. Finally, the complication of prescribed psychiatric and non-prescribed medications should be acknowledged when using the lens of SDT to understand CCO's experiences of using the MCA as these may interfere with SU cognitive processing which may result in an inaccurate assessment.

6.4 Mental Health Practice and MCA

One of the objectives of this thesis was to understand how mental health staff reconcile using the MCA alongside other legislation. In practice, this means balancing the emancipatory principles of the MCA alongside the statutory obligations of the MHA. Good mental health practice places the SU at the heart of the decision-making process. Tension exists for practitioners when the legislation surrounding the decision-making process can override choices which may represent or be perceived as representing a risk. The need to balance people's wishes against a need for care and treatment is a struggle for all staff using the MCA (McVey, 2013), yet the balance for mental health staff appears to be further complicated by the MHA’s ability to remove a person’s freedoms should they present a risk to themselves or others, irrespective of whether they have the capacity to make decisions or not.

Interestingly, in 2018, an independent review of the MHA concluded that reforms were needed to reduce coercion within mental health care and to support mental health SUs in making their own treatment decisions. The review stated that “allowing everyone to make the decisions that affect their life and accept the consequences of those decisions is a key aspect of respecting the unique value and character of each human person” (Modernising the Mental Health Act, 2018 p.4). This aligns with findings in the current study that CCOs struggle with balancing the distinctions between the choices people make and the outcomes of their actions; the two are not the same and should not be conflated.

Working in mental health services requires workers to undertake a number of duties, or job activities, each one may have associated with it different levels of basic need satisfaction. An established literature base exists which accepts that intrinsic and extrinsic motivation are highly influential determinants of staff behaviours within healthcare (Perreria, 2016). This should be considered alongside studies which report staff tend to become happier when pursuing things that are intrinsically motivated and aligned with their own goals partly due to the self-perceived impact of their responsibility for the outcomes (Manganelli et al. 2018).

An interesting idea supported by the findings which sits out with the sphere of motivation is the sense that the MCA could give the legal authority for negative or harmful acts to take place. Section 5 of the MCA holds that where a person is providing care or treatment for someone who lacks capacity, then the person can provide the care without incurring legal liability. Should the professional be motivated by a desired outcome, which the findings concede does happen, then finding the person to lack capacity would then by default authorise the professional's decision-making. This idea suggests the MCA could be falsely employed to contravene the SU will, with the MCA itself protecting the professional from liability. The findings raised concerns that amoral HCPs may perceive this as an opportunity to mistreat SU. The MCA, however, used correctly, does not in any way authorise unscrupulous practice. The overarching principle of the act is one of acting in the best interests of the person in question. Should an HCP act out with the best interests of the person, they cease to benefit from the MCA's legal protection and are at risk of prosecution if the act leads to ill treatment or wilful neglect, (Bogg, 2018).

In summary, the model of SDT is useful in understanding the experiences of CCOs working within mental health services from a motivational perspective. The obstacles that exist for staff to utilise what they inherently see as valuable legislation as part of their clinical duties alongside other established legislation such as the MCA are complex. SDT does not however fully explain staff experiences as some of the issues with the MCA are not related to motivation and are difficulties with the inherent structure of the MCA as well as the culture and resources of the organisation in which they work.

6.5 Quality Assurance

The aim of this research is to produce a piece of quality research which has value to the research community as well as clinicians and strategic decision-makers within the NHS. Whilst there are generally accepted criteria for quality in quantitative methodologies, (Greenhalgh, 2014) there is not such a consensus in qualitative methodologies. There are however some measures that are more appropriate for assessing qualitative data. If one considers reliability as the potential of generating the same results by different researchers to different participants (Bryman, 2016), then this is unquantifiable given the framework being employed. Individual experiences are being sought, therefore removing the knowledge from the context in which it was created is not the objective here.

It is proposed that the measures of transferability, dependability, and credibility will be used as determinants of qualitative rigour (Morse, 2015). In terms of transferability, the results positively lend themselves to a different application, for instance, other mental health professionals outside the study, such as occupational therapists assessing SUs with dementia. As reality is socially built and constantly changing, dependability captures the changing conditions of which reality is the result. A study which offers dependability, according to Lincoln and Guba, (1985) maintains consistency. Triangulation and stepwise replication were not possible due to the sample size, therefore, dependability was addressed using the code-recode procedure. Finally, in establishing credibility, member checks are considered the single most critical process (Rolfe, 2006).

Member checking is a tool which could be employed to give further assurance that the staff's voice and their version of their own reality are being accurately captured within the study by presenting transcripts to some, or all, of the participants for feedback (McKim (2023). Member checking presents an opportunity to correct any errors and reduce the possibility of misrepresentation. All participants were contacted to review some, or all, of their transcripts. Unfortunately, none of the participants chose to engage in member checking. Many cited work pressures are a reason they were not able to contribute further to the study.

Chapter 7: Conclusions & Implications

This study has given rise to some implications for clinical practice within community mental health services that should be addressed, specifically due to the potential impact on SU outcomes and staff well-being. In order for the functions of the MCA to benefit SUs, the MCA requires administration by HCPs who are confident to use it and competent within their practice. Should these elements be missing, the empowering potential of the MCA may not be realised.

7.1 Implications for Organisations & Policymakers

As the MCA is not currently fully embedded in practice, future changes to the MCA in coming years should be implemented very mindfully of the current cross-clinical evidence base. The Liberty Protection Safeguards (LPS) were introduced in the Mental Capacity (Amendment) Act 2019 which the current government planned to bring into force to replace the DoLS. The House of Lords has passed these changes, yet it is unlikely these changes will be implemented within the current parliamentary term (Ruck Keene 2023).

Feeling supported by their organisation, whether on a micro or macro level was a priority for staff. The findings suggest the MCA support should be similar to the MHA support, wherein documentation was reviewed by a senior member of staff. Organisational support may be realised as protected time to complete assessments or offering time for competence development. Policymakers should be vigilant to the support structures they anticipate installing and to ensure adequate funding surrounds these, not just for the period of embedding, but ad infinitum. Research demonstrates the challenges of adopting new practices in healthcare. Embedding innovation is fraught with difficulties from partial diffusion of innovative practices, initial adoption that is followed by abandonment, and incomplete or tokenistic implementation (Dearing & Cox 2018). Scarborough and Kyratsis, (2022) suggest a departure from top-down policy implementation towards a lean to a governance style approach which is collaborative and encompasses the applied clinical evidence and experience to be gained by frontline adopters of new strategies. Ideally, decision-makers should provide greater time, space, and resources for learning, networking, and redefining roles to support the successful implementation of subsequent MCA iterations.

7.2 Implications for Working with SUs in Clinical Practice

Working in partnership with SUs is an important keystone of all mental health interventions, this also applies to MCA interventions. Wilson’s (2017) exploration of how adults lacking capacity and their carers experienced capacity legislation suggested that there is a knowledge gap amongst SUs and carers around the MCA. More recently, Aspinwall-Roberts et al. (2022) underlined the importance of the informed application of the MCA in working with people who self-neglect, which can be a feature of some mental health presentations. An urgent need to consider how this could be enhanced was cited to prevent any SU who self-neglect from experiencing intrusive interventions resulting from professional misinterpretation of the MCA. Participants within this study expressed a desire to work closer with SUs and carers as part of the assessment process and welcomed guidance on how to conceptualise the MCA for these groups. Staff should be mindful of the limits of their knowledge and seek appropriate support when they are reaching the limits of their competence. This however is only possible if the organisation's senior leaders offer their support and value an environment with positively engages with the MCA.

Staff should be accountable for their decision-making and documentation whilst ensuring they are working in the best interests of their SU to empower them to be part of their care. The views of SUs about the MCA in terms of their experiences with the MCA and their thoughts about the MCA have been studied by several researchers. Manthorpe et al. (2011) highlighted the SU view that staff should be accountable for their decision-making when assessing people under the MCA, as currently, this is lacking. The discussion chapter raised a concern regarding the use of Section 5 of the MCA to permit authority for negative or detrimental acts to occur. This would present a significant interference with individual autonomy and HCPs should be mindful of the potential of this occurring in practice.

7.3 Implications for MCA Training and Application

One of the objectives of this research was to determine how staff operationalise formal and informal learning opportunities and the impact this has on their clinical practice. The findings of this study give an insight into staff's application of training and offer implications for learning opportunities going forward. The study raises valuable points about the method and mode taken towards post-qualification training for clinical staff and advances the research synthesised by Rogers and Bright (2021) and Jenkins (2020). Embedding the MCA should continue to be a priority for organisations whose staff conduct MCA assessments. Strategic boards should ensure that the assurances they are being given of training compliance continue to represent the frontline worker's experience and are not merely qualitative assurances of a person’s passive completion of an eLearning provision. This could be done by educators co-designing and developing training with clinical staff and SUs or carers who also support co-delivery.

The findings suggest that experiential learning jointly with a colleague or mentor, and post-classroom familiarisation is a productive route to mastery, which is supported by Rogers and Bright (2020). Within this mode, SDT posits that motivation to engage with the MCA is likely to increase. Staff need for relatedness is met through the joint support of a colleague, but also potentially their relationship with the SU and/ or carer; their need for autonomy is met through the direction of their own learning and their competence increases by virtue of experiencing the MCA in a naturalistic setting. Organisations should consider offering all CCOs the opportunity to train as an AMHP or BIA because this will enrich the workforce with skilled staff who are able to practice with competence and confidence, this in turn will improve outcome potentials for SU.

Organisations must ensure that the time allocated to learning the MCA is commensurate with its importance and is sufficient to enable staff to develop competence and confidence to skilfully apply it into practice. Interprofessional learning is encouraged to promote a shared language and knowledge base within staff teams. While professional stereotyping is particularly resistant to change (Carpenter & Dickinson, 2011), barriers to gaining collaborative competence to working together need minimising to facilitate rather than complicate working together with the shared aim of supporting the SU on their recovery journey.

7.4 Further Research

Future research could consider the mental health SU and carer experiences of being a part of the MCA process. This could build upon the current knowledge base which saw its foundations in work by Manthorpe and Rapport (2005) prior to the inception of the MCA which captured largely positive SU perceptions of the MCA. A more recent systematic review by Wilson (2017) exploring the experiences of adults lacking capacity and their carers found that although the capacity legislation was viewed positively, some experiences were perceived negatively. A large and growing body of literature has investigated SU experiences of being detained under the MHA with recommendations for changes in practice and policy (Blakeley et al. 2019; Grace et al. 2017; Chambers et al. 2014). Further research could be undertaken to investigate the experiences of SUs with mental health difficulties of the experience of the MCA.

In addition, this study focuses solely on the experiences of mental health staff using the MCA within a community setting. A natural progression to further the knowledge base would consider an exploration within an inpatient psychiatric setting, either acute or forensic. Typically, SUs within these settings are detained under the MHA which may affect the attitudes of staff towards employing the MCA within their clinical practice. The MHA does not authorise the treatment of physical health issues, therefore staff should regularly consider the MCA within an inpatient setting which offers holistic care for SUs. This area is also absent from published literature.

The outcomes of this study represent staff experiences within one NHS trust at a fixed point in time. It would be interesting to see this study as a baseline for future research within this trust to determine the effects of any interventions which are employed as a result of the dissemination of this study. This baseline study could be then used as a comparison to assess the impact of the interventions on staff experiences of the MCA.

7.5 Study strengths and limitations

The reach of this study is vast and is indicative of the value it represents. This study is the first that the author is aware of which explores mental health staff's experiences of the MCA. The findings broadly mirror studies conducted with staff from a range of clinical specialities, such as learning disabilities, brain injury and dementia; these being knowledge gaps, systemic difficulties and confidence issues. The findings also support findings conducted with other staff disciplines, for instance, clinical psychology (Walji et al. 2014). The findings here represent novel experiences from mental health professionals working in community care. This study contributes to knowledge of mental capacity legislation and the experience of how new legislation is embedded within a clinical culture where established legislation is also present.

Data analysis of the qualitative data should be considered when evaluating the strengths of a study. This study used TA to identify themes and patterns of meaning across the dataset. Braun and Clark (2006) offer researchers a 15-point checklist of criteria for good TA. This checklist has been adapted into a table to appraise this qualitative study. Appendix K demonstrates the assurance that may be taken from the choices and actions that were selected during the analysis phase.

Furthermore, the methods chosen for this study were chosen with robust, justifiable decision-making, for which the methodology chapter offers transparency around such decisions. The researcher is positioned as active in the process of data collection and has been sensitive to the data (Yardley, 2000) by acknowledging the emotional pressure of the CCO role for staff. As a result, the findings derived from the data collected offer a good example of qualitative research and deliver a detailed insight into the experiences of CCOs when using the MCA.

A key consideration of study limitations must be in relation to the participants who volunteered their time to contribute to the study. Whilst I am thankful for their time, their motivation for engagement must be reflected upon. Self-reporting behaviour which presents the reporter in a negative light can be underrepresented (Chan, 2010) and it is reasonable to assume that some participants may have over-reported positive acts or underreported or omitted acts which were detrimental to their practice or character. The participants may not have the introspective lens required to honestly answer questions related to their clinical practice. Their reflections may be shaped by social desirability bias resulting in a distorted imagining of their reality. The data collected from the interviews conducted in this research suggest that participants were largely frank about their reality due to the parallels which can be drawn with other studies regarding their struggles and difficulties with using the MCA.

This research was situated within one NHS trust located in the north of England, which limits the organisational diversity of the results. However, the participants invited to participate in the research represent eight different teams, each with its own microculture of working practices. The participants held many variants of professional experience and international practice work history, bringing a wealth of unique viewpoints and standards. Future studies in this area may consider a different approach.

7.6 Post-study Reflections

I have found the journey of conducting this research at its worst completely overwhelming. The journey was marred with multiple unanticipated changes in the supervisory team, three periods of intercalation, two consecutively broken arms and a house move. Personally, it has given me more challenge than I expected and caused me to reach the very bottom of my endurance reserves in order to continue moving forward with my goal.

Throughout this study, I was mindful not to transpose my own personal thoughts, feelings and interpretations on the CCOs during the interviewing phase or the analytical phase. As discussed in Chapter 1, I have experienced using the MCA as a CCO, however, this was a role I left in 2013. Separating my own experiences from the participants was helped by reflection both with my supervisory team and within notes that were made after interviews and during coding. The notes I made became helpful during the analytic phase as I was able to ensure my analysis was grounded in the experiences of the participants, rather than aligned with my own experiences from another trust, over a decade earlier.

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Appendix A : Flyer located on staff notice board

Are you a Care Coordinator?

Do you have experience of working with the Mental Capacity Act with Secondary Mental Health Patients in the Community?

What do I need?

I am looking for Care Coordinators working in Community Mental Health teams to take part in my research in which I am hoping to explore the experiences Care Coordinators of using the Mental Capacity Act. There is very little academic research in this area, and it is hoped the knowledge gained from the study will shape Care Coordinators roles going forward, both within the trust and nationwide.

What will I have to do?

The research will entail an audio-recorded interview lasting around 45minutes in which we will talk about your clinical experiences of working with the Mental Capacity Act, your reflections, experiences and thoughts. The interview will take place at a mutually convenient venue, either face-to-face or via Skype. Outside office hours are possible.

Will my Manager know if I take part?

Only if you tell them. The interviews will be transcribed, and any identifying information will be removed.

What do I get out of it?

Possibly refreshments and the gratification that you are contributing to the creation of knowledge. This research will form part of my PhD Thesis and will be submitted to Academic Journals for consideration of publication once completed.

OK, I'm interested…what shall I do?

Please get in touch, either by email or phone. I can either send you a Participant Information sheet which gives more details about the study, or we can discuss the research further.

Julie Leiper j.leiper@lancaster.ac.uk Tel 07975 XXXXXX

I am interested in your *clinical experiences*
This is **not** a knowledge or understanding test!

Appendix B : Email to the Team Leaders

Stage 1: Contact with Team Leaders

Subject: Care Co-ordinator Research

Attachment: Flyer

Dear Team Manager,

Thank you for taking the time to read this letter.

My name is Julie Leiper, and I am an employee of Bradford District Care NHS Foundation Trust currently on a career break to complete a PhD in Mental Health at Lancaster University. My research is concerned with the Mental Capacity Act and the experiences care coordinators have in using it in Clinical Practice. My research is supported by the Interim Medical Director, Dr David Sims as well as the Research and Development Team.

I was hoping you would be able to show this flyer at your next team meeting and also to display one in your staff areas. Should staff wish to get involved, they only need to email, messenger or call me for further details.

I am hoping to recruit 12 care coordinators, therefore staff should get in touch quickly if they wish to be a part of the study.

With thanks for your help

Julie Leiper

Stage 2:Email to prospective participants

Subject: Invitation to join a research project

Attachment: Participant Information Sheet

Dear Care Co-ordinator,

You may have seen a flyer during your team meeting or in your staff area recently concerning a research project exploring staff experiences of the Mental Capacity Act.

As I still have a few places to fill, I have sent you the Participant Information Sheet as an attachment for you to read through and consider if you would like to participate.

I am not concerned with your knowledge of the MCA, more I am hoping to understand the experiences of care co-ordinators using the MCA in practice – good and challenging.

Please consider if you can spare an hour of your time to be a part of this research. It can be done via Skype outside office hours if that would be more suitable.

With thanks,

Julie Leiper

Appendix C: Participant Information Sheet

Participant Information Sheet

Considering the Mental Capacity Act 2005 (MCA) from the perspective of Adult Community Mental Health Staff: Clinical experiences.

My name is Julie Leiper and I am conducting this research as a student in the PhD Mental Health programme at Lancaster University, Lancaster, United Kingdom.

What is the study about?
The purpose of this study is to understand the experiences of Care coordinators working in Secondary Mental Health Care using the Mental Capacity Act in clinical practice.

Why have I been approached?
You have been approached because the study requires information from people who work as Care Co-ordinators for Bradford District NHS Foundation Trust and have experience of working with the Mental Capacity Act with their clients.

Do I have to take part?
No. It's completely up to you to decide whether or not you take part. Your manager and Clinical Supervisor will not be routinely notified.

What will I be asked to do if I take part?
If you decide you would like to take part, you would be asked to take part in an interview, either face-to-face or via Skype at your convenience. Office hours, as well as evenings and weekends, are available by mutual agreement. The interview will be loosely structured and last approximately 45 minutes. It will be recorded on a digital voice recorder. In addition, and entirely optional, you will be invited back for a second interview to reflect on the previous discussion. This will last approximately 20 minutes. Finally, and again, entirely optional, you will be offered the chance to comment on and give an opinion on the data as it is analysed. This will be done via email.

Will my data be Identifiable?
The information you provide is confidential unless the researcher believes there is a risk of significant harm to either yourself or your patients. In this case, either the Mental Capacity Lead for BDCFT or a Senior Clinician will be contacted, and the issues raised will be discussed. You will be told if a decision of this kind has been made. The data collected for this study will be stored securely and only the researcher conducting this study will have access to this data:

- Audio recordings will be destroyed and/or deleted once the interview has been transcribed.
- The files on the computer will be encrypted (that is no-one other than the researcher will be able to access them) and the computer itself password protected.

- The transcribed version of your interview will be made anonymous by removing any identifying information including yours and others names as well as geographical locations and other identifiers which would make it easy for another person to identify you or your patients. Anonymised direct quotations from your interview may be used in the reports or publications from the study, so your name, nor any other identifiers will be attached to them.
- All your personal data will be confidential and will be kept separately from your interview responses.

What will happen to the results?

The results will be summarised and reported in my PhD Thesis and may, in time, be submitted for publication in an academic or professional journal.

Are there any risks?

There are no risks anticipated with participating in this study. However, if you experience any distress following participation you are encouraged to book a supervision session with your Clinical Supervisor. If the issues related to the use and implementation of the Mental Health Act, please contact the Clinical Lead for the Mental Capacity Act at The Highfield Unit, Lynfield Mount Hospital.

Are there any benefits to taking part?

Although you may find participating interesting, there are no direct benefits to taking part. Refreshments will be offered during the interview if the interview is undertaken face-to-face.

Who has reviewed the project?

This study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

Where can I obtain further information about the study if I need it?

If you have any questions about the study, please contact the main researcher:
Julie Leiper – jleiper@lancaster.ac.uk

Complaints

If you wish to make a complaint or raise concerns about any aspect of this study and do not want to speak to the researcher, you can contact:

Dr Fiona Lobban Tel: (01524) 593 752
Email: f.lobban@lancaster.ac.uk
Division of Health Research
Lancaster University
Lancaster
LA1 4YG

If you wish to speak to someone outside of the Blended Learning PhD Doctorate Programme, you may also contact:

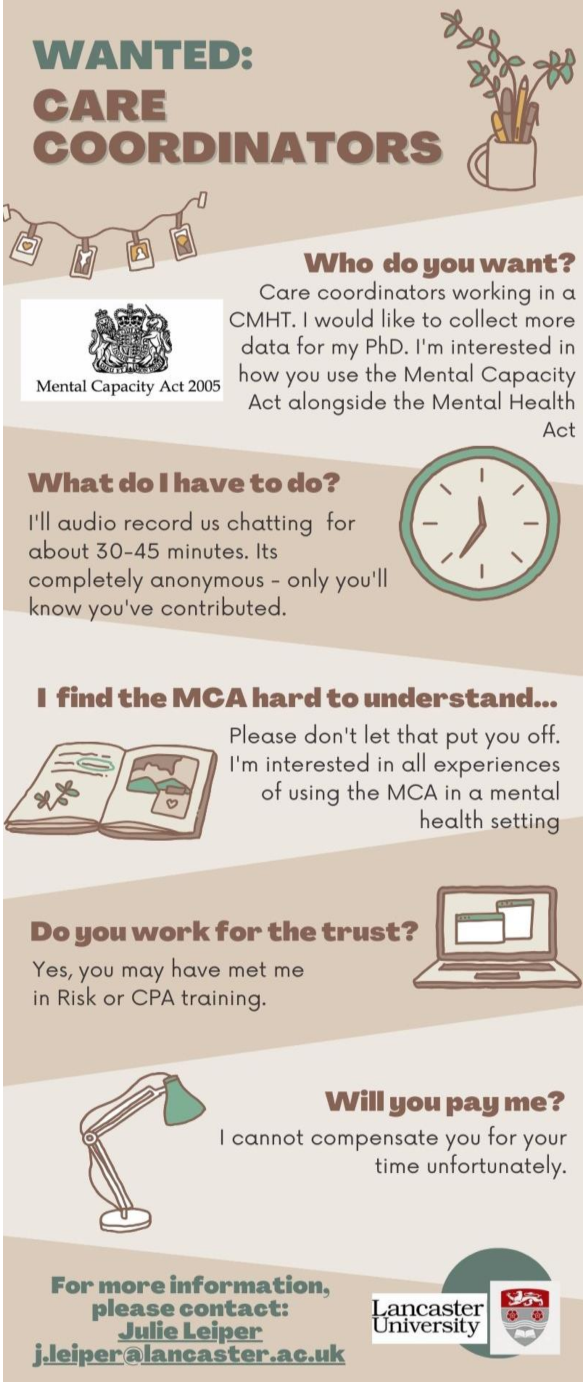
Professor Roger Pickup Tel: +44 (0)1524 593746
Associate Dean for Research Email: r.pickup@lancaster.ac.uk
Faculty of Health and Medicine
(Division of Biomedical and Life Sciences)
Lancaster University
Lancaster
LA1 4YG

Thank you for taking the time to read this information sheet.

Resources in the event of distress

Should you feel distressed either as a result of taking part, or in the future, the following resources may be of assistance
The Samaritans 116 123
Your Clinical Supervisor or Team Leader
The Mental Capacity Act Clinical Lead at BDCFT - XXXXXX@bdct.nhs.uk

Appendix D: Electronic Memo



WANTED:
CARE COORDINATORS

Who do you want?

Care coordinators working in a CMHT. I would like to collect more data for my PhD. I'm interested in how you use the Mental Capacity Act alongside the Mental Health Act

What do I have to do?

I'll audio record us chatting for about 30-45 minutes. Its completely anonymous - only you'll know you've contributed.

I find the MCA hard to understand...

Please don't let that put you off. I'm interested in all experiences of using the MCA in a mental health setting

Do you work for the trust?

Yes, you may have met me in Risk or CPA training.

Will you pay me?

I cannot compensate you for your time unfortunately.

For more information, please contact:
Julie Leiper
j.leiper@lancaster.ac.uk

Appendix E : Consent Form

Consent Form

Study Title: The Mental Capacity Act and Mental Health Staff: Clinical Experiences

We are asking if you would like to take part in a research project to understand the experiences of Mental Health staff when working with the Mental Capacity Act. Before you consent to participate in the study we ask that you read the participant information sheet and mark each box below with your initials if you agree. If you have any questions or queries before signing the consent form please speak to the principal investigator, Julie Leiper.

Please initial each box

1. I confirm that I have read the information sheet and fully understand what is expected of me within this study ☐
2. I confirm that I have had the opportunity to ask any questions and to have them answered. ☐
3. I understand that my interview will be audio-recorded and then made into an anonymised written transcript. ☐
4. I understand the main interview is mandatory. There is also a voluntary second interview I can choose to take part in as well as a voluntary opportunity to review and give feedback on the data prior to the analysis being finalised. ☐
5. I understand that audio recordings will be kept until the research project has been examined. ☐
6. I understand that my participation is voluntary and that I am free to withdraw until 2 weeks after the interview has taken place without giving any reason. If I do withdraw, before this date, my data will be destroyed. This date is ……………………. ☐
7. I understand that once my data have been anonymised and incorporated into themes it might not be possible for it to be withdrawn, though every attempt will be made to extract my data, up to the point of publication. ☐
8. I understand that the information from my interview will be pooled with other participants' responses, anonymised and may be published. ☐
9. I consent to information and quotations from my interview being used in reports, conferences and training events. ☐
10. I understand that the researcher will discuss data with their academic supervisor as needed. ☐
11. I understand that any information I give will remain confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the principal investigator will need to seek advice from a Senior Clinician not involved with the research project. ☐
12. I consent to Lancaster University keeping written transcriptions of the interview for 10 years after the study has finished. ☐
13. I consent to take part in the above study (Signature) ☐

Appendix F: Interview Guide

These questions are an indicative guide only as to the topics which will be covered

Background

Could you tell me your profession and a little about your clinical experience prior to your current role?
Can you describe your current Clinical area and client group and any special interests you have?

Awareness

Can you remember when you first encountered the MCA – describe
What training have you experienced on MCA – describe
Have you found any particular resource or experience valuable in terms of consolidating what you have learnt?

Thoughts

Overall impression of the Mental Capacity Act?
Have you had any particular cases in which the MCA played a significant role?
How have you found applying what you have learnt in training sessions to Clinical Practice?
Could you describe any difficulties you've had applying the MCA to your own cases?

Professional conflicts

How does the MCA sit with your Code of Practice / Conduct?
Have you ever experienced a conflict of legislation – between the MCA and MHA for instance?
How do you feel your patient's mental health presentation affects your assessment?

Empowerment

Do you think the MCA benefits the patients in any way – perhaps in terms of them being a part of important decisions?
What about future or advanced planning? Is this something you've used as a clinician?

Reflections

Thinking about some of the more complex cases you've had, on reflection, would you have done anything differently?
Do you think that would have changed the outcome for the patient?

Appendix G: Codes and preliminary themes from a Transcript

These are a sample of codes and preliminary themes taken from an interview with a relatively newly qualified nurse.

Codes:

Intimidated by role demands
Supporting patients
Little specialised training
Promoting recovery /wellness
Complex diagnoses affect understanding
All patients are different
Constant doubt
Fearful of outcomes
Guilt around own performance
Quandary over capacity origins
Positive risk taking
Professional neglect
Management pressure
Manager expectations
Peer judgment
Peer support
Medical model prevalence
Inexperience
Fear of being wrong
Superficial understanding
Doing the right thing
Consequences
Carer influence
Carer pressure
Lip service
Tokenism
Assessment process difficulties
Empowerment
Complexity
Legal changes

Themes:

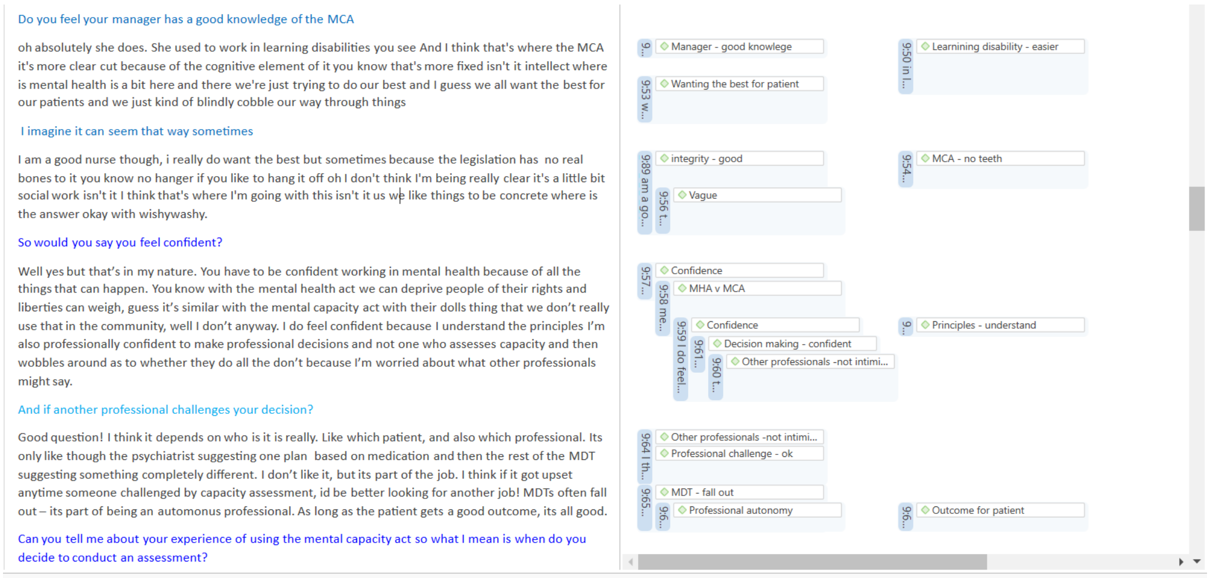
Getting it right for the patient

Pressures from outside

Personal anxieties

Complex Legislation

Appendix H: Screenshots of transcripts with preliminary coding



Do you feel your manager has a good knowledge of the MCA

oh absolutely she does. She used to work in learning disabilities you see And I think that's where the MCA it's more clear cut because of the cognitive element of it you know that's more fixed isn't it intellect where is mental health is a bit here and there we're just trying to do our best and I guess we all want the best for our patients and we just kind of blindly cobble our way through things

I imagine it can seem that way sometimes

I am a good nurse though, i really do want the best but sometimes because the legislation has no real bones to it you know no hanger if you like to hang it off oh I don't think I'm being really clear it's a little bit social work isn't it I think that's where I'm going with this isn't it us we like things to be concrete where is the answer okay with wishywashy.

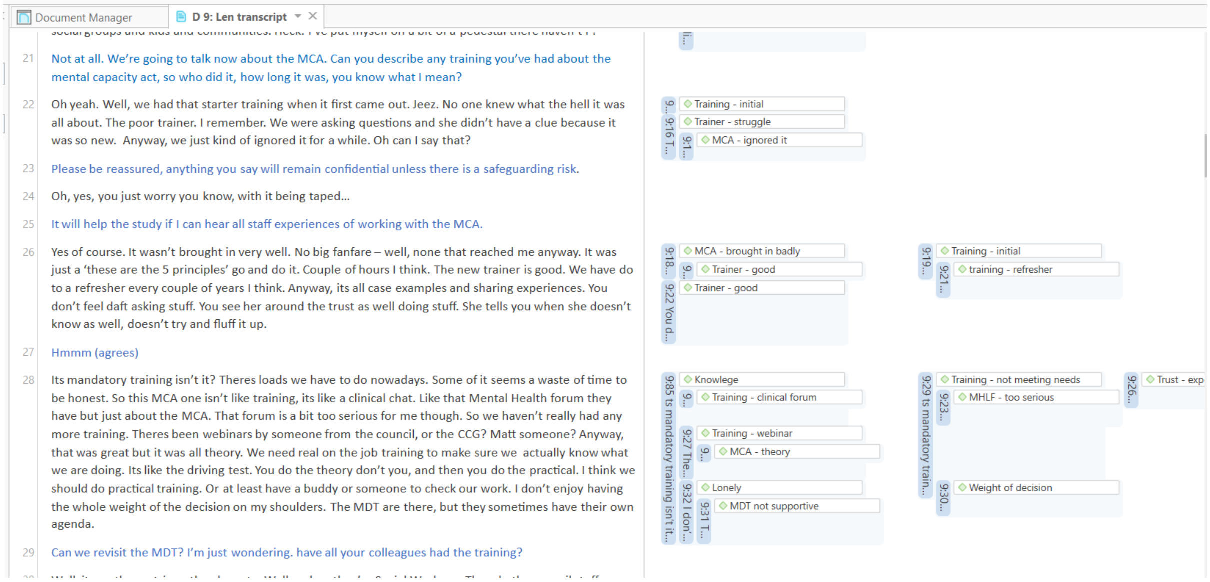
So would you say you feel confident?

Well yes but that's in my nature. You have to be confident working in mental health because of all the things that can happen. You know with the mental health act we can deprive people of their rights and liberties can weigh, guess it's similar with the mental capacity act with their dolls thing that we don't really use that in the community, well I don't anyway. I do feel confident because I understand the principles I'm also professionally confident to make professional decisions and not one who assesses capacity and then wobbles around as to whether they do all the don't because I'm worried about what other professionals might say.

And if another professional challenges your decision?

Good question! I think it depends on who is it is really. Like which patient, and also which professional. Its only like though the psychiatrist suggesting one plan based on medication and then the rest of the MDT suggesting something completely different. I don't like it, but its part of the job. I think if it got upset anytime someone challenged by capacity assessment, id be better looking for another job! MDTs often fall out – its part of being an automonus professional. As long as the patient gets a good outcome, its all good.

Can you tell me about your experience of using the mental capacity act so what I mean is when do you decide to conduct an assessment?



21 Not at all. We're going to talk now about the MCA. Can you describe any training you've had about the mental capacity act, so who did it, how long it was, you know what I mean?

22 Oh yeah. Well, we had that starter training when it first came out. Jeez. No one knew what the hell it was all about. The poor trainer. I remember. We were asking questions and she didn't have a clue because it was so new. Anyway, we just kind of ignored it for a while. Oh can I say that?

23 Please be reassured, anything you say will remain confidential unless there is a safeguarding risk.

24 Oh, yes, you just worry you know, with it being taped...

25 It will help the study if I can hear all staff experiences of working with the MCA.

26 Yes of course. It wasn't brought in very well. No big fanfare – well, none that reached me anyway. It was just a 'these are the 5 principles' go and do it. Couple of hours I think. The new trainer is good. We have do to a refresher every couple of years I think. Anyway, its all case examples and sharing experiences. You don't feel daft asking stuff. You see her around the trust as well doing stuff. She tells you when she doesn't know as well, doesn't try and fluff it up.

27 Hmmm (agrees)

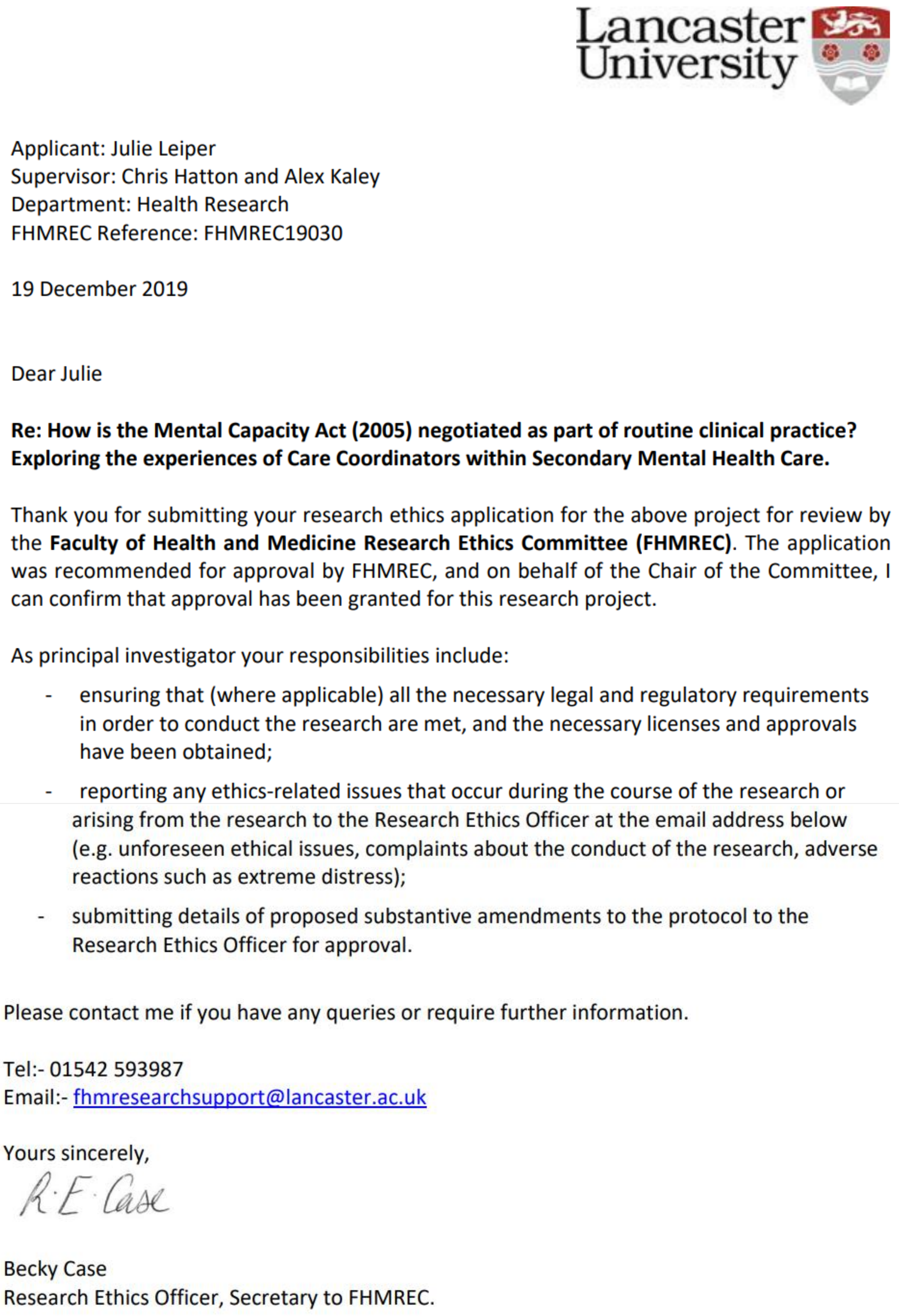
28 Its mandatory training isn't it? Theres loads we have to do nowadays. Some of it seems a waste of time to be honest. So this MCA one isn't like training, its like a clinical chat. Like that Mental Health forum they have but just about the MCA. That forum is a bit too serious for me though. So we haven't really had any more training. Theres been webinars by someone from the council, or the CCG? Matt someone? Anyway, that was great but it was all theory. We need real on the job training to make sure we actually know what we are doing. Its like the driving test. You do the theory don't you, and then you do the practical. I think we should do practical training. Or at least have a buddy or someone to check our work. I don't enjoy having the whole weight of the decision on my shoulders. The MDT are there, but they sometimes have their own agenda.

29 Can we revisit the MDT? I'm just wondering. have all your colleagues had the training?

Appendix I: Quality appraisal results – based on CASP checklist

Author	**Clear aims?**	**Appropriate methodology?**	**Appropriate Design?**	**Appropriate recruitment?**	**Data collection**	**Researcher position**	**Ethical position**	**Rigorous analysis?**	**Statement of findings?**	**Value of Research?**	**Score / 20**
Murrell and McCalla (2015)	Yes	Yes	Yes	Unsure	Yes	Yes	Yes	Yes	Yes	Yes	19
Samsi et al (2011)	Yes	Yes	Yes	Unsure	Yes	Unsure	No	Yes	Yes	Yes	16
Manthorpe et al (2014)	Yes	Yes	Yes	Yes	Unsure	No	Unsure	Yes	Yes	Yes	16
Marshall and Sprung (2016)	Unsure	Yes	Yes	Yes	Yes	Unsure	Unsure	Yes	Yes	Yes	17
Ratcliff and Chapman (2016)	Yes	Yes	Yes	Unsure	Yes	Unsure	Yes	Yes	Yes	Yes	18
Cliff and McGraw (2016)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	18
Walji et al (2014)	Yes	Yes	Yes	Unsure	Yes	Yes	Yes	Yes	Yes	Yes	19
Moore et al (2019)	Yes	Yes	Unsure	Yes	Unsure	Yes	No	Yes	Yes	Yes	17
McVey (2013)	Yes	Unsure	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	19

Appendix J : Copy of Ethics Approval letter



Lancaster University

Applicant: Julie Leiper
Supervisor: Chris Hatton and Alex Kaley
Department: Health Research
FHMREC Reference: FHMREC19030

19 December 2019

Dear Julie

Re: How is the Mental Capacity Act (2005) negotiated as part of routine clinical practice? Exploring the experiences of Care Coordinators within Secondary Mental Health Care.

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Tel:- 01542 593987
Email:- fhmresearchsupport@lancaster.ac.uk

Yours sincerely,

R.E. Case

Becky Case
Research Ethics Officer, Secretary to FHMREC.

Appendix K: Quality Criterion Checklist

Process	No.	Criteria	Study critique – Met / Unmet/ Partially met
Transcription	1	Data transcribed in detail	Met – See Appendix 1
Coding	2	Each data item is afforded individual attention	Met
	3	Coding is thorough, inclusive and comprehensive	Met
	4	All Relevant extracts for each theme have been collated	Met
	5	Themes have been checked against each other and back to the original data set	Met
	6	Themes are internally coherent consistent and distinctive	Met – themes were revised
Analysis	7	Data have been analysed rather than just paraphrased	Met – this was revisited many times
	8	Analysis and data match up	Met
	9	Analysis tells a convincing and well-organised story about the data and topic	Met
	10	A good balance between analytic narrative and illustrative examples is provided	Met – Chapter 5 demonstrates
Overall	11	Adequate time has been allocated to complete all phases of the analysis well	Met
Written Report	12	The assumptions about thematic analysis are explained	Met – Chapter 3 & Chapter 4
	13	There is a good fit between what you claim to do & what you demonstrate you do	Met
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis	Met
	15	The researcher is positioned as active in the research process; themes do not just ‘emerge’	Met